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BUILDING INDECISIVENESS:
PEOPLE'S HEALTH PERCEPTIONAL AND BEHAVIORAL TRENDS IN PORTUGAL AND TURKEY

Doctoral thesis in Sociology, supervised by Professor Carlos Fortuna and submitted to Faculdade de Economia da Universidade de Coimbra

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Coimbra, May, 2021

To my beloved wife

Abstract

At present time, diverse health-relevant information and product choices soar. The variety is a reflection of choices relevant to doctor, products, behavior, therapy and pharmaceuticals. Following the transformation of the variety of choices to a choice overload, many health-literate consumers face a plethora of choices—including conflicting choices. Apparently, most consumers manage health decision-making and behavior management processes without efficient decision-making support systems. The findings obtained through data collected in the fieldwork of this study and empirical research support this argument.

According to the findings obtained from data collected in the fieldwork, health-relevant information and choice overload complicate decision-making and leads to indecisiveness. Indecisiveness leads health-literate consumers to consult health professionals, the internet and family members. The other findings indicate that conflicting health information and the information pollution in media and internet are recognized by consumers. Many different sectors, actors and organizations, as this study shows, produce conflicting health information and advice. Such conflicting advice and information were also found to lead to inefficient health decision making at the individual and organizational level. In addition, empirical findings provided further data from internet and media sources on the emergence of health-relevant indecisiveness occasioned by information and choice overload.

This study was conducted from a micro-sociological perspective in dialogue with theories and perspectives from psychology, management and communication sciences. Assumptions and perspectives from these disciplines and sociology were borrowed and lent reciprocatively. The aim was to procure acceptance of sociological frameworks and data in the analysis of the issues discussed throughout this study with sufficiently convincing arguments and data. Otherwise, as this study reveals, the analysis of the health-relevant decision-making processes are decontextualized and deficient.

Keywords: Information Overload, Choice Overload, Indecisiveness, Decision-making, Healthy life advice

Resumo

Atualmente, a diversidade de informação relevantes para a saúde e as opções de produtos aumenta. Tal variedade é um reflexo das várias escolhas relevantes para o médico, os produtos, os comportamentos, as terapias, os medicamentos, etc. Na sequência da transformação sofrida pela variedade e mesmo a sobrecarga de opções disponíveis, muitos consumidores literados em saúde encontram-se sozinhos frente a uma grande variedade de decisões a tomar, incluindo opções contraditórias. Aparentemente, a maioria dos consumidores gere os processos de tomada de decisão relativos à saúde e aos seus comportamentos sem qualquer sistema de apoio eficiente a essa decisão. Os resultados alcançados através dos dados recolhidos no trabalho de campo deste estudo e na pesquisa empírica corroboram esse argumento.

De acordo com os resultados obtidos no trabalho de campo, a informação relevante sobre a saúde e a abundância de escolhas possíveis complicam a tomada de decisão e provocam indecisão. No processo de indecisão, os consumidores literados em saúde consultam mais os profissionais de saúde, a internet e os membros da família. Outros resultados indicam que as informações contraditórias sobre saúde e o demasiado ruído na informação produzida pelos meios de informação e a Internet são também tidas em conta pelos consumidores. Muitos setores sociais, atores e organizações diferentes produzem variadas informações e conselhos contraditórios sobre saúde. Esses conselhos e informações díspares integram também os processos de tomada de decisão em saúde e conduzem a escolhas ineficientes tanto ao nível individual como organizacional. Além disso, os resultados empíricos alcançados oferecem também dados sobre fontes da Internet e mediáticos relevantes para o surgimento da indecisão em saúde, que ficara à mercê da enorme variedade de informações e de escolhas possíveis.

Este estudo foi conduzido numa perspectiva micro-sociológica e entra em diálogo com teorias e perspetivas oriundas das áreas da Psicologia, Gestão e Comunicação. Vários princípios e perspetivas dessas disciplinas surgem em diálogo recíproco com a sociologia. O objetivo final dessa estratégia teórica foi o de reforçar a análise sociológica e procurar consolidar os dados alcançados e as questões discutidas no estudo com argumentos e dados

suficientemente robustos. Caso contrário, como o estudo demonstra, a análise dos processos decisórios relevantes para a saúde pode ser descontextualizada e deficitária.

Palavras-chave: Abundância informativa; sobrecarga de escolhas; indecisão; tomada de decisão; conselhos de vida saudável.

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List of Abbreviations

SES: Socio-economic status

IO: Information overload

CO: Choice overload

WHO: World Health Organisation

CATI: Computer Assisted Telephone Interview

PDB: Perception-Decision-Behavior

PAS: Product-Advice-Service

SGK: Sosyal Güvenlik Kurumu (Social Security Organization)

SNS: Direção-Geral da Saúde

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Introduction

The introductory chapter outlines the overall view of the thesis calling attention towards the Portuguese and Turkish cases with references to research questions, facts, theoretical framework and methodological procedures. This chapter also provides details regarding the nature of the research question and sub-questions and how the research was conducted methodologically.

A great magnitude of consumer demands has been created by an ever-increasing population, the engagement and integration of consumer culture into the social and individual life, easy access to all kinds of information and the replication of generic products and information. The demand has been met with a booming production in their respective fields. However, the volume of production exceeding the demand has also raised such topics as information overload[1] and choice overload[2]. In fact, an overload in the supply, demand and consumption of many kinds of information and products has always followed the developments in the relevant industries throughout history. For instance, after the invention of the printing press, progress was made in scientific fields and technology, resulting in changes in the perception about access to information and consuming it as well as triggering many changes in individual and social life. Later on, the developments in the culture industry (cinema and television) coupled with the commodification of cultural values produced a consumer audience and the consumption of products of the culture industry.

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[1] Some of the widely-accepted definitions of information overload concept are as follows: Too much information, abundance of information. The general acknowledgment about the definition is that the volume of information disseminated and perceived is above the normal level that the individuals are accustomed to in their daily lives. It can be best exemplified by the number of the advertisements, implicitly or explicitly, the number of advertisements produced in the form of an overload boosted for at least 50 years. Andersen and Palma (2012) revealed that American people were exposed to 560 advertising messages per day in 1971 and 3000 in 1997(Andersen & Palma, 2012). Today, this number is estimated to be between 4000 and 10000 advertising messages per day (Forbes, 2017). These figures may well give an idea about the information overload, either in the form of quality information or misinformation.

[2] Choice overload:Overchoice, too many choices, a feeling of being overwhelmed by the number of alternatives to choose among. Especially, the neoliberal philosophy and moral values promote having more and more alternatives with references to the freedom of choice and do not take the decision difficulty emerging in this process into account. In this manner, like information overload, choice overload concept brings a critical perspective into the analysis of relevant issues as in this study. The father of this concept defined it as the following:"[Overchoice takes place when] the advantages of diversity and individualization are canceled by the complexity of buyer's decision-making process."(Alvin Toffler, Future Shock, 1971)

With the proliferation of internet technology around the world, the higher classes possessed the production potential in relation to this kind of information and cultural artifacts as they also possessed the majority of the means of production through which they acquired the material and non-material power. Especially since the beginning of 1990s, the globalization of the consumer society, the rapid growth in internet technologies and readily accessible information led to the distribution of scientific information and industrial products in the social sphere faster than ever. Chinese production techniques and mentality, namely the replication of information and products with less or no expenditure at all, became manifest in relevant consumption models. This resulted in quite different and unanticipated consequences as well as the incorporation of many social actors into these processes. As a result, an excessive amount of new or replicated, high- or low-quality products, services and methodologies was produced and proliferated in the marketing and commodification of these. In all mass communication devices, health-relevant product advice and services (PAS) were socialized, commodified— relevant issues were conceptualized as culturally specific problems. Especially in Western cultures such as USA, many Eastern health (medicine), exercises, belief systems and techniques were integrated into daily life, and marketed as pilular lifestyles constructed with single-dose/session elements and conceptualized as new-age healthy lifestyles and wellness culture. In time, these lifestyles and philosophies have turned out to be the promoters of a reconceptualization of health and the body. Following the developments in the internet, social media technologies and the proliferation of information sharing culture, the relevant PAS have had widespread coverage and distribution in media and social interaction without constraints.

At present, health-literate consumers are exposed to many kinds of ineffective, low-quality and inaccurate information, philosophies and methodologies produced by unlicensed lay people defining themselves as lifestyle coaches or health experts. Correlatively, consumers have started to experience the negative consequences of information pollution generated by lay people. Moreover, as Coronel stated, information pollution has been reproduced and disseminated in social interaction, too: "People can self-generate their own misinformation. It doesn't all come from external sources. They may not be doing it purposely, but their own biases can lead them astray. And the problem becomes larger when they share their self-generated misinformation with others" (Coronel, 2019). We can say that consumers have internalized neoliberal consumption culture and moral values and that socialization transmits both information and values (functional or dysfunctional).

An overproduction and distribution of health-relevant messages emerged as a result of the involvement of lay people in organizing health communication and behavior management in addition to the top-down media and internet streams of information. When we consider the aspects relevant and specific to this study, that is health information (advice), we see that the production of health-relevant information had already increased in the context of modernist state goals even in 1930's and 1940's during the periods of both Salazar and Atatürk. Healthy life choices and advertisements were disseminated in mass media faster than in previous decades. However, these were still limited to such commodities as toothbrushes, painkillers, nutritional supplements or advice on sports and exercise[3]. In due course, this gradually changed along with advancements in marketing, food and information production technologies during the Post-War years. Subsequent to the Post-War years, an overload in the supply of health-relevant products and information emerged in the process of globalization. In conjunction with this, an increasing number of people in Portugal and Turkey have constantly been exposed to such advice due to developing health communication technologies. In accordance with neoliberalist consumption norms, health-relevant products, advice and services spread throughout society as marketable commodities to be consumed without restriction by the policy-makers, interest groups and organizations.

Today, health information and advice have become an important indication of the individualized notion of health. According to the primary and secondary data collected and provided in further chapters, a majority of patientsin Portugal and Turkey demonstrate a habit of searching health information via the internet as a consequence of an individualized health culture. 88 percent of Portuguese patients(Comissão de Tecnologias de Informação em Saúde do Parlamento da Saúde, 2017) and 77,7 percent of Turkish patients use the internet to search for health information (Gorkemli, 2017: 129). People in Portugal were reported to use the internet to search for information about health because they want to know more about diseases (46.9 percent), to search for ways to improve health (29.6 percent), to get information without going to the doctor (26 percent), to compensate for the insufficient information that doctors give (21 percent) and to overcome the difficulty in understanding the prescription (19 percent), (Ferreira and Silva, 2017: 66)**.** This study reveals the internet as the 3rd most important information source in serious health cases. The most important

[3] In Chapter 2, empirical findings and historical narration about these issues will be presented.

sources of information and support are health professionals/doctors (87,5 percent), family/household (60 percent), internet (57,5 percent) and inner circle (friends, relatives, neighbours etc.), (57,5 percent). According to the study conducted by Ferreira and Silva, health professionals/doctors (80 percent) stand out as the most consulted group and information source, the family and inner circle (31.6 percent) ranks the second most important source (Ferreira and Silva, 2017: 31). Both this study and Ferreira and Silva's study confirm that internet technologies accelerated the information dissemination and conventional sources of health information/messages are still important both in serious and daily health-relevant decision-making cases.

A considerable majority of people (70 percent) exposed to health-relevant messages are inclined to start applying this information to their lifestyles to protect their health in line with their expectations from information and products marketed (Schwartz, 2006: 55). Besides the findings of Schwartz, Pew Internet and American Life Project also found that health information changed ways of thinking (PIALP, 2009). Considering these data, it is safe to say that health-relevant information has an impact on the perception-decision and behavioral (PDB) habits[4]. This explains why a majority of health-literate consumers demand relevant PAS. However, at present, we are living in a world in which the demand has already been exceeded by the production or supply volume. The amount of overproduced advice and products have reached such an extent that scientific terms were coined for these phenomena: information overload (IO) and choice overload (CO), (Schmitt, Debbelt and Schneider, 2017: 1152). Such an overload of choices and information, as any commodified concept or field, has been identified in healthy life issues, as well. There are strong hints that this health-related information overload may be associated with decision difficulties by many health-literate consumers as well as body politicians. For instance, in Turkey, the state has started to organize health decision-making support systems to eliminate information pollution from

[4] Previous studies conducted revealed that these messages influence the majority of the respondents (57,9 per cent) to change their decision and behavior patterns (Baldil, 2019). In another survey conducted with Istanbul sample in 2018 December, 51,6 per cent of the respondents was found to have a perception that these influence their health-relevant PDB. These studies were not a part of the thesis study, but were conducted to collect information about relevant issues within the context of my own research action plan. One in 2015 (N=100) and another in the end of 2018 (N=111). A relevant series of semi-structured in-depth interviews for Portugal and Turkey were also conducted in 2016 and 2017. Through such studies, I had the opportunity to elaborate on the final questionairre and conceptualizations and to get some ideas about relevant issues. The results of 2015 study were published in a journal with the title "Regulating the Self, Health and Body Through Hope and Morality Discourses" (2019).

health-behavior management. Below, a quotation from Erdogan, President of Turkey, may give an idea about how these processes are reflected in even the daily health decision-making of individuals and about the fact that it is an important social and political problem to be taken up in detail:

> "Someone says “eat bread”, whereas others say “do not eat bread”. Some suggest consuming fat/oil whereas others suggest something else. Someone says “eat honey”, some others say that it is unhealthy. In many areas, different and confusing explanations are offered to the citizens. Health and Food Policies Council should find a solution for this problem. (“Son Dakika: Canan”, 2018)

The association between health-relevant information overload and decision difficulty was also supported by data obtained through the preliminary and final surveys of this study. The relevant data is presented in Chapter 3 of this study.

a. Research Question and Goals

The research question should indicate which data types are necessary to answer the research problem as to how, from whom and where to collect data. It should be investigable and be splittable to sub-problems (Dinler, 2006: 99). Besides this, it should also define, reveal and analyze the relationships between variables. In this context, the main objective of this study was identified as “examining to what extent the health-relevant choice overload and information overload create indecisiveness in health-literate consumers”. To be able to produce original data in relation to research goals and to carry out an inquiry in an understudied context rendered the research question more specific. The research question which identified the focus, limitations and directions of this study and underlined the relationships between variables is as follows: “What impacts do health-related choice and information overload have on health-related decision-making/indecisiveness in the health literate consumers in Istanbul and Lisbon?”. This research question points out what this study targeted finding solutions and explanations by outlining the key concepts and limitations. The scope of this research question was identified after a systematic review of historical narrations, policies, statistics and cases of Turkey and Portugal in terms of health-relevant decision making. Even though some global references and findings can be obtained through the data collection and empirical observations, it will only be practical for Turkey and Portugal, not meaningful or applicable for other cultures or countries.

In addition to the research question mentioned above, there are also other research questions (sub-questions defined as research goals) interrogating the relationships between

concepts and phenomena which are deemed important for the research. Such phenomena as negative experiences, relevant regulations to find solutions, the social behavior management and decision-making processes were the points of origin for this research and it was organized to answer relevant sub-questions such as but not limited to these: investigating the reception/perception of the health-relevant information overload/choice overload and indecisiveness about the ideal health behaviors; how the IO influences health-relevant decision making and behaviors through mass communication, internet and social interaction and whether the commodification of the health leads to increased consumption seeking for further information. In the problem statement topic, the theorical, methodological and epistemological explanations and points of origin concerning these research questions will be provided with references to an actual case exemplifying the research subject.

b. Problem Statement

A systematical observation of the similar trends in the results of the online surveys that I conducted (in my previous studies) since 2015 forced me to focus on the association between IO-CO and indecisiveness[5]. These results from the previous study revealed that people in Turkey and Portugal could be experiencing severe indecisiveness about the ideal health behaviors due to information overload. However, there has been no hint or finding in any of the preliminary or final survey indicating that this indecisiveness is permanent. Even if it is a temporary decision-making difficulty, a majority of health-literate consumers was found to experience this process. Therefore, investigating the possibility that the health literates exposed to CO and IO may experience indecisiveness and act in particular manners, developing empirical inquiries to examine these arguments became more important in terms of answering research questions. In the related literature, many supporting data and observations by various scholars indicate an association between IO-

[5] The fundamental definitions of indecisiveness can be summarized as follows: the experience of decision problems (i.e., lack of information, valuation difficulty, and outcome uncertainty) resulting in overt choice-related behaviours such as delay, tunnel vision, and post-decision dysfunctional behaviour (e.g., worry), (Rassin, 2007:1-11). This general tendency to experience decision difficulties is referred to as indecisiveness (Germeijs and de Boeck, 2002). The rationale acknowledged in this study, health literate consumers may have different level of indecisiveness in accordance with their own backgrounds, with their levels of educational level, health-literacy, socio-economic status. The indecisiveness conceptualization will be discussed in different parts of this text with different explanations in relation to the topics.

CO and indecisiveness (Mitchell and Papavassiliou, 1997; Ozkan and Tolon, 2015; Schwartz, 2006). However, unlike them, this study also takes into account the possibility that this relationship can be questioned with reference to such different variables as conflicting[6] factors and conflicting healthy life choices. Thus, upon checking the response trends of preliminary online surveys, it was determined that the overload of conflicting healthy life advice emerged as a crucial area of inquiry.

The heterogeneity of the indecisiveness was taken into consideration. It was assumed that indecisiveness is not experienced by everyone in the same level, even if they are exposed to the same overload and decision-making situations. Thus, this emerged as another issue to be analyzed. The research design and arguments were reconstructed accordingly. It is possible that CO may also produce such positive outcomes as satisfaction with alternatives as well as such negative outcomes as decision difficulty. Thus, the dissection of heterogeneous distributions, namely identifying the range of indecisiveness levels, also turned out to be an important point of inquiry. In this context, the behavioral patterns of these heterogeneous groups were interrogated through various items in the survey. The indecisiveness levels were conceptualized and categorized as low/medium/high level indecisiveness. The different levels of indecisiveness were operationalized in the explanations of some further behaviors following the indecisiveness process. These divisions, differences and their practical implications in terms of health behavior were handled and discussed in the Chapter 3 with survey results, theoretical arguments and empirical data.

This study attempts to make a contribution the body of studies investigating the reasons for and outcomes of indecisiveness with a focus on the healthy life-related issues. In

[6] It might be useful here to outright acknowledge that as a researcher, I am interested in the 'subjective' perceptions of the respondents rather than the objective nature of the picture they see themselves faced with. The conflicting advice, which can also be classified as 'contradictory' can both be perceived as "conflicting or contradictory" due to lack of knowledge or a high level of knowledge about health issues. In this regard, the respondents may confuse their subjective assessments with the 'objective' ones. They may be uninitiated, and when facing something complex, they can be easily confused and see conflict and contradiction in places where an expert would not, and vice versa. Making sense of data and information is not an intrinsic human propensity. It is learned. The expert could easily place these seeming contradictions along a continuum where they make sense in front of a shifting backdrop. However, taking the cumulative influence of both conflicting or nonconflicting information into consideration would probably enrich the analysis of the issues. Distinctions of this sort can be important for the microsociological studies like this study. For further reading on the differences between the perceptions of risk by lay people and experts (see Gabe's Health, Medicine and Risk: The Need For A Sociological Approach, 2013: 18).

addition, it also attempts to establish a dialogue between micro-sociology and decision-making studies with reference to both fields. In line with this purpose, the influences of the health-relevant IO and CO on the health-relevant perception/decision/behavior (PDB[7]) were investigated by engaging arguments from both fields. The basic argument of this study is that the health-relevant IO-CO lead to indecisiveness. The arguments are organized in a process cycle: 1) Perception (Reception), 2) Decision and 3) Behavior (Action). Such a cycle of argumentation was necessary to convey a logical and systematical roadmap based on sociological and psychological theories. According to the process cycle proposed in this study, the sources of the healthy life choices and information are various healthy life sectors, institutions and media. In this study, it is presumed that the messages produced and disseminated by these in a top-down fashion and through social interaction horizontally have an impact on the decision-making and behaviors following the perception of these messages. This theoretical argumentation is demonstrated in the structure of the chapters with relevant discussions, empirical findings and the data collected from respondents.

One of the most important reasons to focus on the health-relevant indecisiveness instead of other life decisions is because this kind of indecisiveness is experienced intensely at the emotional level just as decision-making on a career path or education. Besides health-relevant indecisiveness, these two issues (IO and CO) are the mostly investigated issues in the indecisiveness literature and many scales have been developed for these issues, but not for health-relevant indecisiveness. We can conclude from the context of these issues that what is perceived as vital in life creates indecisiveness in serious decision-making situations, resulting in increased pressure. If health-relevant issues are not solved, a threat against the bodily existence of the individual creates pressure. Thus, decision-making about health is different from decision-making relevant to buying cars, houses, career or education. In this regard, the perception of better health status becomes more important for the individual and social existence as well as for the future of the nations. In today's world, the consumer

[7] Dickinson and Pizlo (2013) call this cycle as PDA framework or loop but it was used as PDB in this study. There are many versions similar to this framework, some of which are formulated as "perception-action", some others "observe–orient–decide–act". However, the most appropriate framework to make an inquiry for this study is perception-decision and behavior, because, the action term connotates immediateness and direct involvement whereas behavior conception does not connotate these themes. Another reason is the fact that this framework will help the researcher in this project to establish the arguments by an application of a very-known cognitive process, but the researcher does not prefer to stick to a theory, only utilizing it for the goals of this study.

culture, a variety of choices and the organization of moral manipulation in health-relevant issues conjointly create pressure to make vital decisions for individual and social sustainability. As health status is considered as the first step to provide the sustainability in individual and social life, relevant decision-making and behaviors are also taken seriously by consumers and decision difficulties are experienced in existence of CO/IO. This is why the health-relevant decision-making and indecisiveness were picked as the issues to be investigated.

Through the Coronavirus pandemic starting in the end of 2020, it was clearly understood that the individual, social and organizational health-relevant decision-making and behaviors are as much important as in the history in terms of sustainability and that their impact on the social and economic life was considerably high. Moreover, so to speak, as Elias claimed in his arguments about the figurational sociology approach, it turned out that the social structure and individuals are interdependent, even more so in urgent and serious public health cases. Although this proposition is applicable only for the state of health-relevant emergency, the more intense regulation and flow of messages emerging in this period produced a process which supported his thesis.

The global panic emerging out of the Coronavirus pandemic has created a feeling of indecisiveness about "what to do" and "how to do" in order to prevent the self and society from the harmful effects of this health problem. This panic was experienced at individual, social and organizational levels—even state and international health organizations such as WHO took drastic environmental, social, medical, economic and political decisions, which would probably complicate many issues in social and economic life. Even lay people could also easily observe various facts; health communication was carried out through an overload of information about the pandemic, infliction, prevention, treatments, social distancing, use of masks and gloves, very different strategies, practices, treatments, medications, methodologies throughout the world. Every day, many discussions about these were made in the mass media and socio-ecological measures were implemented without even consulting the public, thus harming democracy. In this process, the implicit biopower positions of the political powers were transformed into explicit positions and to relevant decision-making. The US president, Donald Trump, Chinese president, Xi Jinping and British prime minister, Boris Johnson, took initiatives that posited them as explicit biopower actors. For instance, Donald Trump claimed that the use of protective masks are not necessarily protective but

American people could use them if they wanted to do so. Chinese president, Xi Jinping, applied the quarantine in an early stage. Boris Jonhson claimed that the herd immunity would be the best solution and decision for his country but then the strategy was changed. In contrast, Sweden did not even adopt a quarantine or lockdown practice and continued the normal daily life.

As for Portugal, António Costa announced a state of emergency in earlier stages of the pandemic and millions of people were kept in soft quarantine with advice (#Ficoemcasa) in mass media channels, billboards, social media, and highway signboards. As a global trend, here, the rise to the biopower in Portuguese territory was also observed by the public. In Turkey, similar trends were observed, but lockdown for specific age groups (below 20 and above 65 years old) was practiced only during certain times. In Turkey, especially in social media, the misinformation and information pollution through the word-of-mouth health communication could not be prevented[8].

The fear tactic was applied through the use of statistical indicators such as the so-called number of cases, number of deaths, death increase rate, contagiousness rate and "number of the tests made" etc.. These indicators were used to convince people to adapt to the norms of the lockdown, quarantine and social distancing. In the application of this strategy, the information pollution as well as information overload was produced by even the official organizations which later disproved their former claims. For instance, many claims about the effective protection of masks and gloves were put forth in the media, social media and billboards in outer spaces and in word-of-mouth communication. All of these claims were disseminated in a period when very few things about what to do in macro, meso and micro levels were known. Many health professionals treated many patients and minimized the panic in society. However, some mediatic doctors also contributed to information pollution when there was too little scientific evidence for their claims[9]. There were hundreds of millions of health-literate consumers who witnessed the fact that the explicit bio-power (states and health organizations) could not establish any visible control

[8] There were such absurd trends as using hairdryers to kill the virus as the information that coronavirus spread could spread in high temperatures was disseminated and some people with lower education levels.

[9] In Turkey, for instance, Oytun Erbas, a recognized doctor claimed in the earlier stages of the pandemic that Turkish race has a lucky gene which prevents the people in this territory from being inflicted as much as Chinese and European cases. Later on, the number of the people inflicted with Coronavirus in Turkey ranked among the highest 10 in the world and this disproved this claim.

for a long period and this created anomie, chaos and unprecedented consequences[10]. The Coronavirus provides many examples that may be explained or discussed within the context of the research questions of this study. However, as the focus is not the examples from the pandemic, it will not be treated in the current study.

Due to both a scarcity and an overload of solutions for the Coronavirus pandemic, a global panic emerged about how to fight the pandemic on the individual and organizational level. This panic was accompanied by the feeling of not knowing what to do, an indecisiveness about the most appropriate actions and the accuracy of the information disseminated. Health communication and health systems of many countries produced both information and choice overloads in an effort to protect nations from the pandemic, to treat the disease and to manage it at social level. Many different and efficient healthcare strategies, therapies, pills, methodologies and advice were offered to maintain health status.[11] However, some influence of word-of-mouth health communication in the form of misinformation was also widely observed in many instances.

c. Importance and Relevance of the Study

Both the global and local health communication carried out during the Coronavirus pandemic supported the arguments and the results of this study. Many cases and details about health issues and the presentation of advice increased the importance of relevant research questions offered by this study, especially those that make reference to the social aspects of health communication and management. Besides this, the appropriateness, many health professionals reevaluated accuracy and effectiveness of the communication strategies as well

[10] In Turkey, 21.000 people who visited Saudi Arabia for religious reasons were admitted into the country with no serious measures in early March. In a short while, the whole early cases in Turkey were found out to be caused by this lack of control.

[11] Telehealth has become one of the most useful apparatus for remotely monitoring of patients in the pandemic as it was held dangerous to have a face-to-face encounter in hospitals. According to Seabrook (2020) "As the country (USA) went into lockdown, its health care went virtual". Thousands of people resorted to the telehealth service offers to recover. "Telehealth comprises virtual interactions between individual doctors and patients, in which the participants rely on an audiovisual hookup instead of an in-person visit. You have a bad sore throat but don't want to wait to see a doctor. You could go to the E.R. or to a brick-and-mortar urgent-care center. Or you could download the telehealth app you saw advertised on MSNBC. You are connected to a physician, who, using your phone to look down your throat and relying on your description of the swollen glands in your neck, can prescribe antibiotics and other noncontrolled substances. You've saved yourself a trip to the clinic, and you haven't made other people sick or caught something else yourself" (Seabrook, 2020).

as treatments, products and services. Many organizations implemented contradictory practices even before the pandemic.

This thesis contributes to what we know about the emergence of health-relevant information and choice overload and relevant decision-making difficulties. The complexity of health-relevant issues goes far beyond the explanations and attributions made towards individual choice and how health systems, economies, alternative lifestyles influence and shape the notion of "choice.". This study reveals and addresses the extent or magnitude of this trend and its implications. In revealing these trends, the arguments were based on the interplay between social and individual factors as well as macro, meso and micro ones. In this context, a holistic approach and framework was developed to examine this micro, meso and macro level health-relevant decision-making with references to the actions and strategies of the actors at all these levels. As part of this approach, clarifications were made about whether the health-relevant decisions are made with references to individual factors or social factors, to family, socio-economic status, social and cultural capital, media and internet usage.

This study emphasizes the problems encountered in the micro-level health-relevant decision-making processes and provides examples for these with supporting results to get an insight to the increasing complexity in health-relevant processes. However, it should also be stated that the pandemic uncovered a hidden fact: the indecisiveness seen in the macro levels. There were already minor references made before the pandemic, but the contradictions at the macro level are not the subject of this research, and, hence they are omitted from analysis.

The discussions and results of this study are useful for various actors, organizations and different sectors. Informing the producers of health-information, strategy, product and services (such as health professionals, authors, editors, policy-makers) about how their productions, macro-level decision-making, cultural and social factors as well as individual ones influence decision-making. The collaboration of well-established organizations and actors playing essential roles in the production of health-relevant choice and information overload is essential in developing all-encompassing health regulations. Such regulations are more in tune with the consumer decision-making, the social and cultural backgrounds of the consumers and could forgo imposing individual imperatives and instead find a balance between real life practices and neoliberal norms. The collected data and information have been presented to provide an insight into how policy changes and practices can be organized with respect to consumer perception.

One of the most important advantages of this study is that it reveals how health-literate consumers perceive the cumulative accounts and implications of the overload produced by relevant organized industries, technologies and actors. These actors can be reminded of the ethical responsibilities they should bear in mind as they are also under the accumulative effects of their own production efforts or overload in any kind of production. This study provides health and media organizations, which carry out health communication activities, with practical suggestions that call for more self-critique in ethical and health communicational proficiency and developing greater control mechanisms. As seen in the Coronavirus pandemic, social media has disseminated a great deal of misinformation. Thus, the artificial intelligence algorithms of these platforms were improved in order to be watchful of such urgent cases. The decision-makers and academicians carrying out studies and operations in these fields can benefit from the arguments and data presented in this study.

There is a scarcity of sociological as well as interdisciplinary studies which focus on the health-relevant IO/CO and indecisiveness, although there is a plenitude of nonholistic and reductionist studies deriving inspiration from biomedical approaches about health information, perception, decisions and behaviors. This study adds a holistic dimension and a theoretical framework to this end. The results obtained may stimulate further discussions and research about health-relevant decision-making, dissemination of information and choice overload and their impacts on the individual and social life.

d. The Intellectual Merit Offered by this Study

Besides rational choice studies in Sociology, the decision-making studies also have attracted academic interest for almost 50 years (see: Bettman 1979; King, 2007; Bruch, Elizabeth and Feinberg, 2017; Chwe, 2001; DiMaggio, 1997; Gross, 2002; Harding, 2007; Hunzaker, 2016; Ignatow, 2009; Kahan et al.2007; Vaisey, Valentino, 2018). King considers the new complicated consumption system to be the reason for the arousal of such an interest: "The magnitude of research on this topic is understandable if one considers the large number of consumer choices concerning the selection, consumption, and disposal of products and services that are made every day. Like any other type of decision one must make, consumption decisions vary in degree of complexity" (King, 2007: 47). The reference made to the complexity perceived by the health-literate consumers in the process of health-relevant decision-making was not studied either in sociology or in any other disciplines.

As in the disciplines of management and psychology, decision-making studies have captured the interest of sociologists. An important implication for this interest in this interdisciplinary field of research can be found in the recent activities of one of the mainstream organizations: American Sociological Association (ASA). ASA's 2016 program covered such themes as choice and decision in many issues. Many sociologists have been theorizing about choices although they do not use choice or decision words (Vaisey and Lauren, 2017: 1). In many sociological analyses, many social trends are defined in terms of consumer society. Sociologists are aware of this recently growing trend, however they are also attentive to the decision-theoretic language as it is generally associated with individualist and reductionist disciplines such as economics and psychology. This language is considered incompatible with sociology (Vaisey and Lauren, 2017: 1). Vaisey suggests that sociologists should borrow some concepts from "judgment and decision-making studies" to integrate these fields by inducing those studying in these fields to adopt a sociological vocabulary (Vaisey and Lauren, 2017: 3). Thus, the important question for this study is how to integrate the assumptions of these allegedly incompatible disciplines with some moderate and acceptable doubts but with valuable contributions to the micro-sociological analysis.

The relationship between choice/information overload and decision-making/indecisiveness have already been interrogated in decision-making studies literature in general terms. However, the limited number of studies in literature having established some relationships between microsociology and decision-making studies have not investigated the possible relationships mentioned above and the relevant social implications, yet. What makes this study different from other sociological studies focusing on decision-making is that it also discusses health-related indecisiveness. There is a mobilization towards studying decision-making in sociology, and health-relevant indecisiveness remains a gap in the field. To be more convincing about the possibility that these micro issues can be discussed and analyzed with language, terms and paradigms of sociology, management sciences and psychology, the arguments, empirical data and survey data were presented from both primary and secondary sources. Through this text, this study targeted opening sociological discussions to other disciplines, but also influencing them through the very assumptions in sociology.

In establishing the integrative theoretical structure through the argumentations, philosophies, worldviews and traditions of micro sociology and decision-making studies, this study made use of the Coleman's boat argumentation strategy as shown below[12].

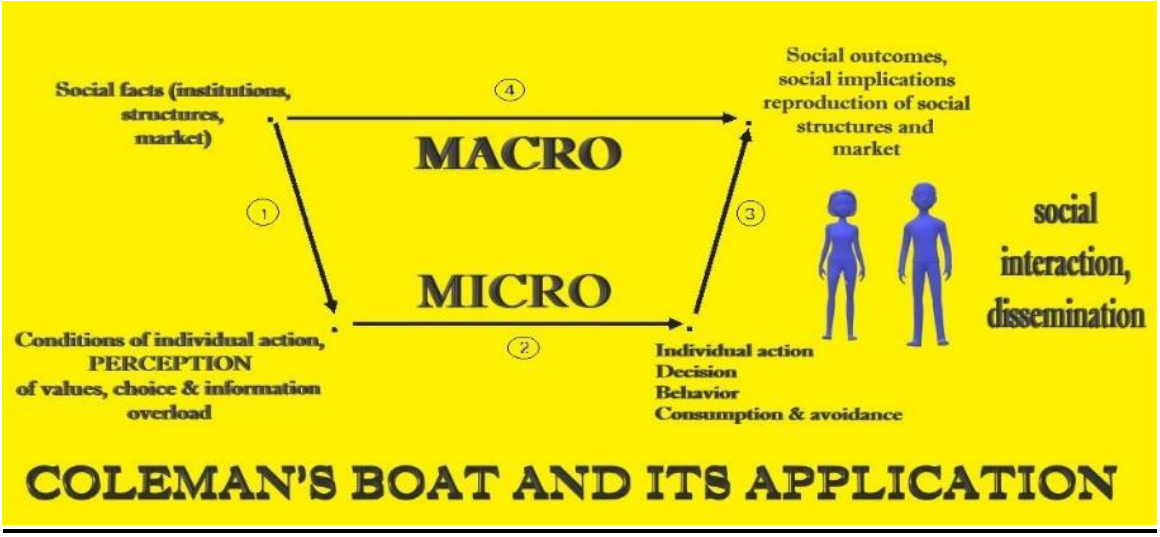

Image 1- Application of Coleman's Boat into this study

The use of this strategy helped to establish connections between structure and agency, the interwoven relations that shape them, and to employ a sociological analysis through inductive and deductive reasoning. The strategy also embraces individualist disciplines, even though some allegedly individualist and also social-level issues have been touched by prominent sociologists (Durkheim, 1893; Goffman, 1974; Simmel, 1903; Parsons, 1936) since earlier times of sociological analysis.

Coleman Boat starts the arguments with social facts and follows a semi-reductionist but also integrative and sociological perspective, bringing the individual and the social together, establishing a dialogue between them, identifying the clusters of decisions, behaviors and how these clusters and trends reproduce the social outcomes and the market

[12]James Samuel Coleman, the former president of American Sociological Association, created a "boat" diagram and established a connection between the macrosociological and microsociological phenomena including individual behavior (Coleman, 1986). In Coleman's boat, a macro-level phenomenon is described as instigating particular actions by individuals, which results in a subsequent macro-level phenomenon. In this way, individual action is taken in reference to a macro-sociological structure, and that action (by many individuals) results in change to that macro structure (Fadul and Estuque, 2011: 55-56). For a further reading, see: Coleman, James S. 1986. "Social Theory, Social Research, and a Theory of Action." American Journal of Sociology, 91(6):1309–35.

structure. The argumentation of a cognitive process suggested by Rettig[13] (1993) was also used and applied within the Coleman Boat context. Within the scope of this diagram and theoretical approach, the health-relevant macros, the cultural values and decisions are conveyed to the individuals through cultural and social structures, norms and interactions. When they receive these messages and alternatives and perceive the norms and values, they may adopt or reject these in accordance with their social and cultural backgrounds. In this second stage, the moderating variables can come into play. Having different cultural capital, habitus and socio-economic conditions will probably impact the attitudes and perceptions of people. The anti-vaccination, smoking or sugar movements, the followers of Dr. Dukan, Keto Diet, organic nutrition are all produced in this process. The warnings or advice of popular doctors can be perceived as 'divine commands' with very scant criticism or objection in accordance with what the consumer brings to the process. The clusters of behaviors, decisions are produced by the health-relevant values and philosophies of these social groups and the impact of these clusters are reflected in the social sphere and economy. Restaurants, fitness clubs and clinical services associated with the healthy lifestyles as well as the emerging huge pharmaceutical industry are all reflections of clusters constructed by each individual action and decision-making, which are also motivated by macro factors. It should be noted that the clusters of behaviors or indecisiveness in relation to health can emerge due to information and choice overload distributed by the market and social structure.

I mounted and developed the relevant arguments with Coleman's approach and tried to answer the research question by investigating the influences of top-down (hierarchical and vertical), horizontal (interpersonal) and upright construction and organization of the health-relevant decision-making and behavior management. In this context, it was presumed that the principal regulating and determining activities and factors are the social structures and activities as well as individual factors as specified in Giddens' (1984) and Bourdieu's (1977) agency-structure notions. The decision-making and indecisiveness concepts were borrowed from individualist and reductionist disciplines in an attempt to produce an integrative perspective which appeals to contemporary micro-

[13] A triangulation framework constructed with three cognitive processes: Perceiving, Deciding, and Actuating (behavior).

sociological tradition. In constructing this integrative perspective, an inquiry was conducted on the social and market-related reasons of indecisiveness, health-related decision-making and the post-decision process (action-behavior).

In investigating the health-relevant issues, building the theoretical and empirical frameworks on a triangulation of perception, decision and behavior was considered to be apparently more practical in examining and explaining the cases to be focused on. The elements of such triangulation could also shed light on the relationships between the social structure and the agency in health-relevant issues as shown in the image 1. Rettig (1993) developed this triangulation framework and model of decision-making upon Paolucci's model (1977) that covers the three processes: perceiving, deciding, and actuating (behavior). Schaber summarized Rettig's model to be used in the design of this study as follows: "perceiving is the feelings the decision-maker brings to the decision process and deciding is the cognitive approach to the decision event. These processes result in actuating or the behavioral outcome" (Schaber, 2004: 26). This study was organized in a theoretical argumentation fashion proposed by Rettig's and Paolucci's models: perception (reception), decision and action (behavior). In this context, the objects of perception, decision and action were presumed to be the IO and CO and what constituted all of these processes were considered to be the social structure and market.

Through this study, I aimed to investigate the cases about a scientifically important theoretical problem in two cities where I have lived. The issues discussed and the problems that need to be answered in this text have the characteristics of scientific inquiry with reference to the relevant literatures. However, the point of departure for the cases is my personal trajectory: the metropolitan cities where I have conducted my researches and the cultures about which I have a considerable amount of knowledge to be able to carry out an investigation through a thesis project. This may not be a totally scientific justification to choose these two cities, but at least these facts have turned out as justifications that convince me as a researcher to the fact that these cities have the characteristics to be universal and appropriate for subsidiary research questions.

One more target of this study was to investigate how the social structures, cultures, health communication, neoliberal health market and politics conjointly reproduce similar and/or different perceptions, choices, decisions and indecisiveness in Istanbul and Lisbon within the context of different lifestyles and class fractions. These two cities have similar

neoliberal economic and consumption-related structures and organizations and were the foci of this research project. Turkey and Portugal have common characteristics that help establish a dialogue between two cases. They both have similar historical progresses such as destabilized past governments during the first quarter of 1900's; both display similar strategies of modernization in industries, reforming the economies and social life after an imperial past through the establishment of modernist regimes. In addition, both societies share a similar agricultural origin in which authoritarian governments in the recent past have resulted in mediocre economies, underdeveloped infrastructures and, subsequently, both are latecomers to modernity compared to other historically Western countries. Even though Istanbul has a considerably larger population than Lisbon, similar conclusions can be drawn owing to the fact that these metropolitan cities provide enough diversity of lifestyles to be observed within the context of this study. The two metropolitan cities have the characteristics of a capital of culture, which is the center of lifestyles, cultural and social practices and policies of vital importance in terms of research questions. According to the results discussed in Chapter 3, no significant statistical differences have been revealed between the Turkish and Portuguese cases in terms of health-relevant decision-making, indecisiveness and behaviors. A scarcity in the systematic comparisons between Turkish and Portuguese health cultures and systems unfortunately left me with insufficient details, but it was determined in the study that similar cultural characteristics reproduce similar consequences under the influence of global practices.

According to the results obtained in the survey study, health information and products disseminated within the context of commodified and individualized health norms lead to indecisiveness. Information/choice overload were found to lead to decision difficulties in both serious and nonserious health cases. The findings also indicate that health-relevant information overload in media, internet and social interactions are recognized by the health-literate consumers, too. Many different sectors, actors and organizations were found to produce conflicting health information and advice. Contradictory advice and information were also found to lead to inefficient health decision-making in an individual and organizational level as it was seen in the pandemic cases of 2020.

As the research problem of this project was defined as a health-literate consumer problem that influences the social and economic structures and is influenced by these, the sample was constructed from the health-literate consumers. Health-literacy was an important

concept and criteria for the research question. The research problems and argumentations were formed to inquire into the behavioral patterns of people having more awareness and experiences about healthy life decision-making and activities. Therefore, those who encounter this kind of information, consume relevant products and use relevant services more often than non-health literates could provide meaningful responses for these research problems. Accordingly, a quota question was used to exclude non-health literates from the survey, because their responses would not provide meaningful data and explanations for research questions of this study.

e. The Organization of the Dissertation

In the introduction, the theoretical framework, historical narration of the research case and methodological procedures were briefly presented to prepare the reader to the relevant research issues. Besides these, the research questions and goals were also mentioned by establishing connections with theoretical and empirical references. Chapter 1 treats the literature review with a focus on discussions on how healthy life advice is disseminated within the cultures and lifestyles ideologically, how health-literate consumers perceive them, how the reception of healthy life advice including conflicting ones is socially organized, how IO and CO are socially constructed, how this process reproduces health-relevant perception, decision-making and behavior management upon these information and choice overload as well as health-relevant indecisiveness. Even in a superficial review of health information disseminated in media and the internet, many conflicts in meaning and advice can be found. Thus, the conflicting information was identified as another issue to be investigated. This discussion was organized with arguments on the reception of conflicting information overload and on the emergence of decision-making/indecisiveness consecutively, but not through the causalityprinciple. The emergence of such processes was explained through an inquiry of the following issues: how could the ideological, institutional, sectoral, communicational and social structures influence the perceptions of health advice and the relevant decisions?

In Chapter 1, the commodification-related theories and argumentations were presented to inquire into what kind of impacts the commodification of health could have on the reception of healthy life messages, decision-making, decision difficulties and the distrust

in health promotion (advice and services). Further inquiries were organized around changing consumption patterns in accordance with choice overload and different degrees of indecisiveness. Besides these, other important discussions were about such issues as how these healthy life advice, indecisiveness and decisions are transformed to health behaviors; how the behavioral and consumption-related values are reproduced; how such processes as consumption, problem solving, overcoming indecisiveness, indecisiveness-induced delays or non-compliance are reproduced in the social interaction; how these phenomena emerged, how they influenced the social groups, individuals, currents of thought, organizations and regulations. These were discussed with references to research questions.

In Chapter 2, Turkish and Portuguese cases were approached with regard to the research subject. In this context, the structural elements constructing the health-relevant PDB were presented in relation to how these phenomena and processes are restructured by politics, organizations, systems of education, health and communication, economy, culture and globalization. The relevant historical narratives, social and cultural cases and information on health were investigated. In this process, following the theoretical argumentations in the review, the empirical data collected and empirical findings were presented. Later on, in Chapter 3, I presented the findings of the survey investigating whether and to what extent these theoretical argumentations and empirical findings were supported by the data collected from health-literate consumers through the online survey. These data were presented in the findings section in Chapter 3. In Chapter 4, the overall summary of the research outputs was presented with references to whether this study was able to answer the research questions and some recommendations for the problems identified in this research and in the relevant literature were provided.

1. Literature Review

In this review chapter, the concepts highlighting the theoretical framework are presented and then, the next focus is on how the arguments about these concepts can be used and discussed within the context of research questions of this study. The investigation and interrogation approaches and paradigms chosen for this study inquired into the possible influences of IO-CO on the health-relevant PDB with references to social structure, media and market[14]. To be more precise, the issues to be focused on are: the interrogation about how IO-CO have been regulated and organized by the social, political and international structures, organizations, discourses and activities and "how this advice and overload are perceived by different social groups", "which social organizations construct people's health-relevant PDB/indecisiveness with ideological, institutional, sectoral, communicational and social activities," and "how this tremendous variety of PAS are disseminated in the social environment and market in the consumer society."

The interdisciplinary theoretical framework is developed through a synthesis of the arguments and data from Deborah Lupton and Peter Conrad, two vastly cited sociologists studying medicalization and health promotion theories, Mitchell and Papavassiliou, from management sciences focusing on confusion (indecisiveness) and Schwartz and Rassin on social theory, action and choice overload issues. Their general conceptions about perception, choice and decision-making and their interpretation about market regulation on the perception, decisions and behaviors were discussed, adapted, criticized and developed in terms of healthy life issues. Scholars studying in the relevant literature and many others did not focus on one little gap. The gap that this study proposes to fill has not been studied yet even in interdisciplinary literature the question of how the health-relevant information and choice overload create a decision difficulty or indecisiveness as well as decisions and behaviors, and what are the related social and market-related implications. In answering these questions, many arguments in the relevant literature were addressed. Firstly, Lupton's argument about the individualization of health is one of these arguments. She (1995) states that the healthy life decision-making has been individualized and the individual is left alone

[14] The ideological, political and health-communicational aspects relevant to discussions will be presented in the Chapter 2.

before a great plethora of choices. Schwartz (2006), Kaplan and Miller (1987) and Rassin (2007) handle the relationship between the CO and indecisiveness asserting that too many choices increase decision difficulty and indecisiveness. Mitchell and Papavassiliou (1997, 1999) and Johnson (2012) focus on the influence of the market and economy on this CO and confusion. Germeijs and de Boeck (2002) defined how indecisiveness may emerge and what kinds of perceptions, decisions and behaviors could accompany indecisiveness. However, all these authors and even those contributing to indecisiveness, CO and IO literature have not yet produced an integrative approach that takes market, state-related, ideological, social, institutional, cultural and communicational discourses and data into the scope of their approaches in terms of the research problem of this study. Healthy-relevant IO-CO and indecisiveness as a social phenomenon constructed by the various discourses and structures and reproducing the individual, social and organizational decision-making and behavior clusters as well as structures have not been adequately addressed.

Most of these scholars mentioned above have developed reductionist, individualist and agency-based interpretations and approaches about IO-CO and their relationships with indecisiveness. In this case, for the research question to be investigated under a sociological scrutiny, a holistic approach had to be developed and this approach proposes that along with market-related and individual factors, the social structure, organizations and demographic factors also contribute to the explanation of health-relevant IO-CO and PDB as well as indecisiveness. This approach required focusing on the influences of social, cultural and economic capital, social network and the household on the PDB/indecisiveness (IO and CO as well). There is a real lack of literature which focuses on the relationships between the variety of health life advice, products and decision difficulties with sociological references and terms. That is a gap in which sociology, psychology, communication and management sciences can meet and have a dialogue. In this way, a sociological conceptualization of this issue may help the dissemination of the sociological perspective and terms to other related fields, as well. As in Vaisey and Lauren's (2017) study "Culture and Choice: Toward Integrating Cultural Sociology with the Judgment and Decision-Making Sciences", some interdisciplinary studies gave thoughts to choice and decision-making. However, even though they pave the way for collecting some empirical data, these do not focus on the gap that this study interrogated, and this gap was the point of departure in developing the arguments.

In establishing this argumentation framework and theoretical dialogues, this review brings the notions of scholars from sociology of medicine, body and consumption and interaction fields such as Featherstone (2007), Baudrillard (2008), Simmel (1950), Sezgin (2010) and Lupton (1995) synthesize these notions and develop autonomous arguments upon relevant and common frameworks of studies of such scholars from communication, management and psychology disciplines as Schwartz (2006), Kaplan and Miller (1987), Rassin (2007), Mitchell and Papavassiliou (1997, 1999), Johnson (2012) and Germeis and de Boeck (2002). Building on these studies, the framework I developed proposes the utilization of a perspective that explains how biopower and the healthy life markets manipulate the stimulants (healthy life choices and messages) in urban life and consumer society. I also attempt to answer how they may transform consumption into a social movement, and then transform this movement into social, individual and economic decisions and behaviors as described in the Coleman's Boat Diagram in the introduction (Image 1). Within this context, dialogues were established between arguments about how these discourses and notions are utilized and exploited by the market in orientating public healthy life consumption decisions and in leading people to indecisiveness in many cases through a vast variety of choices. In discordance with many of the previously-mentioned scholars, the focus of the perspective proposed by this study was on the structural factors, and takes the ideological, cultural, social, economic and individual dimensions into consideration and adapt these dimensions into this interrogation and framework with such focuses on the health-related decision-making, indecisiveness (decision difficulties) in a condition of choice overload, on how these are socially reproduced, influencing healthy-life purchases, consumption and lifestyle change decisions in practical terms.

In the previous studies that I conducted since 2015, I found out that there is a negative correlation between information and choice overload and decision-making (Baldil, 2019: 91-98). This finding may not apply to this study, but gave me an idea about the fact that the increased exposure to choice and information overload could lead to short or long-term decision-making difficulties. This data supported the findings of Schultze and Vandenbosch (1998), Eppler and Mengis (2004), Malhotra (1982) and Ozkan and Tolon (2015). However, a review of the relevant studies of these scholars revealed that other little gaps were not investigated in these studies. These issues are as follows: addressing the heterogeneity in indecisiveness; discussing the possibility that indecisiveness may not be experienced by everyone equally and there may be a practical diversity of behaviors relevant to these

differences in indecisiveness levels. Frankly speaking, some people may be more satisfied with the variety of choices in health (advice, information, therapy, doctors, hospitals, pills, products). However, is it possible that this variety will also bring along with it a difficulty in decision-making? What comes next? Does this continue with satisfaction with the variety of choices or an indecisiveness about these choices? How do people behave when they have these possible choices and experience indecisiveness? Conceptualizing and interrogating indecisiveness through a triangulation of indecisiveness levels would facilitate the explanation of further behavioral inclinations and functions following indecisiveness. For instance, what kind of behaviors can emerge after experiencing high, medium or low indecisiveness? How will they impact healthy life purchase or lifestyle change behaviors practically? This conceptualization of three levels of indecisiveness was discussed and interrogated in Chapter 3but had to be mentioned here along with other relevant issues.

Analyzing the processes about how the consumers pushed into health-related indecisiveness overcome this problem as well as health problems and about the kinds of strategies and movements they have tended towards in overcoming indecisiveness were important in answering subsidiary research questions. Therefore, such arguments as "dealing with overload", "further information seeking to overcome indecisiveness" and "experiencing of everything" were developed and offered after applying the conceptual framework defined by Mitchell and Papavassiliou as "the confusion reduction strategies". Through such arguments, this study interrogated what kind of further healthy life processes and cultures are reproduced through the decisions and behaviors of people experiencing low, medium and high level of indecisiveness[15] and also interrogated how they reproduced these processes, lifestyles and cultures within the context and limits of social factors.

To provide an updated view of the present healthy-life and wellness cultures of urban and metropolitan life, the quickie health and decision-making concepts were developed with

[15] In this study, a conceptualization and operationalization about the practical meanings and implications of indecisiveness have been made. In this regard, a tripartite conceptualization has been made: Low level, medium level and high-level indecisiveness. In low-level indecisiveness, despite an exposition to health-relevant IO-CO, no serious decision-making difficulty is experienced. An internet search for information and a decision-making following this can best exemplify this level of indecisiveness. In medium-level indecisiveness, health-relevant decisions are made after an internet search. Being involved in an increased exposition to choice and information overload and more internet-search is a specific characteristics of this level. In high-level indecisiveness, the internet search does not satisfy and a need for socialization and consulting others emerges to make the final decision. Further information about this subject can be found in the in the Chapter 3 (under 3.1.1. topic).

impressions from “disposable products” and the “displacement of people” discussed in Fortuna et al. (2002: 123) and from the visibility of health through quick tips culture in Gomes (2010). Through the “quickie health”[16] concept, commodified healthy life culture and lifestyles in Portugal and Turkey were shown as lifestyles that have increasingly focused on individual health consumption and notions of tracking and discipline. In doing this, such a theoretical concept as “expert patient”[17] was utilized under the name “prosumer”[18]. These concepts were utilized in offering an actual view of the actors reproduced by health systems and consumer society; the concept also produced novel health trends and perceptions. The use of such concepts enriched the theoretical understanding and explanations related with decision-making and behavioral trends. Other focuses were on the health-behavior management system constructed by the market, media and society and also on how the market and society are impacted by the previously discussed processes by inductive and deductive reasoning while looking at the economy of consumption emerging from meso and micro structures.

In addition to the issues mentioned up until this point, this review addresses other salient issues and raises the following questions: 1) how is this overload of advice received and perceived by different social groups?, 2) how was health commodified or reified and opened to market exploitation?, and 3) how does the reception of commodified health advice influence healthy life decision-making and lead to indecisiveness? In particular, the practical implications of the interrogative approach can be exemplified with such questions which are only written here to show what kind of results are targeted at the end of theoretical discussions and survey data. “How do newly-emerging consumption and behavior patterns

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[16] In earlier stages of this study, the ‘quickie health’ concept was developed to explain the actual trends about the fact that the health-relevant processes, whether in individual and organizational level, have been accelerated and considerably faster compared to the previous decades. With this concept, references are made to a simplified health and body management, reduced to dosages and formulas. “Lose 3 kilogram in just 3 weeks”, “5 ways to have the bikini body in 1 month” are typical examples of Quickie health philosophy. Further information with references to the studies in the literature and to example cases will be given Chapter 1 (under the 1.3.2. topic).

[17] Expert patient, who can also be called active/proactive or scientist patient, is someone who has more technical knowledge about health, acquainted with health-relevant issues and details more than lay people. Today, due to health consumerism, more and more people are being transformed to expert patients and they are also consumers. More information will be given in Chapter 1 (under the 1.5.topic).

[18] Prosumer is defined as those who produce and consume or utilize their own products. In terms of this study, prosumer is those who find and produce solutions for their own health and bodily problems and utilize this. Some people who develop their own health or body techniques and philosophies can also be classified as prosumers. More information will be given in Chapter 1 (under the 1.5.topic).

influence Portuguese and Turkish societies? How do the low-carb dieters or intermittent fasting-followers influence the economy and society? What are their reflections in the lower and higher classes?" These questions were not directly focused on, but similar issues were examined and discussed in Chapter2 and Chapter 3.

1.1.Concepts

Below, the up-to-date discussions and definitions made in related literature were presented to introduce the theoretical framework to the reader. After the explanation of the fundamental concepts (information overload, choice overload, and indecisiveness), their relationships with other concepts such as medicalization, commodification, global dissemination strategies, word-of-mouth health communication, demographic factors and interrelationships were elaborated to open up a terrain for the new discoveries that previous attempts have not been able to reach.

Information overload is defined by some scholars in psychology and information technologies literature as a state in which the information acquisition (reception) surpasses the capacity to process the information (Eppler, 2015; Eppler and Mengis, 2004; Thorson, Reeves and Schleuder, 1985, Schmitt, Debbelt and Schneider, 2017). They assert that this surpassing may result in a nonproductive information processing, confusion and psychological stress (Schmitt et al., 2017: 1). We can trace the beginning of information overload back to the invention of the printing press, when Western societies encountered a huge variety and amount of information compared to their past experiences. Today, the internet has created an effect similar to the invention of the printing press. Schmitt et al. assert that the great amount of heterogeneous information on the internet may be perceived as challenging and may increase the difficulty in evaluating and choosing relevant information. They attribute the emergence of IO to the tremendous variety of choices and content on internet (Schmitt et al., 2017: 1). According to Eppler (2015), IO emerges during the reception of a big volume of information in a limited time when people may have difficulty having a clear idea of how to deal with it (as cited in Schmitt et al., 2017: 2). The notion of limitations may have connections to the decision difficulties defined as indecisiveness by some scholars. Ozkan and Tolon also refer to the time limit in decision-making and suggests that "Information overload depends on three factors: the quality of the information, the available time and the available tasks" (Ozkan; Tolon, 2015: 31). They

summarize definitions and the factors in the relevant literature. These definitions of information overload are:

> -the amount of information that the person has in the period of searching and examining the information,
> -the quality and the feature of the information concerned,
> -the person's capacity for processing information,
> -the available time for collecting and examining the information (Ozkan and Tolon, 2015: 31).

As for the origin of the concept, it is not a new phenomenon. Throughout history, the growing body of information was defined by many as overload, although, today the amount of IO has reached such an extent that it may not be easily measured. It may be due to advancements in the information production and distribution technologies, the phenomenon of society's participation in the information production and changes in the perception of time. IO phenomenon has been proliferated by the fact that the internet facilitated the production and distribution of this socialized information and that it turned out to be an informal education environment. In a similar vein, with the notion of Schmitt et al (2017), Edmunds and Morris (2000) state that the internet or electronic sources contribute greatly to information overload. At the present time, the number of smart phone users is 2.53 billion whereas this number was 1.57 billion only three years ago (Statista, 2019). As people are now connected socially and digitally to each other through the internet, everyone has turned out to have the role of media holdings with only one smart device--most of them have become information producers. Now, in their social or digital social circle, a YouTuber can generate content and disseminate as much information as a TV channel produced in the last several decades[19]. As a matter of course, the dissemination and consumption of information well above the level of the knowledge and information the human being has adapted to perceiving for centuries has been taking place. This study offers this new definition of IO with reference to the habits and adaptation of individuals and society in terms of information reception, but not to the brain capacity as most of the scholars mentioned above propose.

IO has been studied in psychology, decision making and communication studies. However in sociological literature on Portugal and Turkey, we cannot find many studies that address the issues investigated in this dissertation. The reason can be attributed to the fact

[19] It is necessary to note that health-literate consumers have also been coded as the consumers of information pollution, not only acquired quality information overload, but also exposed to low quality overload.

that it is not a pure sociological concept but was coined from another discipline. As this study offers arguments that focus on the relationship between the information/choice overload and indecisiveness and social and market-related communicational factors, it requires borrowing and adapting concepts from other disciplines. In this regard, it will be of paramount importance to mention the other relevant concept used in the analysis of the issue of choice overload.

Now, even while the reader is reading this text, a tremendous variety of lifestyle products, philosophies and relevant information are produced simultaneously in Portugal and Turkey, as is the case throughout the world. The marketing of these activities, practices and products increases the number of relevant information and advice. The equivalent or replications of many generic products is produced and consumed without legal constraint owing to liberalized norms of dominant neoliberal markets. However, this process may be resulting in a historical overload as in the IO phenomenon. In the literature, this overproduction of choices is called **choice overload** by Iyengar and Lepper (2000), Schwartz (2004), Scheibehenne, Greifeneder and Todd (2010), Vohs, Baumeister, Schmeichel, Twenge, Nelson and Tice (2008) and Rassin (2006)[20]. This phenomenon dates back to post-war era, but it finds its real meaning and context especially in the last 30 years along with globalization.

Image 2-Choice Overload – The left stalls offering similar function products with many brands – Cognition-enhancing (psychoactive) medications on the left image

The choice overload (overload of choice) may not be measured easily, although, there are many studies which define an unlimited number of choices as an overload. The

[20] Alvin Toffler called this concept as "overchoice" as the founder of this concept. However, choice overload term was used more in the course of time.

arguments of this study were based on these definitions and assumptions. The neoliberalist discourse on the freedom of choice may indeed work in the free market. However, as Amartya Sen (1999) and Schwartz (2006) assert, more choices do not increase freedom or satisfaction: “Increased choice among goods and services may make little or no contribution to the freedom of choice. Indeed, it may impair freedom by taking time and energy we would be better off devoting to other matters” (Schwartz, 2006: 4). Moreover, consumers may constantly be confused by choice overload or made hesitant and indecisive in choosing/deciding process (Mitchell and Papavassiliou, 1997: 165). According to Schwartz, as the number of choices increases, negative aspects also emerge, resulting in an overload. At this point, choice no longer liberates, but rather debilitates us. For him, this overload might even be defined as tyrannizing (Schwartz, 2006: 2). Schwartz’s interpretation of choice overload is subjective or dystopic one. Nevertheless, he has offered one of the most comprehensive perspectives about choice overload with his “Paradox of Choice” (2006) study in which one can find valuable contributions in this critical approach. His exemplary critique quoted below displays the size of the CO problem and its relationship with IO:

> The avalanche of electronic information we now face is so big. To solve the problem of choosing from among 200 brands of cereal or 5,000 mutual funds, we must first solve the problem of choosing from 10,000 web sites offering to make us informed consumers. (Schwartz, 2006: 55)

Schwartz (2004) and Rassin (2006) focused on how indecisiveness may signal the growing number of choices with which consumers are presented. Schwartz’s notion is in line with the notions of Pine, Peppers and Rogers’ (1995) in that consumer confusion and indecisiveness emerge due to CO-IO and also due to the imitation of products. Pine et al.’s argument can be summarized as follows: "Customers do not want more choice; they want exactly what they want, where, when, and how they want it" (Pine et al., 1995: 103-108, as cited in Mitchell and Papavassiliou, 1997: 164). We may attribute the increase in the variety of information choices and sources to the proliferation of information as in the proliferation of products and to the phenomenon of imitating the information cost-effectively. There are strong hints in many market researches or cases that point to the demand for variety. In this regard, Schwartz (2004) and Rassin (2006) and Pine et al.’s arguments can be disproved. Their arguments should also include the possibility that the human need is eternal and this basic fact could motivate the choice variety. However, it is not an overload which complicates their decision-making, especially in health-relevant cases.

Choice overload and information overload appear to stem from Chinese-type production model, in which the licenses and patents of the generic products are not respected, the prices are reduced with both increasing and decreasing quality but most of the time aggrieving consumers. This low quality-low cost information production model is similar to the Johnson's (2012) analogy between food and information production technologies, cultures and deteriorating quality in these. Many replicas may be produced with lower quality raw materials. However, democracy is also improving in terms of disseminating information without constraints, which also may create information pollution devoid of ethical control. Indecisiveness as well as IO-CO may, in a sense, be influenced by the imitation of the products and information due to the development of proliferation technologies affirming a relationship between IO-CO and indecisiveness. In this context, the health-relevant CO is reproduced especially by the market, namely the healthy life sectors. Different healthy life paradigms in health markets produce different production mechanisms. This diversity in products widely circulates with a diversity of marketing messages with their own respective claims, contradictions in meaning, hence more difficulty in decision-making.

New types of decision-making activities and critical health literacy have been developed through many pedagogical activities in school curriculums and public health decision support systems established by many national and international actors and organizations in Turkey and Portugal. However, IO and CO may well vitiate these improvements, leading to increasing indecisiveness, an increase in decision-making difficulty or inefficiency of these activities, just the opposite of what biopower, governmentality and neoliberalist markets would anticipate, as these would result in a loss in profit and a loss in their dominance over the public.

Indecisiveness is defined by both longer decision time and increased search for information. This brings the question of how indecisiveness should be defined precisely (Rassin, Muris, Franken, Smit and Wong, 2007: 67). Rassin et al. found correlations between indecisiveness and such outcomes as the self-reported tendency to avoid decision making, and with feelings of panic in case of inevitable quick decisions (Rassin et al., 2007: 67). Germeijs and de Boeck made relevant conclusions and summarized the generally acknowledged definitions in the literature: "deciding takes a long time; a tendency to delay making decisions; a tendency to avoid making decisions; leaving decisions to someone else; instability of a decision; worrying about decisions that are made; regretting decisions that are made", (Germeijs and de Boeck, 2002: 115). In this study, Rassin et al.'s (2007)

definition of indecisiveness will be used and it will be associated with “the longer decision time”, “decision difficulty” and “further information seeking” concepts. The definitions summarized above have implications in the individual level. However, they can and should also take social implications into consideration so as to not have an incomplete and inadequate interrogative approach. According to Elaydi, indecisiveness inflicts societies, organizations, and individuals (Elaydi, 2006: 1366). Even though Elaydi has subjective interpretations of the issue, the social and organizational aspects and consequences of the indecisiveness are also underscored in his analysis. The author’s comprehension alludes to the notion of indecisiveness to some extent: “When facing a difficult decision, negative concurrent emotions may be so overwhelming that the individual becomes emotionally paralyzed during the decision-making process. It is this emotional prison which best exemplifies indecisiveness” (Elaydi, 2006: 1366). Through a consideration of the affection created by indecisiveness, it is possible to observe its influence on the healthy life economy, whether indecisive people consume less healthy life products or they search for more information.

Many decision-making processes are experienced by many people in consumer societies and are susceptible to manipulation of the healthy life industries in terms of behavioral and consumption-related regulations. This study had a critical theoretical stance at the IO and CO from a critical perspective. In this context, they were interrogated through a survey to crosscheck whether IO and CO constrain people, leaving them isolated before a plethora of choices with less social decision support or satisfying them and/or making them happier and healthier. Relevant issues and results were presented in Chapter 3.

In psychology and management disciplines, indecisiveness has been handled and reduced to a mere individual level. However, societal level resources may also contribute to indecisiveness and should be taken into consideration in related interrogation and analyses. This study made a contribution to disentangling this area of search from being incomplete in societal level analysis. The social resources and factors also contribute to the reproduction of health-related indecisiveness. Sociological studies should and could interrogate these societal level factors and their influences in society, economy and health perceptions of people from various classes. The sociology of emotions and sociology of health and illness already focus on health-perceptional studies, indecisiveness. Its cultural, economic, emotional and communicational aspects could be discussed within an appropriate integrative

framework. The next topic discusses the arguments about these societal level factors and resources after focusing on the market-relevant factors in the next section and other sections.

1.2. Healthy Life Advice Produced by the Neoliberal Market

An increase in the perceived value of health was caused by the emergence of the medical promises for prolongevity[21] due to the switch of roles between religion and medicine. Like the promise of an afterlife in religious doctrine, medicine has started to offer promises for prolongevity. These promises uttered in the health promotional discourses in consumer societies initiated an increase both in the supply and demand of health-relevant product, advice and services in the last century. Today, offering prolongevity and promoting anti-aging have become mainstream health-care management strategies and generated a demand for relevant information. The demand for health information production surely has justifications which can be empirically observed in many studies. For instance, research conducted in 2019 in USA indicated that 80 per cent of the people use the internet to search for health information (Pew Internet & American Life Project, 2019). Another data concerning supply and demand reveals that 5 percent of the whole information on internet is health-related (Google, 2015). In addition to this, information is disseminated by word-of-mouth, conventional health-related TV shows, hard copy newspaper articles, news and digital health communication and all kinds of smart technologies[22].

Today, health and body relevant issues and decisions require more complex decision-making practices due to the increasing number of imperatives about changes in consumption and behaviors. The narration of a pandemic can probably help to exemplify the global and social decision-making that underlie the theoretical perspective of this study. In 2009, a huge amount of health information and imperatives were disseminated in the media and internet globally to transform people to informed citizens against the fatal influences of H1N1 virus

[21] For prolongevity and health, (see: Turner, 2013)

[22] Smart watch, smart wristband, smart medical technologies (insulin pump, etc.) can measure daily physical and health habits of people, heartbeat, mobility, walking, sleeping, drinking water, blood sugar etc. In a further dimension, the body-worn devices related to the heart and diabetes etc. can inform the doctors and medical teams of the people in case of a possible health problem. At this stage, massively used smart watches, health monitors in wristbands and tracking applications on smartphones produce notifications and warnings when people do not drink water, do not move, that is, they do not comply with the healthy living norms and habits determined by WHO. These notifications can be exemplified as follows: "Today you have completed the time you need to move, congratulations ", gamification-based messages, visualization and color statistics, imposing health norms and tasks through gamification strategy.

originating in Mexico but spreading as a pandemic and causing a toll of death around 284.000 people (CDC, 2012). Vaccination and public spots were imposed as norms, even the presidents and ministers of some countries had different choices for the utilization of vaccinations against this pandemic ("Erdogan domuz gribi", 2009). In 2009, millions of new members of the information society (especially social media accounts) have had an increased awareness and more technical and medical knowledge about health issues. Normally, this could enable them to question the side effects of this vaccination and resist medicalization. However, they were put under pressure through this information overloadand temporal constraints to make decisions due to the danger of death and also due to dangerous side effects. Both in Portugal and Turkey, word-of-mouth communication as well as digital and media communication contributed to a complex decision-making process in which many imperatives, supporting (ARS Algarve, 2009) or objecting to vaccination ("Não é a gripe suína", 2009) were disseminated along within the context of temporal constraints to make decisions. People were explicitly warned that they might die if they were not vaccinated ("21 milyon kisi", 2009). As a consequence, indecisiveness about the ideal health behavior (whether to get vaccinated or not) emerged in the case of the 2009 H1N1 (Gripe A, Gripe Suína), which was also aggravated by temporal constraints as well as market, politics and media pressure.

As in the H1N1 pandemic case[23], indecisiveness in the presence of conflicting advice and imperatives may emerge both for very serious or less serious health problems. When the quick solution approach is assigned as an imperative, it is transformed to a capitalist health regulation in which the individual health problems should be cured, people should be well-informed, nutrition styles should be adopted and the rapid-acting pills should be consumed so as to maintain the labor force within a proper capitalist mode of production. In response to these capitalist pressures and demands, more and more healthy life advice is produced and this overload of choices and advice leads to pressure on the selection of the choice and behavior in Portuguese and Turkish societies. Accordingly, an indecisiveness about the ideal consumption or action results in negative emotions (Elaydi, 2006: 1366; Pine et. al., 1995; Iyengar and Lepper, 2000; Kuo, 2010: 36). These can be such negative emotions

[23] The more actual cases for the Coronavirus pandemic have already been mentioned in introduction with a wider context.

as decision difficulty, temporal constraints, especially in urgent health or cosmetic surgery decisions or even cost-effective daily decision-making.

The socialization of health has increased the accessibility of health knowledge, has popularized it, has also made health individualized and turned it into a commodity. Marketization in health care brings along greater commodification, selling health care as commodities (Agartan, 2012: 456-471). As a result of medicalization, human life has become more and more controlled by healthy life market day by day and human health has been turned into a problematic process to be worked on by different sectors in the market (Conrad, 1992: 209-232). Within the context of this medical consumption paradigm, medical or alternative medical techniques and products are marketed as the solutions for even lifestyle or culture-induced problems. It is done with individualized problem-solving discourses, namely reducing the health problems to individual responsibility by eliminating the social and cultural factors from the analysis of the health problems and health-related decision-making. Fortuna et al. pointed out the growing individual responsibility for general health issues by giving examples concerning biomedical discourses and advice about reduction of alcohol, tobacco consumption, nutritional balance, blood pressure measurement, reading and demanding more health guiding publications etc. (Fortuna, Ferreira and Domingues, 2002: 84). Commodification and medicalization have drastically individualized the concept of healthy life for several decades and this process seems to continue as fast as ever with newly invented marketing and communicational strategies.

Image 3- Skin architecture (Ten Mimarisi -Body as a construction project)

The commodified healthy lifestyle is a system based on regulating health behaviors through the norms that suggest the use of a wide variety of marketable commodities such as products, services and imperatives. Some up-to-date and empirically observable examples for this phenomenon are as follows: the commodification and marketing activities for yoga and meditation which are intensely mentioned in healthy lifestyle articles and messages, the new, expensive and profitable shelves opened for organic-natural-ecologic nutrition in supermarkets after popularization of these in healthy life advice, gym membership becoming

the norm, the hidden advertisements and commercial concerns of many investor groups in the health-promotion messages.

Image 4– A Social Media Healthy Life Advice Example Targeting Lisbon Population

In a commodified health system, people are encouraged to perceive health and body as an architecture that needs constructing with the products, services and marketed philosophies of the cosmetic and healthy life industries as shown in Image 3. As healthy life, cosmetic and culture industries enhance their dominance in health care, consumer culture and markets, the "body and health building/construction" notion is emerging as one of the most important consumption areas, resulting in changes in the perception of relevant messages, products, marketing activities and decision-making.

In urban societies, the commodified health market and media promote the social and healthy body as a construction project in which to invest. As a construction project, the healthy body notion of neoliberalism today requires the commodification (objectification) of many aspects of the body. To commodify health, the healthy life and media industries work primarily on the commodification of everyday life, starting with the production of the lifestyle practices and advice and then building a healthy lifestyle system gradually. In drawing the context of this body project, Bauman uses the limitlessness notion to define the modern preoccupation with the body as part of this project. He defines this notion as an attempt to reject limits of the body (Bauman, 1992a: 18). Today, one can see the reflections of what Bauman claimed in the prosumer behavior, medical and cosmetic technological advancements, most of which are constantly commodified. "Do you want a new heart, a longer life, a huge butt or do you want to live forever by being frozen until you are given rebirth in the future? We have some offers for you…". Even Hollywood has instilled some of these commodified limitless notions through the developed instruments and scenarios of

the culture industry (as in Vanilla Sky, life extension project). These kinds of messages serve the ideal health and body project, an instrument used by biopower in generating artificial needs to be fulfilled with commodified health products and philosophies. Turner's understanding of the contemporary body ideal is in the similar vein with Bauman's, both of these scholars made references to the commodification of the body ideal to build many parts of the body:

> The image today is of an endless youth stretching before us. But one knows that these representations of the young body can only be achieved either by continuous exercise and athleticism, topped up by the periodic face-lift, draining off human fat, operations to the eyelids and so on. These young bodies are literally constructed, but they are constructed against ageing. (Turner, 2000: 252)

The social body construction notion and endless demand for youth and health (see: Bauman and Turner) have created a vast number of philosophies that consumers have found worth buying. Today, we are living in an age in which a body and its functions such as health and aesthetics are presumed to need architectural and engineering capacities and philosophies. In this regard, all efforts form a social and relatively unorganized faculty of body construction.

Scholars studying the sociology of medicine (Christiansen, 2017; Timmermans, 2009; Waitzkin, 2012; Conrad, 1992, 2004; Lupton, 1995; Nichter, 1989) have been interested in analyzing the commodification of health for a long time. They have also paid attention to the analysis of the consequences of the specific responsibilities given to doctors and entrepreneurs in the commodification process, especially to the problems and various issues about commodification emerging in the distribution of the sources, knowledge and equality of opportunities. The commodification of human bodies, health care and medical products still results in inequalities in terms of access to quality health care and healthy life system. Thus, one can conclude that there are social problems to be counted as reasons to focus on this subject. Timmermans takes on documenting and examining "corruption, exploitation and the pursuit of profit without regard for therapeutic efficacy" as a duty to fulfil his academic investigation (Timmermans, 2009: 24). Timmermans' action of advocating for social equality in health-care is also reflected in Lysaght's resistance against the transformation of health-care to a mere market-based commodity. She suggests that "health as a commodity is creating further social divide by promoting differential treatment based on a patient's social class" (Lysaght, 2009: 297).

The inequalities in health are not limited to those concerning health rights, nutrition and therapeutic opportunities as emphasized by Timmermans and Lysaght. It goes further. Even counselling is commodified, and the acquisition of quality health advice is not easily accessible to everyone. In this commodified health system, for instance, those with lower socio-economic status who end up in indecisiveness will not have as many opportunities as with those higher socio-economic status, especially as in such issues as medical consultation. Even online consultation will be less accessible as these are more commodified and require more economic capital to buy subscriptions for information/journals etc. . This process reveals the emergence of an unequal system in which people obtain right to good health in line with their solvency ratios, eventually contributing to a system in which the rich live longer and healthier while the poor live shorter and with health problems, which are further exacerbated by decision-difficulties.

Due to the increasing costs of health-related therapies or services, the states are encouraged by such foundations as WHO to transform their health policies towards a neoliberal health policy, whereby escaping these important expenditures for the public health create budget deficits. A critical opposition from Hedgehog Review editors to the commodification and to establishing a market on over-individualization may well document how far this can go today:

> These days one can buy almost anything. Sperm and eggs are advertised on the web. Human organs are being bought and sold around the world. Universities are increasingly thinking of the education that they offer as a "product" and their students as "consumers." There are fewer and fewer realms of life in which the language of money does not speak powerfully. (Editors, The Hedgehog Review- Institute for Advanced Studies in Culture, 2003)

Image 5-Commodification of Wellness Culture – Entrecampos Train Station – 2016

Healthy life sectors and markets are able to produce imperatives through biopolitics, legal procedures and moral discourses on life and death just as religious organizations did in the past with a symbolic and cultural "divine" power obtained historically, and practicing such approaches as "punishment and reward". Lysaght underlines the "life and death"

themes which are employed in these markets: “By promoting themselves on an ability to enhance, protect or combat changing, aging and dying bodies, health markets contrive a type of consumer that is distinctive from other markets” (Lysaght, 2009: 299). Lysaght defined a type of consumer but did not call it by any term. This new type of consumer can be called expert or scientist patients, prosumers who have a higher knowledge about health technologies and products or consumers experimenting many kinds of products to maintain their health status or improve it in an attempt to prolong their lifespan. These new consumers can also be lay people who impose traditional and patriarchal body and health norms and imperatives and manipulate the emotions of people in their social network.

The healthy life sectors construct a health commodity economy, which operates on the symbolic meanings of survival or well-being “desire” of people. We can take the arguments of Lupton and Lysaght (divine power of medicine) further with a notion of manipulation upon fear and morality. Especially, the fear of death, illness, lower bodily and mental capacity is amplified with moral discourses. For instance, the headline of an article in Sabah Newspaper in Turkey (“Ölümcül Tehlike”, 2019) is an appropriate example for these kinds of discourses: “Danger of Death, It (Liver Cancer) Melts the Organs.” Another example is from a CNNTurk.com article: “The experts have warned! The 12 Killer Nutrients”, the latter mentions about “bread, crackers, snacks, carrot, cheese, chicken meat, grape, apple, candies and sunflowers” and claim that these should only be consumed with specific preparation methods or they should not be consumed at all (“Uzmanlar uyardı”, 2019). Another example is from Mynet.com: “For mercy’s sake, be careful. Do not let the feast of sacrifice be a mess. 5 precious rules!” (“Kurban Bayramini Rahat”, 2019). When people are overloaded with scary health advice and messages, some give up believing in them as it is considered too inhibitive. The ill-society of Baudrillard produces these campaigns of fear and disseminates relevant scenarios. This ill-society suggests and imposes that the individual should care about health, and organizes this culture of advice through campaigns of fear or protective health measures against death, accidents and diseases. Besides the health promotional campaigns organized by states or health sectors, this health-care management is spread by word-of-mouth advice.

Image 6-Sensational news headlines manipulating the emotions of those demanding health information, "TV & Computer Craze is Giving Kids Cancer" - The Daily Mirror (8.12013), "Cancer risk in just two cans of pop" - The Sun (7.3.2010)

In the organization of the health-care management through fear, the techniques, strategies and messages of dramatizing were coupled with holistic approaches and methods, gradually contributing to more health-relevant and bodily preoccupations. However, the use of fear in health management has a history. Unlike for diseases that emerge due to wars and pandemics, doctors have used these strategies and discourses for lifestyle-induced health problems especially for the last two centuries along with the emergence of industrial revolution.

In the Coronavirus pandemic, the fear strategy was employed. Hundreds of thousands of statistical indicators about the number of deaths and active cases were disseminated through internet, social media and mass media. Besides these indicators, a great deal of advice and warnings were disseminated by the health professionals within the scope of this strategy. Biopower obliged people to accept solutions and advice proposed by health professionals in media. As in previous daily health communication practices, such themes as morality, hope and fear (Baldil, 2019) were employed in the pandemic health communication. The main public health management strategy was specified as a fear strategy due to state of emergencies. This can be understandable in pandemics when urgent decisions are taken and actions are made. However, unlike in pandemic situations, nowadays, the use of fear shapes concerns related with medicalization and commodification. As relevant industries were not as developed as they are now, these discourses based on fear had less media coverage as well as less dissemination by word of mouth.

Within the medicalization process, many new definitions of diseases or health problems are fabricated and this fear to escape (from manipulated emotions) is turned into a consumer need (desire) to consume—"you either consume or you die or you have a lower quality of life and health". The fear and the need are becoming two culturally associated and contrived phenomena in a process in which new needs, expectations, imperatives and norms

are stimulated by health politics and the market. In this sense, as emphasized in the studies in the sociology of risk, the risk management is individualized within the scope of risk culture, risk society and risk civilizations[24]. Giddens established a relationship between risk and responsibility to illuminate this individualization (Giddens, 1999). In the consideration of these perspectives, in the Coronavirus pandemic, we witnessed the fact that the international and national health authorities, actors and organizations individualized the risk management and reduced the "organizational responsibilities" to personal responsibilities. These organizations made risk assessments to provide the ultimate protection in the pandemic, however, they also regulated this process in an emotionally manipulative manner as usual and put the fear strategy into practice through the information dissemination in mass media and social media. This practice is a usual one and it was also employed in the pandemic as a process, too. In these kinds of practices, governments conduct health education campaigns to warn the public about the dangers of certain activities, presuming that 'risky behaviour' will be reduced as a result of the information transmitted (Gabe, 2013: 18). The problem is that this individualization of risk is not limited to only fear, but it is also used beyond serious cases and in daily health management practices, as seen in the headlines demonstrated in image 6.

Besides fear strategy, another discourse which can be called "blaming the victim" is employed in emotional manipulation and health regulations. This discourse combines the symbolic power of scientific knowledge with moral power of medicine. The individualist norms formed through the divine cultural power of neoliberal medical enterprises, organizations and expertise have been producing victim-blaming interpretations for simple health problems with such stigmatizations as "weakness of will" or "carelessness". Exemplifying the moral blaming-victim discourse of an extremist but, the most popular health professional of Turkey, Canan Karatay[25] may be appropriate in this point. In one example, she blames the vegans (the victims) as follows:

> Cereal products are animal feed. The human body is not programmed to use these. If we eat only the cereal products, we will be like sheep and have cereal brains. Vegan means having cereal

[24] For further readings on the sociology of risk, see (Beck, 1992; Giddens, 1998, 1999; Zivokic, Warin, Davies and Moore, 2010; Ward, Coveney and Henderson, 2010; Lupton, 1999).

[25] She is known for utilizing a sensational health communication, which is also found attractive by mass media and she has a wide media coverage. In her interviews in media, she usually uses traditional metaphors and expressions that target all social classes

> brains. Vegans are short-lived. Vegans only eat cereal like rabbits and sheep. Veganism is a disease ("Canan Karatay veganlari", 2018).

This disease-guided marketing approach in social marketing denies other social determinants of health in solving the problems of individuals' health. The environmental issues, namely working conditions, the socio-economic background, the regulation of the relevant laws and regulations, and the participation of individuals in the process on which the individual has almost no control (sometimes no control at all), are not included in social change efforts of social marketing (Cinarli, 2012). In the process of blaming the victim, information overload is produced to render the responsibilities of biopower invisible. Crawford made references to 'victim-blaming' tendencies of health promotion and preventive medicine despite general awareness of the social and environmental determinants of disease in medicine (Crawford, 1977, as cited in Lupton, 2013: 4). In this morality-based health care (instead of scientific), if the individual does not make the effort (perform his/her responsibility), if s/he sins by omission, s/he will be punished (Baudrillard, 1998: 129-140). This punishment might be in the form of regret for the decisions made or condemnation by others (inner social circle or health professionals). The analysis of these authors making references to victim blaming can be improved through a consideration of the fact that information overload accelerates the relevant affection and regulation. In the pandemic, the social marketing of "social distancing" was carried out in an accelerated pace and people going outside were marginalized and became blamed-victims, regardless of their justifications. This process was where biopower delegated its responsibilities to individuals in terms of morality.

Today, the commodification of health in public life has reached such an extent that it has started to produce well-developed commodification technologies that prepare healthy life advice instantly without health professionals or organizations at all. One striking example from USA could well demonstrate the commodification process in the public consumption sphere. For the last 5-6 years, Wal-Mart has been offering interactive health kiosks services (see Image 7). In these kiosks, the consumers can check their eye health, weight status, BMI, blood pressure or heart rate and see related results. Within this self-check process, many advertisements and advice about their health concerns and diagnostics are displayed instantly and simultaneously. This kind of neoliberal market operation and procedure produces emotional, social and economic outcomes. People may come, shop and be emotionally and cognitively influenced by these commodified messages; the results of

this digital medical encounter with this new social actor, makes the consumer feel either satisfied or unwell upon leaving public shopping area. On the other hand, we may also see that these kinds of cheaper opportunities for diagnosis may reduce health inequalities in capitalist countries such as USA where health services are more commodified and expensive than in many other countries. In addition, it may decrease the social aspects of health communication and organize a top-down marketing information overload in the process. However, this does not change the possibility that people now come across more choice and information even in their daily lives such as in these kiosks.

Image 7- Wal Mart Interactive Self-Health Kiosks and Commodification of Health Advice

Image 8- Less Sophisticated Self-Health Kiosks from Portugal (left) and Turkey (right)

The marketing of the commodified health promotion philosophies has been made mainly via healthy life advice in mass media channels and digital health communication. This overload of healthy life advice and information has also conveyed the dominant moral discourses and biopolitics produced by medical and pharmaceutical sectors, and it has been one of their most important public governing and regulating strategies (or governmentality as defined by Foucault, 1977-1984). If people do not act according to the "ideal healthy lifestyle" philosophies imposed by the biopower, their behaviors and selves are defined as *deviant, weak-willed, nonadaptive, careless and lazy*. Dominant morality and fear discourses

in the popular culture, biomedical understanding and the market have been producing an immense amount of replicated non-functional pills, teas, diet regimes and leads to a loss of resources which exceeds billions of dollars. For instance, an American experience ended up with a huge loss of resource even 22 years ago. While making use of the use of nontraditional methodologies and products, with trial-error, American people spent $27 billion even in 1997 for nontraditional medicine such as herbs, vitamins, diets, acupuncture and copper bracelets. The problem is the fact that the benefits of most of them were unproven. However, they are increasingly regarded as reasonable options (Schwartz, 2006: 33). In a governmental study conducted in Turkey, it was discovered that 60 per cent of drugs were discarded without being used (Oguz, 2015). The IMF made a warning against overconsumption of drugs in terms of the loss of financial resources in Turkey. As for Portugal, there is another striking fact: 20 per cent of the drugs are thrown away, and 50 per cent of the drugs are misused (Andrade and Aprenda, 2015). The examples from Turkey and Portugal are on different terms with USA. However, in these three countries, drugs and therapeutic discourses are marketed abundantly (see image 9 below) and the rate of throwing drugs away may be a good example of overconsumption organized by the market.

Image 9–Abundant Medication Marketing Activities in Lisbon Metro (Blue Line) and Trains (Sintra-Oriente Line)

The concept of "ideal health" is a significant instrument in the commodification and social marketing of healthy life. Subsequently, one can observe that many discourses started exploiting and manipulating healthy life decision-making through morality and imperatives. Featherstone's notion of commodification may be a felicitous assessment showing the market dominance over changing the definitions and cultural meanings of the commodities:

> Commodities turn out to be free to take on a wide range of cultural associations and illusions. Advertising in particular can exploit this and attach images of romance, exotica, desire, beauty, fulfilment, communality, scientific progress and the good life to mundane consumer goods such as soap, washing machines, motor cars and alcoholic drinks. (Featherstone, 2007: 14)

Image 10- The Planet of Healthy Life Related Concepts – Cultural Meanings

Cultural associations may show us that the idealized meanings and images concerning specific issues could be altered and manipulated with commercial and marketing-related concerns. We can take Featherstone's notion, inspired by Baudrillard who underscored culturally decontextualized discourses, and apply it to healthy life. Weight management can be offered as an example as it is a common issue of both the aesthetic and healthy ideal body concepts and exploited in both of these areas. Many sectors can manipulatively operate in healthy life-weight management, some of these are the following: health and medicine sectors, wellness sector, alternative, preventive, regenerative medicine sectors, media and public relations sectors, sports industry, food and catering industries, new age sports industries, herbalist sectors and genetic manipulation sectors. Each of these sectors has produced their own marketing philosophies, products and services, commodification patterns and contributed to the social and health-related norms by setting out with a diversity of cultural meanings, health-related perceptions and perspectives in accordance with their financial concerns and biopolitics. Moreover, they contributed to an increasing body/health-consciousness. In accordance with this increase of awareness in consumers, companies positioned the products as "healthier" (Byrd-Bredbenner and Grasso, 1999; Klassen and Wauer, 1990-1991, Adams and Geuens, 2007: 173). Ever since, the related consumption, production and marketing intensity have had a trend of increasing, too. Giddens, who considers that people have acquired another identity as health consumers, observes this trend, too. He asserts that the individuals are increasingly becoming health consumers and present an active stance about their own health and welfare (Giddens, 2005: 300). This regulation based on proactive stance and individual responsibility has imposed so many norms upon the individuals that now they may feel obliged to closely follow everything and have to follow the health paradigm even for aesthetic reasons.

Along with the commodification of healthy-life image, the number of herbalist shops offering natural and herbal products to those who seek remedies for their newly-commodified problems has increased. Accordingly, sales of health kits and unregulated

advertising have exploded. In Lisbon, one can find many stores of such organic, biologic or ecologic healthy life markets such as Go Natural, Celeiro, Mercado Biologico, Puro Bio, Biomercado, and many departments in such retail market chains as Pingo Doce, Minipreço, Continente (including Wells and Meu Super), Lidl, Aldi and El Corte Ingles. For Istanbul, we can say that Carrefour and Migros brands lead. However, the main provider is the herbal stores, because the preference of herbal stores in natural and herbal product purchase over market chains or pharmacies is historical. In 1885, the number of herbal stores was about 2000, whereas the number of pharmacies was only 45 during the Ottoman period (Unyazici, 2015: 5). There is no reliable data or statistics about the number of these stores in Istanbul at present. However, we can easily observe that they are still widely distributed throughout the city despite a huge number of pharmacies. The sector may provide solutions for public health problems with reference to alternative and complementary medicine of Turkey, China or the Far East. However, they sell many unlicensed products as well. As for the consumption of these alternative medicine products and some other methodologies, the market share is estimated to be around 107 million dollars in Turkey[26] ("Alternatif Tip", 2017). For many health problems, the pharmacies are still dominant, but the rise of alternative medicine has provided the sector with an opportunity to expand. As such, commodified alternative traditional methods have been transformed into global medical traditions relevant to decision-making.

The commodification may have its implications and influences in consumption and behavior patterns. Be they products or commodified health services, the decisions made concerning healthy life will not be the same as nondurable consumer product purchase or consumption decisions. These decisions refer to diverse consumption decisions, which require huge financial, bodily or temporal investments, lifestyle changes, adaptations to specific norms in long-term or sometimes in urgent conditions threatening the bodily existence. And they also refer to the changes of social circles in addiction-related cases and to the reception of support from social support groups. Some of these decisions, especially in more urgent health cases, may not be made easily or out of a habit. On the contrary, people will have to make in-depth information searches and to allocate time and energy to make evaluations for the behavioral and lifestyle changes they are expected to make.

[26] For Portugal, no official record about this issue could be obtained.

1.2.1.Choice Overload in Consumer Culture and Decision-Making

Simmel's (1950) notion about the individual (personal) gain and Baudrillard's (1998:138) narcissistic investment through health promotion could be in a correlation in the development of gender-age-individual-based consumption and production models. For quite some time, soap, shampoo, pills and many products have been produced with male and female versions and also with many age variations. We can conclude that, in such a production model, diversifying the needs and consumption has allowed capitalism to reproduce itself, the consumerism and consumer culture, but most importantly created the choice overload. Now, even for a less serious health problem or issue, many alternative choices are marketed with references to age, sex, etc. (see image 11 below).

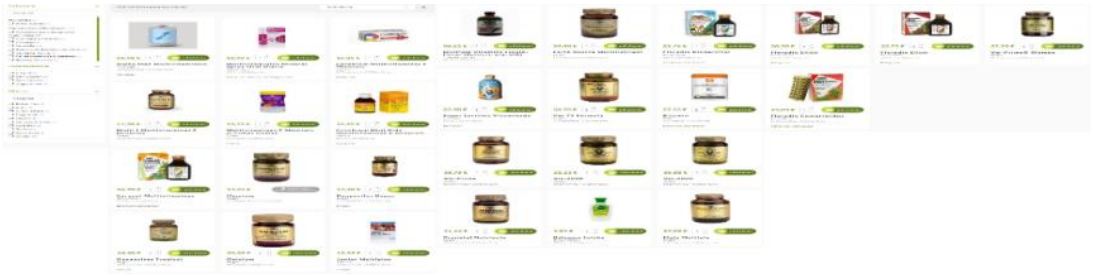

Image 11- Celeiro "'Multivitamínico" product range one will encounter in any store in Lisbon – 28 different products[27] - Product range shaped by concerns about age, sex, price etc.

Simmel elaborated on the market construction of the relationship between emotional manipulation, differentiated needs (as an antecedent of choice overload) and consumption as follows:

> In order to find a source of income which is not yet exhausted, and to find a function which cannot readily be displaced, it is necessary to specialize in one's services. This process promotes differentiation, refinement and the enrichment of the public's needs, which obviously must lead to growing personal differences within this public. (Simmel, 1950: 420)

The promotion of the differences was an appropriate way of establishing a commodified neoliberal health model. The construction of the liberated individual, according to supporters of neoliberalists, could be possible with an increased awareness of their health and body-related needs or imperatives as well as turning them to informed

[27] In any chain of supermarkets, pharmacy markets or biomarkets in Lisbon, one can come across a similar variety of choices, some with same brands, some with other brands and even many proliferated Chinese products, not in ethnic markets but in big chains.

consumers. In this way, health products and information were marketed in a fashion targeting the whole population which now had lured customer identity (Simmel, 1950), too. Grace reveals this phenomenon below:

> According to this philosophy, the customer is an individual with needs, wishes, desires; she or he has the freedom to choose, is a decision-maker, is a "private individual." The marketing agent merely describes and displays the goods and services; the individual potential customer is free to resist persuasion and to make up her or his own mind. There is no coercion, and the marketplace is "free." (Grace, 1991: 335)

Another justification and strategy of the commodified health is the argument of "freedom of choice". It was one of the mostly utilized justifications in increasing the market exploitation. Kivelä argued that the freedom of choice was underlined more and more in neoliberal health policies and health systems all around the world (Kivelä, 2018: 161). This evaluation should be improved with the analysis of the fact that freedom of choice has been underlined in the individualized and globalized health-related norms and decision-making, too. According to Bauman, however, the freedom of choice does not guarantee the actualization of the decisions, choices and the freedom of attaining the planned results. For him, for the individuals to be able to act in a free manner, they need more than just free-will and freedom of choice (Bauman, 2010: 29-31). He summarizes the paradox in the freedom of choice notion and rational choice notion:

> Money is not the sole source upon which our freedom of choice is dependent. I may realize that my freedom to act as I desire does not depend on what I do or what I have but depends on who I am. I may be refused entry to a club or employment because of the manner in which my qualities such as race, sex, age, ethnicity or disability are judged. None of these qualities is dependent on my free will or action and I will not be able to change these no matter how much freedom I have. (Bauman, 2010: 32)

Consumers are often trapped in or carried away with the variety of choices within the free grounds of neoliberal consumer culture. As Giddens emphasizes, in post-modernity or late modernity, we are of the opinion that we can acquire a constructed body by selecting among many different identities and choices and that everything is possible (through "plurality of options which late modernity makes available*"*), (Giddens, 1991: 106). The most popular example for this is the ideal body and slimming craze.

In this freedom of choice, a variety of choices in healthy life products and information is demanded by the consumers. One can find evidences about this demand of health information in mass media, social media and in any market research study. However, this demand does not necessarily justify the uncontrolled and conflicting overload, but may serve as a function of generating the needs and wants with many different stimulants in the form

of messages and images. Such scholars as Pine et al. (1995) and Schwartz (2004) object to this CO that is allegedly to serve as a market function: supply and demand equilibrium. Pine et al. (1995) finds no justification in the CO: “customers do not want more choice” (Pine, Peppers and Rogers, 1995: 103-108). In their perspective, the health consumer should not be coded as a consumer craving for alternatives due to their needs and wants. Hiding behind a “needs and wants” discourse may not justify the countless numbers of proliferated and replicated categories and products. The proliferation and replication in the production of goods and information plays an important role in Schwartz’s analysis of the influence of this overload on decision-making. This increasing intensity of proliferation and producing overload of choices produces such emotional consequences as stress in health-related decision-making. This notion can be seen in his statement: “The combination of decision autonomy and a proliferation of treatment possibilities place an incredible burden on every person in a high-stakes area of decision making that did not exist twenty years ago” (Schwartz, 2006: 33). Quelch’s and Fielding’s critique also serves as an important example demonstrating the vast number of proliferated categories: “products have proliferated at an unprecedented rate in every category of consumer goods and services” (Quelch and Kenny, 1994). Some extreme examples of this "product clutter" can be taken from the study of Fielding:

> Take buying a toothbrush. It used to be manageable enough - hard or soft? Bristle or nylon? Red, green or blue? But these days Boots stocks 75 kinds of toothbrush, not taking into account the colour variations. Single-tufted head? Angled head? Contoured head? Soft standard? Extra hard? Firm? Contoured massage filaments? Non-slip rubber grip? With or without interdental brush refills?...Shampoo is worse. There are 240 varieties in Boots. Do you want body, shine and manageability without the waxy build-up? Or just manageability and shine? What kind of shine exactly? Healthy shine or jojoba shine? Would a dash of sea kelp, pina colada, or marshmallow be nice? Massoia nourishment? Elastin volume? Anti caspa? Ginkgo strength? Or, hang it all, just stick with the old Swiss botanical humectant? (Fielding, 1994)

Actually, the engine or the motivator of the variety of choices is the customer demand and this can easily be identified in the market researches and focus group studies, however, some of these researches are also conducted through the manipulation or techniques invisible to the consumers. We can not see such distinctions in the studies of the scholars opposing to the idea that customers do not need variety. The tracking and monitoring of the search functions on internet-based platforms should also be included in such analyses (at least in studies conducted for the last 15 years).

The main categories in which there is an overload of choice can be summarized as the nutritional supplements, vitamin supplements, pills and organic products…Marketing

activities are conducted for all of these product and service categories. This, in turn, results in CO-IO even in daily supplements. Many counterfeit or dysfunctional products are manufactured and marketed. “One extension of this line of argument seems to suggest that current proliferations are being driven less by customer needs and more by companies' desire to increase profit by utilizing extra production capacity through making minor changes to existing product lines” (Mitchell and Papavassiliou, 1999: 323). Although the original products or productions are also driven by the consumer needs, the healthy life markets are organized in a way to generate maximization of profit through unsatisfied experiences rather than the permanent result-oriented and effective solutions. This analysis should also cover the fact that a basic strategy based on an ephemeral problem-solving which needs a repetitious purchase and consumption of the same services and products. This can be best exemplified by the cases in bodily and cosmetic industry products. Nowadays, the pharmaceutical and medical industries have adopted this practice, too. Otherwise, their market shares and dominion will be shrinked by the reduced profits and number of consumers who will not need any service anymore.

The market and health communicational sources of indecisiveness come into play when the market offers only superficial solutions for some problems within this choice rhetoric. The consumer may be stuck even in the first step, in the perception and evaluation of the choices and in deciding on the choice that will meet the expectations among the 1000 thousand same-quality or price products. This is only one reflection of the market-related reasons for indecisiveness[28].

In the consumption of healthy life products and services, the individual choice rhetoric and discourse ignore many social and market-related aspects, factors and mechanisms such as the class, family type, occupation, the time limits, the number or variety of the choices, prices, the qualitative and quantitative features and functions of these choices, the similarities, the differences, brand name, side-effects etc. even in a simple selection of a vitamin pill. This market structure may be some of the most important determinants of consumer indecisiveness in health behavior.

[28] Some other market-related factors contribute to confusion, too. These are: “the fragmented nature of the market; the fashion and lifestyle driving force; too many brands distributed by too many intermediaries and sold by too many shops” (Mitchell and Papavassiliou 1997: 166).

Market combines morality and choice rhetoric and confuses the consumer. In this construction of market-related indecisiveness and decision-making, some choices are defined as bad or unhealthy and others are as good and healthy. Concerning this rhetoric, Gabriel and Lang argue that "Choice lies at the center of the idea of consumerism, both as its emblem and as its core value...Choice is inextricably linked with morality, questions of right and wrong, good and evil" (Gabriel and Lang, 2006: 26). We can take Gabriel and Lang's argument further and examine the underlying issues. The more choice, the more moral evaluations about choices about good and bad deed, inclinations, actions of people, their capacities etc. …This eventually causes the scientific health care management and health information to be shifted to a health and behavior management technology (like the technology of self, Foucault, 1988), making evaluations with "positives and negatives" of people's behaviors, creating pressure through "good and bad deed". When the "good" and "bad", "healthy" and "unhealthy" come to the fore as choices with other criteria, people may have to make further evaluations, research and applications to make plausible decisions for themselves.

In the Marxian view, the choices are imposed upon the powerless by the powerful and these choices serve as the limits of freedom or constraint. Those who offer choices are the ones who draw the limits as the powerful capitalists. As for the neoliberalist notion, freedom of choice may contribute to the improved health status and human rights and many positive associations are bound between the number of choices and improvement in life conditions. Schwartz criticizes severely this neoliberal freedom notion which confuses the customer with the loss of temporal capital as follows:

> Freedom is essential to self-respect, public participation, mobility and nourishment. Not all choices enhance freedom. Increased choice among goods and services may contribute little or nothing to the kind of freedom that counts. Indeed, it may impair freedom by taking time and energy we'd be better off devoting to other matters. (Schwartz, 2006: 4)

The neoliberalist surplus production or choice overload stresses the valuableness of the alternatives in the social sphere. However, a possible indecisiveness caused by these conflicting choices in this surplus production also leads to a reduction in the frequency of consumer consumption or behaviors. As it can be seen in Marxian view, the upper and managing classes not only produces these choices but also the moral discourses about these choices and decisions. They produce such dualities as accuracy or inaccuracy in these health choices. As a powerful management instrument of the biopower, the biomedical perspective

does not hesitate to stigmatize the patients and consumers who do not adopt healthy life norms and choices as deviant.

May choice variety make a sense for those who have become indecisive or unconcerned? For some, yes, it may, for some others, it surely will not. With “Blasé attitude” concept, Simmel implies that those unconcerned people will not be influenced by this variety of stimulants (choice overload). According to him, “the blasé attitude results from the rapidly changing and closely compressed contrasting stimulations of the nerves” (Simmel, 1950: 414). The compression and stimulations of the nerves are today caused by the ceaseless flow and consumption of conflicting information and by the increasing number of choices that the consumers are exposed to in everyday life. In Blasé Attitude, people have difficulty in responding to the ever-increasing stimulants in the urban areas and may turn to and/or adopt Blasé attitude after a while (Simmel, 1950: 414). Some people may be in Blasé attitude and/or ignorant, some may be indecisive but also some people may be satisfied with choices, even those experiencing indecisiveness to some extent (especially people with lower indecisiveness in healthy life decision-making process). In Simmel, all these choices, “(they) will probably appear to the Blasé person in an evenly flat and gray tone” (Simmel, 1950: 414). The Blasé may ignore the information and choice overload even though it is very difficult to resist at present.

The fact remains that the choices or the freedom are enjoyed by many people in consumer society. Even though choices can be motivating and consumers enjoy the freedom to choose, some studies have shown that people may have difficulty in handling complex choice tasks (Kuo, 2010: 35). Iyengar and Lepper found in their study that the choice variety was perceived positively or attractive due to a belief that it would be beneficial. But, in the end, this variety brought about a reduced motivation due to a difficulty in choosing in the purchase process (Iyengar and Lepper, 2000: 995-1004). These study results can be considered to be in line with the general perspective finding a correlation between the choice overload and indecisiveness.

"Healthy" and "diet" are highly marketable terms and useful in selling food to health-conscious consumers, but such product claims can be inaccurate or misleading. Mitchell and Papavassiliou (1999) give an example about this: The "light" in Asda Pure Vegetable Oil refers to its color; it is no lower in fat than other oils. Both Prince's Premium Light Tuna and Asda Light Meat Tuna claim they contain 0.2g fat per 100g respectively, no

less than other brands (Which?, 1995, as cited in Mitchell and Papavassiliou, 1999:321). Although this example is about only one nutrient, similar cases can be found for many health-relevant issues. Many products, services or behaviors which can be proved to be unhealthy are marketed in the same manner and an information overload is produced upon the marketing activities of these.

When one visits a Celeiro store or any other supermarket chain store in Lisbon to find any vitamin pill or a healthy life product, s/he will probably encounter tens of similar quality and price products. Many factors concerning this purchase are evaluated by the consumer: variety of choices, prices, brands, the impact, calorie, fat rate etc. Some of these products do not work for some people, but anyway, each of them is marketed abundantly and manufacturers capitalize on these exploited images[29]. In Lisbon and Istanbul, there are tens of healthy life entrepreneurs producing and delivering only healthy life products, organic products or only consultancy services. Many companies operate in the diet industry, especially the economy of dietary food delivery services is growing very fast and contributing to the choice overload, exploitation of healthy life image. We can see the same concern revealed in studies conducted in 1990s, that is, the medicalization of food and nutrition through Alicamento (Foodicine[30]) conceptualization. Through this concept, an unusual concern is revealed in relation to health, the diets and the maintenance of the body, which generally tends to see the body as if it were a machine (Warde, 1997: 129). One of the reasons for such an approach and concern is the individualization of the risk management as suggested in the sociology of food and risk. In this regard, several studies revealed that the globalization of the food ingredients, messages and increasing access to information have relations with an increased awareness of risk about food (Knight et al., 2007; Ward, 2010: 347; Warde, 1997: 130). The substantial factors contributing to such an awareness about health issues were the scary messages dominating the news coverage in mass media, especially the messages about nutrition, lifestyle and health-management.

The dominant capitalist concerns of many industries may change the trends of consumption and purchases as well as lifestyles. These concerns respond to the supply and

[29] For further readings on capitalizing the exploited images, see: (Wiseman, 1994)

[30] Alicamento can be translated as foodicine (an also nutricine), a kind of nutrition having references to healthy nutrition, to the belief that nutrition constructs the health and a healthy nutrition is as useful as medications. It is the combination of the Portuguese words “alimento” (food, nutrition) and “medicamento” (medication).

demand equilibrium; however, they also transform people to consumers. As for the health-related issues, many problems are defined and specified in medicalization theories and the solutions for these are generally the products and services of medical and pharmaceutical enterprises. Besides these industries, the food industry also capitalizes on some discourses. According to Sezgin: "Traditional meals and foods were abandoned in the past due to the notion that it was necessary to adopt modern life norms. Now, they are considered healthier and replace the modern ones in the dining tables. The traditional cooking methods and apparatus which were abandoned due to same notion are being utilized again as in the past" (Sezgin, 2010: 235). Ever since the marketing activities started exploiting the healthy life image actively, some incoherent management and manipulation activities have emerged especially in nutritional issues: defining the nutrients, behaviors, ways of thinking, habits, techniques, apparatus and self etc.

In the course of time, the calculation of the calories of the meals or foods gained importance. Now, the inscription plates about the calorie amounts are installed in the fast-food restaurants and/or ordinary restaurants in order to prevent any kind of acquisition of incorrect information and behaviors. A study carried out by Warde in 1990s revealed that the concern about healthiness in nutrition showed a dramatic increase in references to health. In 1967-68, references to health were very rare in the columns of gastronomy. Only 4% of articles explicitly recommended certain foods for healthy, while in 1991-92 this figure rose to 16%. The other finding was that the percentage of articles that refer to a diet healthy went from 9% to 65% in 25 years (Warde, 1997: 127). The social marketing of healthy life or nutrition is not limited to the media or restaurants or relevant industries. These kinds of informative applications are becoming standard for many issues in public transportation, restaurants, public spots, product packages or working environment. The increased awareness about healthiness and risk in the society and the social accelaration (Rosa, 2013) influenced foodicine (alicamento), the relevant calculations, the cooking utensils, time and methodologies. In conjunction with this, the relevant messages about these issues and a preoccupation with these increased in mass media an internet. Such contradictory themes and types of motivation as novelty and habit, health and pleasure, ease and care, economy and extravagance came prominent also with references to the social pressures that influence food choice (Warde, 1997: 125). In addition to these contradictory themes disseminated, with very few clear distinctions about the accuracy of these information, the advice from health authorities about how many calories should be consumed and how long an exercise

should be made are easily disseminated in public spaces. However, some vital differences between these messages can be observed, especially due to information pollution caused by quick dissemination of semi-scientific information on internet. The next section will focus on the conventional and digital media's influence on health-related perception, decision-making/indecisiveness and behaviors.

1.3. Healthy Life Advice Produced by the Media

The healthy life advice was introduced by the authoritative professionals (primarily doctors) in the beginning of 19th century along with the emergence of industrial modern society, but now in the end of 2010's, popular culture and consumer culture prevail in the dissemination of these. Besides the advice in media, digital media and word of mouth health communication, nowadays, the healthy life images, messages and information are attached to so many products and to the nutrient product packages, into restaurants, cafes and many other public places. Even the packages are turned to promoting agents for purchasing decisions with an innovative and emotion-provoking way (Fortuna et al., 2002: 78).

Health promotional activities have successfully convinced, been manipulative and imposed the behavior changes through fear-producing discourses. These moral and emotion-targeting discourses is easily associated with the commodification process in such a simplified fashion: "If you do not want to experience this problem, you should do this and that", with suggestions of products, services and ideal behaviors for a healthy and beautiful body. In this regard, even the public health customs and practices are reinterpreted and new neoliberalist consumer slogans are derived from these.

The consumer society member having a compulsive demand for narcissistic investment (Baudrillard, 2010) especially in the body beauty and cosmetics, the pills or products are also likely to have a compulsive demand for information. However, this demand for information and products alternately brings about the production of a variety of choices by the entrepreneurs, but not necessarily an overload of choices, including conflicting advice overload. This variety of choices can be seen in the formation of many groups of experts supporting some theories (supporters of proteins carbohydrates in Facebook, enemies of fat or sugar, low-carb consumers in Instagram, macro-counters, social media cultural intermediaries etc.). In conventional or digital medias, one dietitian or nutritionist asserts that any kind of sugar use is fatal, so the fruits should be consumed very carefully (Karatay,

2018, 2019), the other may assert just the opposite (Sousa, 2014). In this case, the market along with media will lead people to indecisiveness by not controlling the information replication and pollution.

Cultural intermediaries have for long been one of the most important actors organizing this global health decision-making process. In the literature, there is a variety of different names and terms to define them. Gomes (2010) calls them as health brokers but we may call them as cultural intermediaries (actors) as Bourdieu (1984) and some others named them. Featherstone attaches a particular importance to the role of cultural entrepreneurs and intermediaries in health commodification and advice. He defines them as those people creating postmodern pedagogies, educating publics and states that they are engaged in fashion occupations and in symbolic production in consumer culture and popular culture (Featherstone, 2007: 10). "They produce popular pedagogies and lifestyle guides…They can be found in market-oriented consumer cultural occupations – the media, advertising, design, fashion etc. – and in state-funded and private helping professions counselling, educational and therapy occupations" (Featherstone, 2007: 35). Featherstone's definition has long been appropriate and sufficient for relevant issues, but this definition should be developed to include the present issues of today with references to exploitations in health. In this regard, we can add another function of this group, today, they may also fulfill a duty of "disease mongering[31]" within the scope of medicalization, biomedicalization, para-medicalization, pharmaceuticalization and pathologization activities. The number of disease mongering activities and of cultural intermediaries that target health-related decision-making has increased drastically in line with the increasing usage of internet technologies, especially social media applications such as Instagram and Facebook. The dissemination of information that guides the decision-making has increased drastically as well. Today, even the smart-bands (smart bracelets), smartwatches or activity tracking applications in smart devices function as cultural intermediaries and they offer some behavioral norms as imperatives of commodified ideal health[32]. Levitin indicates the information literacy deceptions full of

[31] Disease mongering is a function of medicalization, a proactive practice which labels many conditions as illness, increase the publicity of these newly defined "disorders" so that some cures for these can be produced and offered by the market, for further reading, please see (Fontecilla, 2014: 104-107),

[32] The health and body tracking devices and applications by Google Corp. displays and disseminates the messages produced with the norms of WHO. These kind of systems are also used in telehealth (remote health-care) and run predictive algorithms powered by artificial intelligence to monitor patients' prognoses. The system constantly updates each patient's "acuity score," a grade that reflects remotely gathered patient data—

biased or pseudo-scientific health information including the disease-mongering activities in the following example:

> If you are looking up a particular prescription drug and trying to figure out whether you want to take it or not, the first thing that is part of information literacy that every eight-year-old should know is, whose website are you on? Is it the drug manufacturer's? Might there be a biased information on there? Is it the site for the manufacturer of a competing drug? Maybe it is some sort of shadow site for the manufacturer of a competing drug under the name americansforbetterhealthcare.com or something like that. (Levitin, 2014)

Especially, in Instagram and Facebook, the cultural intermediaries are defined as "influencers" and "lifestyle coaches", they are taking the commodification issue several steps further and many famous "lifestyle experts/coaches" or popular social figures (actors) disseminate the images, videos and texts about their healthy lifestyle and body exercise activities and also relevant advertisements in social media. These are organized insofar as to govern and manipulate people's decision-making in a convincing manner in that they will decide to consume that particular brand or act in the proposed or imposed manner. For instance, in Portugal, we can check this website which has a genre-based name, not a brand name: https://www.saudebemestar.pt/pt/ . It has much advice about general healthy life issues which can be easily accessed through search engines. However, in some of the messages and pages, it can also be easily observed that these information sources belong to specific investor groups in medical and pharmaceutical sectors. There, anyone can find visible or hidden advertisements and commodified advice that go beyond "the needs and wants" discourse.

Johnson (2012) focused on the similarities between production and consumption of food and information, on the similarities between production models of these markets and sectors. In media, one can easily find examples for the health information production models, which generally provide sensational information to be able to attract reader who are accustomed to consuming this kind of sensational information. Johnson claims that the consumers prefer this sensational information rather than informative ones:

> The food companies learned that if they want to sell a lot of cheap calories, they should pack them with salt, fat, and sugar—the stuff that people crave—and that affirmation sells a lot better than information… These media companies are driven by a desire for more profits and for wider audiences and produce information as cheaply as possible. As a result, they provide affirmation and sensationalism over balanced information. (Johnson, 2012: 6-10)

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such as blood pressure, oxygen level, heart rhythm, and pulse—to evaluate the risk of a sudden deterioration. (Seabrook, 2020).

Image 12 - Sensational news headlines for manipulating emotions of those demanding health information -Mushrooms Beat Cancer" - Daily Express (30.11.2009), "Blood Pressure Risk From Salt" – Daily Express (17.05.2013), "Eating Fat Is Good For You" – Daily Express (23.03.2013), "Processed Foods are Driving Up Rates of Cancer" – Daily Mail (14.02.2018), "Eat Up, Fat is Good For You" – Sunday Express (11.12.2016), "Diet That Will Add Years To Your Life" - Daily Express (22.11.2012), "Diet That Will Add Years To Life" - Daily Express (3.12.2014), "Healthy Diet To Beat Dementia" -Daily Express (11.3.2014)

Johnson claims that the production and consumption models are similar in the food and media industries. That is to say, the targeted emotional consequences or outputs are similar and the information is now "consumed", not acquired in a systematic and pedagogical manner due to the information overload. He establishes a relationship between over-supply and overconsumption in food industry and states that it is applicable for media industries, too: "In the food industry, the cost of a calorie has been reduced down so low that now obesity has become more of a threat than famine. The food supply became more abundant, and access to it improved. Obesity is no longer just for a fortunate few" (Johnson, 2012: 6-10). His notion assumes that an overconsumption occurs as a result of these kinds of production models, which have mostly become cost-effective: "the media companies learned how to produce and distribute information in an almost free manner" (Johnson, 2012: 6). In a Bourdieuan way of thinking, this notion proposes that that the food-nutrition industry has changed the products and the tastes of people, so have done the media-internet industries. Esitti makes reference to the capitalist justifications for this similarity in food-information production and consumption:

> Media companies target more profits and a wider audience. To reach this goal, they produce as more cost-effective information as possible. After awakening to the fact that sensational and sexually explicit information are consumed more than informative content, they focused on producing more magazinish information and news instead of informative content and entered into a competition. Such elements as the sensational and sexually explicit information, advertisements, public relations activities, informational intervention, propaganda and spin doctors came to the fore in new media. (Esitti, 2015: 82)

In Web 1.0, people received the healthy life advice from cultural intermediaries and applied this information into their lives and behaviors. Now, we have transcended the limits of Web 1.0, we have social media and Web 2.0. In Web 2.0, the opportunity for the people to share information has contributed to information and choice overload. The number of healthy life advice sources through which we are expected to make the decisions has exploded. Schwartz attributes this information bombardment to the emergence of healthy life information dissemination in internet:

> It is not just a matter of listening to your doctor lay out the options and making a choice. We now have encyclopedic lay-people's guides to health, "better health" magazines and most dramatic of all, the Internet. So now the prospect of a medical decision has become everyone's worst nightmare of a term paper assignment, with stakes infinitely higher than a grade in a course. (Schwartz, 2006: 32)

The overload of choices and information has also transformed lay people to cultural intermediaries, consumers of this overload and to decision-makers in healthy life. Within the context of this transformation into information consumerism, a majority of people's habits were altered in a way that covers the utilization of these information technologies. In 2010's, almost half of the day of many people has been allocated for consuming a variety of information choices, Johnson underscores which kinds of information transform us to infosumers[33] as follows:

> People spend more than 11 hours per day consuming information—reading newspapers and books, checking out friends' Instagram and Facebook pages, reading the newspaper, watching television, listening to the radio or portable music player. For those who work in front of a computer all day, the number of hours is even more, spending all day reading and writing in front of a screen. (Johnson, 2012: 4)

An extensive consumption of information, as held by Johnson, "can have physiological effects on our bodies, as well as fairly severe and uncontrollable consequences on our decision-making capability" (Johnson, 2012: 5). Accordingly, the decision-makers and regulating structures, aware of the power of information on decision-making capability, develop management techniques through which they overproduce information and manage their marketing strategies. Many eye-tracking glasses or devices are used by the market research companies to monitor and observe the decision-making patterns and habits of people from each class. Many digital mouse-tracking software are employed in online shopping sites and many analyses are conducted to observe people's decision-making and

[33] Infosumer: information consumer

emotional reactions to the images, messages or sensational information. By using these kinds of techniques, they affirm the relationship between this information consumption habit and manipulation. The ruling classes reproduce their power through these and produce a well-elaborated govermentality.

1.3.1. Overload of Healthy Life Advice and Indecisiveness

In indecisiveness literature, many scholars focus on the influence of the IO on the emergence of confusion and indecisiveness (Ozkan and Tolon, 2015:33, Walsh, Hennig-Thurau and Mitchell, 2007:704). However, as indicated in introduction, none of these scholars have focused on the impact of the overload of health advice on relevant health behaviors. Many people seeking advice about how to lose weight are exposed to very different kinds of diet regimes, many of which set off with conflicting assumptions and data sets and come up with very different philosophies and lifestyle recommendations. In the middle of all these conflicting regimes, clear and understandable ways of managing health are created and also destroyed by the diet market and media. Ozkan and Tolon assert that decision-making will be impacted by the confusion emerging after being exposed to the overload in the market: "confusion causes the misunderstanding or misinterpretation of the market by the consumer who wants to find the optimal solution for himself/ herself with the results not displaying the expected performance during the consumers' decision-making process" (Ozkan and Tolon, 2015: 33). In the same line with Ozkan and Tolon (2015), Mitchell and Papavassiliou state that decision-making may be more complicated and stressful as we can see in Simmel's urban complexity, too:

> The number of products, the increasing amount of information carried by each brand about their products, the product proliferation and production of a decision-making imperative could cause the consumers' exposure to information overload and the consumer confusion, resulting in stress and poor decisions. (Mitchell and Papavassiliou, 1999: 319)

A combination of delay in decision making and postponing the act of buying (see: purchase avoidance) is considered to be another consequence of indecisiveness or confusion (Ozkan and Tolon, 2015). Ozkan and Tolon found statistically meaningful relationships between IO and indecisiveness. They also found that this confusion has a negative effect on consumers' buying decisions, leading to a decrease in purchasing (Ozkan and Tolon, 2015: 27). According to Malhotra, the "information load" may lead to decision difficulty with undesired consequences (Malhotra, 1982: 419), an undesired consequence for both the

market and the consumers. Fletcher and Wald also make references to this possibility in terms of health-related indecisiveness: “Confusion is central to consumer protection because confused consumers may suffer physical harm when they unknowingly buy a product other than the one they intend to buy” (Fletcher and Wald, 1987, as cited in Mitchell and Papavassiliou, 1999:324). These opinions and data should be updated with references to the possibilities of increased risks associated with increased information pollution and imitated products in many areas of life such as food, non-prescription drugs, supplementary nutrients, beverages, cosmeceutical products etc..

The macro implications of this limitless and uncontrolled dissemination of health advice may be striking. While the health market overloads the customer with information and choices, it may also hinder the expansion of the market, by producing permanent indecisive, indifferent and unconfident consumer groups tending towards purchase and decision avoidance in such phenomena as anti-consumerism and resistance against vaccination. Johnson underscores other possible impacts of information and choice overload, the influence of sensational diet philosophies on the health-related decision making:

> No matter which way you turn, abundant information makes it easy to distort our relationship with food into something unhealthy. If you’re looking to surf through a land of false promises, spend a few minutes in the diet aisle of your local bookstore. You can lose weight by thinking like either a caveman or a French woman, or by eating only food that’s cooked slowly. You can lose it, says the updated 2012 edition of *Eat This Not That!* (Rodale Books), by simply swapping in a Big Mac® for a Whopper-with cheese®. (Johnson, 2012: 16)

Johnson attributes the existence of these kinds of complicated and conflicting philosophies to the free market: “The emergence of these kind of false premises is unavoidable in a free society: the right answers— healthy information—compete side-by-side with the answers we may want to hear but which may not be true. Only the highly nutritionally literate can easily tell the difference” (Johnson, 2012: 17). Similarly, Kuo underscores a possible correlation between less indecisiveness and high literacy despite the choice overload: “Even though consumers might feel overwhelmed or dissatisfied under an extensive choice variety situation, those who are high in product expertise will suffer less than those who have less expertise about the product they are customizing” (Kuo, 2010: 38). Being uninitiated about health issues or highly health-literate can impact the levels of indecisiveness in a given health decision-making case, however, here again, it should be kept in mind that both of these two types of consumers are exposed to an overload and there are no serious structural mechanisms that protect them from decision difficulties.

Johnson brings another perspective and argument to the information overload issue. According to him, IO is not a problem, for him, the main problem is 'information overconsumption' (Johnson, 2012: 4-26). In his definition, he uses the information overconsumption instead of "maximum capacity" discourse or "information overload" as most scholars did in the literature. In fact, this perspective could offer a new insight in the related literature, in the construction of policies to eliminate the low-quality information production. However, this could also be counted as one of the blaming the victim discourses of biomedical perspective, because, the overconsumption cannot be controlled only by the individuals. Without the consent of people, all kinds of mass communication products, a great plethora of healthy life advice and related issues appear before their eyes in public spaces and daily conversations.

Image 13- Information consumption

Another biomedical categorization and stigmatization in the information overload literature is the concept of "information obesity", similar to "information overconsumption" concept suggested by Johnson. As in overconsumption notion, it makes references to the individual free-will instead of structural mechanisms that also regulate decision-making. However, Esitti developed another perspective which does not dare to blame the victim as the "victim" is not aware of the stigmatization. For him, "the information obesity has turned out to be an inevitable result of the disfunction emerging in media. Accordingly, it has become almost impossible for the people to refrain from the information obesity, even to notice it" (Esitti, 2015: 83). Those main suppliers of healthy life advice and the conflicting ones should also be kept responsible in the management of the health care, because these suppliers contribute to an information pollution as well as information overload, too. For instance, as one of the biggest news and information suppliers of the world, Twitter had to deactivate more than 70 million user accounts so as to contribute to the elimination of the information pollution even though this meant a decrease in the number of users by almost

20 per cent[34]. However, this elimination by a very big information disseminator platform shows us that this regulation is two faceted, one for the individual (agency) and another for the information providers and policy makers or structural factors (structure).

Mitchell and Papavassiliou (1999: 324) stress the importance of respecting the ethical norms in information production for advertisements: "Even though the law and regulations require that advertisements should be honest, and truthful, with a sense of responsibility to the consumer and society, in line with principles of fair competition, little protection from information overload or consumer confusion is provided". In Portugal and Turkey, there is no specific protective law and application that underscore the influence of the accumulation of the advertisements. No serious analysis of the accumulated messages and sanctions that impact the health decision making has been made by the regulatory organizations. In the recent years, some improvements may have been made in the dissemination of health information in the conventional medias of these two countries, however, the inclusion of the social media in health communication has paved the way for another discussion, the necessity of considering the accumulative effect of all these medias, messages and images. Mitchell and Papavassiliou (1999: 324) have focused on this accumulative impact of discourses and advertisements in media: "this may be because overload generally results from the accumulated effects of many advertisements rather than being caused by any single advertisement or promotion. It could be argued that the codes should address this cumulative effect as well as the confusion resulting from any single advertisement". This accumulative effect can mainly be analyzed with powerful software by information technology enterprises; however, overload can even be observed in many mass-communication devices. This notion can be developed to include the accumulative effect of not only the advertisements but also information overload and information pollution, choice overload relevant to health, too.

Today, the plethora of healthy life product and services is almost limitless and the information about how to use this variety of products and services comes in the form of an overload when the accumulation of the information received is taken into consideration. Among these various choices in the market, some sources offer some possible conflicts or

[34] Twitter announced in 2018 that they deactivated 70 million user accounts in May and June of 2018. Most of these accounts were fake users and exploited to create an information polluted digital universe, further information can be found: https://www.reuters.com/article/us-twitter-inc-suspensions/twitter-suspends-over-70-million-accounts-in-two-months-washington-post-idUSKBN1JW2XN

confusion in information and meaning, too. This “confusion usually arises from three main sources, (1) over-choice of products and stores, (2) similarity of products, (3) ambiguous, misleading or inadequate information conveyed through marketing communications” (Mitchell and Papavassiliou, 1999: 320). From the sociological perspective, Giddens focused on “late modernity’s role in fostering a diversity of lifestyle choices, the necessity of having to choose and the tendency of choices to cluster in particular patterns...” (Cockerham, 2013:134). In this regard, the similar products, the ever-increasing diversity of lifestyles, communication styles, the pressure emerging out of the information and choice overload may be leading people to an indecisiveness or decision difficulty in terms of how to regulate the health behaviors, how much sugar, meat or bread to consume, how long to “do work-outs” or “six-packs” etc.. The inefficient replicates or information as well as products are not monitored seriously by the states or suppliers of information and products.

Image 14– Some of the very popular diet regimes

Image 15– Some of the very popular healthy life practices and diet regimes

Especially in internet marketing of consumer-oriented advice, there is a lack of filter of choices. The emerging inability of filtering the choices offered in the market may be another consequence of IO and the reason of the confusion felt by the consumer. Mitchell and Papavassiliou (1997: 172) point to this strain and difficulty with "shopping fatigue" concept and assert that this fatigue could lead to a considerable strengthening of the anti-consumerism movement in Europe, as already observed in the USA and Canada. As healthy life consumerism is one of the areas in which tens of foods in many diets are considered as healthy or unhealthy in a manner and intensity that may create indecisiveness, it may be another area that is prone to anti-consumerism. Today, anticonsumerism extends to such divergent health-relevant areas as anti-vaccination and minimalism in nutrition and stands as a socio-political problem constructed by the neoliberal market structure.

Indecisiveness can be experienced in macro levels of healthy life regulation as well as in micro and meso levels. According to Santos, even the health care providers may experience indecisiveness about the nature of the emerging information and its impacts on their decision-making (Santos, 2017: 2). Boateng also makes references to macro levels, to an increasing difficulty in managing the complex health systems of the present time:

> Modern health care systems are confronted with the task of effectively managing the resources necessary for improving the health and wellbeing of those they are committed to serving. Fulfilling this task successfully implies sound and effective decision making at critical points throughout the entire system. (Boateng, 2007: 14)

The regulations and applications employed by the non-governmental bodies and structures, the state organizations, enterprises and international organizations may sometimes collide or be in direct conflict with each other, because all these organizations have distinctive targets, interests, strategies and information sources as well as common or similar ones. It is also caused by the decision-making mechanism, the number of sources and the agendas structured in line with the targets of these bodies. Some references to the complexity of decision-making in different levels can also be seen in the following interpretation by Boateng: “The contemporary health care systems can be divided into macro-, meso-, and micro levels of decision-making. Each level has a distinct mandate, but all are linked to contributing to overall health care system performance” (National Advisory Council on Aging, 2005; Wilson et al., 1995, as cited in Boateng, 2007:14). Here, it is essential to note that almost all macro-level health structures, World Health Organization being in the first place, experienced an ultimate level of indecisiveness in the management of the Coronavirus pandemic and these macro-level decision difficulties were perceived by the other organizations as well as individuals, because of the accumulative impact of the contradictory information disseminated by WHO.

In the diet industry, hundreds of researches, popular articles, books and reports focusing on weight, fat, sugar and fast-food issues are published each year. Some of these are even funded by the huge enterprises making productions in these issues which are stigmatized in the society. These are even employed in the health policies of the health organizations. It is generally held that a glass of wine per day may be healthy for the heart. However, this is disproved by some studies announced in Turkish and Portuguese media as well as global media (“Bir alkol arastirmasi”, 2019) and there are some doubts (“New alcohol guidelines”, 2016) about these kinds of propositions as the researches claiming its

healthiness may also be funded by the alcohol companies as in the cigarettes example pointed out in the next chapter. In these sources, it can be also observed that maximum alcohol consumption is recommended in Portugal in a higher level than in UK, if, it is 50 ml per day in UK, it is recommended to use 75 ml in Portugal.

Many different healthy life messages, namely choice overload, may be observed to conflict[35] with each other in terms of applicability, meaning, scientific correctness and knowledge quality. We can argue that the increase in the number of healthy life messages may also increase the number of "conflicting" or "contradictory" ones. These conflicts in meaning and the difficulties in healthy life decision making should not be reduced only to the health-related perception, knowledge level and responsibility of lay people (individuals), but should also be attributed to the structure of the healthy life market, the inefficient management or regulation of the health promotional activities in digital and conventional medias. Hemp holds that the digital mediums facilitated the IO and the magnitude of loss of resource by this information pollution was very high even 10 years ago:

> Digitizing content also removed barriers to another activity first made possible by the printing press: publishing new information. No longer restricted by centuries-old production and distribution costs, anyone can be a publisher today…Information overload costs the U.S. economy $900 billion a year. (Hemp, 2009)

In a similar vein with Hemp, Schwartz asserts that, "internet can give us information that is absolutely up-to-the-minute, but as a resource, it is democratic to a fault—everyone with a computer and an internet hookup can express their opinion, whether they know anything or not"[36] (Schwartz, 2006: 55). Even though people are media literate, they do not always perceive whether the cultural intermediaries or content generators lead them with correct and quality health information. As this study also inquires the influences of the

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[35] The "conflict" concept is used in this study for the information received from different sources which collide in meaning and accuracy. For instance, one source states that fat-based nutrition is healthy and carbohydrate-based nutrition is unhealthy whereas the other source states the contrary. These kinds of information are conceptualized as conflicting in this study. In the Chapter Three, the reader can find relevant examples for the cases in Portugal and Turkey

[36] Here, it would be useful to explain the distinction between 'information overload' and 'information pollution'. In information pollution, the poor quality of the information concerned. In principle, information overload is possible with both high and low-quality information and this is a fundamental problem. Too much information is disseminated especially on the internet and this makes the human brain to process this information more difficult and to arrive at useful results with the quantity of available information. Even if there were little information of only very poor quality, it would possibly confuse and even mislead the decision-maker. When the information overload and information pollution coexist, they confound the problem by a multiple. Together, these generate complexity and obfuscation.

information disseminated lay people, the overall impact of information overload is not limited to those by cultural intermediaries and it should be noted here that our minds can be the final destination as trash bins of other people, of their inaccurate or misleading information. This impacts the reliability of the internet-based information received through any kind of communication technology devices. In a research conducted by The RAND Corporation more than one decade ago, the quality of web sites with medical information was evaluated and nearly all of these sources were found poor in quality. It was figured out that the information presented was occasionally misleading or inaccurate. Besides this study, some surveys indicate that these web sites actually influence the health-related decisions of 70 percent of the people who use them (as cited in Schwartz, 2006: 55). According to a study conducted in Turkey over 600 texts about health-related news and articles, 29.1 percent of the texts has a sponsorship relationship and 65.9 percent of these include advertisements. (Can, Sonmez, Ozer, Ayva, Baci, Kaya, Uyan, Ulusoy, Ogutcu and Aslan, 2014: 486-489). That is to say, majority of the healthy life messages and advice one comes across has financial concerns and initiates the pressure to make consumption decisions before a plethora of choices offered by capitalist markets. The choices concerning therapies are usually made with misinformation (unintentionally formed missing or incorrect information), in a fully-emotional and anxious atmosphere/mood. As one can conclude from these kinds of instances, the health information should be correct, clear, applicable and informative so that it can be impactful in the decision-making process (Cinarli, 2012). Unfortunately, this study has found out so many example cases which demonstrate that the health information reality is far from the ethical and desired level for the benefit of the public.

1.3.2. Quickie Health as a New Phase of Medicalization and Commodification

This study proposes using a specific term or concept to offer explanations for the supply-demand chain of medicalization which creates decision-making difficulties due to time constraints and invented solutions. This concept is *Quickie health*. This conceptualization has been developed upon Simmel's watch example (1950), "the ordering of many areas of life through the tracking of time", upon Fortuna et al.'s "displacement of people" (2002), in that this constant displacement may require better health and bodily functions as suggested by Gomes (2010), and upon his simplified quick tips culture and visibility of health notion. The concept was developed on the studies of Simmel, Fortuna and Gomes. However, it also has theoretical affinities with the works of Urry (2009), Rosa

(2013) and Harvey (1996) with references to social changes, pace of life and the evolution of capitalism.

Simmel focused on the punctuality and exactness emerging in social and economic relations in modern society. The lack of punctuality in premodern society was replaced by the punctuality in connection with others in modern society. This new modern order entailed arranging and configuring yourself in accordance with the other people more frequently. He revealed through his premodern-modern society analyses the impacts of this new order on the dispositives and capital accumulation in the economy and conditioning behaviors.

In Simmel, the pocket watch or timing concept organized the exploitative capitalist perspective and business relations. A certainty in calculation or measures was defined in commerce. Capitalism organized the life and commerce in depth within this new fragmented timing in urban life. “Time is money” philosophy has been used in industry and banking. According to Simmel, “money economy has filled the days of so many people with weighing, calculating and numerical determinations”. This idea is based upon Simmel’s complex metropolitan type personality: “Punctuality, calculability and exactness are forced upon life by the complexity and extension of metropolitan existence” (Simmel, 1950: 412-413). This condensed lifestyle was celebrated in modern society as it facilitated advancements in many areas of life including social changes. It also brought about a faster consumption and travel. Concerning this accelerated speed and/or rhythm of urban lifestyle and consumption patterns, Fortuna et al. pointed out the changes in the consumption and production types, with an emerging pattern of the disposable product usage: “Hasty lifestyles, nomadism and lack of time that characterize a large part of current consumers in displacement require portable (disposable) and user-friendly products. To this end, manufacturers have developed disposable, miniaturized products and products in individual doses” (Fortuna et al., 2002: 78) and “these portable and user-friendly products were accepted wide among consumers” (Fortuna et al., 2002: 123). Fortuna et al.’s description of urban life can provide us further implications regarding consumption in urban culture. In this body economy, lifestyles created for urban life and aggravating capitalism require the labor force to enhance their working performance in a faster and more effective manner. This neoliberal market requires a more rapid body and mind capacity to work, that is to say, quickly consuming, controlling and regulating the body and health for a quickly improved

body and health performance. Health market has gone beyond treatment of illness and taken up a leading role in the enhancement of physical and mental capacities.

Urry (2009) attributes the quickness, disposability and throwaway mentalities to Weberian rationalization and individualization through such conceptualizations as "acceleration society", "instantaneous time", "pace of life" and rhythm of the society. In his analysis, he establishes a connection between technical and social acceleration. What motivates these quickie life styles and messages is social acceleration. This phenomenon encourages individual acceleration in perception, decision-making and behavior. Now, everything, social or bodily, should function faster. The system demands speed. Many things are consumed, disposed and renovated by going into overdrive. Urry defines this systematic acceleration through such concepts as "the increased pace of change, the rapid dislocation and the ephemerality of products, places, and people". Urry's evaluation points out the "Quickie" and Simmel's punctuality in a clear way:

> The information can become instantaneously and simultaneously available more or less anywhere. New informational and communicational technologies based upon inconceivably brief instants, which are wholly beyond human consciousness; second, the simultaneous character of social and technical relationships, which replaces the linear logic of clock time (Urry, 2009: 189).

In the same vein with Simmel, Urry and Rosa, Harvey elaborated on the trend to perceive the increased capacity of the systems, actions, technologies and adaption to this new quick system:

> The capacity to measure and divide time has been revolutionized, first through the production and diffusion of increasingly accurate time pieces and subsequently through close attention to the speed and coordinating mechanisms of production (automation, robotization) and the speed of movement of goods, people, information, messages, and the like. (Harvey, 1996, 240)

Rosa (2013) focuses on the spontaneous time generated by this quick system and accelerated society and makes references to quickly changing mentalities and production. This organizational and ideological configuration produces the accelerated and intensified search for health solutions, rapidly-corresponding health and consumption systems. The systematic production of ephemerality and quickie philosophy requires focusing on getting visible results in a short while in line with the time management capacity. This brings about common practices and changes. As Rosa puts it: "when people find themselves subject to a time squeeze, they look for faster devices (faster computers, faster transportation, etc.) to get ahead of the curve. But when everyone else adopts the same new devices, it merely

accelerates the pace of life further, leaving no one better off than they were before" (Rosa, 2013: 153). In this regard, we can also add to his analysis that the products, fashions, messages and images are consumed in this quickie system. This pace of life demands quick and visible problem solving in high-speed health and body management. At this point, the quickie health concept comes into play.

Quickie health is a fad in structure; it is a short-term lifesaver and protector. We can define this phenomenon with intense diets and gym subscriptions, capacity-increasing drugs and everything quick. It may also be defined with feelings of indecisiveness, regret and potential negative body image[37]. It may be a reflection of a philosophy of simplicity in that the body, self, health and life may be regulated with simple formulas, and the desired body, health, bodily capacity and beauty may be achieved accordingly. Baseless promises such as "being beautiful and healthy is everyone's right" and "everybody deserves these" are formulized by various markets to motivate people, some of whom will find these promises attractive as they seek for self-fulfillment and bodily satisfaction. The aesthetic and cosmetic concerns are also manipulated under such categories as "skin health", "hair and scalp health" or "eye health". It is not "self-health, but *fait accompli* health". "Do you want to have a healthy and beautiful body? Go to a dietician. Buy this dietary supplement. Drink this and that. Eat this and that, and you will be purified of your fats and be someone else. However, if you do not do this, your lifespan may be decreased. So, track and control yourself". We may conclude that the "longevity", "beauty", "brain capacity", "physical capacity", "organ health", "minutes, days, weeks", "organic" are the motivating factors for health behaviors in quickie health and body building. The other motivating factors may be: as green, healthy, long-lasting, additives-free or demotivating factors such as unhealthy, fatal and harmful, "The things you should never do in order to_____", "The things you should do to_____", body tracking tasks, health behaviors recommended on social media, the rapid increase in the value of healthiness and organic products and lifestyles, the blaming or criticizing for unhealthy behaviors or unregulated body and health behaviors and nutrition…

[37] Body image: The individual's feelings and opinions about his/her body, about what other people thinks about his/her body, about aesthetics and health status.

Quickie health may be formulized numerically or with digits. It may be based on deadlines throughout when the imperatives and tasks should be accomplished. This understanding targets to show the instant-short term, visible and "magical" results concerning the body and health. As such, it may use and recommend short-cuts, the cosmetic, chemical and well-being products, therapies and operations which are also based on the principle of getting "visible results" in a short period of time. This kind of semi-scientific or non-scientific health message may contribute to an increase in choice overload and information overload, which may eventually lead to indecisiveness or decision difficulty about health behavior. The main context of this understanding is healthy nutrition, aesthetics and capacity increasing, which are all perceived as urgent needs in urban life.

Image 16– Simplified Solution Package Advertisement for Weight Loss – Benfica Train Station - Simplified Solution for Depression – Numerical Formula – Disseminated in Amadora Region

Quickie health may be the fake-science created by media and post-modern health pedagogs. The relevant trends can be summarized as follows: positive life approaches, self-healing, sublimation of the spirit, the latest healthy life trends, using the body and self-tracking technologies, "dos and don'ts" lists, "advantages and disadvantages of consuming nutrients", organic products, calorie calculations, dieticians and personal coaches, the celebration of Far-Eastern exercise and belief systems in the name of a healthy life, the therapies such as detox and ozone. . These have become the mainstream health applications. Disease-health awareness campaigns, news and columns written in magazines or formal language, healthy life ideas combined with aesthetical concerns, explanations of risks within the context of fear and hope, the quick tips culture, public spots, separating the health of men and women conceptually in a sharp-reverse manner in health communication all have increased the need for postmodern health pedagogies.

As revealed in the studies carried out in the sociology of food, preparing practical meals and providing recipes with information about the cooking time demonstrates the

growing importance given to the "time" factor (Warde, 1997: 128). In this sense, timing, punctuality, disposableness and practicality are emphasized by the system, industries and society. Today, even the minor changes in the body and health are monitored, evaluated and regulated through technologies. Many actors and sectors pursue exploitative and manipulative regulation strategies for such issues as bodybuilding, fitness, nutrition and healthy life issues, some of which can even deceive health consumers. These kinds of trends and movements should be kept under control.

Besides the temporal aspects of quickie health, there are other issues which point to the exploitation of hope for a better health promised by quickie health information sources. For instance, the negative changes in body image and health perception may lead to over-loyalty to or overconsumption of the medicines and to the risk of deteriorating health and wasting financial resources on the misled discourses in hope and marketed health-related promises. There are supporting data which can be interpreted to comply with this claim. The unused gym subscriptions and exercise devices are the norm; 80 percent of the members quit the gym in 5 months (Couponcabin, 2013). This indicates that resources are sacrificed as hope for bodily images wanes and returns to the regular "unhealthy routine."

1.4. Healthy Life Advice Produced by the Social Structure

After discussing the influences of the healthy life market and media regulation on the health-relevant PDB, focusing on the influences of social and cultural variables will provide an important further theoretical expansion in the interrogation of the research problem.

Throughout history, knowledge has become one of the most significant sources of power by making the owner of the knowledge more advantageous in social mobilization, in the production of food, agriculture or industry. It also organized the social class structure, creating the elites and bourgeoisie which disseminated it within a limited framework until the invention of internet, most probably WEB 2.0. Johnson's argument may well offer some ideas about why we have needed health information more since the periods of Atatürk and Salazar and how these successfully protected next generations of Portugal and Turkey: "information and power are inherently related. Our ability to process and communicate information is as much an evolutionary advantage as our opposable thumbs...it's been a key to our survival" (Johnson, 2012: 5-17). People demand this health information to attain this

bodily advantage, to maintain the quality of life and to prolong their lifespan thanks to this perceived power of information. Within the context of word-of-mouth health communication, they share and practice this power of information in each other's healthy life processes. An acne which is perceived, shared or communicated both as a health and cosmetic (aesthetical) problem, a cancer therapy or detox could be the subject or example for a health communication case. Anyone can encounter countless examples. Today, anyone with a sleeping problem can be suggested to go to "Sleep Hospital", to download applications in smartphone or use fitness tracking watches as well as traditional and conventional practices...Hair transplantation, sleeve gastrectomy, new fad diets, hormone-based diets, mental health improvement applications etc...This primitive fear of death or unhealthiness may produce a healthy life information store, however, we also can see that it is also socially reproduced in interaction and the market may take this notion to a very consumerist point in which greater losses of resources can be observed instead of having this individual advantage, creating a quick problem-solving culture, tough.

Following the socialization of medical and health information, this kind of information began to spread by the word-of-mouth communication besides mass-media and internet. However, besides encompassing the scientific health information, word-of-mouth communication has also disseminated fake-science, produces and reproduces low quality and incorrect information. Even health communication professionals, among themselves, cannot come to an agreement on specific healthy life philosophies and discussions, however, they may still contribute to the health education of the public so as to provide protection against diseases.

Health-literate consumers share and apply health information and experiences in the social interactions and activities. As a consequence of these interactions, the information is evaluated, found either functional or dysfunctional and interpreted with cultural judgements, beliefs and information brought from background. This social interaction manifests some aspects of the social organization of health. The social network, household, inner-outer social circles, peer groups, neighbors and relatives participate in this organization and the influence of most of these social factors on the perception, decision/indecisiveness and behavior may be as important as the market and media influence.

Besides word-of-mouth communication in inner circle, **the social network**, the group membership and identity also impact the ways of reception and perception of the messages. Fillenbaum (1979) stresses the influence of group identification and membership

on PDB. In the decade we have been living, the community, network or group influence may have gradually increased due to influences from internet sub-cultures (social media, forums etc., see Image 17). This may have resulted in an increasing group membership influence on the health behaviors through religious networks, social support groups, healthy life exercise and activity groups in Facebook, groups organizing healthy life activities even before Facebook and similar networks…

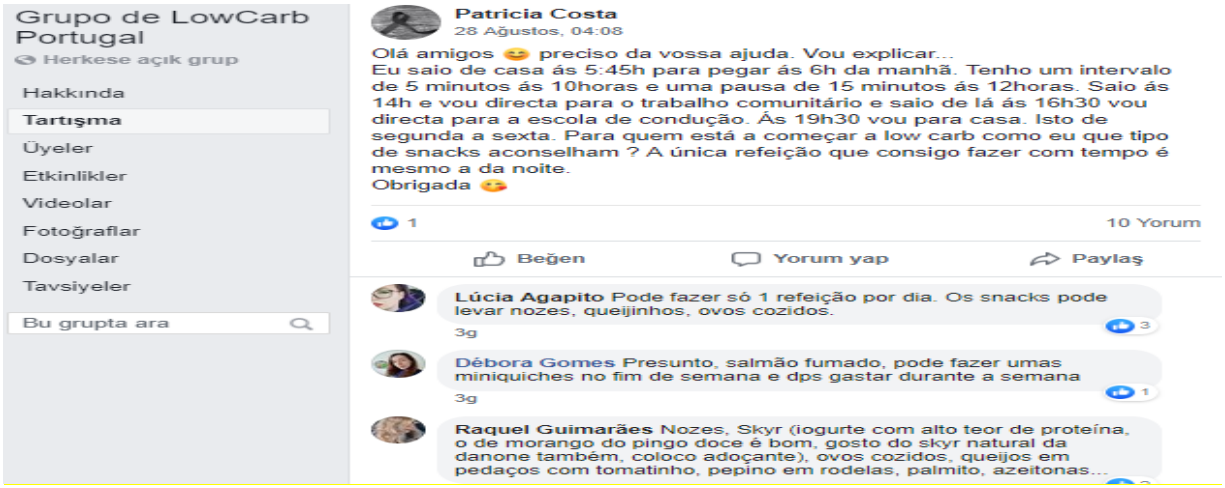


Image 17– Group membership and social network influence on the healthy life-decision making

Social networks and family circles can facilitate the exchange of information and experiences. People can learn through word-of-mouth communication and get support from these sources (Limbu, Jayachandran and Jeonghwan, 2018: 372). Health-literate consumers have been receiving this social support from various digital social networks through internet, forums and even healthy life, self and body tracking applications in smart technologies. In the health organization process in the social network, such processes as the impression, interaction and taking someone as role model about the health-related behavior and decision-making will probably be occurring. Bolin et al. consider the social network as a social resource of decision-making and behaviors in healthy life management:

> A social network may, especially in times of stress (e.g., bad health), provide the individual with emotional, instrumental and informational support. Thereby it functions as an expansion of the individual's own resources. A social network may further exercise regulation and control over health-related behaviors such as drinking and smoking. Thus, health-related behavior and social interaction are interrelated. (Bolin, Lindgrena, Lindström and Nystedtc, 2003: 2380)

Our social sources of information may be our inner circle such as family members, friends or relatives and outer circles such as neighbors, colleagues or other community members. Schaber suggests that there is a connection between the ways of receiving and

collecting information and decision-making and that our way of collecting information and the amount of information may construct our decision-making (Schaber, 2004: 30). For instance, if people have been grown up by overprotective, religious (devout), hippie or highly health-literate parents, this may have some specific impacts on their health-related deciding styles as they will probably receive specific information within specific cultural and social contexts.

The household is one of the most influential structures or actors in the construction of family health intervention, protective health behaviors and also of the information pollution. For Klauss, household functions as a decision-making unit in the healthy-life and regulate the decision-making of individuals. He considers that the health production of the household can be understood through analyzing the decision making and negotiation processes as these occur at the household level (Klauss, 2000: 20). For instance, the parents take nutrition or exercise decisions in the name of their children for many years, probably until the end of adolescence, as their social role, even in many families, this organization still exists. However, the household theoretization may not work for the flatmate situation as much as it does for the family. This distinction should be emphasized in Klauss's evaluation.

Some studies found out that household attitudes and behaviors may have an impact on the family members. This impact may well be seen in nutrition or healthy life activities of them (Chassin, Presson, Bensenberg, Corty, Olshavsky and Sherman, 1981, Webber, Hunter, Baugh, Srinivasan, Sklov and Berenson, 1982). The health communication occurring in the household may influence more profoundly than the other groups because it has a crucial place in the reproduction of the family health and healthy life advice culture. In this reproduction, a common and shared life, nutrition, sheltering and economic behaviors take an important place. In the household environment, healthy life information and techniques are often discussed, suggested, imposed within the family or among flatmates as there is a routine health communication taking place in many instances such as nutrition, consumption or ill-health conditions. They may question and evaluate the ingroup behaviors, attitudes, lifestyles, cuisines, cultural and individual meanings of nutrients and allocate more time and energy to convey these within the group. Some authors assert that "continued social interaction with friends, family and community has a protective effect, and thus a greater influence on health choices" (Tobis and Hurnell, 1994; as cited in Fenner, 2002: 10). However, this argument or assertation should be developed with the consideration of the

possibility that this social interaction may reproduce both protection of health and also indecisiveness about some health information to be utilized in the protection of it.

The incorporation of body and health education into the family education starting from infancy, the nutrition and health-care organization, information sharing and parenting roles manifest the influence of household on decision and behavior. The family members share the same or similar information sources, economic, social and cultural capitals and reproduce the health-care management together. Berman et al. probes into the household influence in health and state: “households combine their (internal) knowledge, resources, and behavioral norms and patterns with available (external) technologies, services, information and skills to restore, maintain and promote the health of their members” (Berman, Kendall and Bhattacharyya, 1994: 206). MacCormak’s example of the female production of health summarizes this notion well: “women usually draw and protect domestic water, clean toilets, sweep, kill pests, remove babies' excreta, wash children and clothes, prepare food and educate children within the traditional sexual division of labor. In this sense women 'produced' health” (MacCormack, 1992: 832). Today, each member of the household, not only women, has turned out to be a potential regulating actor thanks to increasing digital health-literacy in the household.

Concerning the network influence on the health behavior, Tomé et al.’s study found out that “adolescents’ health is influenced by their relationship with their parents and peers” (Tomé, Matos, Camacho, Simões and Diniz, 2012: 1315). Another study from Turkey also presented similar results which demonstrate that the household lifestyle choices contribute to the construction of family members’ lifestyles, nutrition, choices and even bodies (Babaoglu and Hatun, 2002:9). In this regard, it becomes more likely to conclude from such data that household may have impact on the formation of indecisiveness as well as Perception-Decision-Behavior cycle.

Giddens asserts that people act freely, however they do it within the limits they (society or groups) have produced. Most of the time, they are not completely free or restrained. Choice is always out there, however, the restrictions surrounding these choices are put by some who represent the social structure or the system and have the power to influence and change the society (Slattery, 2003: 488). According to Giddens (1984), the structure both limits people’s choices and liberates them by providing resources for them to make their decisions, and go further. This duality in Giddens provides the framework or rationale of the decision-making with or without constraints, which choices are plausible,

which are not, what kind of choices are available to choose…The enabling function suggests that resources increase the range and style of options from which the actor can choose, but constraint means that resources also invariably limit choices to what is possible (Cockerham, 2013: 128). As in the delusion caused by fashion in the personal aesthetic taste issues, cultural resources, fashion and/or public health industries disseminate healthy life and body philosophies so that people can see, adopt and be influenced by these according to the perceptional boundaries constructed by their social conditions. Many healthy nutrition messages, recipes or diet regimes are disseminated in mass media and internet, some of these sources are lifestyle-relevant sources and they have their own audience, be it higher classes or lower. They can take the socio-economic or cultural conditions of their audience into consideration; however, a huge variety of alternative mainstream sources target the whole population and there arises the problems concerning the imposed norms and the constraints that determine the PDB of the audience.

According to some theoreticians, agency never gets determined by structure, but Emirbayer and Mische object to this notion by asserting that it never gets free of the structure, too (Emirbayer and Mische 1998: 1004). Bauman also elaborates on the constraints as Giddens did and on the codes of choosing or deciding, how the decision-making is structured:

> Individual choices are in all circumstances confined by two sets of constraints. One set is determined by the agenda of choice: the range of alternatives which are actually on offer. All choice means 'choosing among', and seldom is the set of items to be chosen from a matter for the chooser to decide. Another set of constraints is determined by the code of choosing: the rules that tell the individual on what ground the preference should be given to some items rather than others and when to consider the choice as proper and when as inappropriate. Both sets of constraints cooperate in setting the frame within which individual freedom of choice operates. (Bauman, 1999: 72)

The social construction of the health-related perception and decision process is ignored by the reductionist and the individualist perspectives. This may eventually cause people to take the burden in their healthcare management. With impressions from Bauman and Giddens, Cockerham objects to this individualist "free will" and "freedom of choice" discourses in healthy-life in an interrogative manner:

> One might think that lifestyle practices are simply a matter of individual choices. That is, a person either chooses to do healthy things as a lifestyle or not...On the surface, such a decision appears to be largely a matter of free will. But is this really the case? Are health and other lifestyles constructed by individuals without any specific reference to the social structures in their lives? Let's think that this is true, then why do lifestyles tend to cluster in particular patterns, reflecting distinct differences by class, age, gender and other structural variables? Maybe it is because the healthy lifestyles are shaped from the top down by structural influences that people adopt as their own. (Cockerham, 2013: 128)

Piano probes into the social factors contributing to this social construction of health-related perception, decision and behavior as follows: “family support, significant others, social networks, interactions with health care professional, social pressure, external cues to action, community factors, organizations, culture, churches, neighborhoods, voluntary associations, public policy, situational factors, health services/health care system” (Piano, 1997: 111). The interwoven and interdisciplinary nature of decision-making should not be disregarded and the complex framework that contributes to healthy life decision-making should be highlighted in response to reductionist theses.

1.4.1. The Influence of Economic, Social and Cultural Capital on Healthy Life-Related Perception, Decision/Indecisiveness and Behaviors

Abel’s focus on the social aspects of decision and behavior is important in showing the collective nature and complex framework of health-related decision-making: “the resources needed to choose or adopt specific health-relevant lifestyles emerge from the inter-play between economic, social and cultural capital” (Abel, 2008: 3). A similar Bourdieuan perspective is seen in Fenner, too: “There are potential barriers to the commitment of a health behavior such as incomes, health care coverage, advancing age, and education” (Fenner, 2002: 33). Besides this notion of barrier, Fenner also establishes the connection between decision-making construction and social and economic capital: “the commitment or an adaptation, routinely making the same or similar decisions also rely on the economic and social capital” (Fenner, 2002: 7). In this regard, assuming that the health-literate consumers have the freedom to make healthy choices will not be consistent with what many of them experience as real possibilities in their everyday lives. Concerning this class-based constraining conditions, William states that they understand the behavioral risk factors that made poor health more likely and for which they could be partly and personally responsible, but they are also aware that the health risks they encountered were in part caused by the social conditions that they could do little to resist (Williams, 2003: 147).

People bring their social resources (their social, economic and cultural capital) and the individual resources (educational level, occupation and demographic factors) to the health-related perception, decision and behavior processes. These often construct the

information consumer's (infosumer[38]) choices of the channels to receive and consume information. Concerning the influences of socio-economic status on the perception of the healthy life messages, on the transformation of this perception into decision-making, indecisiveness and behavior, women who get pregnant for the first time in their life may provide an opportunity to observe how newly acquired health information (emerging biomedical pregnancy information) influences health behaviors...Hernandez states that throughout the pregnancy progress, the pregnant women are literally overloaded with relevant information (Hernandez, 2000: 20). There are parenting academies etc., which provide an organized curriculum, however, the internet channels and social network disseminate hearsay information, too.[39] We can see his argument about a possible relationship between socio-economic status (SES) and decision-making through these parenting academies etc. practices. In most countries, such academies are affordable only to middle or higher classes, so it may be another implication of the possibility that higher classes may have more organized healthy life information besides the possibility of being overloaded due to easier access to health information. Korenbrot, Steinberg, Bender and Newberry (2002) and Hernandez (2011) lay stress on SES and self-education concept, and also on the influence of SES on the situational evaluations of informational choices and decision-making atmospheres:

> The majority of women begin their pregnancy with lower levels of knowledge about healthy pregnancy behaviors and they are presented with a plethora of new information about their pregnancy. So, a portion of women, in particular, those with higher levels of SES, seek information about preconception health prior to becoming pregnant. (Korenbrot et al., 2002, as cited in Hernandez, 2011:16)

Besides SES and self-education relationship, Montgomery and Casterline (1996), Kohler, Behrman and Watkins (2001) and Hernandez elaborate on the influence of SES through network and household. Their focus may set an example about the accumulative impact of the constant household health communication and SES conditions on decision-making, perception and behavior:

> A woman's highly educated sister might inform her that consuming omega-3 fatty acids will help with brain development of the fetus, which influences the woman to consume a fish oil

[38] One who consumes information routinely, information consumer

[39] In the Coronavirus pandemic, we witnessed a bombardment of public health courses offered online. The majority of these had an organized curriculum and many people were provided with protective health norms through these courses.

> supplement. Social influence arises when social contacts exert normative influences on behavior (Hernandez, 2011:17).

Fenner's argument is in line with this example, he underscores the fact that lower levels of education may be associated with community-based decisions and lower levels of health promotional behaviors, but for higher classes, the decision-making and indecisiveness can have their roots both in social interaction and on individual autonomy (Fenner, 2002: 33). Despite having an increased awareness about health promotion norms in lower classes, the lack of sources needed to make the decision and enact accordingly probably confines lower classes in adopting the health promotional consumption norms, instead, directing them to using social and cultural capitals in a community and environment or having less adaptation to these norms due to a lack of material resources. The social positions of people will probably determine their sources of information and allocation of resources and time in terms of healthy life decision-making. Fenner's argument can be challenged at the present time, because, even in lower classes, due to the wide access to information technologies, the level of interest in or awareness about health information has increased compared to 20 years ago. This is also a game-changer and impacts the individual autonomy, too.

In a similar vein with Abel and Fenner, Calnan emphasizes the effect of socioeconomic status on health seeking behavior. He states that "socioeconomic circumstances may provide a setting which can act to enable or constrain the practice of health-related behavior." (Calnan, 1989: 131). However, it is only one of the various factors making contributions to this complex decision-making system. There may be some relationships or correlations between sources, capitals and decision-making opportunities. Some different patterns of healthy life decision making can also be observed within the fractions in the same class. It may be caused by the impacts of differences in social, cultural or economic capital distribution among the people in the same class. The family size, the temporal capital, the social roles of the people, the municipality where people live or even the company where they work can be some important determinants in the health management and decisions of consumers. Calnan's evaluation can be enriched with these distinctions.

The socio-economic conditions have already been found in many studies as a determining factor in health protection behaviors (Hudson and Brown, 1983, Langlie, 1977, Limbu et al., 2018). Some other studies figured out that people having more social, cultural and economic capital tend to have a higher motivation to engage in health maintenance

activities more as compared to low-income population (Fukuyama, 2002; Krishna, 2002, Limbu, Jayachandran and Jeonghwan, 2018: 373). Cockerham takes this argumentation of the influence of income-class structure further and proposes an integrative perspective making reference to Bourdieu's (1984) distinction and taste conceptualizations: "education, income, and occupational status are separate individual qualities, collectively they constitute a structural variable whose influence is evident when people express the tastes, distinctions, outlooks, behaviors, and lifestyles common to their class as a whole" (Cockerham, 2013: 141). Thanks to having wider opportunities in higher classes, they are able to deal with this health-relevant IO by receiving expertise and consultancy which can help with indecisiveness and behavior regulation. As for lower classes, the contrary may occur, they may also still receive social support, but only within the limits and context of community resources, consequently, less utilization of expertise and consultancy as well as less health literacy and more word-of-mouth health communication.

Social capital is one of the most important factors impacting the healthy life decisions, behaviors, purchases, consumption and perception as it is presumed by some social capital theorists to be a source of information, social support and financial means. They also propose that people share health information with other people through social support practice and the trust in these connections and their advice is higher (Putnam, 1995; Umberson and Montez, 2010, Limbu et al., 2018). In this regard, even if they do not possess enough economic capital to be able to adopt commodified health promotional norms, they can at least benefit from their social circle resources whereby they can receive social support. "Social capital provides the community with the health-related information to improve their health-related issues such as diet or exercise, or selecting a physician or a hospital. Such advice encourages individuals to lose weight, to be vaccinated, or to avoid or give up smoking" (Scheffler and Brown, 2008:325). Many scholars hold that it is an important health determinant because it enables a reduction in informational costs within the health care system and facilitates the dissemination of health information and norms, allocating the health responsibilities to everyone (Putnam 1993, 2000; Veenstra, 2000; Kawachi & Berckman, 2000; Folland 2007, Berchet and Jusot, No Date: 1). However, this argumentation should be developed with the consideration of one possibility that the social capital organizing the decision-making and transforming the group members to informed consumers also disseminate the conflicting health advice, consequently contributing to the indecisiveness.

Social capital is acknowledged as the information sources and channels of the social units in society. Kawachi argues that social capital influences health preventive behavior by "(1) promoting more rapid diffusion of health information, (2) increasing the likelihood that healthy norms of behavior are adopted (e.g., physical activity), and (3) exerting social control over deviant health-related behavior" (Kawachi et al. 1999: 1190). It organizes the health decision-making through macro, micro and meso level structures providing sources for health management**.** Song's (2011) interpretation of social capital shows the interplay between social capital and complex decision-making structure:

> Social capital can have unmediated impacts on health through "influencing macrolevel health policy decision making, microlevel sense of control, and microlevel access to health resources, providing valuable health-related informational support, acting as social credentials in accessing health resources; delivering health-related material support; encouraging engagement in healthy norms and behaviors. (Song, 2011:480)

Social capital can also increase people's chances to accumulate health relevant cultural capital, for instance through informal access to health information, expert knowledge and advice (Abel, 1991: 3). These economic, cultural and social capitals (including the educational level and occupational status) will probably channel these clusters of people in specific consumption and purchase patterns, contributing to a structural determination in health protection. An important missing aspect about which the authors mentioned above have made no reference to is the relationship between information overload and social capital. The relevant results were already presented in Chapter 3, but it should be noted here that the social capital has been found as one of the sources of health-relevant information overload.

Social capital can be considered to be the most important resource of cultural capital. Some scholars defined **cultural capital** "as people's symbolic and informational resources" for action (Bourdieu and Wacquant, 1992, Cohn, 2014, Abel, 2008). Those resources can be values, behavioral norms and knowledge. These are acquired mostly through social learning. The conditions of learning vary according to the social classes, status groups or milieus (Swartz, 1997, as cited in Abel, 2008: 1). In his definition below, Abel offers a generally-acknowledged cultural capital conceptualization which is also associated with health-related issues:

> Cultural capital is considered a non-monetary form of capital that is interaction with economic and social capital to constitute people's health chances and choices…the values attached to health, knowledge about health effects of certain food products and norms that guide health behaviors

> are all cultural resources that structure people's preferences and choices, including their eating and physical activity habits (Abel, 2008: 3).

The patterns of people's healthy life decisions have their roots in their cultural capital as well as economic and social capital. Bourdieu elaborates cultural capital and offer an extensive definition of it:

> Cultural capital can exist in three forms: in the embodied state, i.e., in the form of long-lasting dispositions of the mind and body; in the objectified state, in the form of cultural goods (pictures, books, dictionaries, instruments, machines, etc.), which are the trace or realization of theories or critiques of these theories, problematics, etc.; and in the institutionalized state, a form of objectification which must be set apart because, as will be seen in the case of educational qualifications, it confers entirely original properties on the cultural capital which is presumed to guarantee. (Bourdieu, 1997: 47)

For many decades, people have been acquiring objectivized cultural capital through their structured environment, especially in such forms as walking paths or exercise equipment in parks, this contributing to a symbolic and cultural adaptation to healthy life through the transfer of objectivized cultural capital. Health books, internet access and recreational equipments serve as examples of objectivized cultural capital closely linked to health and health-promoting behavior. Outdoor exercise equipment is an appropriate example of objectivized cultural capital and its functional and symbolic use. Veenstra observes that cycling to work is a typical middle-class lifestyle behavior signifying the cultural capital. It is associated with a better status of health. In a similar vein using helmet, back pack or rain gear can also be counted as objectivized cultural capital which has a symbolic function such as distantiating or isolating the owner of the capital from the other classes (Veenstra, 2007:30). As, it can be seen in image 18, at the present time, the cultural capital is also transferred through images, information, slogans, emojis and the structured environment by the enterprises which today take the role of the states in 20th century and they provide another form of informal health education. Therefore, cultural capital theory deserves to be updated with references to information overload.

Image 18– The objectivized cultural capital transferred for health promotion– An example from a company located in Lisbon – 11.07.2019

As for the dissemination of these messages through informal education, social interaction, transfer of social and cultural capital and for the reception of these by various groups of people such as elderly or women, meaningful demographic and structural differences were found in Fenner's study. Fenner's report indicates that the elderly's awareness about current health information and trends is less than young generations. They are encouraged and more likely to use community resources and references such as churches, senior centers and schools (Fenner, 2002: 15). In such cases, the cultural capital is mediated through the social capital and the habit of seeking health information through digital sources (digital transfer of cultural capital) is observed less compared to conventional media, because, in older generations, the main information sources (or cultural capital source) are more social capital and conventional media. The conventional media may impact older generations more, younger generations less in health promotion. In another study by Kahn (2001), it was revealed that women preferred conventional and digital media to receive health information without meaningful differences in terms of demographic variables. However, it should be noted here that some differences between younger and older generations of women should be highlighted or Kahn's evaluation can be updated with references to the actual cases and trends of the present time.

Family and inner social circles can produce and transfer the cultural capital in embodied and objectivized forms and the organizations provide institutionalized capital more and sometimes objectivized. Within the context of the imperatives imposed by biopower and the demand by the public, the organizations could also transfer objectivized cultural capital for the healthy life regulations. In the pandemic period, we have recently seen many important example cases in relation to this issue. The public demanded lockdown and quarantine and some health-relevant information updates as well as ecological and social imperatives were implemented. In this period, a new form of an urgent cultural capital was developed and conveyed through information overload. The pandemic has turned many people to health-literate consumers by transferring the cultural capital from the organizations of biopower as well as the public. People started to be informed about health-relevant issues through SMS, TV, social media and all other internet channels. So many people have had an increased health-literacy or awareness about these issues even if they normally do not have such concerns.

Health literacy is one of the most important products of the health-related cultural capital transfer organization. It is produced through all kinds of cultural capital, in

objectivized, institutionalized and embodied way through social networks, institutions and education etc.. It incorporates media literacy and is an important component of health promotion and education (Cinarli, 2012). We should be aware of this beneficial and protective aspect of health literacy; however, we should also keep in mind and critically review the metaphor of Naisbitt, society getting drowned in the information but also starving for information (where a mere health literacy may not work only for the protection, but also with confusion or inaccurate decisions and behaviors about health). The health-relevant IO, high in quantity and low in quality may be associated with low-quality health literacy. Health information which is not correct, informative and applicable may lead to ill-health and an increasing health commodification (Cinarli, 2012). Information pollution as well as information overload can create decision difficulties as there will be too many questions about which information or choices are correct in relation to physical or mental health, therefore, a well-balanced health literacy education should be provided with the people from all social strata.

Link and Phelan makes reference to the inequality or differences in the health literacy and state that higher classes will have more advantages in this process: "persons of higher socioeconomic status are able to deploy a wide range of resources—including knowledge, money, power, prestige, and beneficial social connections—that can be used individually and collectively in different places and at different times to avoid disease and death" (Link and Phelan, 2010: 5). In a similar vein with Link and Phelan, Santos focuses on the capacity of social classes, not underlining the agency. He figured out in his study that higher levels of health literacy allow better health decisions, stronger commitment with them and superior levels of efficiency (Santos, Sá, Couto and Hespanhol, 2017: 1). In biomedical philosophies and biopolitics, people are expected to be health literate to make the correct decisions and to take the correct actions, however these imperatives and expectations are not assigned as social class imperatives but as individual tasks. In the provision of informal health education and health literacy through health promotion, such problems as indecisiveness may be experienced due to information overload. Like Giddens (2005: 300), Santos et al. make references to the changing health-information, the health-consumer identity and IO, consequently hinting at indecisiveness: "the current technological development makes yesterday's knowledge almost history. Even health-care providers have some difficulties about the precision of the concepts and we can imagine that general population has many more doubts and misunderstandings" (Santos, Sá, Couto and Hespanhol, 2017: 2). Being

health literate in this era of the history is not enough itself, but renewing the related information is also assigned as a task in the health promotional discourses. The Coronavirus pandemic has revealed that even the ruling classes could be in a decision-crisis due to a huge variety of variables, data and political concerns. So, this crisis was partly delegated to the public in the form of health promotional and moral discourses.

1.5.The Transformation from Indecisiveness/Decision to Behavior-Consumption and Social Implications

The healthy life behaviors and actions follow the indecisiveness and decision-making. This process may continue with such approaches as “trial and error” and “further information seeking” so as to reduce indecisiveness. The consumers are inclined to consider the indecisiveness to be an inefficient and negative process in healthy life behavior management. After experiencing decision difficulties, some attempts to fight against indecisiveness can be observed. Many scholars such as Drummond and Rule (2005), Leek and Kun (2006), Matzler and Waiguny (2005) and Ozkan and Tolon (2015) argue that consumers will probably endeavor to reduce at least the confusion so as to focus on the resolution of the perceived problem. This perspective underscores that indecisive consumers will seek for ways to eliminate the negative emotions (pressure caused by indecisiveness) associated with indecisiveness and confusion (Drummond and Rule, 2005, Leek and Kun, 2006, Matzler and Waiguny, 2005, Ozkan and Tolon, 2015). Mitchell and Papavassiliou (1999) argue that the consumers who become indecisive in the process of purchase will probably have more difficulties in making rational purchase decisions, in selecting the products that give the best quality, may postpone or stop purchase behavior, experience shopping fatigue or regret the decisions made. These scholars focus on the negative influences of indecisiveness, and they may bring convincing arguments and data to prove their claims. However, in their analysis, they did not point out that different levels of indecisiveness could produce different levels of affection. For instance, people with lower levels of indecisiveness in daily healthy life consumption or behaviors such as the application of some specific diet regimes may not experience bad feelings in the daily organization, however, such urgent health cases as accidents or serious health problems requiring a surgery bring about more negative feelings even in people with lower levels of indecisiveness in the daily regulation of consumption and behavior. Even the regulation of everyday healthy life consumption and behaviors still requires some specific obstacles to be overcome. Even though people experience decision difficulties in urgent health cases, this

indecisiveness is generally for a very short while and eliminated with an urgent evaluation of the conditions and realistic choices for them.

Within the health promotional context, a wide variety of methodologies and techniques are proposed and experimented by different groups of people from various backgrounds just to overcome the perceived indecisiveness. Mitchell and Papavassiliou (1999:327) provide a theoretical framework about this process and define this experimenting process as "confusion reduction". These general confusion reduction strategies are utilized by consumers in eliminating the indecisiveness: (1) do nothing, (2) postpone/ abandon the purchase, (3) clarify the buying goals, (4) seek additional information, (5) narrow down the set of alternatives, (6) share/delegate the purchase. These strategies may provide a facilitated overview of the further processes of indecisiveness. The individual and social information seeking efforts constitute one of the most important earlier stages in the resolution of health-related indecisiveness problem. This further seeking process is considered to reduce indecisiveness. Accordingly, the indecisiveness is associated with making further investigation. This process could reduce the perceived indecisiveness, bring it or the information seeking to an end, because the indecisive people can find the exact information they need in this further seeking or be satisfied with this additional effort[40]. The fact remains that this process which is proposed as the solution to indecisiveness problem may not be applicable in serious health cases which need a surgery or intervention. It is worth to note here that especially doing nothing and postponing and abandoning the purchase as proposed by Mitchell and Papavassiliou may not even be possible in these serious cases.

Mitchell and Papavassiliou (1999:327) claim that through the use of these reduction strategies, clarity in consumption and purchase decisions increases. The consumer's effort to eliminate the conflicting and ambiguous information engages him/her in additional information search. Paradoxically, too much information may create indecisiveness, but

[40] In the analysis of the previous online survey study conducted for Istanbul in the end of 2018 (part of another study), December, relevant data was revealed about this further information seeking to cope with indecisiveness in health-care management. 85,3 percent of the respondents partially or totally agreed with the statement "I make a more comprehensive search for information if I feel indecisive about specific health-related issues". 72,6 per cent of the respondents partially or totally agreed with the statement "When I apply the healthy-life advice but feel that these are not useful for my health, I continue searching for and applying other advice". By looking at this previous data of another study, it is possible to support the argument that additional or further information seeking can be considered as an indecisiveness management strategy.

further information is also sought with a belief that it may help in dealing with the indecisiveness. However, this information seeking sometimes also increases the clarity. For these kinds of ambiguities, we can use the argument by Rassin et al (2006, 2008). This seeking may be caused by the necessity to be clearer about the decision to be made. According to their study results, indecisiveness correlates positively with the amount of information gathered. Related to the increased amount of time required to decide, indecisiveness seems to imply that more information is sought and received before a decision is reached…Their data indicates that indecisiveness increases the tendency to seek for more information to eliminate this negative emotion (Rassin et al., 2008: 96). Some emotional consequences emerging out of indecisiveness were also found by Jeong. According to his study results, indecisiveness may lead to an increased anxiety, unhappiness and increased variety-seeking (Jeong and Drolet, 2016: 55). In this further increased information-seeking, someone attempting to solve their health problems may also exert efforts to overcome indecisiveness and these negative emotions caused by conflicting information. A very-known example for this issue can be the "slimming" issue. For instance, health-literate consumers who want to lose weight and think that they cannot solve this problem by themselves, they will probably consume, evaluate and try too much additional information, many choices and techniques, some of which may even be conflicting. This is where one can encounter **the experiencer of everything** or the **consumer of choice overload**.

Presently, besides media organizations which disseminate the top-down information and IO, people generate user content, contributing to a digitized health notion through a "word of mouth health communication" culture. People or some social networks such as the patient support groups in the Western world (especially USA) attempt to compensate for their problems which cannot be solved only through biomedical solutions. These new social networks produce more than just word-of-mouth conversation about their experiences. Some members of these health-literate consumer groups have also been transformed to prosumers, developed healthy life methods, techniques, products or services even if they are not professionally involved in the healthy life market. Along with the emergence of semi-professional consumers and digitized health, these kinds of orientations and approaches have started becoming manifest in everyday life and social life.

Health-literate consumers experiencing difficulty in finding affordable or effective solutions to their health problems and to medicalized problems have recently started a pursuit of finding their own solutions. This pursuit is usually made in co-operation with medical

sectors or health professionals, some of these without any connection to corporates or with social networks. The interactions taking place have started having impacts on the health-relevant PDB of these groups.

According to Sillence et al., these proactive patients ‘‘act as scientists’’ and use websites to test out theories about their health (Sillence, Briggs, Harris and Fishwick, 2007: 397). This phenomenon of scientist consumer can be observed in Portugal, too. One example is the “Patient Innovation” case. Now, many restructured healthy lifestyles such as “Patient innovation”, “body hack”, “healthy is fit” etc. emerge in online forums and regulate the lifestyles of those members of these post-modern networks. The networks consist of prosumers who build and develop new philosophies, new items or techniques and technologies, doing amateur experiments for their own health problems by also overcoming indecisiveness. These problems are mainly those which cannot be not solved by the medical or pharmaceutical industries in an effective or cost-effective way, leading the consumers to decision difficulties and unhealthy and costly experimentations.

What was to be done by health professionals in the past is now produced and used by the consumers. This proactive health culture reproduces both consumerist and anti-consumerist lifestyles. Along with the emergence of proactive, expert and scientist patient and consumer profile, making body observations and experiments especially in online groups has been a global practice[41]. This has resulted in an increased dissemination of individually-produced solutions within these networks, along with attempts to prove the functionality and efficiency of these solutions. For instance, a group of people who have seborrheic dermatitis problem (both a cosmetic and a health problem) and apply the health advice they have acquired from health professionals, relatives or peers etc. disseminate, advertise or sell their experimental formulas and techniques that have worked for them in social media, internet forums, sites or smart applications. They even market and sell these products or do-it-yourself kits in these platforms, contributing to a conflicting IO, including the misleading and ineffective applications as well as innovative and efficient solutions.

Ritzer and Jurgenson (2010) and Zwick, Bonsu and Darmody (2008) assert that consumers are employed in the production process ideologically. The biopolitics and

[41] Especially in Reddit Forum, many sub-forum topics, many scientific and experimental information is disseminated and this post-modern tradition contributes to a global health-related decision-making in the similar vein with health groups in social media.

biopower are reproduced with the incorporation of the consumers into production whereby this process provides rights and freedom to the consumers as they are defined as more autonomous as well as providing insights to the enterprises about consumers. In this regard, one can propose that prosumption process is changing the manipulative aspects of health promotion, which see the individual as a repository of medical products and services. Instead, a more participative, innovative and creative healthy life production practice is created and it may be more democratic as the individuals themselves can resist some aspects of semi-scientific or unfruitful aspects of medicalized healthy life discourses, products or economy overall. In addition, they can generate amateur but customized solutions that may be more useful for a group of people who can not find the exact solutions for their problems. Consequently, they develop new cures and techniques. Ritzer and Jurgenson (2010) assert that prosumption online, a widespread version of this active/scientist patient notion, is a reversal of the historic trend and serves as *de*McDonaldization process (Ritzer and Jurgenson, 2010: 18). The democratization of the healthy life consumption and communication process is made possible thanks to prosumption online, the top-down or hierarchical aspects of this process are eliminated to some extent along with the participative characteristics of prosumption. It can be considered to have emerged with the invention of Web 2.0 internet technology, however when the massive involvement in and popularity of these developments (e.g. social networking sites) are considered, it can be argued that it is currently both the most prevalent location of prosumption and its most important facilitator as a 'means of prosumption' (Ritzer and Jurgenson, 2010: 20). Of course, there are some oppositions against and suspicions about the consideration of prosumption as a cyberlibertarian, democratizing process, one of these arguments is proposed by Ritzer and Jurgenson (2010) as follows:

> Consumers do these formerly paid tasks for no recompense (and do it not only without complaining, but seemingly find it to be 'fun', at least at first). This serves to buttress the Marxian view of capitalism as an exploitative system that is constantly searching for new ways to ratchet up the level of exploitation. (Ritzer and Jurgenson, 2010: 26)

In the online healthy life practices, one can easily find evidences about the exploitation of the data or personal health issues as well as the tracking of many habits[42]. However, there are also many anti-consumerist or counter movements against the realm of

[42] In many digital health monitoring and physical activity applications and devices, the users consent to grant permission to the companies in the collection of confidential data

biopolitics and biopower. This study takes a stance that favors the prosumption in healthy life practices and presents an example to convince the reader into the benefits of prosumption practice as there are hints that posit it as an equilibrating factor in healthy life consumption and communication and in overcoming indecisiveness in all social classes. One striking example to prosumption in health is "Patient Innovation" Project from Portugal:

> The Patient Innovation is a social network that aims to facilitate the sharing and dissemination of innovative solutions developed by patients, caregivers and collaborators of any disease". According to this approach, each patient and health-care provider own a significant innovative potential. "The more patients, caregivers and/or collaborators share their solutions, the more information to be available to those who are looking for answers for their problems and the higher the potential value of each solution proposed is" (Patient Innovation, 2016).

Image 19– Patient Innovation

Although this approach underscores the variety of information ("the more information to be available…"), it provides a more democratic and less top-down way of health communication and also less decision-making pressure due to less commodification. Network effect is explicitly stressed as one of the most functional aspects of these cases and approaches. The logic of Patient Innovation could be efficient in developing new approaches which view people not only as consumers but also as co-operating partners in healthy life processes. There may be some criticisms about having a Neo-Marxian prosumer in hand, but they will not be as useful and functional as a less consumption-oriented healthy life process. In such practices, the healthy life processes and imperatives are shared between individuals, groups (networks), health care providers and organizations. Some examples similar to Patient Innovation are (i.e.: Inspire project), (i.e.: PatientsLikeMe platform) and Tell us! ". There are many other crowdsourcing networks (prosumer networks) that involve many people having severe or non-severe problems and share their experiences by socializing their

health, contributing to a social health regulation in a prosumer community. Lamy Report points out that “fully mobilizing and involving stakeholders, end-users and citizens will increase the co-creation levels and maximize the impact of this co-operative process by stimulating a greater demand for innovative products and services besides a better grasp of social changes” (European Commission, 2017). With this “Patient Innovation” approach, people or the patients are not seen as the sole object of medical gaze but as partners of the medical process. Here, in this crowdsourcing process, multidimensional perspectives and processes are combined, omitting the individualist or agency based, top-down biomedical approaches among health professionals and caregivers.

As pointed out in the application of Colemans Boat diagram in the introduction, the top-down nature and structure of healthy life information dissemination produce the prosumer and active scientist patient (Sillence, Briggs, Harris and Fishwick, 2007: 397). However, these also produce an informed consumer resistance against medicalization and low-quality information dissemination. The emergence of the anti-consumerist resistance against medicalization in internet forums, social media etc. as well as co-operative platforms like Patient Innovation (2014) may be starting to change the conventional top-down nature of information dissemination and health management. Unlike the reproduction of conventional healthy life cultures, the metropolitan lifestyle stimulants such as the overload of advice, choices and information may be producing the Blasé of Simmel (1950) and this possibility deserves to be taken into consideration. Some examples were given throughout this review chapter; however, more practical examples and implications will be presented in Chapter 2.

Within the context of this literature review, many theoretical contributions such as arguments and survey data from interdisciplinary studies were reviewed to find relevant answers for the research question under scrutiny. Some of these contributions and sources were directly related with cases in Turkey and Portugal whereas others were not but adopted and developed to make investigation in these two countries.

Many perspectives, notions and data discussed and interpreted within the context of this review have contributed to and improved the theoretical framework to be developed in this study to be able to investigate the cases in Turkey and Portugal by providing historical, pedagogical, ideological, economic, sociological, communicational, psychological and theoretical outputs as well as methodological ones.

2.Politically and Ideologically Produced Healthy Life Advice in Portugal and Turkey - 1900-2019

In this chapter, the gradual development of the ideological health communication, global mass-communication technologies, culture industry and the social evolution taking place in Turkey and Portugal in the last century is presented. Firstly, the political histories of these two countries and health-relevant politics and activities are explained in relation to the research questions of this study. The scope of this chapter is "the ideologies, discourses and propagandas constructing our health cultures and PDB in Portugal and Turkey". In a more detailed fashion, these issues are explained through the presentation of both local and international biopolitics about health education, health systems, infrastructures and politics. After the historical and ideological discussions and narratives, the examples of discourses and health communicational products (from the conventional and digital media and public spaces) are presented as the empirical and supporting data. This is not a comparative study, but rather aims to establish a dialogue between two different cases: Turkish and Portuguese societies. Thus, this chapter is not organized to make comparisons, but rather to present the issues and examples of these two countries together.

The reason to choose and define the periods of Atatürk and Salazar as the most important periods for health understandings celebrated in the societies of Turkey and Portugal was that the fathers of the regimes established and revolutionized the body and public health politics and cultures of their times, well beyond their days as Heads of State. Today, some of their modernist body and health ideologies are still reproduced in the daily life[43] of people in these two countries.

Examining the cultural evolutions, revolutions and discourses since Salazar and Atatürk could provide valuable insights into an investigation on the historical and social changes taking place in Portugal and Turkey and how these have been constructing our

[43] The proverb by Atatürk is still quoted in the daily life of people in Turkey "a healthy mind in a healthy body" Other proverbs are: "Our aim in health and welfare matters is: protecting and improving our nation's health, reducing deaths, increasing the population, the elimination of infectious and contagious diseases, in this way, members of the nation will have vigorous and healthy bodies capable of working." 1922 (Atatürk'ün S.D. I, S. 217) . "The health and well-being of the Turkish citizen, to whom the revolution and revolutionism has given various and vital tasks, is always our national question, which will always be considered carefully. Because the Republic wants strong and intellectually, scientifically and physically high level protectors"(see:Dusunceleriyle Atatürk)

health cultures, perception, interpretations, decision, behaviors and lifestyles for many generations until now. As there are some differences and similarities in the politics, ideologies and cultures, these distinctions were taken into consideration in the arguments.

In post-modernity, the formal health education philosophies of modernist states have been to a large extent replaced by informal health education, namely health promotion. These informal pedagogies offered as substitute for formal education have always aimed to provide the public with exact health-related messages. Many lifestyle choices offered in informal education are now marketed as health educational discourses. These also hinder the informal, neoliberalist, medicalized and magazine-like nature of this overload of messages. For Portugal and Turkey, the healthy life advice, the main product of this informal education, had its origins in the modern urban city life, during the rule of Salazar and Atatürk. After assuming power, they adopted nationalist and modernist ideologies, and carried out many cultural, ideological and technological practices. Within the context of their health ideologies, these messages were produced and disseminated with gradually developing medicine and media technologies, growing more complicated but a lot more influential.

Image 20– Commodified Health Advice Even Before Salazar – Marketing of Products from 1908[44]

Both leaders and their cadres had similar targets and ideals: to modernize the underdeveloped infrastructures, to accelarate urbanization and modernization to survive in the developing and war-inflicted world. Both nations had an imperial past and an unstable political system by the time they took over the power, but these two leaders had similar

[44] 110 years ago, a relationship between the consumption of ready-to-serve-foods and being in intellectual class, however, this is disproved by the science and healthy life market today.

biopolitics[45] as well as different ones. As for the similar ones, both regimes held that the health of each person was important for the continuation and economy of the regimes and the nation. Their philosophy was that the nations could not generate a brighter future without healthy people and generations. In this regard, in 20th century's modernist urban life, the political power and biopower imposed a modernist imperative suggesting that people should take care of themselves for the good of the nation. The regimes adopted modernization (in Turkish case both Westernization and modernization) strategies to improve the social and individual lives and to cease being weaker nations in politics, military, health and economy. Both states organized modernized health systems and discourses, started delegating health responsibilities and imperatives to individuals and they did this on citizenship grounds, not on capitalist norms. They organized basic formal and informal educational activities for health responsibilities. However, it was not in the form of an overload of information and choices created by consumer and information societies later on.

As for the different biopolitics, these two regimes had divergent approaches and values upon which they based their state and health ideologies. Unlike Salazar, a supporter of Catholic doctrine, striking a balance between traditional and modernist values, Atatürk was a supporter of secularism[46] in state-governance and confronted conservative opposition from supporters of the empire which had for long governed the Anatolian territory. Within the context of modernization, he made reforms in clothing styles in an attempt to westernize the image of modern Turks. As such, the regime introduced dress codes in 1925. However, Salazar regime's view of modernism was different from Atatürk in other aspects. Traditional values were respected more in the Estado Novo ideology and was called as "'evangelical'

[45] Biopolitics is the practice of discipline and power through which "biological factors are drawn into the social domain as targets of political intervention... As knowledge of living matter and power over the components and conditions of human life move biological factors out of the realm of divine or natural fate, so individual bodies and entire populations have become integrated into new rationalities of governing. Here, they are subjected to intrusive techniques of self-discipline and regulative control; drawn into mass warfare that places life itself at risk but also into mass welfare regimes that enhance it; utilized in economic systems where biophysical capacities are exploited and recalibrated. Such is the domain of biopower". (Coole, 2015: 1). According to Foucault, biopolitics focused on the species body, the body imbued with the mechanics of life and serving as the basis of the biological processes: propagation, births and mortality, the level of health, life expectancy and longevity, with all the conditions that can cause these to vary. Their supervision was effected through an entire series of interventions and regulatory controls: a biopolitics of the population (Foucault and Hurley: 1990: 139).

[46] Ataturk was a positivist and had a deep belief in the values of the age of enlightment. He was deeply interested in the French enlightment.

modernism" (Zúquete, 2005: 48). Zúquete reveals this view of modernism in Ferro's[47] interpretation of Turkish modernization, westernization and the transformation of Turkey into a European nation:

> Ferro describes his 'anxiety (Atatürk's) to civilize' and his vision of a nation that is free from the grasp of religion. He understands Atatürk's desire to create a new Turkey, although he asks himself if the destruction of the old Turkey was not exaggerated and barbaric. Ferro warns of the dangers of destroying the soul of a nation, of the 'character of a race'… As Ferro reported: 'Mustapha Kemal can westernize Turkey. Of this I have no doubt. What he cannot do, however, is Westernize its stubborn soul' (Ferro 1927a: 348, as cited in Zúquete, 2005: 48).

Ferro held that Atatürk's regime was "deeply nationalist, but deeply against tradition". For Ferro, "tradition and progress are not mutually exclusive. The Spanish and Italian dictatorships, for example, look to the future, but they have their foundations in the past" (Diário de Notícias 18 March 1928, as cited in Zúquete, 2005: 48). However, Ferro neglected certain historical and cultural aspects in his critique of Atatürk's mode of modernization in that Atatürk inherited a nation with religious traditionalism that had never gone through a reform throughout the empire (dynasty) period. He considered that such traditionalism would not be capable of modernizing and catching up with the Western countries. On the contrary, such a traditionalist religious system would be destructive in establishing a westernized and modernized civilization. Throughout the Atatürk period, however, many historical and cultural studies were conducted to bring the cultural practices of former or ancient Turkish states into the new cultural revolution like many other states did in Balkans throughout 19th century.

From the early 1900s until the 1950s, modernist state ideology, citizenship and gender norms regulated health and body-related perception, decision-making and behaviors in both countries. In Portugal, for instance, the higher classes and corporations organized the economic and social life along with the establishment of Estado Novo. Many different lifestyles emerged in the two countries along with economic progress, capitalist influence and modernity following the establishment of the regimes. In this regard, modernist ideals of the body and health were also adopted in the state ideologies. In the Portuguese case, for instance, the modern athletic Western image of the woman was promoted to encourage doing exercises for a stronger and healthier body. The body discipline and sportive activities in

[47] António Ferro, one of the most important politicians of Estado Novo period, mainly working on propoganda. He travelled to many countries and prepared international reports. His interpretation about of the Turkish modernization reflects Estado Novo's interpretation and views about the issue.

Mocidade Portuguesa and Mocidade Portuguesa Feminina increased the body and health awareness of the youth at the time. The bourgeoisie introduced and imposed their philosophies and ideologies into these lifestyles in public life through mass media. In this way, the frequency of body intervention and the social control of the body increased in the form of imposing marginalization and exclusion. Even in the 1930s-1940s, the medical sector and the culture industry in the developed world had already recognized the importance of dramatizing health information and of presenting visual material in an interesting manner to capture the attention of the audience (Lupton, 1995: 45)—the consumer citizens. The 1920s had already seen the global spread of the American culture industry and media products and the health and bodily issues came to the fore along with WW 1 and pandemics following the war. Although it was not information overload, the influence of mass communication on social and individual life could be observed starting from the 1920s and 1930s. We can say that the body acquired more visibility and prominence during the periods of Atatürk and Salazar.

Image 21– Medication Marketing in 1940s in Portugal (The references to genders, to the issues of the period)

2.1. The Dissemination of Health Ideologies in Salazar and Estado Novo Period and In the Republican Period

Many scholars see the period of Estado Novo (New State) Regime in Portugal as an anti-democratic, anti-liberal, totalitarian, anti-parliamentary, one-party state period (Campinos, 1975; Cruz, 1988; Georgel, 1985; Loff, 1996; Lucena, 1996; Monica, 1978, as cited in Pinheiro, 2006: 64). This study establishes the arguments in a similar vein with the ideas of these scholars. However, here it should also be noted that in the past, after many political instabilities experienced before Salazar, he and his doctrine was seen as a savior. After Salazar assumed the leadership—a regime change was made in 1933. A corporatist state was established in this period. It was considered that national interests had to rank in

priority over individual interests so that it would be possible to have a steady, harmonious and organized society (Pinheiro, 2006: 65).

Image 22– Mocidade Portuguesa and Mocidade Portuguesa Feminina Activities

In the Estado Novo regime, the state utilized clubs, national trades unions, people's houses (Casas do Povo), and corporations (commerce and industry), such professional associations as doctors association (Pinheiro, 2006:64) in order to organize health and body politics and activities within the context of modernist and traditionalist state ideals. The most important institutions to shed light on specific issues in this study are Mocidade Portuguesa and Mocidade Portuguesa Feminina. As in the other regimes in Europe, fascist and nationalist ideology in Portugal anticipated that the Portuguese youth, both female and male, had to be healthy, to follow healthy sports and nutrition habits for the continuation of healthy generations and for the future of the nation. The leaders of the regime considered that the Portuguese people were physically weakened and this was considered to impact the economy and security of the nation (Brito, 1982:8). The formal health and body education in the school was considered inefficient. Therefore, some corporations, social centers and gymnastic centers were established to compensate for this inefficiency. These were utilized to regulate the body and health of the generations, physical and mental training of especially the youth, who would shape the country's future. In accordance with the ideological and pedagogic activities, organizations and politics of these institutions, many books, guides and articles were written and stories were published in newspapers and journals during New State

regime. Some of these sources were Stadium, Femina, Voga, Sport Ulustrado, MP and MPF bulletins, Crónica, Modas e Bordados –Vida Feminina, Menina e Moça, O Norte Desportivo, O Atleta, O Sport Ilustrado and newspapers such as República, Novidades, Mundo Desportivo, Jornal de Notícias, Público, A Bola and Os Sports.

Through the corporatist health care management and mass communication, the officially approved healthy life messages were disseminated and social control mechanisms were introduced in the medical, social and cultural centers to impose health-related decision-making and moral behaviors. Mocidade Portuguesa was a dominant institution regulating this notion of corporatist healthy life in Estado Novo. The Portuguese body politics, fitness, gender, citizenship norms and traditions were influenced by the practices of MP during this period and later on. Women and young girls were encouraged and imposed to avoid the practice of male-associated physical education and sports. The physical and sporting activities promoted by MP and MPF respected the views of the Catholic Church (Pinheiro, 2006: 96), because Salazar was conservative and received the political support of conservatives before assuming leadership. These institutions provided official health, body and mind education and regulated mass decision-making and behaviors in related issues. It might be said that they implemented traditional body politics based on dominant religious gender norms and political culture to empower their discourses about healthy life and reproduce the regime itself.

After its establishment in 1933, Estado Novo had great influence on the body and health politics of both genders and on the promotion of healthy modern men-women through establishing institutions (MP, MPF and FNAT[48]) and organizing health and sports related communication. In the 1930s and 1940s, along with Portugal's ideological and international relations with Germany, Spain and Italy, the body politics and ideals were influenced by these cultures, healthcare systems and body ideologies of these countries. Like these countries, Portugal implemented the Bismarck healthcare model based on conservative, statist and partly corporatist ideologies. In this context, the social security law (Caixas de Previdéncia) began implementation in 1946 (Pereirinha and Caroloand, 2009: 17). At least the Portuguese labor force began to benefit from modernized health-care systems and was

[48] FNAT abbreviation stands for "Fundação Nacional para a Alegria no Trabalho" (National Foundation for Joy at Work).

partly saved from suffering the huge financial burden of private health-care expenditures as this was a system that protected the household of the labor force.

Like MP and MPF, "Fundação Nacional para a Alegria no Trabalho" (FNAT—National Foundation for Joy at Work) was a product of Estado Novo's body and social control politics. It was established in 1935. It created a doctrine out of the ideologies of the regime, the bodily and cultural practices of the nation. FNAT held that sport was an important bodily and cultural practice for the nation, therefore, it supported competitive sport and presented sport as a healthy activity with a belief that would help create a stronger Portuguese worker who would assist the nation in its competition with other European powers (Drumond, 2013: 407). Estado Novo wanted to take particular care of the population when they were not working. Accordingly, FNAT's main concern was specified as providing healthy and cultural activities and was clearly inspired by the German Kraft durch Freude and the Italian Opera Nazionale Dopolavoro (Cadavez, 2013: 92). Through establishing FNAT, Estado Novo aimed to ensure greater physical development and the elevation of their intellectual and moral levels in their free time. In order to foster greater physical development of the workers, FNAT promoted tours and excursions, organized summer camps, challenges, athletic demonstrations and sports parties, created gymnastics and physical education courses[49] .

Besides organizing gymnastics classes and sports competitions between workers of both sexes, it also facilitated the dissemination of cultural norms through "recreational evenings for workers" and radio lectures (Costa, 1998). These were organized through six cultural intervention practices such as intellectual training courses, (general culture), technical (professional) and physical (gymnastics, physical education), (Branco and Branco, 2003: 51).

[49] "Decreto-Lei n. º 25 495, de 13 de Junho de 1935" (Decree-Law n.25495, 13th of June, 1935) Article 1 and Article 4, Criação da Fundação Nacional para a Alegria no Trabalho (FNAT), No page number

Image 23- FNAT

Apart from the healthcare systems, the cultural impressions from the ideologically relative cultures (as in FNAT, inspired by German Kraft durch Freude and the Italian Opera Nazionale Dopolavoro) could be observed in the body culture and politics through the body ideals presented in mass media. Especially German and Spanish women athletes were involved and these athletes were presented in mass communication as "modern women who loved being outdoors in contact with the sun and nature" (Pinheiro, 2006: 113). Sporting activities were considered to be very significant due to a belief that it contributed to the development of attractive and healthy bodies. Pinheiro considers that the New State regime introduced a traditional and modern way of managing the body and health and summarizes this gender-based body and healthy politics influenced by international politics:

> The idea was transmitted that sport helped women to develop a "nice" figure without losing their femininity…These publications urged Portuguese women to follow the examples of German, Spanish and Scandinavian women, and not to be afraid of losing their feminine grace. (Pinheiro, 2006: 113)

Image 24– Stadium Magazine from Salazar Period (Taken from Pinheiro, 2006)

Aesthetic arguments served not only to encourage women's participation in sport but also to indicate which sporting activities were considered "appropriate and suitable" for women. During New State period, many social evolutions took place in Europe, but one of the many important phenomena affecting the social life in Portugal was the participation of women in the labor force and social life increasingly. The rate of the female labor force increased to 16.97 percent by 1960 and 24.6 per cent by 1970[50] (World Bank, 2019). Along with the improving democracy in the continent, the international women and feminist social movements, more and more Portuguese urbanized female labor force started participating in sportive and athletic activities and gradually entered public and business life. As a political response to this social evolution, the restraining body politics and discourses were also introduced and disseminated against these developments with the help of mass communication and corporatist institutes. Some of these were religious and conservative discourses, whereas others were medical and politics of aesthetic restriction.

Until the 1960's, the Portuguese economy had been under the control of the agrarian bourgeoisie (Pinheiro, 2006: 67), but modernization and development politics, the colonial management as well as global economic and social issues were impacting social life and the economy in Portugal, compelling the regime to join EFTA and GATT in 1959, in IMF 1960. This led to increasing openness of the Portuguese economy to outside (Graça, 1999). In the 1950's, there was a stabilized economy compared to the period before Estado Novo. However, it was still not a well-developed economy compared to most European countries. A major part of the economy was in the hands of specific entrepreneur groups in the corporatist economy. Portuguese industry began to seek foreign investment. Older industries were modernized and new industries were developed. However, as a result, they had to demand financial support from the state and banks. This helped the emergence of powerful (bourgeois) financial-industrial groups which would control the Portuguese economy later on (Pinheiro, 2006: 67).

A gradual transformation from corporatism to a neoliberal economy started to take place beginning in the 1960s when Portugal joined EFTA, attracting foreign investment as it modernized many industries, paving the path for further economic developments in 1970s.

[50] After the revolution, these rates increased up to 44.68 per cent by 1978 and 54.07 per cent by 2017 (World Bank, 2019)

Although Salazar's corporatist economy politics provided a stabilized economy, health and education, such targets as prolonging lifespan, developments in education, economy and politics were achieved compared with the beginning of the Estado Novo period, it was still behind most European countries. The middle class could not grow enough due to the corporatist economic model. However, during 1960s and 1970s when the Portuguese economy was opened up, and social, educational and economic developmentwas achieved. Substantial mobilization was generated in literacy and education.

In the post-war period, the globalization of the neoliberal economy and proliferation of technologies allowed for easier dissemination of many issues globally. In this regard, especially the developments in media technologies and culture industries rendered all the commodities more visible to consumers. Besides this, the increasing participation of women in labor force and the 1968 leftist political and social movements made the bodies more visible in public life. This visibility fostered the ornamentation and stylization of the bodies, clothes, body modifications, with consequences concerning bodily preoccupations occurring to women and men. Especially in USA and UK, women started to have a negative body image and began dieting. Through such social movements and gender-based bodily phenomena, the neoliberal economy, social and consumption-related norms started to influence Portuguese social life. The cultural and social evolutions and revolutions took place, more fragmented and clustered patterns of micro-cultures started to emerge in the form of lifestyles and subcultures (i.e. feminists, rocker subcultures and Latino immigrants' cultures). These, in turn, changed how health communication was carried out for organizations' and corporations' target audiences and groups. Aesthetic concerns became prominent as well, and news with visuals on the beautiful social body (healthy life advice for beautiful body) were published in magazines, newspapers, advertisements and all kinds of television shows.

During the Estado Novo period, a considerable number of financial resources was allocated for colonial management and military expenditures. This led to an economic and social crisis, and, as a result, many people left the country with the hope of finding a better social and economic life. However, the crisis also forced the Salazar regime to open the economy to the foreign investment and this was followed by the involvement of international cooperations in the Portuguese economy and social life. The state expanded the social security system. However, funding was not enough to provide quality health-care for society. Towards the end of the Estado Novo period, the economy was worse than many other

European countries. The rate of preventable diseases and infant deaths were higher even though the issues were held important and measures were taken throughout Estado Novo period. However, in practice, this was not enough to provide a European-average healthy life (Perreira, Amorim, Correira and Menezes, 2016: 69-80; Neave and Amaral, 2011: 95-102). The corporatist economy model delayed economic modernization and the economy impacted the social life and health status of the Portuguese citizens. This also contributed to the economic and social crisis caused by colonial management. From 1969 onwards, the final crisis of the Estado Novo began. (Santos, 1969: 885). About 1.5 million people left the country from 1960 onwards. Portugal had one of the highest rates of child mortality (Varela, 2020: 6). The Estado Novo period came to an end with the increasing demands for individualization, better economy and democratic governance, which were emerging during eliminating the social problems of the industrializing societies. Portugal survived the military coup d'état in 1974 following the Carnation Revolution just as Turkey did in 1960 and 1980. On May 1, 1974, one week after April 25, two million people came out celebrating the first of May, demanding not only democratic changes like the end of the dictatorship but also voicing revolutionary social demands such as a minimum wage, not working on Saturday and Sunday, being paid for night shifts, or an equal pay for men and women (Varela, 2020: 6). The demands were not limited to these, but these focused on many individual and social problems. Boaventura de Sousa Santos discusses these post-revolution demands in detail with the following:

> Popular movements have made demands for social security (broadening of categories and eligibility criteria), housing (housing occupation; social housing), health (National Health Service), education (literacy; access of the working classes to different degrees of education), culture (animation and cultural dynamism), justice (participation in the administration of justice; generalized access to the courts), male / female relationships (elimination of forms of discrimination against women in the family and at work), etc., claims that not only required more or less profound legislative changes,but also linked the State to greater involvement in regulation social reproduction. (Santos, 1969: 888)

Both countries suffered from political and economic instabilities on the eve or in the wake of the coups and had to make democratic reforms. However, the Portuguese economic conditions improved following the revolution and even grew beyond the European average growth rates. Popular worker movements fought for determining wages and controling the production process. This quickly forced the global modernization of the legal and institutional framework of capitalist production relations, equating it to those in force in the central European countries, and in some respects, even going beyond (Santos, 1969: 886).

This accelerated advancement may be due to the fact that Portugal had been for 48 years the most backward country in Europe until 1974 (Varela, 2020: 6).

Portugal had such political poles as the "conservative Northern" and the "radical Southern". In a similar vein with Portugal, Turkey had rightist-leftist pole tensions between 1960's and 1980's and now has a conservatist (inland) and secularist pole tension (coastal cities) in state-governance struggle. In Portugal, after political stability was assured in the second half of the 1970s, many reforms were made in health and education following a retarded economic growth in 1960s and 1970s (such as the establishment of national health system "Serviço Nacional de Saúde" in 1979). These carried Portugal many steps further, at least in education and health. However, public funding for this system was not enough until 1990s and could not save the country from being a latecomer due to the structural relationship between the economic system and health system (Giarelli, 2007: 200). The foundations of many socio-economic developments which had not been succeeded in constitutional monarchy, first republic and corporatist Estado Novo were laid after revolution. Many economic and industrial advances had been made after joining EFTA in 1960 and Portugal received financial support from the IMF during the 1970s and 1980s as Turkey did in the 2000s to assure economic stability. Socio-economic growth was achieved following the integration with EEC and EU until the global crisis in 2008. Many rooted improvements were made in health and education starting from the 1970s, enlarging the social security system and health technology investments in the 1980s and 1990s. The targets having been defined throughout the Estado Novo period concerning the health of the nation and the development of the socio-economic status and politics were sustained even after this period.

After the Salazar period, the democratization and revolution years, many social, economic developments and integration with the EU (1986) opened Portugal to global capitalism, neoliberal production and consumption ideologies and practices. The EU and global health politics started to impact the Portuguese health ideologies, practices and health promotional activities. In the meantime, democratization, urbanization and globalization in Portugal may have made the health and body management a more social and a more commodified process than during previous decades. The perception about such issues as elderliness, improving health and eliminating diseases through social support as well as individual imperatives, the family size and fitness culture was changed to an important extent by the reorganization of health communication. The highly educated generation with higher

levels of health literacy and technical knowledge started to resist both traditional and modern health imperatives imposed.

The body health has been transformed into a neoliberal consumption instrument along with the emergence of the accelerated society and health regulations. The global body and health ideologies reproduced since the 1960s and socio-cultural changes taking place since 1970s transformed the body and health into a device and project to be invested on, to be satisfied and through which the social mobility was sought in Portugal. In addition to these, the lifespan was prolonged too fast through extensive measures, technological advancement, regulations and health policies. The average lifespan was 62.81 years in 1960 and now it is 81.93 in 2019 (United Nations, 2019). Today, the rate of the population over 65 years in Portugal has reached 22 per cent and it is the 3rd highest rank after Japan and Italy, making Portugal one of the countries which has the highest rate of elderly population within total population (World Bank, 2018). The cultural perception of the elderly changed from 50-60 years to 80-90 years. The successfully implemented health policies and strategies and advice made the Portuguese population healthier compared to the beginning of Estado Novo.

Post-modern urban life, the economic difficulties it posed and hedonistic life philosophies generated a norm limiting the number of children in a family. A body and health ideology requiring the adoption of individual consumption, the usage of mass-communication to be informed about this ideology was introduced and encouraged with further biopolitics and practices. In the neoliberal health system in Portugal now, pharmacies, herbal stores and supermarket stalls have become health centers. These places have become not only commodified medication centers but also have emerged as concrete structures of the new health-problem solving culture. Physicians were replaced by the marketers of specific funded medications. This new culture gave birth to many health life markets mentioned in the Chapter 2 and these were associated with consumption.

The other cultural change taking place after revolution was the gradual abolishment of traditional public health practices. Until the 1970s, social and personal life had not been overmedicalized and people made use of folk remedies about which they had acquired information through word-of-mouth health communication throughout the ages. Not all of these practices were abolished along with the integration with the EU and its health politics and practices. Some are still practiced despite being of limited use. For example, such public

culture remedies and practices as the use of carrot and sugar for such health problems as cough in Portugal are still utilized. Until several decades ago, in lower classes, bonesetters were preferred in Turkey for such urgent problems as fractures. Folk healers still exist in both of these countries even though this practice is decreasing.

Image 25– The exploitation of hope fountain built by medicine – An example practice of the exploited quickie health[51]

The present healthy life system, social and cultural reflections and conditions will be discussed in this chapter. However, focusing on the Turkish case and respecting the chronological order may be more appropriate in this point.

2.2. The Dissemination of Health Ideologies in the Late Ottoman Empire and in the Early Republican Period

Ottoman society embraced a self-enclosed lifestyle, and did not follow and adopt contemporary developments in the world. It lagged behind in the areas of science, technology, and health as it lagged in other areas (Aydin, 1995: 44). The desires and expectations of the body were culturally minimized, controlled and disciplined in an ascetic style through mystic organizations. The already mentioned self-management technology created ascetic moral values required by the closed economic system of the Empire reproduced power relations (Ulgener, 1981:97, as cited in Yasar, 2014). Healthy life advice was disseminated mostly by word-of-mouth health communication among lay people in the Ottoman Empire, because the most-advanced mass communication technologies of the time had not been adopted until late 1800s. During this period, traditional public remedies were

[51] These kinds of practices are not legal or common in Portugal or Turkey, nor are the cultural practices of these countries, however, they still exist in some immigrant communities, even in the form of agents of quickie health. “Resultados Máximos Em 7 Dias” (see image 25)

dominant in public health practices[52]. Instead of health organizations, traditional, cultural and religious health advice was produced by the public itself (by traditional healers and religious health experts) and disseminated within the society through religious or mystic organizations and groups and Darussifa[53] centers. Darussifa centers were similar to Misericordias in Portugal[54].

In the end of 19th century, the Ottoman Empire was considered to be the "sick man of Europe" and was about to collapse. As a consequence of the waning power, the constitutional monarchy, faced with the Allied Powers, Ottoman rule collapsed after World War I, upon which time, andAtatürk assumed leadership in the independence struggle and subsequently established the Republic of Turkey in 1923. The newly founded republic started a series of cultural reforms and 'revolutions' as a continuation of the former incomplete Westernization movement of the Ottoman Empire. As Salazar, Atatürk (Father Turk) was seen as a savior.

After the collapse of the Ottoman Empire and establishment of the republic, many developments in health and body care politics were made. The nation was afflicted with many health relevant issues due to prolonged periods of war in the collapse process of the Empire and new remedies and technologies had to be adopted to prevent the loss caused by warfare. Most of the traditional public health organizations, methods, practices and philosophies were abolished in the beginning of the republican period, because they had already been replaced by scientific health management in the West in 19th century. It was held that they were incapable of producing solutions for health problems caused by contagious diseases, epidemics that emerged during and after WW 1. The regime had already established the Ministry of Health even three years before the republic was founded, because the elimination of the health problems emerging during the war-inflicted social and

[52] There were such traditional practices as the usage of midwives assisting at childbirth, the bonesetters in recovering the fractures etc. These practices were even dominant in the last decade. The oldwives' tales were also dominant in public health beliefs in Turkey even in 1900s.

[53] Darussifas were public health centers similar to Misericordias. They functioned like hospitals of the present time. These date back to 1400s. However, in the latter centuries, these were not enough to provide a quality health service for the public.

[54] In Portugal, the charity health foundations such as Misericordias, which have a religious origin still provide a health service similar to the public and private health sectors. Before 18th century, these health centers and hospitals provided service for the poor in Portugal. In Portugal, in 1800's, the state and municipalities also provided public health services. In early 1900's, the scope of the public health service offerings was broadened through specific legislations and policies (see: Sargutan, Kocabacak, Zehir, Dizlek, Kiygi and Duran, 2010: 2236-2244).

economic life was of paramount importance. Like the Salazar regime, the new regime in Turkey held that health care should be improved urgently for the welfare of future generations of the nation. According to the leaders of the regime, there was a relationship between socio-economic factors and health problems. Hence, they formed their body and health policies and ideologies accordingly (Aydin, 1995: 46). In Turkey, educating the body was associated with educating the mind as in Portugal where mainly Mocidade Portuguesa functioned in this way. The regime held that organizing sports activities and culture even in villages was the most useful thing for the youth (Apak, 1935). Halk Evleri (People's Houses) functioned in the same way as Mocidade Portuguesa and FNAT even though its name is similar to Casas do Povo in Portugal. Ozsari summarized the regime's body and health politics organized within the perspective of the preventive medicine and the nationalist idea of stronger generations for a stronger economy and army. The basis of this preventive health perspective was the sports activities organized by Halk Evleri:

> The sportive branch of Halk Evleri arouses love and interest in Turkish people for sports and body movements, turns these into a mass movement and a national activity… It teaches citizens home and room gymnastics, which is the basis of modern health concept…It functioned on the basic principle "body, spirit and mind development together". The whole public were encouraged to participate in the sport activities (Ozsari, N.D.).

Image 26-Halk Evleri Sportive Activities

At the beginning of the republic, the literacy rate was very low. Thus, information concerning health was spread through cultural and religious discourses and as a part of literacy education. In Atatürk's period, nutrition, sporting styles and socio-economic status of the people in Turkey changed. Thanks to the technological developments in medicine, visualization and media in the globe in 1920s and 1930s and the adoption of these by the new regime, health philosophies and practices inherited by the Ottoman Empire were replaced by modernist practices and discourses assimilated from Western European

countries. In this process, health advice (even commodified advice) was introduced in an intensive manner through various forms of news media accordingly (see image 27 and 28).

Image 27- "37,000 people die every year" – Healthy Life Advice for protection against tuberculosis in 1930s - Cumhuriyet, 16.2.1930[55]

[55] In the newspaper article and interview presented in the image in the previous page, the official ideological perspective and the typical perspective of the early republic period towards health issues (in this case, it is tuberculosis) are presented: "It is necessary to open tuberculosis dispensary in Istanbul and to put the first cornerstone of a new and necessary struggle in this process" (Atatürk, 1930). The physician provides health advice to be protected against the deadly disease with such flashes as "tuberculosis vaccine", danger signs (symptoms)", "What are the imperatives to be protected against tuberculosis": "Remove the cages. Open air and sun are the enemies of tuberculosis. In good weather it is a good and healthy practice to sit and sleep with the windows open during the day and at night". "37,000 people die every year. The financial damage caused by tuberculosis in our country is at least 90.000.000 TL annually." ("Senede 37000 kisi", 1930)

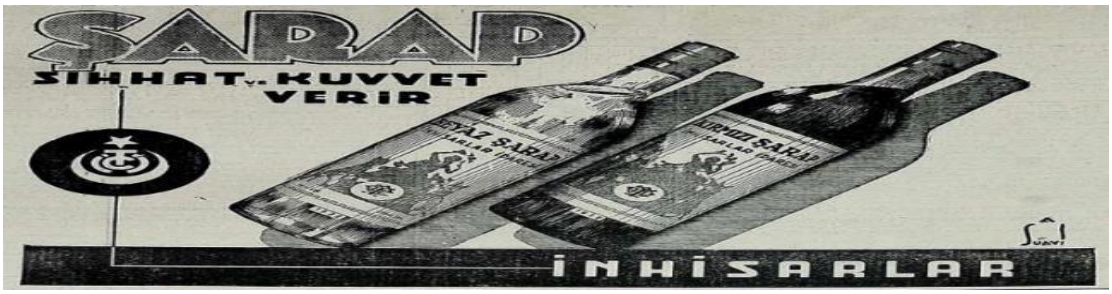


Image 28- "Şarap sıhhat ve kuvvet verir" (Wine makes one healthier and revitalizes)"- Aksam- 09.12.1942

From the early 1920s until the 1930s, the state struggled to construct a national bourgeoisie and attempted to establish a liberal economy. However, the state was also forced to develop a statist economy, politics and even to establish corporatist organizations after the Great Depression. In the late 1940s, a multi-party system was adopted and the bourgeoisie started to impact the national economy and politics. However, throughout the history of the republic, there has never been a period in which fully a liberal, corporatist or socialist economic model was in practice. The state had instructed the business world and acted in a restrictive manner and also produced their own rich and elite partisan business groups (Bugra, 2003).

Image 29– The Milk Powder Provision by USA within the context of Marshall Plan and the obligatory consumption of it in primary schools in 1950s

After the early republican period, Atatürk, the liberals and conservatives dominated regulated the body politic for several decades. With the Marshall Plan in the 1950s, Turkey was opened up to further integration with the international capitalist order, and joint actions with USA became one of the main targets of governments. The Marshall Plan was implemented in Turkey as in Portugal. The relevant global biopolitics within the context of this plan were implemented by United States in an effort to find allies in Europe and to fight

against communism and the Soviet Union. This contributed to political and economic division in the continent and in Turkey in particular. Turkish politics was strongly polarized, thereby leading to a deadlock before both coups[56]. The state, governments and bourgeoisie made reforms and policy changes concertedly, adopting liberal norms and strategies between 1950 and the 1980s gradually. Along with the transformation from the statist economic model to a neoliberal economic model, individualism came to the forefront as of 1980s. Following the collapse of the Soviet Union and the depoliticized social life after the 1980 coup in Turkey, the search for social mobility encouraged individual consumption, neoliberal self-actualization-improvement philosophies, capacity increase and a prolonged life ideal. This was facilitated by the increasing dissemination of healthy life advice and sportive activities in many channels of mass media.

Since the 1920s, Turkey has had a long history of westernization, modernization and democratization with interruptions in political progress. Though still considered as a latecomer as its industrialization and economy are not as developed as those of Western countries, Turkey has modernized and developed commercial and industrial activities in cooperation with the West. However, the OECD reports (2015) and other global social reports prepared by EU (Eurostat, 2017) and the World Bank (2017) continuously suggest that economic, social and legal indicators still need to be improved. As a continuation of 200 years of Westernization and modernization movements which started towards the end of 18th century during the Ottoman Empire and of the republican regime's development policies, Turkey has been transformed culturally, and is open to Western culture. As a result of the cultural revolution in the 1920s and 1930s, progress in many areas of life has been sustained despite all political turmoils.

At present, religious authorities and groups may still have a social and cultural capital impact on the body and health politics, consumption and behaviors in Turkey where 51 percent of people define themselves as religious (Konda, 2019). TV technology emerges as the main source of cultural capital of the conservative, older, less educated and low-income

[56] In Turkey, the military administration has seized the political power twice, in 27.5.1960 and in 12.9.1980. Many deadly incidents had taken place before these coup d'états. These incidents were taking place between such civil ideological and political poles as right-left, nationalist-communist blocks and groups. As a consequence of 1960 coup, the Prime Minister was discharged and the junta governed the country for a year until a civil election was made. Again, in 1980 coup, the prime minister was discharged and this time, junta governance took three years, the political and social life were interrupted.

audience. Many television channels target this audience[57]. In some of these channels, healthy life philosophies are disseminated in a fashion that provides and suggests religious duties as well as alternative public medicine solutions. In the first half of 2010s, there were also enterprises that marketed the products they manufactured through a discourse combining scientific facts and religious beliefs. They spammed satellite television channels, sold many unlicensed products uninterruptedly for a long time[58].

Image 30– Two proliferated products which were prohibited but marketed abundantly in Turkey in 2010s[59] - "Diabetes Support Pack" by Dr. Omer Coskun on the left – "Kibarli Panax Ginseng" on the right

Today, Islamic bourgeoisie as well as the secular bourgeoisie in Turkey own many modern health facilities, hospitals, clinics and media channels. Beside their huge determining roles in the formation of biopolitics, the media channels of the Islamic bourgeoisie disseminate healthy life advice that tend to offer more moralistic, traditional and alternative solutions, techniques and discourses, which are only partly scientific and accurate. In this regard, the conservative "star doctors" make use of religious stories or myths to emphasize religious duties by linking health care with religious norms. For instance, some doctors use prophet name (Mohammad), holly book name (Quran) and such terms as miracle or miraculous for ordinary remedies, fruits, vegetables or techniques to capture the attention

[57] In Portugal, the rate of those defining themselves as conservative is 37 per cent (PEW, 2019). The cultural capital sources of the conservatives in Portugal are such channels as TV Fátima, Angelus TV, Enlace Portugal, S+, Globo HD)

[58] For more than 6 or 7 years, a specialist named Dr. Omer Coskun found a company which produced or proliferated unlicensed (not licensed by the Ministry of Health but only by the Ministry of Agriculture) health products targeting to recover organ diseases. This man was found guilty by the Ministry of Health after many efforts by academics or reporters, however, no serious precaution was taken and he constantly bought or spammed many television channels in satellite TV after being banned in national channels.

[59] There have been some firms (which exploited the religious norms and took a conservative political stance by using religious norms in their marketing activities. These firms produced and marketed a vast amount products and marketed in satellite TV channels despite being banned in many TV channels due to being reported as firms producing with licence received by the Ministry of Agriculture, not by Ministry of Health.

of the conservative audience. In this kind of advice, conservative doctors also make use of moral terms as “sins” to instill fear into their audience with the intention of having them abstain from unhealthy behaviors. They make interpretations with references to the “religious afterlife belief” and say: “you are not the owner of your body and the body belongs to God. You should take good care of it, because you will return it to God when you die”. These kinds of messages can be easily observed in conservative discourses, both in conservative media and word-of-mouth health communication among lay people. Some conservative discourses even claim that “praying five times per day every day is like physical exercise with reference to scientific healthy life discourses.

Image 31– An example of the regulation by religious organizations, they offer healthy life advice through religious norms and discourses - The advice on the left - ([Our prophet S.A.V. orders: “Eat fig, because, it prevents hemorrhoids and pains in the feet” and “Those who want their hearts to beat healthily and comfortably should continue eating fig”]) – The advice on the right “You should pay utmost attention to two things: What you consume and words spoken”

The mystic, religious and community type organizations that originated during the Ottoman period still regulate the self-technology and the health and bodily consumption habits of many conservative Muslim communities today. There are many devout communities in Istanbul that produce their own body politics allegedly in accordance with religious norms (references to the Quran, prophets or their leaders) and they deem the consumption of some drinks or food as immoral and unhealthy in their publishing, meetings, internet websites, social media pages, word-of-mouth communication and TV broadcast coverages (see image 31). In the Quran, alcohol, drugs, pork and bushmeat are directly defined as unhealthy and strictly prohibited. Fasting once in a year and consuming hygienic food were defined as healthy. Now, even some religious groups claim that the religion does not collide with science and associate the popular intermittent fasting with Islamic fasting duty, reproducing the religious beliefs with references to scientific body-health

developments[60]. These kinds of concerns are generally manifested because religious communities want to attract the secularist groups into their own worldview or doctrine.

2.3.A Brief History of Regulating Healthy Life Decisions Through Neoliberal, Religious and Ideological Sanctions

In ancient Egypt and Greece, clerics and organizations of many religions took active charge in the mental and body health practices as well as religious practices. Both in Islam of Turkey and Christianity of Portugal, this cultural practice was maintained until the 20th century. *Misericórdias* can be an institutionalized example for this cultural practice in Portugal and *Darussifa* for Turkey during the Ottoman period. These were public centers functioning to reproduce religion and health. For centuries, there was a dominant belief or superstition that the diseases were connected to the sins of the individual. In this regard, a variety of religious rituals, ceremonies and practices were implemented to solve health problems (Kilavuz, 2002: 74). Today, religious beliefs and discourses are still making contributions to healthy life decision-making and indecisiveness despite their diminishing power and impact. For instance, alcohol was prohibited in Islam due to a belief that it was considered harmful for mental and body health. However, in Christianity, it is largely permissible, still making contributions due to changeless health norms of religions. The consumption of alcohol is still prohibited in Islam, and has very little to do with health.

Ayten found in his study that there may be a correlation between adopting religious norms and adopting healthy life norms[61] (Ayten, 2013: 27). Baudrillard's (2008) and Lupton's (1995) arguments are in the same vein with these notions. That is, life and death issues are in the dominions of health and religion, and these life and death themes provide

[60] As for the influence of religious norms in Portugal, in the contemporary interpretations of Bible or in Christian beliefs, such responsibilities as balanced eating, responsible alcohol consumption are suggested and drug use is constrained in some sects as Mormons. Religion makes contribution to the healthy life discourse within its own context and we can observe this direct influence in the religious sanctions and decisions taken according to these norms.

[61] The correlation to be mentioned here is about the fact that the health messages and issues are considered and perceived to be like religious duties and that those who produce these kinds of messages are respected more by those audience who are scared to death through the messages produced by these sources. As demonstrated in 2.2. and 2.3. topics and 30th-31st images, the authorities and sources producing religious messages and those conservative biopower actors having close relationships with these authorities can exploit the healthy life themes. In the outset of the Coronavirus pandemic lockdown, too many exploitative messages and discourses were produced by these sources (religious-healthy life groups) in Facebook for people with especially lower literacy levels.

cultural power to those practicing relevant activities. For instance, in the Portuguese case, the religious or conservative authority had influences on the norms assigned by Mocidade Portuguesa, especially on gender-based exercise and bodily norms[62], such as directing women to female-associated sports instead of male-associated ones. Such a traditional and religious culture was dominant in Turkey, too. However, today, secularist body politics are the norm in these two countries, replacing traditional and religious body management politics. However, it has not been totally abandoned and is still implemented in Istanbul although in a limited scope. The metropolitan municipality of Istanbul provides gender-sensitive sports facilities (gymnastic centers, pools etc.). Men and women either use the facilities at different times or in different places with regard to neo-conservative biopolitics[63]. Moreover, in the same vein, in some public health shows in Islamic television channels, physical exercise activities are demonstrated with live practices, especially for the old generation's conservative audience. They are expected to participate (see Image 32) and be proactive in the health communication and promotion strategy adopted by the show and its spin-doctor. In such programs, the doctors generally act like showmen and opinion leaders, promoting morning sports and healthy nutrition philosophies that are culturally applicable and accessible. In Portugal, we see similar trends in such TV shows as Praça da Alegria (RTP) despite not targeting only conservatives but the whole population. In satellite TV channels in Portugal, there is the TLC channel broadcasting the MY 600LB Life show

[62] "These two youth organizations established a clear gap between both the social indoctrination of young men on the one hand and young women on the other, and the strategies for training their bodies. This gap was visible from the outset in the imposition of moral limits on the display of the female body, with a set of increasingly severe prohibitions on how it should be exhibited in public. In this domain, the restrictions on the physical education, clothes and bathing suits of girls in the Mocidade Portuguesa Feminina were exemplary by the standards of Christian morals" (Pimentel, 2001: 348–349; Ferreira, 2020:105). The conservative and traditional views of the female body and relevant bodily norms were dominant in these organizations. Many images of femininity were attached to this traditional view of woman. From this point of view, "The body of the "virtuous woman" should be seen as a "temple of the soul", sacred, preserved in the "gifts" and "natural" attributes that God gave her. The young woman's body was socialized primarily with a view to reproduction, playing her role as the "mother of the family", and thus "remaining in the domestic space" and "not using makeup, laughing or being educated, but being discreet, intelligent, disciplined, polished in manners and poise" (Brasão, 1999: 134, Ferreira, 2020:105)

[63] There are some similarities between the body politics of Salazar period in Portugal and the one in Turkey in the last two decades (2000s and 2010s). Both these periods are defined by the conservative body politics with references to patriarchal and traditional religious views of the leaders in power (despite the differences in Catholic and Muslim worldviews and bodily norms). The dominant bodily practices, the organizations and the media coverage were dramatically influenced by the worldviews of these periods.

that tells the stories of formerly overweight people and their anecdotes for losing weight (see image 34)[64]. The channel is broadcasted in Turkey, too.

Image 32– Example Exercise Scenes from a Conservative Healthy Life Show in Kanal 7 Channel

Image 33- Example Exercise Scenes from a Healthy Life Show in RTP Channel (Praça da Alegria)

Image 34- MY 600LB Life Show in TLC Channel

[64] As in Portugal or in any secularist country, there are many healthy life shows in Turkey which have a wide media coverage about such body concerns as aerobics, pilates, yoga or other health issues and these do not have religious moral agendas.

In the post-war period, when mass communication, marketing technologies and methodologies were developed at an accelerated pace compared to previous decades, many markets besides healthy life markets were also actively and predominantly involved in producing healthy life discourses. Especially, between the 1950s and 1980s, a great deal of commodified semi-scientific advice was intensively disseminated, actively exploiting the cultural and symbolic power of doctors and medicine. There was a strong belief that smoking neither harmed health nor caused cancer. Many doctors, probably funded by American cigarette companies, supported this claim in advertisements and scientific reports (see images 37-38-39-40-41). As such, it became culturally more convincing for decision and behaviors involved with smoking. Scientific advancements disproved this "healthy smoking" thesis even during 1960s. However, tobacco industry was very powerful and manipulative health-management through mass media and word-of-mouth communication.

Despite the power and dominion of the "Cigarette Lobby", many anti-smoking social movements have been created over the last 25-30 years owing to the accelerated dissemination of related healthy life advice, reports and statistics in media, public health spots and the internet. In this regard, social support has been received. We can see the reflection of these movements and anti-smoking promotion in Portugal and Turkey, too. For instance, a non-smoking practice has been implemented for indoor areas in the two countries over the last 12 years (for Portugal, 1st of January, 2008, for Turkey, 19th of January, 2008). The sanction was reinforced by fines, and many authorities held that it greatly influences decision-making on smoking (see image 35 and 36). In Portugal, the price of cigarettes and tobacco products increased due to an increase in tax, which targeted the purchase/avoidance decision due to financial limitations (Silva, 2016). Likewise, the consumption of hookah (water pipes) in Turkey has increased drastically since the admittance of Syrian refugees into the country as it is a sector dominated by Syrian migrants, refugees and their culture. The Turkish state has designated some public spaces and organized some activities ("Cumhurbaskani Erdogan'dan", 2019).

Image 35- Non-smoking Area Warning Plates from Turkey

Image 36- Non-smoking Area Warning Plates from Portugal

Image 37– Example Advertisements Showing that Smoking was Recommended Through the Exploitation of the Moral and Cultural Power of Health Sector

Sigara içmek zararlı değil bilakis vücuda faydalıdır

Uzun yaşamak istiyenler üzüntüden şeytan görmüş gibi kaçmalıdır. Böyle bir kovalamacada insanın bacaklarına en büyük kuvveti veren serom ancak sigaradır

Amerikan doktorları son günlerde oldukça garip bir iddiayı savunmaya başlamışlardır. Bu iddia «Daima sigara içiniz!» şeklinde üç kelime ile ifade edilebilir.

Yek nazarda tıp ve hakikatle taban tabana zıt gibi görülen bu iddianın derinliğine inildiği zaman pek çok hakikat payı olduğunu siz de ister istemez kabul etmek zorundasınız. Amerikada bu iddiayı ileri sürenler evvelâ şunu söylüyorlar:

«Insanın ömrünü kısaltan en büyük âmil sıkıntıdır. Çok yaşamak istiyorsanız, daima tebessüm ediniz, hayata neşe içinde bağlanınız ve üzülmek zorunda kaldığınız zaman kendinizi oylayacak bir şey bulunuz.»

Insanın üzüldüğü zaman hiç çekinmeden baş vuracağı sırdaşının kim olduğunu hiç düşündünüz mü? Eğer bütün hayatınızda böyle bir külfete katlanmamış iseniz, yine de katlanmayın. Çünkü bulmak için sıkıntı çeker, binnetice üzülürsünüz.

Onun için biz size yardım edelim ve derhal bu sırdaşın ismini söyliyelim: Insanın en yakın arkadaşı ve sırdaşı sigaradır. Bunu hiç tereddüt etmeden ve itiraza yeltenmeden kabul edin. Çünkü bu hakikat şimdiye kadar bir çok insanları uğraştırmış ve neticede bu noktada ittifak edilmiştir.

O halde üzülecek bir mesele ile karşılaştığınız zaman hiç çekinmeden başvuracağınız arkadaş sigara olsun. Fakat sigara ile arkadaşlık yapmak hem tehlikeli ve hem de çok zevklidir. Çünkü bu arkadaşlığı biraz olsun suiistimal etmeğe kalkarsanız hayatınıza kasdetmiş olursunuz. O halde ne yapmalısınız? Bir kere bir biri üstüne sigara içmekten kendinizi menediniz. Sonra sigaraları asla dibine kadar tüttürmekten sakınınız.

Herkes bilir ki sigaranın insana en fazla zarar veren tarafı dibidir. Sigara hattâ pipo içerken bir an için bile olsun aklınıza kansere tutulacağınız gelmesin. Bu boş bir iddiadan başka bir şey değildir. Çünkü insanın sigaradan kansere tutulması için günde en aşağı 120 adet sigara içmesi icap eder ki, buna da gerek maddeten, gerekse mânen imkân yoktur. Çünkü insan üç paketten daha fazla sigara içtiği zaman ağzının burkulduğunu ister istemez hisseder ve bundan sonra içeceği sigaraları uzun fâsılalarla tüttürür.

Sigaranın en büyük faydalarından biri de zihin üzerinde yaptığı yaratıcı tesirdir.

Bunun ilmen ifadesi ise şu şekildedir: Sigara içen bir insan düşüncesini bir nokta üzerinde gayet kolaylıkla toplayabilir ve dışarıyla olan temasını keser. Bunun neticesi olarak zihin bir nokta üzerinde teksif edilmiş olur.

Sigara zihni bir nokta üzerinde teksif ettiği gibi, bir noktaya takılan zihni de dağıtma hassasına sahiptir. Hiç dikkat ettiniz mi? Sıkılan veya üzülen insanlar sigaranın bu hassasını ister bilsinler ister bilmesinler, mutlaka sigara içerler. Sonra yine bu şekilde sigara içenlere dikkat edecek olursanız, sigaralarının dumanlarına bakarlar. Bunun da sebebi gayet basittir. Çünkü onlar bir noktada takılı kalan zihinlerinin sigara dumanı gibi dağılmasını isterler. Bu gayri şuurî bir istektir. O anda kendilerine bu hükmü hatırlatacak olursanız, size asla böyle bir şey düşünmediklerini kolaylıkla söylerler. Düşünmezler, fakat bu bir hakikattır.

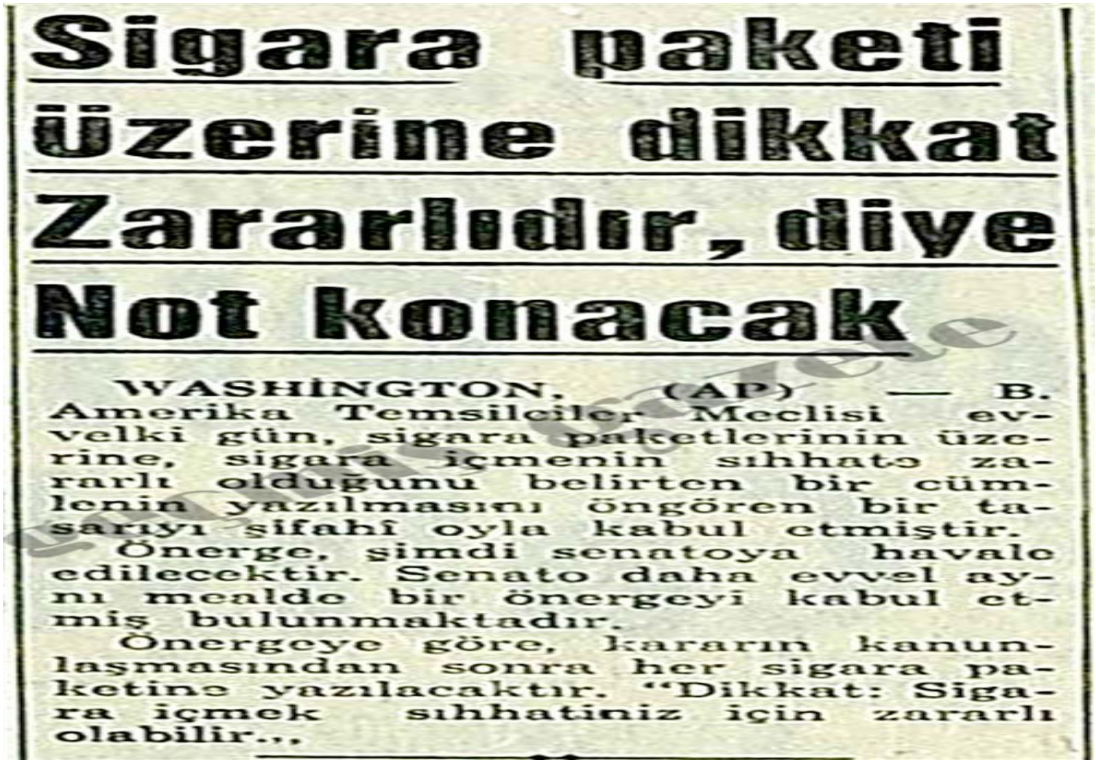
Diğer bir mesele de sigara tiryakiliğini daima içki tiryakiliğine tercih etmektir. Belki sigarasız içki içilmiyeceği iddiasında bulunanların taraftarısınızdır. Fakat bizim bu sözümüzü yabana atmayınız. Hiç olmazsa bir kaç gün için bizim tavsiyelerimize uyun, sonra göreceksiniz ki, içkinin vücudunuzda yarattığı tesir, çok daha başka oluyor. Sanki içki eskisi kadar vücudunuzu yormuyor ve sizi yıpranmadan neşelendiriyor.

Sigara hakkında size yaptığımız tavsiyelere son verirken şunu da söyliyelim ki, ya sigara tiryakisi olun veya hayatınızın sonuna kadar sigara içmeyin.

Necdet SELENER

Marilyn Monroe keyifli bir anında sigara içerken

Image 38- "Smoking is not harmful, but rather beneficial to the body health…Those who want to live long must escape sorrow as if they saw devil. In such a chase, the serom which gives the greatest strength to the legs of man is only cigarettes." 29th of January, 1954 - Milliyet Newspaper



Sigara paketi üzerine dikkat Zararlıdır, diye Not konacak

WASHİNGTON, (AP) — B. Amerika Temsilciler Meclisi evvelki gün, sigara paketlerinin üzerine, sigara içmenin sıhhate zararlı olduğunu belirten bir cümlenin yazılmasını öngören bir tasarıyı şifahî oyla kabul etmiştir.

Önerge, şimdi senatoya havale edilecektir. Senato daha evvel aynı mealde bir önergeyi kabul etmiş bulunmaktadır.

Önergeye göre, kararın kanunlaşmasından sonra her sigara paketine yazılacaktır. "Dikkat: Sigara içmek sıhhatiniz için zararlı olabilir...

Image 39– "Notes stating "the smoking is harmful, be careful" will be attached onto the cigarette boxes" – 24th of June, 1965 - Hurriyet Newspaper

Sigara içen daha fazla yaşıyor

LAHEY, (Hollanda) — Burada yayınlanan resmî bir rapora göre, sigara içenler içmeyenlerden daha uzun ömürlü olmaktadırlar. Rapor, sigara tiryakilerinin sigara içmeyenlere kıyasla ortalama 4 seno daha fazla yaşadıklarını açıklamaktadır.

Rapor, buna sebep olarak, sigara içmeyenlerin bu yüzden kilo aldıklarını ve bu fazla kiloların da zamanla insan sağlığını tehdit edecek hale geldiğini ilâve etmektedir.

Rapor, Amsterdam'daki Sağlık İstatistikleri Bürosu Şefi Dr. V. Oppers ile Hollanda Ordusu Sağlık İstatistikleri Bürosu Şefi Dr. G. Hoeflako tarafından müştereken hazırlanmıştır.

Image 40 – "Those who smoke live longer, according to Lahey Health Statistic Bureau" – 21st of January, 1966, Hurriyet Newspaper

Bir kanser araştırma merkezinin iddiası bomba gibi patladı

Sigara kanser yapmıyor

Sigaranın kanser yaptığının kanıtlandığını ileri süren doktorlar ise raporu şiddetle eleştiriyorlar

Ama, yine de bıraksanız iyi olur...

5 yıllık iryaki alil Tunç igarayı raktı

rk-Iş Genel Başkanı, alışkanlığı'nı yenmek n anahtar sallıyor

NKARA, (Hürriyet) - Günde en az ikişer paket sigara içen, 35 yıllık sigara alil Tunç, sigarayı bıraktı. rk-Iş Genel Başkanı ve Kontenjan Se- alil Tunç, sigarayı bıraktıktan son- yük güçlükler çektiğini ama direttiğini , sigarayı bırakmanın bir tek yolu ol- nu açıkladı: "İrade..."

marlarında tıkanmalar meydana gel- in doktorların sekiz yıl önce "Sigarayı ka bırak" tavsiyesinde bulundukları Tunç, geçen süre içinde sigaradan bir vazgeçememiş ve hastalığı giderek art- Bir buçuk ay önce, hastalığı yürütme- engel olacak hale gelen Tunç, tedavi k için Almanya'ya gitmişti.

(Devamı Sa. 13. Sü. 3'de)

BIRAKTIM İŞTE: Halil Tunç, tam 35 yıllık sigara tiryakisi idi. Birinciden Amerikan sigarasına ka- dar her türlüsünü içmişti. Ama bu "lanet şey"den bir fayda görmemiş- ti. Tuttu, sigarayı bırakmaya karar verdi. Şimdi başı dönüyor, gözü kararıyor, ama anahtar sallayıp, avutuyor kendisini...

FLORIDA- Kenningi Halk Sağlığı ve Koruma Enstitüsü Kanser Araştırma Bölümü'nden 1960 yılından beri 46 ülkeden 60 kanser uzmanının da işbirliğiyle yürütülen dünya çapında "kanser-sigara ilişkisi" konu- lu bilimsel araştırma, büyük yankılar yaratan bir açıklama ile son buldu: "Sigara kanser yapmıyor. Daha doğrusu tek başına etkin olabilecek bir akciğer kanseri nedeni değil!"

Profesör Doktor Bill J. Hendricks'in baş- kanlığında 155 uzmandan oluşan kanser araştırma ekibinin imzalarını taşıyan rapor- da sigaranın önemli bir akciğer kanseri nedeni olmadığı, hattâ diğer faktör- lerden daha az bir önem taşı- dığı kaydedildi. Son sayılara göre dünya nüfusunun yakla- şık beşte (ikisini oluşturan 1 milyar 633.5 milyon kişinin sigara içtiği ve araştırmanın

(Devamı Sa. 13. Sü. 9'da)

Image 41- "Smoking does not lead to cancer" - "The claim of a cancer research center exploded like a bomb…Doctors arguing that cigarettes have been proven to cause cancer are strongly criticizing the report… 155 experts in USA.... But, you had better give up smoking…" ("Sigara kanser yapmiyor", 1978)

As documented above, advice and news published during the 1950s to the 1980s in the global media (both US and European medical sources) offered conflicting reports, statistics, campaigns, and information to the public. It was not in the form of an overload. However, these may conflict with each other. For a long time, health communication channels offered both information stating that "smoking is healthy, and does not cause cancer" and information suggesting that "it is not healthy and causes cancer". Many health professionals in the medical sectors were in conflict with each other. This created an indecisiveness in health communication even when there were scant implications for an overload of information. It can be seen here from the examples of advice presented in the

previous pages that mass media disseminated conflicting information in the globe even during the Salazar period (see images 37-38-39-40).

Today, states regulate decision-making in some other health issues besides smoking. The additional taxes implemented for sugary drinks are striking examples of these regulations. This demonstrates the fact that the macro structures can easily impact purchase decisions and behaviors extensively with a variety of implementations. In 2016, through the "Programa Nacional para a Promoção da Alimentação Saudável" program, the Portuguese state started to implement an additional tax on the price of sugary drinks with lower nutritional value to reduce the consumption of these with the ultimate aim of fighting against obesity (DGS, 2016)[65]. With this law, the state also aimed to reduce health expenditures necessary to fight against sugar-related obesity rates and increase the income from taxes (PWC Portugal, 2016). In literature, this kind of tax is called "obesity tax". Similar taxes are implemented in many countries to regulate the smoking-related decision-making. Some of these countries are as follows: France (2012), Finland (2014), Norway (1981), Hungary (2011). Despite these legal precautions, there are still many paradoxical practices. Both in Turkey and Portugal, beverages that contribute to the obesity are still sold in public schools and in vending machines in the street. Besides these, the same beverages are sold in fast-food restaurants with free refills. There are no protective measures for these practices. State and health organizations have all the legal and political apparatuses to monitor and limit these practices as they do for the tax practices. However, these organizations prefer regulations through the dissemination of neoliberal moral discourses and delegate these responsibilities to the individual.

As in many countries in the world, in Portugal and Turkey, the state, municipalities and many institutions fund and organize healthy life and sports activities to provide free health measurements, diagnoses, education and courses to impact the health-related decision-making of the public (see Images 42-43-44-45). Besides these, they also transfer cultural capital through such facilities as walking trails and outdoor exercise equipment and impact the decisions concerning healthy life and sports. In 2014, in Lisbon, "Lisbon's Pedestrian Accessibility Plan" was approved (Flow, 2015), and many walking paths were

[65] In Portugal, the prices of sugary drinks were increased during 2016 summer, most probably in July and August. The prices of no-sugar products are less expensive than those with sugar.

built. Besides this, some continental sports and healthy life festivals such as Wanderlust are organized in Lisbon with the cooperation of many local organizations; thousands of people participate in these commodified healthy life activities.

Image 42– Walking Paths Built within the Context of "Lisbon's Pedestrian Accessibility Plan" Approved in 2014

As in Lisbon, many healthy life activities are organized in Istanbul and within this context, escalators were operated only for the old and the disabled during specific hours. In Istanbul Metros and people were encouraged (even forced) to walk. Besides this, such sporting activities as stretching, aerobics, mini golf and Far-Eastern sports were organized. Public health authorities set up a "fat measurement station" and offered health advice in accordance with the results coming out of these health and body analyses ("Metroda spor var", 2017).

Image 43– Organizations of Healthy Life by Lisbon Metropolitan Municipality and Many Companies in Healthy Life Sectors

Image 44– European Mobility Week Organizations By Municipalities and Metro Companies of Lisbon (Left) and Istanbul (Right) – An example of the globalization of health-related decision-making

Image 45– Regulation of the health-care management by "freguesias" and companies in Lisbon

Especially, in the last 30 years, the medical, pharmaceutical enterprises, associations and international organizations have defined obesity, cancer and cardio-vascular heart diseases as an epidemic and attributed them to sedentary lifestyles, consequently determining and implementing body and health politics and regulating decision-making and behaviors of the population. However, as this study has argued, the regulation of the behaviors and decision-making is organized in a moral and exploitative way by the market to such an extent that many issues in the social and individual life are

stigmatized, labeled and utilized to manipulate people. Sometimes, patients or consumers are left with no choice than be stigmatized and marginalized by moral health discourses[66].

In Turkey, in the last 40 years, neoliberal health politics has been gradually adopted, and relevant activities have been organized within the framework of integration with the EU and into the global economic system. The private health sector is growing reasonably fast in order to satisfy the demand for a higher quality of health service and for an increasing the population as well as increasing commodification of health.

The increase in obesity, heart and cancer-related disease rates deemed to stem from unhealthy lifestyles, the increasing visibility and facilitated diagnosis of these diseases provided political power to local and global health organizations. They started to have more cultural and symbolic power, prestige and capital in the eyes of the public. In this context, they started to disseminate information without restriction or surveillance. Moreover, bourgeoisie's influence on the construction of health politics and legislation support this neoliberal trend[67].

After discussing the health-related, economic, social, cultural, communicative and political practices over the course of a century, it will be plausible to look at actual statistics and facts in order to see how general behavior and consumption patterns are constructed by the structural factors in these two societies, and how the newly-emerging trends impact health-relevant decision-making, behaviors and indecisiveness through the complex health-promotion structure.

The broadest health structure designating health-relevant decision-making is the national health services, the social health security and private health insurance systems. These are similar in Portugal and Turkey in many aspects[68]. At the present time, SGK (Social Security Organization) is the main provider of the public health service in Turkey and SNS (Serviço Nacional de Saúde) in Portugal. The community health centers in Turkey and

[66] For instance, seborreik dhermatitis, both a cosmetic and health problem or disease can not be cured with the use of many suggested products, however, many people are critizised for not behaving in one way or another in the great plethora of advice and choices.
[67] Many enterprises create political and financial pressure through trade associations.
[68] The main difference may be the obligation to pay premium for social security system in Turkey due to the target of covering the whole population in the social security system. If the unemployed do not prove that they have no income, they may have to pay premium. This may mean, some allegedly free public health services have been commodified to some extent.

"Centro de Saúde" in Portugal operate in similar ways, providing free health services for the people residing in the neighborhoods near these centers.

The rate of health expenditures within the GDP in 2000 was 8.4 percent and now it is 8.9 in Portugal. As for Turkey, it was 4.8 percent and now it is 4.2 (Statista, 2019). The public health expenditure per person has increased for Portugal and decreased for Turkey since 2000s[69]. This may result in increases or decreases in out-of-pocket health expenditures individually and in the advice disseminated based on individual health responsibility notion.

With regard to the funding of health expenditures in Turkey and Portugal, there are different sources and applications. Portugal receives funds from the EU to finance health services whereas Turkey does not (Sargutan et al., 2010: 2258). This affects the financing of health-care management and out-of-pocket expenditures and the governmental allocation of relevant resources.

If the rate of privatization and neo-liberalization of health in Turkey increases, the statist health politics that have the function of stabilizing and equilibrating public health financing in Turkey may leave its place to a completely free market, which may exploit the notion of freedom of choice as in USA. Compared to previous decades, access to public health services has increased drastically in 2010s, even the lower socio-economic status groups have been transformed into health consumers through facilitated access to health-consumerism. However, they also have the opportunity to receive free or cheap health services through state-funded health service provisions. This is mainly because of improving infrastructures, facilitated procedures, cheaper access to private health institutions through public health insurances and the commodification of health services together. In this half neoliberal/half statist health market (mixed economy), the variety of healthy life services, products, hospitals and professions has rapidly increased.

The increase in such diseases as obesity, stroke and cancer, which are considered by biomedical authorities to be the problems of the former civilized or more developed world, is also observed in Turkey as in Portugal. The increase has brought about the demand for preventive or protective medicine and healthy life advice. This has also led to a new healthy

[69] While the public spending is reduced in Turkey, this burden is mostly delegated to the public within the scope of individual responsibility. Although the state still partly provides free or inexpensive health services, it increases individual expenditure with the obligation of insurance premiums and the collection of examination fees during the purchase of drugs in the pharmacy, not in the health institution.

life culture in which Turkish and Portuguese societies have had more health and fat talks in daily life interaction in the last several decades.

As for health education in schools in Turkey and Portugal, both countries have carried out health-related pedagogical activities in co-operation with health centers (DGS, 2019). In the general public education system in Turkey, at the primary education level, healthy life advice is disseminated in such courses as "physical education and game", "physical education and sports" and "life sciences" (the issue of healthy life). These courses are mandatory while other sports and physical activity courses are optional. In secondary education, a course named "health information and traffic culture" is mandatory and "emergency and health problems" are handled in English language education. As for Portugal, no specific course is offered for health information at the primary or secondary education level. However, in "physical education" courses, health promotional norms are presented.

2.4 The Investigation of Conflicting Healthy Life Advice Disseminated in Portuguese and Turkish Media and Market

Urgent, serious and time-pressured health cases and regulation activities may bring along with them specific economic, social and psychological consequences as well as biological ones. The overload of advice disseminated with capitalist profit maximization concerns in media and marketing activities leads to a point where negative emotions can emerge in cases of indecisiveness or decision difficulty, especially between alternatives. For instance, Istanbul has recently become one of the most popular cities providing a vast number of opportunities for hair transplant surgeries. Every year, 500.000 people from all around the world visit Istanbul as medical tourists to have hair transplants (Deutsche Welle Turkish, 2019) and the related decisions generated a huge "medical tourism economy" reaching 1 billion dollars annually (CNNTurk, 2019). The point is, there are more than 300 hospitals and beauty centers with health professionals who can carry out the surgeries, and a lot more marketing activities and advice about these alternative choices are disseminated in many languages in addition to word-of-mouth marketing[70]. This choice and information

[70] The marketing activities of hair transplantation industry of Turkey even reaches Portugal, which is 3709 kilometres far from Turkey

overload may serve as a very appropriate example for the indecisiveness caused by digital advice and advertisements. Especially, men are forced to experience indecisiveness before a plethora of choices. Such choice situations show that the relevant markets may generate insolubility and choice overload as well as better health-related solutions.

In social media or digital media, one can see a huge variety of specific and conflicting advice. However, below only very common and known issues will be presented. This daily healthy life advice is about such issues and imperatives as how long should one walk, how many calories do specific bodily activities burn and what is the proposed ideal nutrition. Some examples include conflicting advice, too. These messages were published by both professionals in conventional media and amateur content generators in social media in Turkey and Portugal.

In Turkey, one can come across a diverse range of advice in conventional media or social media concerning the daily walking imperative, some of which present conflicting numeric figures or claims. For example, there are references made to the benefits of walking 20 minutes a day in a CNN Turk article, (Ciftci, 2016), to walking or being active for 25 minutes a day in a Yeni Akit article, ("Sagligimiz icin gunde", 2018), to walking for minimum 30 minutes a day in *Milliyet* article ("Saglikli bir yasam", 2015), to 6 benefits of walking 30 minutes a day in a Sozcu article ("Gunde 30 dakika", 2017), to the imperative of starting walking for 15-20 minutes and increasing it to 45-60 minutes in another *Milliyet* article (Haftada kac saat", 2015), to the imperative of starting walking for 15-20 minutes and increasing it to 30-60 minutes to lose weight in a Haber 7 article ("Kilo vermek", 2016), to the imperative of walking with 10.000 steps a day in NTV article ("Gunde 10 bin", 2017), to taking 2000 steps to maintain the weight, but the literally suggested advice is taking 5000-10.000 steps in a *Vatan* article (Arslan and Arslan, 2018), to taking 5000-12.500 steps a day in a *Sabah* article ("Gunde en az", 2018) and a *Hürriyet* article (Muftuoglu, 2016). Here, we can see that there is a variety of advice and choices starting from 15 to 60 minutes, from 2000 to 12500 steps and references made to the accuracy of each advice. As for Portuguese sources, references are made to walking for 10000 steps a day in a Sapo.pt article (Baptista, 2015), to walking 8 km and 10 minutes and 3 times a day in a Diário de Notícias article ("Três caminhadas rápidas", 2018) and to 30 minutes a day and variations in a Beleza e Saude article ("Que tal começar", 2018). In terms of walking, Turkish sources were found to have more variety in terms of conflictingclaims.

A variety of information about **how much calorie** is burnt through physical activities and exercise besides walking is also disseminated in media. According to a Posta article in Turkey, swimming for one hour burns about 500-600 calories ("Hangi egzersizle", 2018), a Sozcu article states swimming for 30 minutes burns 360 calories ("Hangi sporda kac", 2018). In a Posta article, it is stated that cycling for 1 hour burns 600-650 calories ("Hangi egzersizle", 2018) whereas it is stated 30 minutes burns 400 calories in a Sozcu article ("Hangi sporda kac", 2018). As for Portuguese sources, an E-konomista article states that walking for 30 minutes burns 200 calories (Silva, 2018), for a Lev.pt article, it is also 200 calories ("Caminhadas: 30", 2015), and in a Tuasaude.com article, 400 calories is claimed to be burnt in 60 minutes (Bruce, 2018), without any significant conflict in meaning or accuracy. An article in Correio da Manhã states that sexual intercourse for 30 minutes burns 250 calories ("Sexo: Queime 250", 2014) and in another article in Correio da Manhã states that females burn 90 calories and males burn 120 calories in 30 minutes of intercourse ("Sexo queima", 2014), an easily observed conflict. Besides these, various methodologies of calculation are offered concerning weight loss and calorie burning. Even in the same media channel (Sapo.pt), one article states that 1 kg is 3500 calories ("Nutricionista revela", 2019) whereas another article takes 1 kg as 7000 calories (Baptista M., Rodrigues, Baptista, P., 2015). A Milliyet article in Turkey states that 1 kg is 7000 calories ("1 kilo vermek", 2015) whereas it is 5200 in a Diyetasistan.com article ("1 Kilo Vermek", 2018). In Portugal, an article in Sapo.pt states that burning calories depends on such factors as terrain and person and that it is not one-size-fits-all (Baptista and Miranda, 2018). However, many other Portuguese and Turkish media sources offer specific calculations and formulas as one-size-fits-all. Some articles have had this "increased" awareness about the possible consequences of recommending one-size-fits-all and they did not offer this kind of advice but they focused on the article in Sapo.pt (Baptista and Miranda, 2018).

Other important and extensively discussed issues in healthy life, which disseminate conflicting advice are "how is the ideal nutrition style", "what is the ideal diet regime", what is the ideal number of meals a day", "what should we eat and what we should not", "what is healthy and what is not" …Let's start with the discussions about how many meals a day is recommended. One can observe that there are some sources which suggest 3 main meals and 2-3 snacks a day (Muftuoglu, 2018), some others suggest 2 meals a day (Halici, 2018), 5-6 meals a day without any specific references to main meals or snacks to lose weight ("Kilo vermek icin", 2018), 3 main meals and 3 snacks (Rodriguez, 2018)…A Sabah article

suggests that the decision concerning the number of meals a day should be left to the people and that the important criteria is what to eat instead of when to eat (Tuzun, 2012) whereas some nutrition regimes such as intermittent fasting[71] propose that the more important thing is when to eat instead of what to eat. There are some reasons which can be proposed as the underlying factors. The diet industry is one of the industries which are influenced most by the beauty and health ideals in the society and culture but it is also one of the most influential industries in terms of penetration of the healthy life discourses. There is a high demand for healthy life products and services in the society by those who have a lower body image or health problems. This demand may initiate the supply of the information. However, this supply of information often surpasses the demand. The surpassing can be caused by the proliferation and replication of the issues, the incorporation of non-professionals, nutrition coaches, social media influencers without occupational or vocational qualifications or licenses. The production of the information overload about what, when and how to eat may be inflicted with the information pollution created by the unlicensed, unqualified content generators.

Another issue sparking debate in healthy life advice is "**how much water people should consume**". One TRT Haber article suggests that consuming 2-2.5 liters of water is the ideal ("Su icmenin", 2017), a Sabah article suggest 1.5-2 liters ("Gunde ne", 2018), a CNN Turk article, it is 2 liters (Oz, 2017) and a Marasmanset article even recommends 3 liters (Ozdemir and Temiz, 2018). A RTP article suggests that it is necessary to consume 1,5-3 liters (8 glasses) of water daily, 2 liters is, also mentioned in the same article as a conflict (Ramos, 2017), whereas for a Sabado article, it is 2-4 liters, 3.7 liters for men and 2.7 liters for women in the summer (Riso and Oliveira, 2018) and 1.2 liters (12 glasses) in a Noticiasaominuto article (Teixeira, 2017), 2 liters for women and 2.5 liters for men in another Noticiasaominuto article (Monteiro, 2019), 1.5-2 liters in an E-konomista article (Freitas, 2017).

Another issue which arouses interest concerning nutrition is "**how much calorie people should consume/take daily to lose weight or to maintain a healthy life without gaining weight**". Many messages are disseminated about this subject. In Portugal, a Notícias

[71] In this nutrition regime, it is suggested that the time period in which people consume is more important in maintainin the weight.

Ao Minuto article suggests that people should multiply their weight by 20 or 25 if they want to lose weight by consuming no less than 1400 calories a day (Monteiro, 2019). If they want to maintain the weight, they are suggested to multiply their weight by 25 or 30, for example, if one's weight is 70 kilograms, this person should consume between 1400 and 2100 according to the decision either to maintain or to lose the weight. In Turkey, a Haber3.com article suggests that women should consume 1200 calorie daily and men should consume 1600 if they want to lose weight ("Gunluk kac", 2012) whereas a Milliyet article suggests 1800 for women and 2300 for men (Aydin, 2014). We can see the variety here, some sources provide some categories as women or men; physically active or inactive, to lose or maintain weight. The number of criteria has changed drastically. Some of these, as one can guess, can also be observed to be in conflict with each other. In an Internet Haber article, the physically inactive people are recommended to consume 400-500 calorie more daily ("Kilo vermek", 2017) whereas in a Mynet article it is recommended to consume less than normal ("Yasiniza gore", 2016). A Haber7 article suggests consuming even less than these former two sources ("Kilo vermek", 2018). Men in the age span between 31 and50 are suggested to consume 2600 calories in Mynet article whereas it is 2200 calories in a Haber 7 article ("Kilo vermek", 2018).

In a limited time period, the systematic investigation of these messages by the patient or consumer in an emergency may offer confusing or conflicting ones. However, a really productive and convincing investigation about this possibility can most probably be made upon focusing on the "accumulation affect". Several sources may not be convincing enough to be able to offer an argumentation, but during the course of time, tens of messages may be encountered to conflict with each other as one can see from the examples above.

2.5. Health Agenda Changes and Relevant Overload in Health Communication

Within the context of quickie health activities, the healthy life agenda is regulated within specific periods of time and within the context of social changes. Sezgin found out in her study that the health agenda for organs, lifestyles and even aesthetics is changed in monthly in Turkey and the medicalized coverage is widening every day (Sezgin, 2010: 213-231). We can carry Sezgin's argument one step further and give some examples concerning these changes of agenda in the course of time. The regulation of the agenda is conducted in tune with seasonal, monthly and weather-related changes, probably has its own capitalist justifications in information production to attract more audience and consumer. The seasonal

changes in the body image of people in terms of body weight, size, healthiness may support such a relationship between seasonal changes and body image changes under the term "bikini season". This example of "bikini season" discourse implies that people should care about the body and health and lose weight by trying and going on various diets. The problem is the fact that the market also urges the mass media and social media sources to reproduce conflicting advice and to present these to public without a scientific consensus, constraint or accuracy. Sometimes, this order may function only for the reproduction of the market's power.

Concerning the changes in the agenda of dissemination, when we compare the annual religious periods of Turkey and Portugal, some similarities can be observed in terms of disseminating healthy life advice for similar concerns, to help people maintain their health, but also to reproduce the biopower in governing the society. In Portugal, before, during and even after Natal (Christmas) period, many messages are disseminated especially in media and social media about how to feed without gaining weight and having any health problem and also how to lose weight after gaining weight during these religious periods of feast. It can also be observed in Pascoa (Easter) period. In Turkey, a similar dissemination pattern can be observed in Ramadan period during which people who fast do not consume anything and stay away from prohibited deeds for about 17 hours a day. Especially, if Ramadan is in the summer season[72], more health problems can be experienced due to seasonal influences on the body health and the nutrition habits of people are regulated with many messages during this period. Many sources of news, TV channels, religious TV shows and radio programs provide advice about how and what to consume. For Portugal, we can observe this in the references for Pascoa period in two Correio da Manhã articles (Santos, 2016; Figueiredo, 2017), in a Sabado article "É Natal! Cuidado com a sua saúde" (Lúcio, 2016), in a Sapo.pt article "Cuidado! A noite de Natal é um perigo para o coração" ("Cuidado! A noite", 2018) and an Averdade article "Conheca os cuidados alimentares a ter nesta pascoa" ("Conheca os", 2019). The similar advice is offered for the Turkish religious festival periods: "Saglikli bir ramazan icin 12 onemli kural (12 important rules for a healthy Ramadan)" in a Haberturk article (Guleryuz, 2019), "kurban bayraminda et ve seker tuketimine dikkat (Pay

[72] It shifts every year due to different calendar systems used. Turkey uses the Western calendar system, however, for religious issues, it uses the moon-based calendar system of the Muslim world.

attention to the consumption of meat and sugar in the Feast of Sacrifice) in a Sabah article (Kula, 2019). During these religious festivals, one can come across an information overload especially in digital media and internet.

We can also find some implications in the agendas of television channels, especially in the official state channels. Some information concerning the agendas were collected from websites of the official state channels of Turkey and Portugal concerning healthy life TV shows and these were presented below. These two channels, TRT from Turkey and RTP from Portugal were selected as they may provide some implications about the general health system and ideologies of the Turkish and Portuguese states and governments. The presentation of the themes and subjects of the programs which have been broadcasted since the beginning of 2019 may provide some ideas about what kind of healthy life messages are conveyed to people (or the target audience).

In recent years, many TV shows offering healthy lifestyle advice and appealing to popular culture have been broadcasted in the national TV channels of Portugal. In 2016, there was “Diga Doutor” program. From time to time, in the morning and afternoon broadcasts and shows, although they are not health programs, in “A Nossa Tarde” and in the “Agora Nós” TV shows, health-related conversations are also discussed. The agenda of Praça da Alegria, the interactive TV show which offers healthy life agendas in RTP in 2019, was selected as its coverage is comprehensive and satisfying for observation. The agenda to be observed is as follows: "Euromelanoma day / day of skin cancers" -14.5.2019, "a very taboo subject: female masturbation" - 8.5.2019, "oral health of pregnant women and babies” - 2.5.2019, "doubts about varicose veins" -30.5.2019, "the perspiration of the feet" - 26.5.2019, "Raising the contributions of Chinese medicine", "like acupuncture, in combating this problem" -12.4.2019, "Truths about physical activity, a conversation with the CEO of Fit Brasil, Sérgio Ferreira" - 9.4.2019," the health of the pilgrims' feet, at a time when the pilgrimages of May are approaching" - 5.4.2019, " Give life to hope "promoting the donation of ova and spermatozoa " - 1.4.2019,"showing some methods of cleaning the teeth of dogs and cats" - 28.3.2019, "National Donor Day"- 27.3.2019", Life after parkinson" - 27.3.2019, "Men at 50’s: doubts and care for health" - 26.3.2019, "skin care" -12.3.2019, "Sín Asperger's syndrome"-19.2.2019, "heart failure" - 12.2.2019, "what results in the ingrown toenail? How can we treat it?" - 8.2.2019, “Otitis: Symptoms, Treatments and Causes” - 29.1.2019, "Living with Anorexia Nervosa - Learn the story of Carolina", "Plan for HPV

Screening in the Northern Region and the vaccination plan" - 28.1.2019, "Spontaneous abortions, care to keep the nails clean", "'Tips from the Square' - Aloe Vera miraculous recipes by Izabel de Paula" - 25.1.2019, " Preventing falls and accidents in the elderly - "22.1.2019, "How to control reflux and improve sleep? Chinese medicine can help" - 18.1.2019, "The importance of sleep" - 15.1.2019, " What are the most appropriate shoes and socks for our feet?" - 11.1.2019, "Intimacy after illness - Advice of a psychiatrist" - 9.1.2019[73].

TRT 1 is the primary state-funded television channel of Turkey. Its main healthy life show is "Halit Yerebakan ile Hayatin Ritmi" (The Rhythm of Life by Halit Yerebakan). It is broadcasted almost every day and thus only one month of its agenda will be presented, not months of coverage as presented for RTP, otherwise, the list would be too long, but anyway, it will give enough details for the agenda. The agenda of TRT covers the agenda of Ramadan, too, because it started in early May, this year, so one can see the changing agenda of the program and coverage as follows: "Proper nutrition methods in Ramadan" – 2.5.2019, "restless intestinal syndrome, renal calculus, cholesterol" – 1.5.2019, "urinary incontinence problem, athetosis" – 30.4.2019, "treatment methods of diabetes, diabetes surgery" – 25.4.2019, "reasons of skin dehydration and nutrients that are useful for skin" – 24.4.2019, "process of weaning the baby" – 23.4.2019, "We try to debunk the myth of the Diet with experiments, Keeping Dietary Diary" – 22.4.2019, "eye traumas" – 19.4.2019, "How to take the spilomas through surgical methods" – 18.4.2019, "What is scoliosis? Symptoms and treatment methods, Waist and back pain, hernia" 16-17.4.2019, "Foods with pain relieving-killing properties" – 15.4.2019, "Nasal diseases, nose surgeries, allergic nose currents" – 11.4.2019, "Migraine, natural painkiller plants, knee pains, calcification, Mannequin Challenge trial-experiment" – 10.4.2019, "keeping a diet diary, what to do after a fire" – 9.4.2019, "Developmental disorders-short stature, stains and treatments in infants, baby baths, foods that increase breast milk" – 8.4.2019, "Health benefits of artichoke, puerpera syndrome, chocolate cyst, cesarean delivery" – 5.4.2019, "birth in the past, birth coaches, obstetricians, birth with yoga instructors" – 4.4.2019, "hair and eyebrow loss" – 3.4.2019, "autism treatment, game addiction, fear in children" – 2.4.2019,"constipation" – 1.4.2019[74].

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[73] This list was prepared by looking at the webpage of Praça da Alegria in website of RTP, http://media.rtp.pt/praca/

[74] This list was prepared by looking at the social media page of Halit Yerebakan, the presenter of the program, https://www.facebook.com/dryerebakan/, the date retrieved: 20.08.2019

2.6. Healthy Life Advice and Quick Problem-Solving Culture in Health Magazines

The best-selling "health and sports" magazines such as Men's and Women's Health, their Instagram and Facebook pages and many columns and news pages in conventional, digital and social media in Turkey and Portugal were reviewed. In these, many messages for simple-quick-use solutions for some specific health issues were encountered and observed, this search for quick solutions was impressed by the perspectives offered in Gomes (2010) and Fortuna et. al. (2002). For example, if one has a flue, the health magazines and health pages say "If you have this illness, use this, consume it and lie down, walk or whatever". The direct, pseudo-scientific health information overload filled with aesthetic or commercial concerns may influence the consumers to an important extent and they may seek the ways to overcome newly-defined and perceived problems such as chronic fatigue syndrome or burnout syndrome and use some popular unlicensed and illegal alternative drugs or recipes. "Use this and don't die" ... Such a quick tips culture ("Consume it, do it and get well") may be a reflection of the neoliberal individualist quick self-fulfillment (self-actualization) norms and the neoliberal consumer identity, which become well manifested in new-age health, body building and psychiatric discourses.

The consumption and aesthetic-related subjects are also profoundly discussed and suggested in parallel with health agendas in some Women's Health Portugal issues. The coverage of this magazine and the subjects in its content can be summarized as in one issue: "dressing, fashion, body care, wardrobe, hair care, make-up, beauty, skin, fast training, good sleeping positions, how to be good, sports fashion, 1500 calories, be fit in party time, love, sex, lose weight in sleep, procrastination, rules of drinking water, marathon in Lisbon, only exercise cannot be enough…" (Women's Health Portugal, 2016 January-February: 1-136). These subjects were not commodified until several decades ago, but now, they have acquired a cultural value in terms and in the form of lifestyles and these values can be exchanged for money through neoliberal healthy life philosophies and economy. However, as these messages are produced and disseminated by multi-sources in digital media, social media and conventional media, the quality and trustworthiness of this information turn out to be questionable and there are so many intervention issues in the lifestyles of people.

Regardless of the consequences, people motivated by the metropolitan life and quickie health norms to consume and enact quickly tend to utilize products, solutions, methods or philosophies, especially disposable ones, irrespectively of whether these are

health related or not. Getting visible results may encourage the consumption of these techniques or products. For the manipulation of emotions, the quick visibility of results is of capital importance in the consumer society, because the visible result will be a marketable product of the providers of health-care or healthy-life discourses. In this context, the latest communicative and graphical technologies are utilized in the dissemination of health-related messages and news. To amplify their effect, the bodily (aesthetical and medical) promises and limitlessness discourses may be combined. Gomes summarizes these discourses and the presentation of these messages to the public as follows:

> Set within a framework of perfectionist, naive speech and graphics where youth and the ability to manipulate the body are deemed endless and eternal dreams, stereotypes and promises are sold. The offer is made of quick tips to improve one's life, ranging from three exercises to grow muscle mass in a few weeks to formulas to relieve stress in only 40 minutes. (Men's Health Portugal, No. 85, as cited in Gomes, 2010: 95)

The notions of tracking and visibility are also promoted so that the healthy life market will be able to describe how individual responsibility can be taken with such imperatives: "Don't fall victim to heart attack […] know how your eating habits impact on your blood pressure and be on the safe side". (Men's Health Portugal, No. 80, as cited in Gomes, 2010: 98). One can also see in these kinds of messages that quick tips are associated with quick solutions, leading to the dissemination of quick survival notion which can culturally be accepted as a norm. These quick consumption norms are adopted more and more in the urban cultures in the form of the consumption of disposable products (Fortuna et. al., 2002).

If even 'the number of calories burned by the speed of heart beat while watching a horror movie'[75] can arouse interest in these kinds of news, the relevant advice can be considered to have a cultural value for a media coverage. This media order and agendas may imply that the consumer society we live is still instilling emotional obsessions and concerns with overweight, fat and calorie regulation. In women's magazines and health publications, this implication can be observed and more supporting material can be found. In these messages, the well-being and beauty are constantly linked with beauty care and treatments. We can see the "new" and slimmer body is promoted in the healthy life magazine messages:

> The idea is created that body appearance can be changed instantaneously: *breast size boosting in 30 minutes* (Happy Woman, No. 29), or that a new body shape is achievable over a two-month period: stop cellulite – get a new body in two months (Happy Woman, No. 14)… eat this and never get sick

[75] See: (The Telegraph article, "Watching horror films burns nearly 200 calories a time", 2012)

(Men's Health Portugal, No. 79), the 16 worst things you can eat (Men's Health Portugal, No. 84). (as cited in Gomes, 2010: 96)

As for the health messages targeting male population, Gomes also found out in his research that the headlines targeting men emphasize body volume, strength and physical exercise as health signs and the examples are quickly attained, socially acceptable and affordable and summarized as below:

> More muscle in less time – only 30 minutes a day (Men's Health Portugal, No. 78) and strong shoulders with no effort at all (Men's Health Portugal, No. 76)…Headlines aimed at building a social body image that is within everyone's reach…Lifestyle magazines clearly undertake the traditional healthcare player role as they suggest the the best homemade exercises, the best health secrets for Man (Men's Health Portugal, No. 85, as cited in Gomes, 2010: 96)

The health magazines could be considered as one of the media sources producing the quickie and fad health philosophies, some of which may lead people nowhere but only waste of sources and left with indecisiveness. In the review of the Men's Health and Women's Health issues, it has been calculated that almost half of the total pages are allocated for healthy-life or lifestyle-relevant advertisements, taking the commodification several steps further. Some recent examples from Portugal are "New year new body", "See results in less than 4 weeks", "Burn more in less time" "8 ways of losing 5 kilos", "Lose fat by sleeping" (Women's Health, Jan-Feb 2016)…The analysis of more recent volumes of these magazines may show that the number of formulas may be increased in accordance with the self-body tracking trends-cultures which can be summarized as follows: "Fit in 5 Minutes", "In shape in 5 minutes", "3 kg of muscle In 4 Weeks", "Perfect body in half of time", "5 Rules for a stronger heart!" (Women's Health, Jan-Feb 2016). As for the other examples for the quickie body management, we see the simple but sophisticatedly formulated lifestyle and body discourses: "Goodbye Belly, New Body Before Summer, everything you need to do to get in shape before summer!", "Save now, your life! Protect Your Heart", "The Secret Formula for Results, Fast and Visible!", "Do this and eat better. 4 solutions to some failures. Start to eat like that and say goodbye to fat", "Do not ignore these five rules that are true lifesavers!". (Women's Health, Jan-Feb 2016).

Besides health magazines and conventional media channels, **social media** and **internet** have emerged as the most important resources of healthy life messages, advice and word-of-mouth health communication. Today, many people have turned out to be cultural intermediaries telling their narratives and disseminate these in these platforms whether these are scientifically accurate or not. Many examples by prosumers which make references to

these narratives and anecdotes can be seen in social media, especially in the Facebook and Instagram groups (see the images 46-47-48-49).

Image 46– Healthy Life Support Groups Comprised of Prosumers – Visible Result Notion - Facebook

Image 47– Healthy Life Support Group-Personal Narratives, Advice as in Health Magazines- Facebook

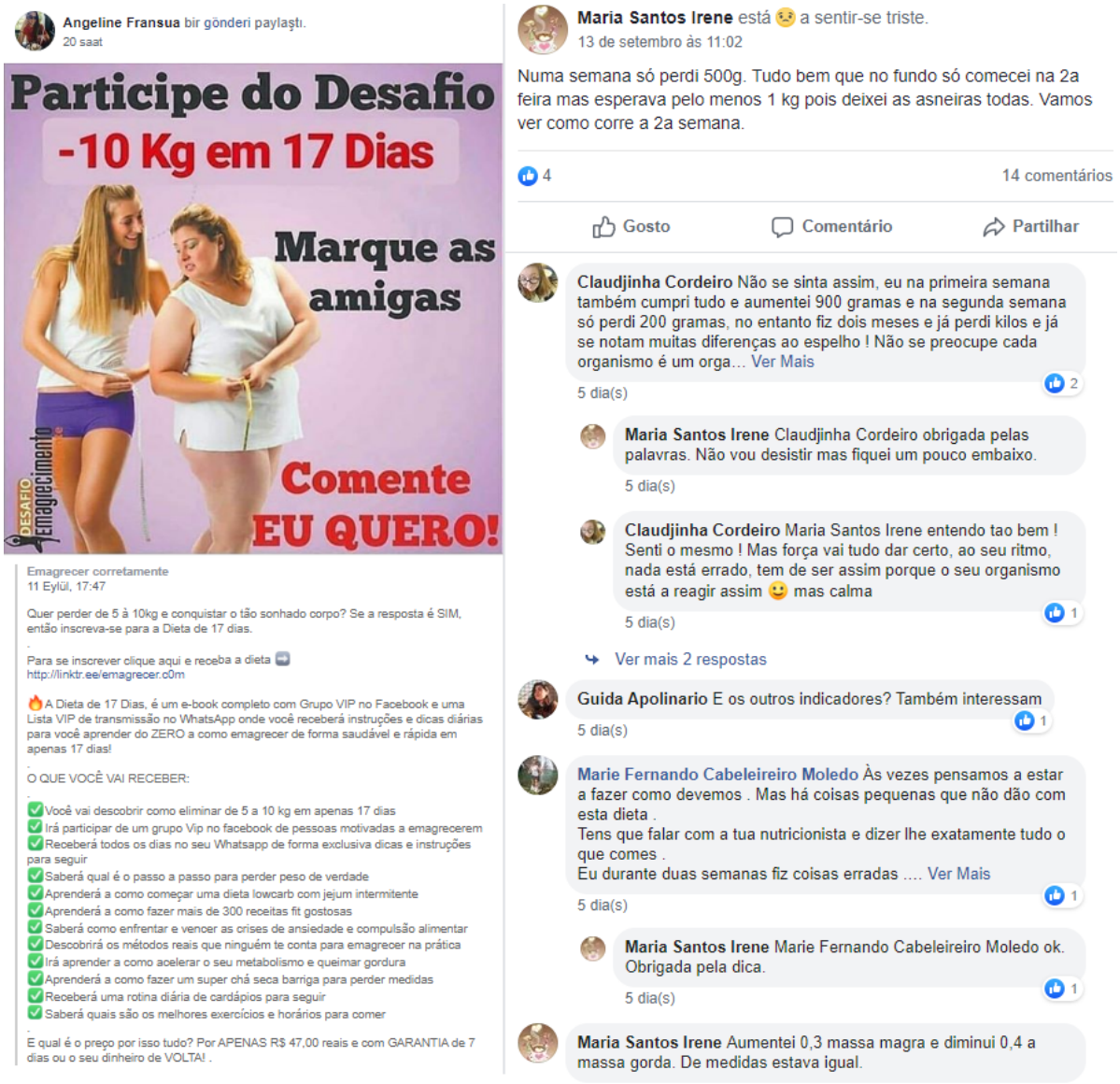


Image 48– The Exploitation of Healthy Life Coach Concept and Extension of the Health Communication in the Social Networks - Portugal

In social media, one can also come across many internet profiles (user accounts) under the name “healthy life and diet counselling centers”, “fitness and healthy life coaches”. These new cultural intermediaries share mottos, aphorisms and philosophic quotes, keep their followers and customers under control with special commercial tips, tricks and pseudo-scientific information. This kind of social control is possible because there is a demand for this kind of information and control from the consumers. Above, this demand for information and social control of the body management can be seen in the social interaction in social media groups (see the interaction in the image 48, on the right) and the corresponding supply of information, promises and lower quality of health-management (see the commodified

supply of promises in the image on the left). In this new type of commodified "word of mouth health-communication", the prosumers and newly-emerging cultural intermediaries utilize the social media channels such as Facebook, WhatsApp and Instagram.

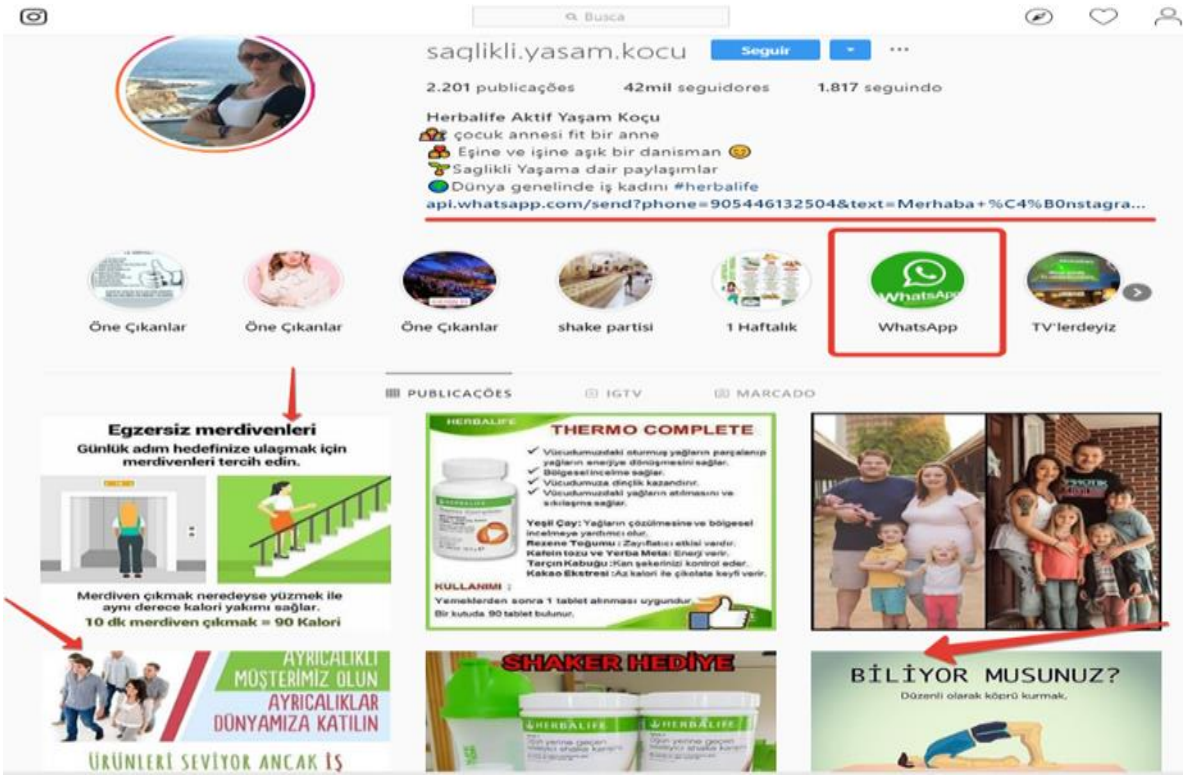


Image 49– The Exploitation of Healthy Life Coach Concept and Extension of the Health Communication in the Social Networks – Turkey

The number of health organizations, enterprises and prosumers bringing the success stories to forefront to advertise the products and services in social media and internet has already boomed. The stories and advice disseminated only in the conventional media channels in a limited fashion in the past are now freely disseminated in social media and internet without any cost or broadcasting-publishing policy restriction. Besides this, the number of the television channels and broadcasts has boomed and now, even some television channel enterprises (mostly in satellite TV subscriptions) are incorporated only for this kind of fad products. All of these newly-emerging health promotional activities and products may contribute to a relevant overload of choice and information in media and internet. In Turkey, many (see image 30) companies have exploited this free-market notion and in Portugal, similar exploitations were observed even in the state channels such as RTP.

There are strong hints about the possibility that the globalization also produced a globalized health-related decision-making even in countries having very different cultures, economies, histories, religions etc. This chapter targeted to investigate and show how this

possible globalization of health decision-making has been occurring since the periods of Salazar and Atatürk. Both Turkey and Portugal have come from imperial past, experienced political and economic instabilities in the first several decades of 20th century, adopted modernist strategies and practices. However, there were also some differences in the struggles of the regime's leaders. Although both Salazar and Atatürk were somewhat autocratic modernist leaders, the population and cultural characteristics of their countries were different. For instance, religious establishment in Ottoman Empire delayed social, cultural, religious reforms; scientific and technological developments in Anatolia. Atatürk's struggle against traditional and religious norms forced him to start cultural revolutions in many areas of social life as well as body and health politics with severe consequences in society. Salazar had the support of religious authorities and his perspective of modernism was partly different from Atatürk's, respecting the traditional values more in governance, which were also reflected in the body and health management with gender norms.

Throughout the periods of these leaders, serious changes and developments taking place in media technologies allowed them to use these as self-body management technologies. They adopted the ancient Roman philosophy "healthy body, healthy mind" in between two wars, preparing their population for warfare through body regulating organizations and media. Supporting material and examples of practices were presented in this chapter (images and organizational activities mentioned). These may show that both traditional and modernist discourses were implemented in these two countries beginning from their times. Many discussions, news and advertisements were disseminated in the developing mass-communication (see images 20-21-24-25-27-28). Besides this, the pedagogical and organizational activities were also utilized with corporations and associations created by their regimes and these imposed the modernist and traditional body and health ideologies, ideals and cultures representing their leaders' perspectives (see images 22-23-24-26-27-29). During the interwar period these regimes were preparing their population for a possible warfare and also eliminating health problems which would endanger the future of society and jeopardize economicdevelopment. The international and national practices and ideals were implemented and, as some statistics reported here in previous pages, one can say that their activities and practices paved the way for healthier generations with longer life-span.

The health consumerism starting from the years following Post-War period has today reached to such an extent that people may be making considerably more health-relevant decisions than the first and second half of the 20th century. At the present time, they are surrounded by an agglomeration of word-of-mouth communication, health communication, all kinds of internet medias, social groups, organizations focusing on health-issues and conveying many messages to consumers, transforming their habits. Some health promotional activities organized in the media, social media, public spaces and transportation (also including word of mouth communication in the internet) were documented in this chapter and in the literature review chapter. One striking example could be the discussions on smoking and exploitation of scientific knowledge and medical dominion under the freedom of choice and moral discourses. Besides the smoking issue, some other conflicting messages from media (from 1950s until 1980s) and social media about daily health issues were also documented for Portugal and Turkey, these examples may support the arguments inquiring into the main research question and sub-questions. As it can be seen from the examples taken from media and social media sources, the similar health-care advice stems from the global dissemination of information including the low-quality information and word-of-mouth communication despite the cultural, historical and structural divergences between two cultures. These differences will also produce or result in different health decision-making and behavior patterns, contributing to a different health economy and culture. Some relevant issues focused on in the previous chapter have been brought to an updated view with further examples and empirical data collected in and for Lisbon and Istanbul. In the next chapter, some relevant arguments were interpreted concerning the expected and unexpected results coming out of the data collected in online survey.

3. Methodology and Findings

In the introduction, the research questions and the context of the study were briefly presented and in Chapter 1 (literature review), the different theoretical perspectives and opinions by many scholars and secondary data were reviewed, discussed and evaluated. In Chapter 2 (empirical data and political history), the example cases, politics, health communication products and arguments were presented with references to concrete evidence collected as primary and secondary data. In Chapter 3 (Methodology and Results), the findings obtained through the fieldwork and the methodological procedures are presented. The data was collected from the health-literate consumer groups to examine whether these inquiries and argumentations can be supported by data from respondents or not. Before the presentation of the results, in the methodology section of Chapter 3, such issues as the methodological procedures followed in the online survey study, the problems encountered in data collection and details concerning sampling are the focused points. In the results section, the interesting trends identified arepresented (some are explained with cross analyses). The main findings are explained with references to research question and goals. Less relevant findings are spared for the annex at the end. In the Chapter 4 (Conclusion), evaluation of the whole research process will be made with reference to whether the results presented in this chapter were expected or not and whether the research questions are answered with this thesis or not.

3.1.Methodology

In the previous chapter, cases based on the political, historical and communication narratives of Turkish and Portuguese societies, supportive of the theoretical discussions in the literature review chapter were presented. In this chapter, firstly, the inquiry was conducted within the context of the action plan; secondly, the explanations of the methodological procedures are done and thirdly, the findings are presented in detail. The inquiry in question was about whether such cases/processes presented in Chapter 3 have had a measurable impact on the respondents' health-relevant PDB or not. In the results section, the relevant findings will provide a response for this question.

In the coming pages, the research approach, universe, samples, the data collection, data analysis techniques, variables, reliability, sampling technique, quotas and questionnaires are explained in relation to the research design of this study with references

to theoretical justifications. After the explanation of methodological details in the methodology section, the findings of the survey study are presented in accordance with the research goals (sub-questions). The data has been processed through simple descriptive statistical analysis techniques and the findings are explained in the same reporting methodology. After the examination of the trends in the frequency analysis, a cross-tab analysis was conducted to see whether some trends were impacted by some specific variables. The results of this cross-tab analysis were provided only for specific items in the survey, those considered significant in answering the research questions.

The quantitative approach was chosen as the research approach of this study. The numerical data analysis, which is epistemologically in the positivist line will be made with this approach. No flexible analysis based on meaning was made. In quantitative studies, it is more probable to generalize the data to the universe, but the disadvantage is that these studies cannot offer an in-depth analysis (Vanderstoep and Johnston 2009: 8). In the studies conducted through the quantitative approach, variables can be measured and the numbered data can be analyzed using statistical procedures. The final written report has a set structure consisting of the introduction, literature and theory, methods, results and a discussion (Creswell, 2013: 4)[76].

The main reason to use quantitative approach was a search for answers to the research questions through such questions: what? Where? How much or how many? How often? In which level. These questions were good enough to answer the subsidiary questions as well as main research question. Besides this, investigating the relationships between the clearly defined variables was more suitable through quantitative. Another reason was the fact that testing the theoretical framework, assumptions and hypotheses was appropriate with this approach. Quantitative study can be more standardized and another researcher can do the same measurement with the survey and analysis will be similar, that being another reason to choose this approach.

[76] As this study is a quantitative study, it was organized through a similar structure to the one mentioned by Creswell (2013).

An additional reason why this approach was adopted is that it allows for collecting information systematically from the population to be studied, with less bias compared to some data collection forms of qualitative approach, less flexibility in analysis and subjective treatment in collecting and analyzing the data. Besides this, research questions and sub-questions required that a survey be employed in the collection of relevant data.

The research design is the strategic plan for a research project or research program, setting out the broad outline and key features of the work to be undertaken, including the methods of data collection and analysis to be employed, showing how the research strategy addresses the specific aims and objectives of the study and whether the research issues are theoretical or policy-oriented (Marshall, 1998: 36). The research design of this study was constructed as an action plan to answer the research questions about the possible impacts of health-relevant information/choice overload on health-relevant perception, decisions and behavior. To implement this action plan and navigate via this roadmap in a more straightforward manner, a survey study was conducted in five steps: 1) defining the problem, 2) defining the population (sample), 3) preparing the data collection tool, 4) collecting and analyzing the data and 5) interpreting and evaluating after analysis (Fraenkel and Wallen, 1990, Karakaya, 2011: 60). The survey methodology was utilized as it helps the researcher with providing explanations through descriptions of the opinions and attitudes of the group members (Karakaya, 2011: 59).

Through this fieldwork study based on a survey model, I targeted measuring the perceptions and judgments about the health-relevant situations that started in the past but may still be occurring now or will be occurring in the future. Data was collected from many groups in the universe to maintain the diversity as much as possible. Several variables were integrated into the items in the measurement tool and some inferences to be made on the relationships between these variables can be seen in the results. Descriptive techniques were utilized in conducting this deductive reasoning while reporting findings.

As this study has a descriptive research design, it focused on the phenomena to be investigated, did not test hypothesis, but provided information about the variables and grouping of these variables. In this way, it became possible to provide the necessary information about the characteristics of the assigned variables (Erdoğan, 2007: 138). Although there was not a hypothetical test procedure, there were subquestions to be

answered through scientific measurement scales and these were defined as research goals. The list of the goals (sub-questions) is below:

G1-Investigating the reception/perception of the health-relevant IO/CO and the confusion about the ideal health behaviors in terms of social class.

G2-Investigating how the imperative of choosing among the overload of commodified healthy life philosophies influences health-related decision-making in daily life and in serious health conditions.

G3-Investigating the perception of healthy life advice offering quick ways to improve health.

G4-Investigating how the IO influences health-relevant decision-making and behaviors through mass communication, the internet and social interaction.

G5-Investigating how the IO (advice-messages) creates confusion and indecisiveness about ideal healthy life behaviors through mass communication, internet and social interaction.

G6-Investigating to what extent the overload of conflicting health advice leads the health-literate consumers to indecisiveness/confusion.

G7-Investigating whether the commodification of health leads to increased consumption and seeking further information.

G8-Investigating whether the socio-economic status influences the trends related to PDB and indecisiveness.

G9-Investigating the process of discouragement and consumption in the indecisiveness process.

G10-Investigating the structural mechanisms regulating the health decisions through the utilization of healthy life advice.

G11- Investigating whether the health-relevant choice or information overload leads to a difficulty in choosing/deciding on the ideal one among these.

G12- Examining the behavioral patterns according to each level of indecisiveness.

These goals will be mentioned in the 3.2. topic and the necessary relationships will be explained. Before that, it is necessary to mention about the transformation of these goals and concepts to variables used in the scale in the following section.

3.1.1. Transforming the concepts to variables and operationalizing these within the survey item

According to Neuman, in descriptive studies, "conceptualization and operationalization bridge the gap in measurement just as the use of sampling frames, the sampling process, and inference bridge the gap in sampling" (Neuman, 2007:271), that is,

conceptualizing (defining and describing) the research topic and identifying how to measure these concepts (operationalizing) is very important (Erkenekli, 2009: 7). In this context, the concepts which are considered very important for research questions of this study were transformed to variables so that it would be possible to use these in a relevant-measurement. Afterwards, these variables were integrated into the survey items and used in the inquiry to be able to produce ordinal data. Some of these variables are: information overload-choice overload, decision-making and indecisiveness. These have already been extensively used throughout the text as they are the fundamental concepts of the theoretical framework of this study.

In operationalizing and functionalizing these variables within the measurement tool, the items in the scale were prepared based on these variables and research questions. They were used in the analysis of the deeper dimensions of sub-questions (mentioned in research goals). The most significant issue to be investigated was whether health-literate consumers become indecisive in health-behavior management as a result of the exposure to health-relevant choice/information overload. IO and CO were designated as the independent variables and "indecisiveness", "decision-making" as dependent variables according to the context of inquiry in sub-questions. In many items of the indecisiveness scale, the relationship between health-relevant choice/information overload and decision-making/indecisiveness was investigated through these variables and also through demographic variables. Unlike this, some of these variables (such as indecisiveness) were also designated as independent variables in some items to investigate the further impacts of indecisiveness on health relevant behaviors (dependent variable). In some items of the scale, demographic factors were designated as moderating variables, whereas in others, these factors were used as independent variables. These variables were integrated into the items only to observe respondents' perceptual and behavioral changes according to these. In fact, data about the demographic variables (as also moderating and independent variables) was also collected and the socio-economic conditions and background information were also taken into consideration in the data collection and analysis processes. Besides this transformation of concepts to variables, another conceptualization and transformation was also considered necessary: the levels of indecisiveness. These were also transformed to some specific variables to be able to measure the perceptual and behavioral changes in health-literate consumers according to indecisiveness levels, which was one of the important sub-questions of this study.

In the findings section**,** the reader will find a further interrogation of the practical implications of different levels of indecisiveness, because indecisiveness is not presumed to be a static or an invariant process in this study. In this regard, the further individual and social implications were evaluated within the scope of this inquiry.

It is obvious that health-literate consumers can experience different levels of indecisiveness: higher, medium and lower levels of indecisiveness or none at all. These levels were defined with the positions taken regarding different levels of decision difficulties. These indicate at which point the respondents start feeling uncomfortable and indecisive. Rather than asking the respondents directly to self-identify their level of indecisiveness, a limit drawn by the researcher between these levels was considered to be less biased. In this way, the respondents would not categorize themselves as indecisive, but the researcher could investigate the extent of the indecisiveness through the hidden practical cases in the items in the scale.

The issues analyzed may be summarized in a current of thought and questioning as follows: does everyone have the same level of indecisiveness when exposed to choice/information overload? Some people may be satisfied with having a wide variety of alternatives, but in practice, they may also have decision difficulty despite their rationale about the wider variety, or some others may have increased levels of indecisiveness. An inquiry was made through several items in the scale to find relevant answers for the following questions: how do people with higher, medium or lower level of health-related indecisiveness make decisions and behave in complicated or daily health situations? What do these levels of indecisiveness mean in practical terms? If people have higher levels of indecisiveness, does this mean postponing buying, being totally blocked, stopping purchase or consumption? Or does having a lower level of indecisiveness mean consuming more, trying alternatives among this variety of choices, and behaving differently than those other health-literate consumers with higher or medium level indecisiveness? An investigation of the practical correspondences of these indecisiveness categories was made with several cross-check questions in the survey. The respondents were requested to indicate in which level of indecisiveness they see themselves when they encounter IO-CO relevant to health-relevant products and services as well as therapies doctors, hospitals. In the Q1 item, the respondents posited themselves among three hidden categories such as High – Medium - Low level (Finding relevant decisions highly complex, partly complex and little complex or

not complex at all). Besides this, some questions were designed in a fashion that allows the respondents to posit their indecisiveness level with some practical cases such as what they would do in case of urgent health-decision making. I reviewed the relevant literature and the fieldwork notes of previous in-depth interview studies that I conducted in 2017 as part of other studies and worked on drawing a conceptual distance between these levels, namely an interval. The practical implications and aspects of these indecisiveness levels or tripartite classification were defined based on the literature review and empirical data collected in the form of fieldwork notes is summarized below:

1-Low-level indecisiveness suggests being able to make a decision immediately out of habit, as well as making a decision after a simple evaluation of the choices involved. Having no decision difficulty can be counted as low-level indecisiveness as well. There is no need for socialization to overcome low-level indecisiveness. A simple series of evaluations and interpretations about the choices and information are enough to make decisions at this level. A minimal degree of internet-based search is often ancillary. The distinguishing feature is still a comparative cost-benefit evaluation of alternatives, but for the evaluation, a search for information is usually indispensable. As for the conditions when there is no indecisiveness at all, habit-based decisions suffice to serve the purpose. This is how people would normally behave in most cases. It is not incorrect to classify this level as an individualistic level.

2-Medium-level indecisiveness is the inability to make a decision immediately or out-of-habit, searching for information about the choices on internet or in publications and then making the decision. The fundamental methodology utilized in this level of indecisiveness is the internet search. Internet's foundational role in overcoming indecisiveness (as well as reproducing it) may be seen best in this level. In low-level indecisiveness, internet is an ancillary apparatus when needed, whereas for the medium-level indecisiveness, it is the defining factor, that is, sine qua non attribute. Socialization to overcome indecisiveness is still not a vital issue, and the main methodology to overcome this level of indecisiveness is searching for information through internet and media. As in low-level indecisiveness, it still has an 'individualistic' character and nature.

3-High-level indecisiveness: is the inability to make a decision immediately or even after evaluating the alternatives and the search for information by consulting others in the household, network or professionals (socialization). They could very well postpone the

decision or give up making a decision. This may also include or lead to doing nothing at all, or embarking upon an extensive search for more information or experimenting many types of choices before final decision. In addition, they could evaluate the advantages and disadvantages before coming to a conclusion or experience such negative post-decision emotions as regret or doubts. What separates this level of indecisiveness from the previous two levels is its 'social' rather than 'individualistic' character.

3.1.2.Data Collection and Analysis Techniques

The online survey technique, mostly used in quantitative research models, was adopted as the main data collection technique. There were practical advantages and necessities to which this technique corresponded. The research questions required a sample comprised of those using the internet to search for health-relevant information in order to make decisions. Therefore, reaching this health-literate population through internet technologies and platforms was considered to be the most logical method as these have turned out to be the principal actors and sources producing and being influenced by the health-relevant IO. Today, health literate consumers from every segment of society make health-relevant searches on internet and exchange information in many websites and social media platforms. The online survey technique allows the researcher to collect data from the target population (the health-relevant consumers exposed to information overload mainly on internet) in a cheaper and faster way. This is one reason for adopting this technique in this study. Below, the advantages and disadvantages are listed to justify the rationale behind adopting the online survey technique.

The advantages

-The digital algorithms of online survey software allow the researcher to control the data collection process simultaneously, better than many other techniques as it is highly visual and configurable.

-The survey quotas can be defined and selected through web-based software and the irrelevant responses or respondents are left out automatically, no place for man-made mistakes in filling out the questionnaire.

-If there are mandatory questions, the warnings are displayed by the software and the respondents are instructed to respond to the questions through the algorithms inserted by the researcher.

- Temporal and budget-relevant issues are eliminated. Normally, these are some of the difficulties posed by such alternative techniques as the face-to-face and CATI survey.

-Many online survey software can even offer a technical capacity to conduct such a simple descriptive statistical analysis technique as crosstab analysis throughout the data collection process. This helps with the control of the quotas better as it allows the researcher to choose specific variables and to view the response trends according to the chosen variable. The presentation of these subsidiary results is usually enriched with highly graphical visuals, which may facilitate viewing more interesting response trends in the data.

The disadvantages

-There is no opportunity to reach each group or class in society, especially those not using internet technology. It can be representative of only those groups who come across the survey online and are willing to participate in it. The representativeness for various internet user groups may be higher than conventional techniques. However, it is not the best technique for researches that do not target internet users especially. According to Denscombe, the primary concern here is that people contacted and responding might be representative not of the general public but just of those who are online and interested in a particular subject (Denscombe, 2007: 24).

- As the respondents do not meet face-to-face and their voices are not heard as evidences of the survey, there is a risk of exploitation of this technique by the participant and researcher. However, there are some measures such as getting the IP addresses and viewing the beginning-ending timeline.

Some of the critiques stems from the biases emerging as a consequence of the errors observed in earlier/preliminary applications of this technique. In this regard, researchers compared findings from web-based and paper-based questionnaires and found that there is little or no difference between the modes of delivery (Denscombe, 2007:10; McCabe, 2004). Taking all the disadvantages and advantages into consideration, an evaluation was made and

the advantages outweighed the disadvantages, Finally, a decision to adopt this technique for this study was made.

The data was collected through the online survey software link (Esurveycreator.com). In the application of this survey technique, the respondents were requested to fill out the questionnaire. In this way, the data entry was made by the respondents in the survey system.

The other data collection and analysis techniques utilized in this study were document analysis and visual data analysis.

3.1.3.The Problems Experienced in Data Collection

In the data collection, there were only two quotas: gender and health-literacy. This did not lead to any difficulty in collecting data. However, the online data collection procedure was prolonged due to technical problems emerging in survey software (Esurveycreator.com) and in Facebook. The Facebook algorithms detected “the survey link” and “introductory survey text” as spam after the distribution of these in the relevant groups (approximately 100 groups in Portugal and Turkey). This prevented the distribution of the link in these groups for a specific period of time—Facebook suspended the link and my account for 4 days, and later for 7 days). A second Facebook account was used in the distribution of the links, but it also had the same limitations due to usage of the same survey link. The ban was for the survey link and the accounts that distributed it. Thus, opening other Facebook accounts did not solve the problem and I had to wait for the removal of this ban. This prolonged the data collection period for 11 days. During this period, data was collected from Twitter, Instagram, Reddit (Portuguese and Turkish pages and groups). Besides this suspension problem, access to many relevant groups to collect data required joining these groups, which are not open to everyone. Some groups required the approval of the admin whereas others required answers for several questions, mainly to eliminate irrelevant people from interfering in these groups. After the approval of the page and group admins, the survey link was distributed and data collection activity started afterwards.

In the beginning of data collection process, some surveys could not be completed due to a technical problem experienced in the data collection survey, and the surveys were therefore finished in the second question. After interrupting the data collection for an hour,

the algorithms of the software were controlled and the problem was solved. In this process, 9 surveys were detected to have problems. The survey continued after this and responses were collected from 223 respondents in total. Another 10 surveys were eliminated due to such reasons as “continuously giving the same answers for each item” and “very limited answers to several answers”. If these 19 surveys had not been eliminated, this could have resulted in a deviation in the data and less reliable results. 204 out of 223 surveys were accepted as valid for Turkey data. As for data collection on Portugal, the number of surveys with problems were only 2 and 196 out of 198 surveys were accepted as valid.

3.1.4. The Development of the Survey Questionnaire

I developed the questionairre as no scale having the characteristics to measure the issues that this study targeted to investigate has been found in the relevant literature. The items of the health-relevant PDB scale were formed in accordance with the research question and study goals of the study. The statements responding to the research questions of this project had to be matched in order not to leave the discussed issues unaddressed. The questionnaire scale was tested with a pilot online survey study in December, 2018, with a sample composed of 95 respondents. After analyzing the findings of the pilot study, the number of the questions was reduced as some questions were found as irrelevant or overlapping as a result of the evaluation based on the statistical analysis. The central issues were identified and included in the inquiry to be able to obtain the necessary data. In some items of the scale, more than one variable were presented in the statement so that people could imagine a more thorough and comprehensive real-life situation and remember their own past experiences while responding. This reveals their real-life perception, not the morality perception usually seen in surveys when the respondents do not reflect their normal behavior and attitude but rather what is morally expected of them.

The questionnaire consists of three sections. In the first section, there are five questions about whether the respondents are health-literate or not; the respondents’ social media and internet usage habits; from whom they receive social support when they feel indecisive about serious health-relevant cases, and to what extent the health-literate consumers experience decision-difficulty/indecisiveness in serious health-problems when they have a wide variety of choices to evaluate with regards or no regards to their socio-economic conditions. The second section can be called “Health-Relevant PDB Scale”. It

consists of 26 items that mainly focus on the investigation topics specified in the research questions. In the third section, demographic information was collected through five items. Through these, data on such basic socio-economic variables as respondent's gender, age, education level, occupation and household income level were collected.

The 4-point Likert scale was used in the questionnaire. The "neutral" choice was found unnecessary in a scale where indecisiveness-related issues are evaluated or measured as this choice is usually considered an indication of indecisiveness.

As indecisiveness[77] and decision-making literature is dominated by studies conducted within the reductionist disciplines, the relevant scales and measurement items were developed in accordance with reductionist worldviews and philosophies that ignore the social factors. Borrowing such scales from these disciplines would not have been appropriate for the goals of this study. A majority of scales developed and studies conducted concerning health-relevant PDB act upon such biases as the "noncompliance of individuals in health imperatives". According to these assumptions, health-related indecisiveness stem from the individual capacities and individual overconsumption. They generally do not take the market-related and social sources of information and choice overload into consideration in this measurement of indecisiveness or relevant decision-making processes. These kind of studies and scales construct their assumptions (items or statements) on an individualist and reductionist basis. They are inclined to seek the reasons and responses in the individual

[77] Decision-making can be conceptualized as essentially different for serious health problems and less serious health issues. Both of these decision-making cases can be represented by different decision-making functions, and they are procedurally different. In less serious health issues or problems, people go through all consecutive stages, search for information or socialize by consulting to make a decision. Ultimately, they may postpone or put off decision making, the cost of postponing or putting off will barely be like the one for serious cases. For instance, when they are faced with a heart failure during which an urgent decision should be made with time and financial constraints, this may be hardly the choice. Time constraint due to urgency could extract a decision out of those who are in a need for an urgent decision relatively easily. Thus, mentioning here about two different behavioral functions and procedures could be more accurate. The impact of choice overload on these two different cases and behavioral functions could be different. Anyway, an indecisiveness as well as uninitiatedness may well occur in both of these cases and the social characteristic of the decision-making could be seen in both cases when people consult others and get their opinion about similar experiences. This process does not necessarily mean a postponement in decision-making but a tendency of making evaluations about the choices or alternatives is indispensable. The indecisiveness experienced in serious and urgent health problems can take less time than nonurgent health cases, however may be experienced as emotionally more complex and stressful and a social regulation may be necessary. The people who are uninitiated about the most suitable doctors, hospitals or treatment choices for themselves may need to consult others to benefit from their experiences and knowledge. Even the highly health literate people can also get others' opinion and some results about the socialization in indecisiveness process were obtained in the online survey study.

qualities, capabilities and stories, with no regards to social, cultural and market-related factors. However, health communication besieges culture, structure, discourses, life, doctrines and bodies in consumer and information societies. Health-related perception and indecisiveness should also be evaluated and investigated within the context of these environmental factors, and not exclusively individualist factors and relevant assumptions. The questions and topics of this study were formed in with a goal to unravel the invisible aspects hidden by biomedical paradigms, which exclude social factors from the inquiries in the reductionist studies. As these disciplines usually take the individual qualities as the principal resource of problems, so do biomedical and health communicational scholarship and approaches; they set out with reductionist questions. The societal resources of indecisiveness are not investigated adequately and data and findings are derived from the inquiries in relation to individual qualities. Contrary to this approach, this study integrates the social structures, the perceived surroundings such as household, social network, social, cultural and economic capital into the analysis of indecisiveness.

3.1.5. The Reliability of the Data Collection Tool

According to Creswell, the researcher should mention about the reliability checks for internal consistency of the scales (Cronbach alpha), (Creswell, 2013: 163). Such reliability statistics calculated through reliability analyses allow the researcher to identify the irrelevant items that affect the overall reliability and consistency. The internal consistency and reliability ratio (Cronbach alpha) for the all items in the Health-Relevant PDB Scale have been calculated as ,828. This value shows that the items are correlated in a significant amount and the number of items in the questionnaire is acceptable. When the results were checked with the "Alpha if item deleted" option, the distribution was found considerably balanced and the figures were too close to each other. Thus, it was not necessary to repeat the analysis as there was no deviation.

3.1.6.Data Analysis

After the data collection, the data was downloaded as an Microsoft Excel© spreadsheet and coded in the software. After the coding process, the coded data was processed and analyzed through the IBM SPSS 23© software. The simple descriptive

analysis techniques such as frequency analysis and cross-table analysis were applied in the analysis process. The relevant results are presented in the findings section. The analysis results are reported to show whether and/or how the results answered the research questions. To this end, inferences and conclusions from the results are drawn by involving discussions about the theoretical and practical consequences of the results. In the discussion chapter, explanations focus on whether or not the research questions are supported (Creswell, 2013: 165), but partly be mentioned in the results section, too.

3.1.7. Sampling and Universe

The sample group consisted of the health literate consumers living in Istanbul and Lisbon and using social media, forums and interactive platforms. In terms of the research questions, the lifestyle practices, and awareness, experiences of the respondents having these characteristics were considered statistically and empirically more significant than the general population. The online survey link was distributed in social media groups and internet platforms comprised of people interested in a wide variety of subjects such as health issues, patient support, dietary issues, veganism, vegetarianism, gymnastic and fitness issues, national and international cuisines, pilates, yoga, education (higher education, student groups) as well as many other specific diet regimes. Besides these groups and interests, data was collected from social media and internet users subscribing to many popular national media platforms to keep the variety of the respondents in the sample wide open to include and represent many kinds of opinions, lifestyles and socio-economic variables in the sample to have a more reliable and valid sampling. Thanks to including a wide variety of respondents from various segments of society, the practical implications of the indecisiveness or decision-making styles of any group (educated lay people, young, old, and those preferring word-of-mouth health communication) could be figured out statistically and empirically in a more accurate way.

3.1.8.Sampling Technique

According to Denscombe, “social researchers are frequently faced with the fact that they cannot collect data from everyone in the category being researched. As a result, they rely on getting evidence from a portion of the whole in the expectation and hope that what is found in that portion applies equally to the rest of the population” (Denscombe, 2007: 13).

Besides this handicap, the sample should also reflect the true proportion in the population of individuals with certain characteristics (Creswell, 2013: 158). Researchers are forced to take these two principles into consideration in the construction of the sample. For this study, these principles were regarded and the survey link was distributed in tens of social media and internet groups with around ten million members. To this end, the representativeness ratio and proportion of the respondents having the certain characteristics approximated the real rates in the universe.

In the data collection of this survey, the purposive sampling methodology was utilized and the informants were selected in accordance with the principles of the methodology. Although the purposive sampling technique is utilized in studies with qualitative research design more often, it is used in some quantitative studies, too. Along with designed quota sampling, it is also used in surveys in which research questions require the collection of data from respondents having specific characteristics. This study made use of the quota sampling. However, the principal technique was purposive sampling and its principles have been regarded as summarized below:

> "With purposive sampling, the sample is 'hand-picked' for the research. The term is applied to those situations where the researcher already knows something about the specific people or events and deliberately selects particular ones because they are seen as instances that are likely to produce the most valuable data. In effect, they are selected with a specific purpose in mind, and that purpose reflects the particular qualities of the people or events chosen and their relevance to the topic of the investigation". (Denscombe, 2007: 17)

In this sampling methodology, as stated by Denscombe (2007), the researcher decides which sample (target population) or who will provide the best and most appropriate information and data for the study. This decision is based on his/her knowledge about the research subject and phenomena. In this process, the participants are not picked at random, but with judgment and justifications about their original positions, experiences, knowledge and stories significant for the research questions (Stacks, 2002, Ural and Kılıç, 2005, Erkenekli, 2009: 10). In this context, the health-literate consumers who are also internet users were picked with the assumption that they are exposed to health-relevant IO-CO more than lay people and can produce better and more appropriate data for the research questions. Denscombe explains further advantages of this sampling technique below:

> The advantage of purposive sampling is that it allows the researcher to home in on people or events which there are good grounds for believing will be critical for the research…The researcher can concentrate on instances which will display a wide variety to illuminate the research question at

> hand. In this sense it might not only be economical but might also be informative in a way that conventional probability sampling cannot be. (Denscombe, 2007: 17)

When everything is taken into account, it can be seen that the utilization of this technique allowed me to collect data about relevant cases, real-life scenarios, decision-making/indecisiveness experiences which were critical for the research questions. However, I should also state that the whole procedures of purposive sampling were not followed and, in this study, purposive sampling does not actually go as far as selecting 'individuals'. In other words, the sample was neither constructed only with the purposive selection nor with random selection without my control as a researcher. In online surveys, some respondents decide to respond themselves. There may be some respondents who are in fact 'addicted' to internet and filling out questionairres as a pastime. There are many Facebook or Reddit cooperation communities (communities of citizen science and crowdsourcing), and people who are also members of such groups were probably involved in this survey. Therefore, we can say that the addictive and altruistic behavior cannot be totally ruled out in the sampling. However, these kinds of cases can also be easily controlled through certain quotas and the number of cases may be negligible, with no significant statistical value in this study, too.

3.1.9. Designed Quotas for the Sample

In the data collection, several quotas were assigned through the use of quota sampling. These quotas were “number of participants by country-city”, “health-literacy” and “gender”. Unlike these, there was no strict quota, but the official demographic figures were also taken into consideration in the data collection process to have a balanced distribution of factors such as age and education. The sampling procedures will be taken up in detail below and the details about the gender quota will be presented in the findings section.

Istanbul and Lisbon have a population diversity that represents the cultural and demographical characteristics of Turkish and Portuguese societies. When we look at the intensity of the population in these cities, we can see that a big part of the country population resides in these cities. 18,6 percent (n=15,0 million people) of Turkey’s population (n=80,8 million people, World Bank, 2019) resides in Istanbul and 28,7 percent (2,94 million people) of Portugal’s population (10,2 million people, World Bank, 2019) resides in Lisbon. In the light of such information, it can be said that the data collected from the sample in Istanbul

and Lisbon probably reflects the general trends of the population of the two countries in terms of the research questions to a certain extent.

Besides including the approximate proportion of the general population in the survey, another statistical calculation was made to foresee the margin of error and interval of reliability and to specify the number of respondents included in the survey according to these two criteria. This way, the prevalence of the breakdown of important issues produced more balanced, coherent and reliable data. In accordance with the sampling methodologies, 204 respondents were reached in Istanbul, with a 0.07 margin of error in 95 percent reliability gap.

SAMPLING																	
A.D.						p q margin of error											
	Population(>120)	t	p	q	$t^2.pq$	0,01	0,02	0,025	0,03	0,04	0,05	0,06	0,07	0,075	0,08	0,09	0,1
90%	14.500.000	1,65	0,5	0,5	0,680625	6803	1701	1089	756	425	272	189	139	121	106	84	68
95%		1,96			0,9604	9598	2401	1536	1067	600	384	267	196	171	150	119	96
99%		2,58			1,6641	16622	4159	2662	1849	1040	666	462	340	296	260	205	166

Table 1– Aksoy Research Company Sample Calculation Formula - Istanbul

196 respondents were reached in Lisbon, with a 0.07 margin of error in 95 percent reliability gap.

SAMPLING																	
A.D.						p q margin of error											
	Population(>120)	t	p	q	$t^2.pq$	0,01	0,02	0,025	0,03	0,04	0,05	0,06	0,07	0,075	0,08	0,09	0,1
90%	2.800.000	1,65	0,5	0,5	0,680625	6790	1701	1089	756	425	272	189	139	121	106	84	68
95%		1,96			0,9604	9571	2399	1536	1067	600	384	267	196	171	150	119	96
99%		2,58			1,6641	16543	4154	2660	1848	1040	665	462	340	296	260	205	166

Table 2– Aksoy Research Company Sample Calculation Formula – Lisbon

The number of sample participants may provide variance and diversity in the data and explanations for the relationships between variables[78]. The sample might be larger, but, the margin of error and interval of reliability does not change drastically. Sampling is like a blood test (blood analysis), having one or ten units of blood will not change the conditions drastically, despite a multiplication in sample size, changing only at a minor level. In a similar vein, when the researcher has a satisfactory level of respondents, having multiplied rates of respondents will not change the trends and reliability in the same rates.

[78] These numbers were calculated with the sampling calculation utility used by Aksoy Research Company in Turkey.

The main quota for this survey is health literacy. As the fundamental assumptions of this study require a comprehensive understanding of the utilization of the health-related information that can only be acquired with an increased level of health literacy. Thus, the health literacy is an important criterion in the selection of respondents. The sample has been constructed with the health-literate informants who are presumed to experience the conditions discussed throughout this study (being exposed to IO-CO and experiencing decision difficulties) more than non-health-literates. One health literacy question used as a quota is whether they consider themselves as a health literate person or not. The following question was asked in the beginning of the survey: *Do you think that you have enough knowledge of healthy life advice to be able to meet your daily bodily and health-related needs*? In the online survey system, if the respondent did not consider himself/herself as health literate and chose "no", the interview was stopped by the algorithms of the online survey software. So, these non-health-literates were neither included in the survey nor discussed in the chapters.

According to Cinarli, no consensus has been reached about the best method to measure health literacy (Cinarli, 2012). The existing scales on the level of health literacy target measuring the level of knowledge of people directly and do not hesitate to categorize people according to these levels. In this study, the relevant literature was reviewed. However, attention was given to the perception of health literacy, whether the respondents see themselves as health-literate or not. In this regard, no measurement of health literacy was made as is done in many studies in the literature, no question such as "Do you see yourself as health-literate?" was directly asked to the respondents. However, the respondents were asked indirectly whether they think they have the qualities defined in health-literacy definitions in the literature. This question excluded those who do not consider themselves as health literate, those who do not think that they have enough knowledge and procedures to be able to manage their own health and utilize health care services in everyday life. The necessity for such a quota stemmed from the possibility of collecting meaningful data from the respondents concerning the research questions and the issues discussed in this study.

In the next section, the main findings were presented in detail. These data were produced through the data collection and analysis procedures mentioned in this section.

3.2. Evaluation of the Findings

Before going on with the sample characteristic and profile, the mean and standard deviation values should be checked to monitor the variability and distribution of the response trends obtained through the scale. The mean values and standard deviation values of the variances were calculated for each item in this scale and are listed below:

Table 3- The Mean Values and Standard Deviation Values

	Total (N)	Mean	Std. Deviation
Health-related decision-making is a confusing process in which I take action by taking many things into account	398	1,83	0,837
If I experience a serious health problem, have limited time and budget but a great variety of choices (therapies, doctors, hospitals, pills, techniques, products, advice) before me, choosing among these becomes a more complex task.	395	1,86	0,828
When I can not find a solution for my body/mental/skin health problems, choosing among a variety of solutions such as therapies, products, lifestyle changes etc. would make me feel uncomfortable	398	2,24	1,019
When I feel uncomfortable in choosing among the health-relevant choices such as “therapy, doctor, pills etc.”, I would post-pone buying-consuming relevant products-services	397	2,39	1,047
When I feel uncomfortable in choosing among the health-relevant choices such as “therapy, doctor, pills etc.”, I would be totally blocked and stop searching	395	3,23	0,926
When I feel uncomfortable in choosing among the health-relevant choices such as “therapy, doctor, pills etc.”, even my indecisiveness would be temporary, I would immediately continue searching for further information and trying alternatives	397	1,67	0,841
I think that the abundance of choices about health (information, pills, nutrients, therapies, techniques etc.) may lead to confusion/indecisiveness about appropriate choice	396	1,88	0,879
The health-related decisions are investment decisions. Healthiness can be achieved when the anticipated investment is made	391	1,96	0,894
The health-relevant drugs, behaviors, therapies, doctors, hospitals and services are suggested as if they are ordinary consumer products or services.	392	1,9	0,844
In media and internet sources, I come across health advice and information which are in conflict with each other	394	1,42	0,661
Various conflicting health information and advice lead to decision difficulties about the appropriate health behaviors.	396	1,63	0,783
Internet and media distribute confusing health advice whether I like it or not	396	1,41	0,678
I think the state and health institutions should control the dissemination of the very different health-related information, product, service choices and be consistent in this control	392	1,69	0,969
I prefer not to apply the conflicting health information in which I have no trust.	395	1,73	0,814
In internet and media, there is a redundancy of healthy life advice.	393	1,74	0,849

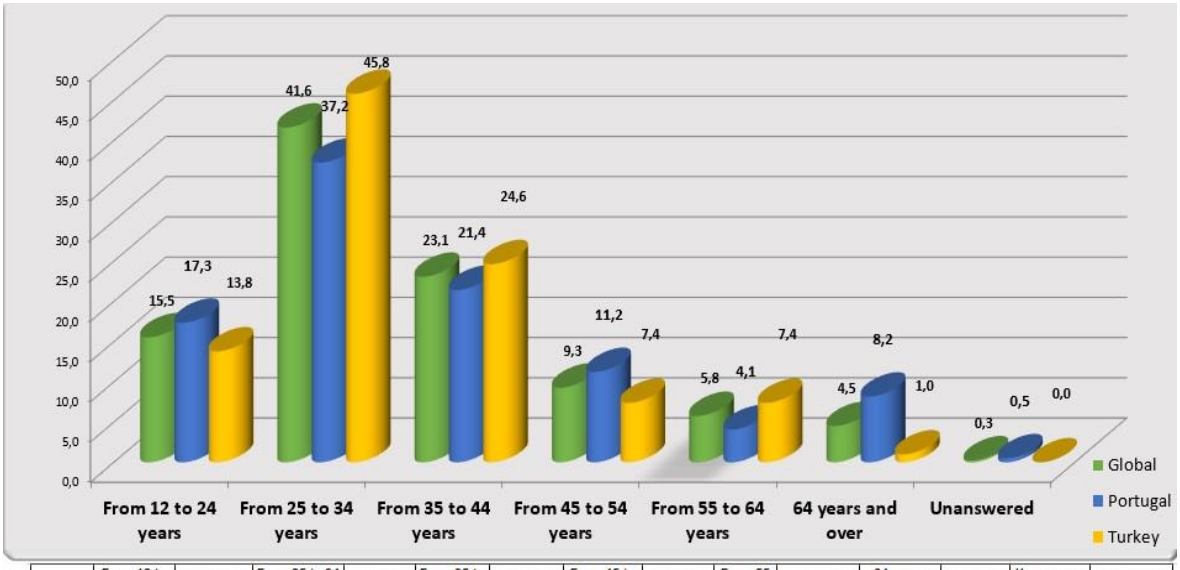
I hear such health-relevant quick tips and advice as “if you experience this, you should do this”.	394	1,61	0,748
Members of my family/social circle share health information and advice that they have learnt from media/internet/publications.	394	1,83	0,869
Members of my family/social circle share hearsay health information.	393	1,96	0,871
My family/social circle share conflicting health information and advice with me whether I like it or not	391	2,04	0,915
Having more financial means may facilitate having more temporal opportunities and physical energy opportunities for applying the healthy life advice.	393	1,44	0,705
The conflicts in the diet regimes imposed break my confidence in these information and advice.	393	1,86	0,903
When my confidence in the conflicting advice is broken, I start ignoring these kinds of information	393	1,9	0,854
There is too much information pollution about healthy life in internet and media	395	1,42	0,695
There is too much information pollution about healthy life in face-to-face social interactions and relations	393	1,79	0,851
When I have health problems, someone in my family/social circle shares advice with me for me to solve this problem and to recover with short-cut methods.	393	2	0,845
When I apply the healthy-life advice but feel that this is not useful for my health, I continue searching for and applying other advice	394	1,56	0,69

As it can be seen from the results presented in table 3, the standard deviation values are low and it can be said that the distribution of the responses are homogeneous for many items in the scale. Most of the results obtained for mean values also support this.

3.2.1.Demographic Characteristics of the Respondents

The field work of this research study was completed with 400 respondents in two countries. The distribution of the respondents by country was as follows: 204 respondents (50,7 percent) in Turkey and 196 respondents (49,3 percent) in Portugal. The target population of this study was the health-literate consumers.

Figure 1- The Distribution of the Age Groups in the Sample

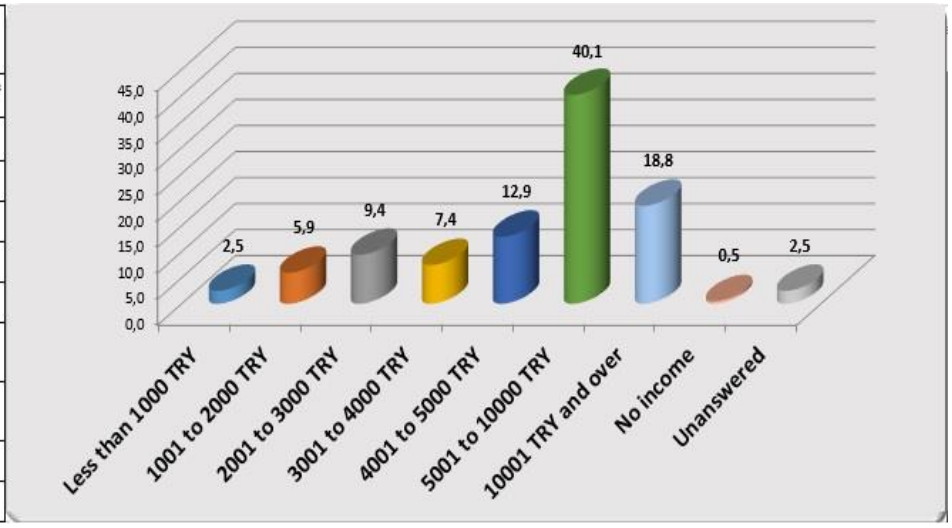


	From 12 to 24 years (%)	Frequency (N)	From 25 to 34 years (%)	Frequency (N)	From 35 to 44 years (%)	Frequency (N)	From 45 to 54 years (%)	Frequency (N)	From 55 to 64 years (%)	Frequency (N)	64 years and over (%)	Frequency (N)	Unanswered (%)	Frequency (N)
Global	15,5	62	41,6	166	23,1	92	9,3	37	5,8	23	4,5	18	,3	1
Portugal	17,3	34	37,2	73	21,4	42	11,2	22	4,1	8	8,2	16	,5	1
Turkey	13,8	28	45,8	93	24,6	50	7,4	15	7,4	15	1,0	2	0	0

No quota for the age groups have been used in the construction of the sample. The distribution of the age groups in the sample is as follows: 15,5 percent of the respondents (n=62) is in the 12-24 age group, 41,6 percent of the respondents (n=166) is in the 25-34 age group, 23,1 percent of the respondents (n=92) is in the 35-44 age group, 9,3 percent of the respondents (n=37) is in the 45-54 age group, 5,8 percent of the respondents (n=23) is in the 55-64 age group, 4,5 percent of the respondents (n=18) is in the 64 years old and above age group, 0,3 percent of the respondents (n=1) did not answer this question. A majority of the respondents in the sample are in the 25-34- and 35-44-years age groups. These age groups can also be seen as reference groups in the economic behaviors as they have relatively developed consumption habits, increased levels of education, health literacy awareness as well as starting to experience midlife health problems. When we look at the data collected concerning age distribution, we see that a balanced sample was maintained in both countries, with no significant statistical difference, that is, the representation of all these age groups in these two countries can be succeeded in the same level.

Figure 2- Distribution of the Income Levels of Respondents in Turkey

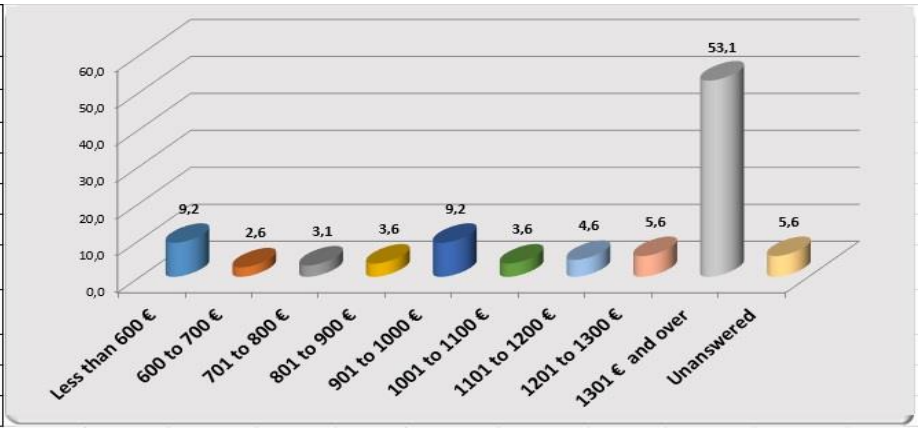
TURKEY (TRY)	(%)	Frequency (N)
Less than 1000	2,5	5
1001 to 2000	5,9	12
2001 to 3000	9,4	19
3001 to 4000	7,4	15
4001 to 5000	12,9	26
5001 to 10000 TRY	40,1	81
10001 TRY and over	18,8	38
No income	,5	1
Unanswered	2,5	5



In Turkey, a majority of households earn 5001 to 10000 TRY (40,1 percent, n=81) and 10001 TRY and over (18,8 percent, n=38), the rate of the low-income families living on almost below the poverty level is 38,1 percent (n=78). The distribution of the income level of respondents in Turkey is as follows: 2,5 percent of the respondents' household (n=5) earn less than 1000 TRY, 5,9 percent (n=12) earn 1001 to 2000 TRY, 9,4 percent (n=19) earn 2001 to 3000 TRY, 7,4 percent (n=15) earn 3001 to 4000 TRY, 12,9 percent (n=26) earn 4001 to 5000 TRY, 40,1 percent (n=81) earn 5001 to 10000 TRY, 18,8 percent (n=38) earn 10001 TRY and over, 0,5 percent (n=1) of the respondents does not have income and 2,5 percent (n=5) of the respondents did not provide any answer for this question. The total annual household income level of Turkish citizens (after taxes) is 9,870 $ (OECD, 2016), (822,5 $ monthly, approximately 4,688 TRY). According to these figures, we can say that the income level of the respondents participating in the survey is a bit higher than the national average of household income. As the research questions of this study focus on the experiences and perceptions of the health-literate population which is well-educated and with higher socio-economic means of living, the discrepancy between the average income in the sample and in the national level does not pose a threat to the representation strength of the data collected.

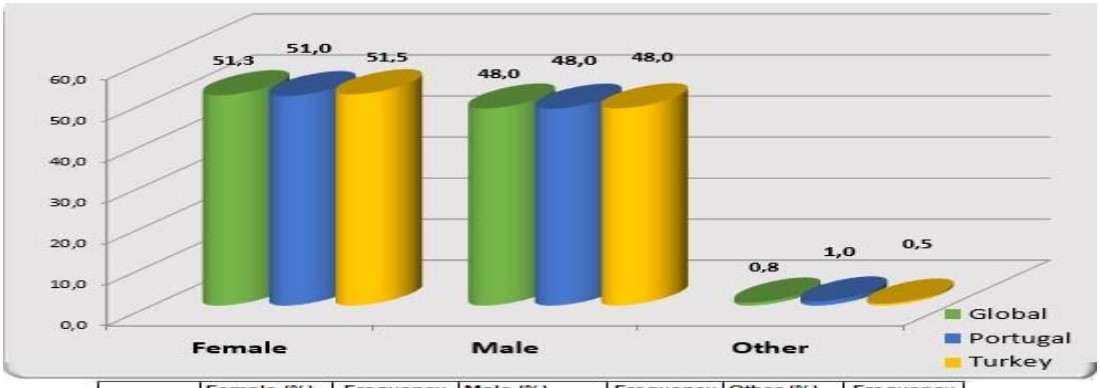
Figure 3- Distribution of the Income Levels of Respondents in Portugal

PORTUGAL (EURO)	(%)	Frequency (N)
Less than 600 €	9,2	18
600 to 700 €	2,6	5
701 to 800 €	3,1	6
801 to 900 €	3,6	7
901 to 1000 €	9,2	18
1001 to 1100 €	3,6	7
1101 to 1200 €	4,6	9
1201 to 1300 €	5,6	11
1301 € and over	53,1	104
Unanswered	5,6	11



The distribution of the household income level of respondents in Portugal is as follows: 9,2 percent of the respondents' household (n=18) earn less than 600 €, 2,6 percent (n=5) earn 600 to 700 €, 3,1 percent (n=6) earn 701 to 800 €, 3,6 percent (n=7) earn 801 to 900 €, 9,2 percent (n=18) earn 901 to 1000 €, 3,6 percent (n=7) earn 1001 to 1100 €, 4,6 percent (n=9) earn 1101 to 1200 €, 5,6 percent (n=11) earn 1201 to 1300 €, 53,1 percent (n=104) earn 1300 € and over. 5,6 percent (n=11) of the respondents did not provide any answer for this question. In Portugal, the majority of the respondents' household (53,1 percent) earn at least 1301 Euros and over (more than twice of the minimum salary in Portugal). The total annual household income level of Portuguese citizens (after taxes) is 15,403 $ (OECD, 2016), (1283 $ monthly, approximately 1160,7 €). For Portugal, the average of the household income of the sample group is a bit higher than national average as in Turkey, 59,7 percent of the respondents' household have higher income than the national average.

Figure 4- Distribution of Genders

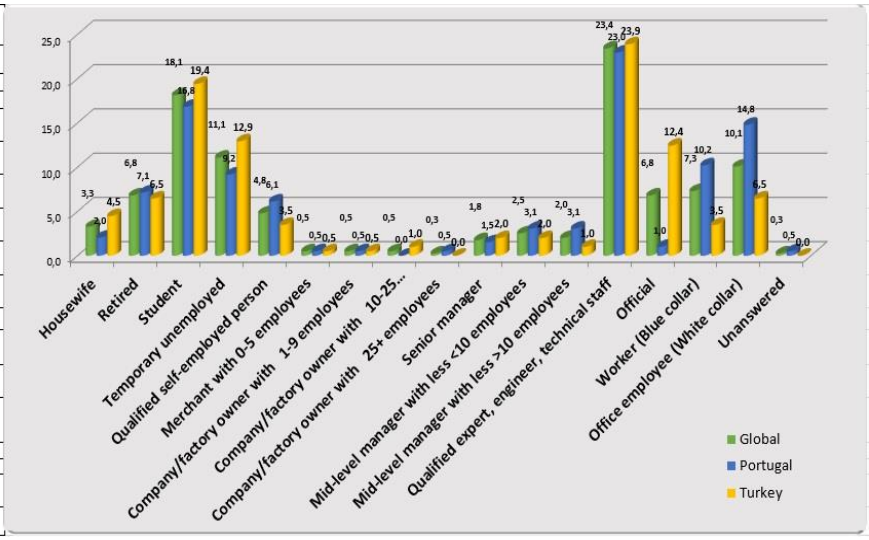


	Female (%)	Frequency (N)	Male (%)	Frequency (N)	Other (%)	Frequency (N)
Global	51,3	205	48,0	192	,8	3
Portugal	51,0	100	48,0	94	1,0	2
Turkey	51,5	105	48,0	98	,5	1

A gender quota was applied in this survey study to provide the equal representation of all kinds of gender categories in the sample group. The gender distribution of the sample is in parallel with these two countries' statistical distribution of genders. (For Portugal, 89.9 males per 100 females, for Turkey 96.9 males per 100 females, World Data Atlas-2015). The global rate of the female respondents participating in the survey is 51,3 percent (205 respondents), whereas the rate of the male respondents is 48,0 percent (192 respondents), the other gender categories rate is 0,8 percent (3 respondents). As for the rates in Portugal, female rate is 51,0 percent (100 respondents), male rate is 48,0 percent (94 respondents) and other gender category is 1,0 percent (2 respondents). As for the rates in Turkey, female rate is 51,5 percent (105 respondents), male rate is 48,0 percent (98 respondents) and other gender category is 0,5 percent (1 respondent). For both countries, the female gender quotas were reached before male quotas. When the number of female respondents reached the required level, no female was allowed to participate and the survey continued with collecting data from only male respondents. In the data collection process, to keep this quota under control, a relevant message was disseminated stating that only male respondents were needed.

Figure 5- Distribution of the Occupational Status

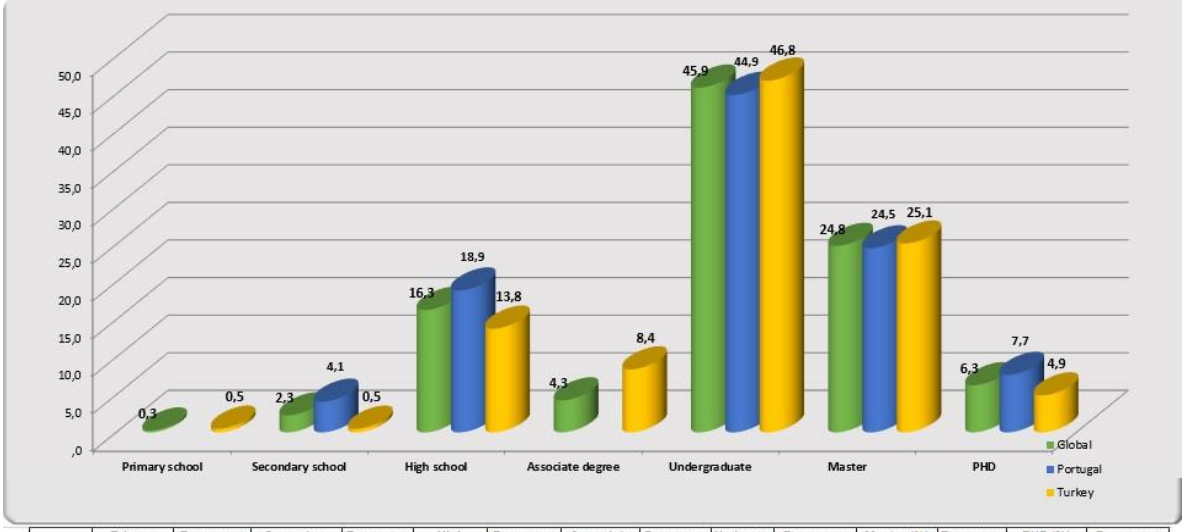
	Global	Portugal	Turkey
Housewife	3,3	2,0	4,5
Retired	6,8	7,1	6,5
Student	18,1	16,8	19,4
Temporary unemployed	11,1	9,2	12,9
Qualified self-employed person	4,8	6,1	3,5
Merchant with 0-5 employees	,5	,5	,5
Company/factory owner with 1-9 employees	,5	,5	,5
Company/factory owner with 10-25 employees	,5	0,0	1,0
Company/factory owner with 25+ employees	,3	,5	,0
Senior manager	1,8	1,5	2,0
Mid-level manager with less <10 employees	2,5	3,1	2,0
Mid-level manager with less >10 employees	2,0	3,1	1,0
Qualified expert, engineer, technical staff	23,4	23,0	23,9
Official	6,8	1,0	12,4
Worker (Blue collar)	7,3	10,2	3,5
Office employee (White collar)	10,1	14,8	6,5
Unanswered	,3	,5	0,0



The distribution of the occupational status of the respondents is as follows: 23,4 percent of the respondents define themselves as a qualified expert, engineer or technical staff, 18,1 percent as student, 11,1 percent temporarily unemployed, 10,1 percent office employee (white collar), 7,3 percent worker (blue collar). The remaining occupation groups and relevant statistics can be seen in figure 5. We can say that the distribution of the

occupations is balanced and respondents from many occupational groups and status were included in the sample group.

Figure 6- Distribution of the Educational-Literacy Status



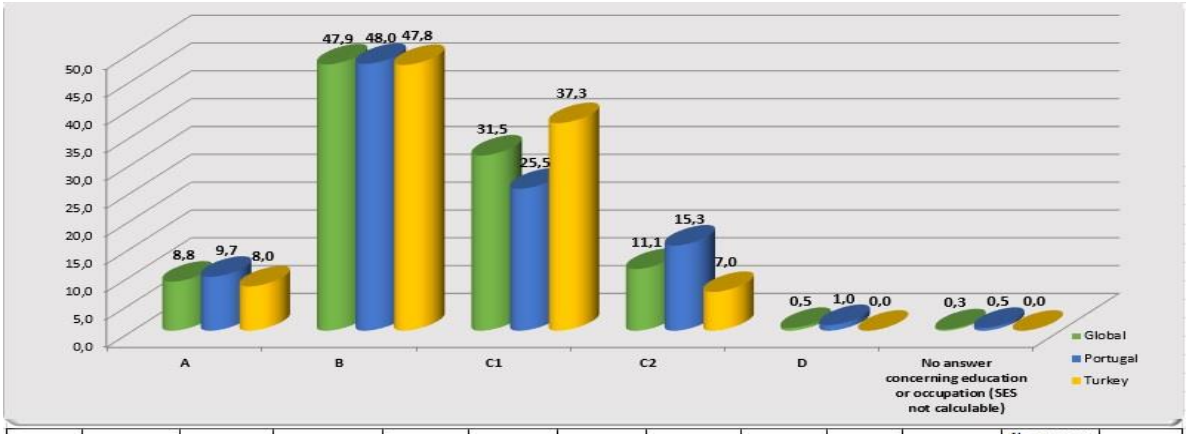
	Primary school (%)	Frequency (N)	Secondary school (%)	Frequency (N)	High school (%)	Frequency (N)	Associate degree (%)	Frequency (N)	Undergra duate (%)	Frequency (N)	Master (%)	Frequency (N)	PHD (%)	Frequency (N)
Global	,3	1	2,3	9	16,3	65	4,3	17	45,9	183	24,8	99	6,3	25
Portugal	0	0	4,1	8	18,9	37	0	0	44,9	88	24,5	48	7,7	15
Turkey	,5	1	,5	1	13,8	28	8,4	17	46,8	95	25,1	51	4,9	10

When the distribution of the literacy/education levels of respondents participating in the survey is checked, it can be seen that the sample has been constructed with respondents from the well-educated. The rates of schooling are as follows: 45,9 percent (n=183) undergraduate, 24,8 percent (n=99) master, 16,3 percent (n=65) high school, 6,3 percent (n=25) PHD, 2,3 percent (n=9) secondary school, 0,3 percent (n=1) primary school. The figures from the sample group in Portugal are: 44,9 percent (n=88) undergraduate, 24,5 percent (n=48) master, 18,9 percent (n=37) high school, 7,7 percent (n=15) PHD, 4,1 percent (n=8) secondary school and no respondents in primary school. The figures from Turkey are: 46,8 percent (n=95) undergraduate, 25,1 percent (n=51) master, 13,8 percent (n=28) high school, 4,9 percent (n=10) PHD, 0,5 percent (n=1) secondary school and 0,5 percent (n=1) in primary school.

There was no expectation and necessity to have a close figure (such as a quota) to the actual educational levels to represent the national distribution of educational levels. Highly educated population which is also found highly health-literate in many national surveys was more preferable to the general population in terms of collecting data relevant to research questions and sub-questions. The main reason why the higher education level is more preferable is that the higher educational and health-literacy level provide statistically

meaningful data as these characteristics provide these people with a facilitated access to health information, an increased awareness about relevant issues, higher income and consumption decision-levels etc.

Figure 7- Distribution of the Socio-Economic Status



	A (%)	Frequency (N)	B (%)	Frequency (N)	C1 (%)	Frequency (N)	C2 (%)	Frequency (N)	D (%)	Frequency (N)	No answer concerning education or occupation (SES not calculable) (%)	Frequency (N)
Global	8,8	35	47,9	190	31,5	125	11,1	44	,5	2	,3	1
Portugal	9,7	19	48,0	94	25,5	50	15,3	30	1,0	2	,5	1
Turkey	8,0	16	47,8	96	37,3	75	7,0	14	0	0	0	0

8,8 percent of the respondents (n=35) are in the "A" socio-economic-status level[79], 47,9 percent of the respondents (n=190) are in the "B", 31,5 percent of the respondents (n=125) are in the "C1", 11,1 percent of the respondents (n=44) are in the "C2", 0,5 percent of the respondents (n=2) are in the "D". There was no respondent from "E" level. No SES level could be calculated for the respondents not providing information about their educational or occupational status, 0,3 percent of the respondents (n=1) are in this category. For both Turkey and Portugal, the socio-economic status of the sample groups is higher than the national averages.

3.2.2.Findings Related with the Items in Health-Relevant PDB Scale

After examining the demographic profile of the sample and the distribution of the socio-economic variables within the sample group, proceeding with the evaluation of the

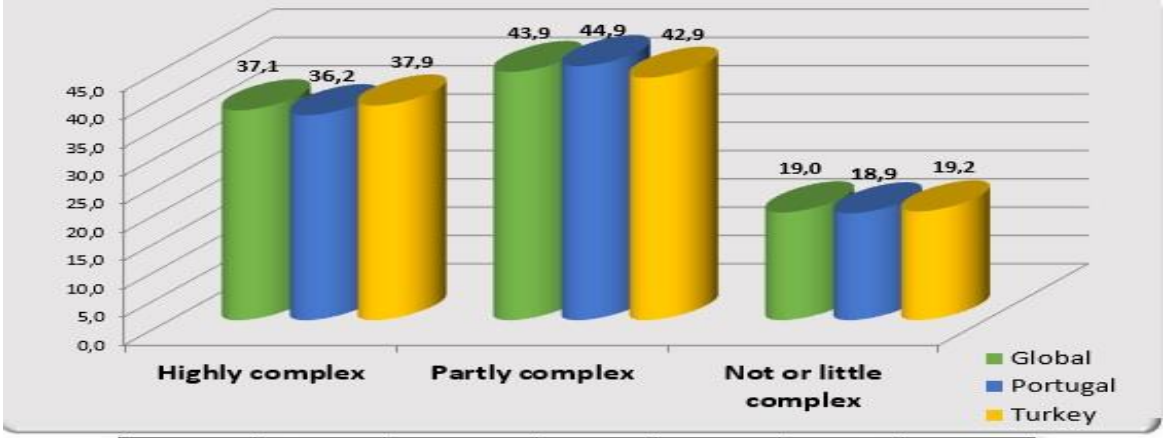
[79] The socio-economic status (level) was defined according to a measurement methodology used by GFK Turkey Research Company. According to this methodology, the educational level and occupational status of the respondents are indicators of their socio-economic status. This information has been taken in the survey and is sufficient to define the socio-economic status.

trends emerging in response to survey items will be the next step in reporting the data collected. The survey items were created in accordance with the research sub-questions and goals. Below, the readers will find the response trends. Besides the empirical findings, such a survey inquiry would provide a cross-check with the perceptions and opinions of the health-literate consumers about the arguments investigated in the previous chapters. The findings which are considered most relevant and significant were presented in this chapter whereas less-relevant and significant ones were presented in the annex in the end of the thesis text.

The theoretical framework of this study required the indecisiveness level to be measured, but not in a reductionist manner as in psychology discipline. Therefore, as specified in the introduction, a conceptualization of indecisiveness level based on such interval variables as high level, medium level and low-level indecisiveness has been made. Such a conceptualization was necessary in grouping the trends and patterns of perceptions, decision-making and behaviors relevant to research sub-questions. An inquiry was conducted through indecisiveness level concept. This concept was assigned as a variable to check whether there is a relationship between indecisiveness levels and behavioral patterns relevant to health. A cross table analysis was made for some items and evaluations were made accordingly. By this means, figures were extracted out of the data to support the arguments for the empirical findings in previous chapters. A differentiation in the behavioral patterns was investigated for each indecisiveness level. As respondents participating in the survey were defined and conceptualized as health literate consumer groups with high, medium or low-level indecisiveness, an inquiry about their health behaviors according to their indecisiveness levels could offer some explanations about how the clusters of the actions of these groups could reproduce the health consumption, contribute to the health economy and social health regulation. Below, there are two items used in measuring the indecisiveness levels relevant to this study, Q1 item was assigned as the principal statement to identify the indecisiveness level.

3.2.3.Health-relevant choice overload constructed by the market and society and its relationship with indecisiveness

Figure 8– (Q1)- Assume that you have a serious health problem (like heart disease or cancer). You search for relevant advice, information, therapies, doctors, hospitals, pills, products etc. You see that there is a great variety of these. You would find this variety



	Highly complex (%)	Frequency (N)	Partly complex (%)	Frequency (N)	Not or little complex (%)	Frequency (N)
Global	37,1	148	43,9	175	19,0	76
Portugal	36,2	71	44,9	88	18,9	37
Turkey	37,9	77	42,9	87	19,2	39

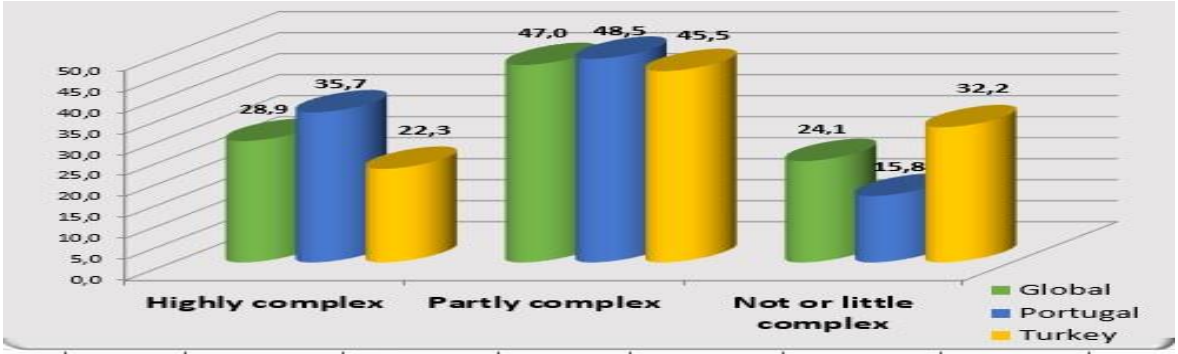
This item seeks to inquire about whether the health-relevant choice/information overload constructed socially and/or by the market lead to a decision difficulty or complexity in the serious health problem experiences of the respondents. In this regard, an inquiry was made to have an insight into the nature of the relationship between the independent variable "health-relevant IO-CO" and the dependent variable "health-relevant decision-making". Findings for the goal and the sub-question mentioned in G-11 revealed that there can be a relationship between IO-CO and indecisiveness. Only 19 percent of the respondents objected to such a possible relationship and 81,0 percent of the respondents stated that there is such a relationship. The distribution of the responses for this statement is as follows. 37,1 percent of the respondents stated that they find this health-relevant variety of choices in serious health problems highly complex, 43,9 percent find this variety partly complex and only 19,0 percent or find little complex or not complex at all. No significant statistical difference was found between the data collected from respondents in Turkey and Portugal. The responses for this statement from Portugal are as follows: highly complex (36,2 percent), partly complex (44,9 percent), not or little complex (18,9 percent). The responses from Turkey are: highly complex (37,9 percent), partly complex (42,9 percent), not or little complex (19,2 percent). The similar findings from these two countries indicate that we can find implications

in these results about a globalized health-relevant decision-making phenomenon, at least for the health-care culture and systems of Turkish and Portuguese societies. The data indicates that even the cultural differences between Turkish and Portuguese society do not play any significant role in the scenario presented in this item. This was an expected result.

As it can be seen in the figure 8 above, the results shaped by the opinions of Turkish and Portuguese respondents for this statement show that health-literate respondents experience health-relevant decision-difficulties caused by the variety of choices when they have serious health problems. Even only the imperative of choosing among a variety with no regards to other factors, variables or actions is found complex (more difficult) in serious health-relevant life scenarios. This may imply that those health-literate having some serious health problems will probably experience a decision-difficulty in severe or mild levels.

The levels of indecisiveness were inserted into the item as choices and were conceptualized as follows: Highly complex (high-level indecisiveness), partly complex (medium-level indecisiveness) and not or little complex (low-level indecisiveness). These levels of indecisiveness were also used as variables in cross-inquiries and analysis of some items. Some inquiries were made about the decision-making, behavior or perception patterns of high-level indecisive consumers (conceptualized as highly indecisive according to this statement).

Figure 9– (Q2)- Choosing among the relevant alternatives (advice, therapies, doctors, hospitals, pills, products etc.) about this situation by taking all my conditions (time, budget, emotions etc.) into consideration would be



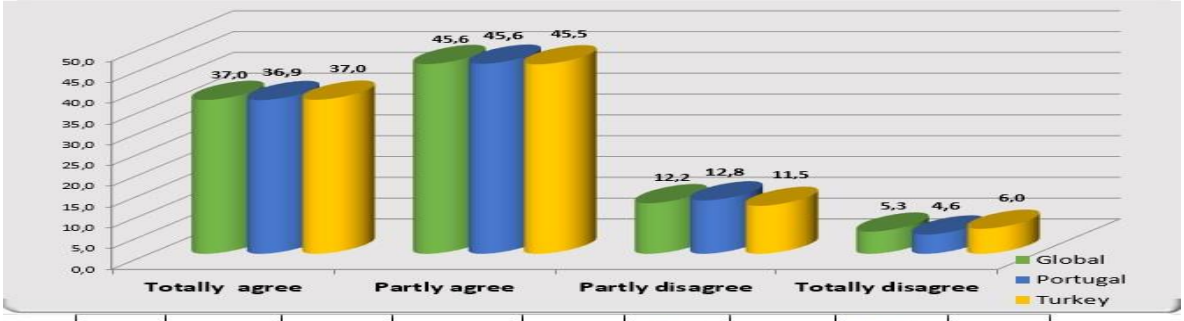
	Highly complex (%)	Frequency (N)	Partly complex (%)	Frequency (N)	Not or little complex (%)	Frequency (N)
Global	28.9	115	47.0	187	24.1	96
Portugal	35.7	70	48.5	95	15.8	31
Turkey	22.3	45	45.5	92	32.2	65

This item seeks to inquire about whether such socio-economic and personal factors as economic, temporal capital and emotions play an important role in health-relevant

decision-making in serious health problems besides the role of the health-relevant choice overload, about how the interplay of all these factors complicates the health-relevant decision-making and leads to indecisiveness. A moderating variable (socio-economic factors) besides the independent variable (choice overload) and dependent variable (decision-making process) was included in this inquiry. The relevant goal and the sub-question were mentioned in G8, G-11 and G14 and inquired into the respondents' perception about whether socio-economic conditions influence the patterns of the regulations made with the healthy life advice to overcome indecisiveness or not. The supportive results were obtained for such a possible relationship between information/choice overload and indecisiveness. 75,9 percent of the respondents totally or partly confirmed that there is such a relationship and only 24,1 percent of the respondents objected to such a relationship. For the same scenario presented in Q1 item, but also taking their socio-economic conditions into consideration, 28,9 percent of the respondents stated that they would find this health-relevant variety of choices in serious health problems highly complex, 47,0 percent find this variety partly complex and only 24,1 percent or find little complex or not complex at all. The distribution of the responses for this statement from Portugal are as follows: highly complex (35,7 percent), partly complex (48,5 percent), not or little complex (15,8 percent). The responses from Turkey are: highly complex (22,3 percent), partly complex (45,5 percent), not or little complex (32,2 percent). A partly significant statistical difference was found between the data collected from respondents in Turkey and Portugal. The difference was between the high complexity (high and low indecisiveness) rates. This discrepancy may stem from the interplay of public health policies and applications rather than personal backgrounds. When such socio-economic factors as budget and time are taken into consideration, the decision-making in serious health-care management practices is deemed more complex in Portugal. What is not visible in this result may be the impact of public health practices and legislations considered to impact the health-relevant decision making. These practices may be such practices as making out-of-pocket health expenditures, differences in social security measures etc.. Even though the health-literate consumers have adopted healthy-life norms in Portugal, they may experience more complex conditions in the access to therapies, pharmaceuticals, health insurances when socio-economic factors are taken into consideration. The public health policies and bureaucratic procedures as well as facilitated access to social security system in Turkey provide the health-literate consumers with a relief in the decision-support system of the country despite the fact that IO and CO

were observed to be more intense in Turkey. This may be one of the most important reasons why socio-economic factors play less role in health-care management as these are compensated by the infrastructure and health politics, increasing the role of structural measures and reducing the role of personal factors[80].

Figure 10– (Q5)- If I experience a serious health problem, have limited time and budget but a great variety of choices (therapies, doctors, hospitals, pills, techniques, products, advice) before me, choosing among these becomes a more complex task.



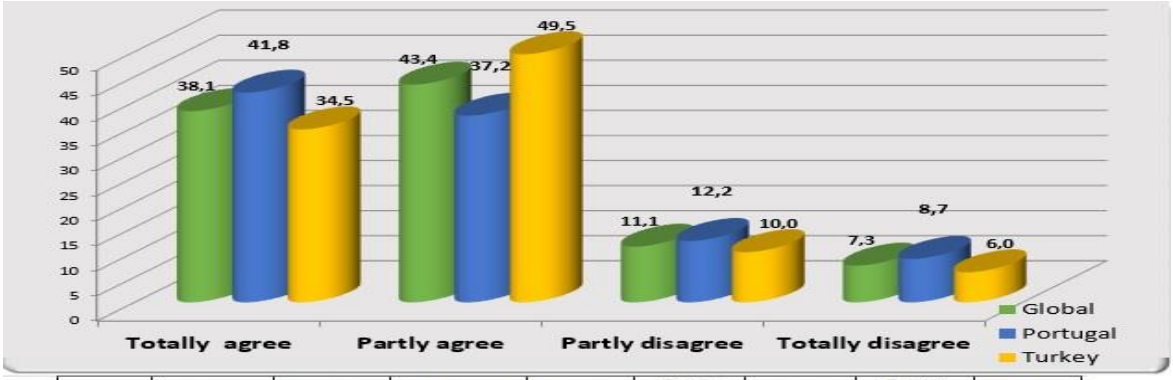
	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	37,0	146	45,6	180	12,2	48	5,3	21
Portugal	36,9	72	45,6	89	12,8	25	4,6	9
Turkey	37,0	74	45,5	91	11,5	23	6,0	12

This item seeks to inquire into how the interplay of health-relevant choice/information overload and socio-economic conditions (temporal and economic capital.) impacts health-relevant decision-making in serious health cases, and to what extent these complicate the health-relevant decision-making. In this item, the goals and the sub-questions mentioned in G-8 and G-11 were investigated. Findings indicated that the interplay of socio-economic factors and IO-CO contribute to decision difficulty. According to the scenario provided to them for real-life situations, when they have limited financial means and time, 82.5 percent of the respondents find the present health-relevant decision-making a totally or partly confusing process in serious health cases. Only 17,5 percent of the respondents objected to this statement. 37,0 percent of the respondents stated that they totally agree with the statement, choosing among a variety of health-relevant choices with limited time and financial means becomes a more complex task; 45,5 percent partly agree, 12,2 percent partly disagree and 5,3 percent totally disagree. No significant statistical difference was found between the data collected from respondents in Turkey and Portugal. The

[80] The state and government allocate specific resources within the context of social policies and the disadvantaged groups can receive free or very cheap health services and this contributes to reduction of the complications in health decisions.

distribution of the responses from Portugal is as the following: totally agree (36,9 percent), partly agree (45,6 percent), partly disagree (12,8 percent), totally disagree (4,6 percent). The responses from Turkey are: totally agree (37,0 percent), partly agree (45,5 percent), partly disagree (11,5 percent), totally disagree (6,0 percent). The results were expected and are in parallel with the results in Q1 and Q2.

Figure 11- (Q10)- I think that the abundance of choices about health (information, pills, nutrients, therapies, techniques etc.) may lead to confusion/indecisiveness about appropriate choice



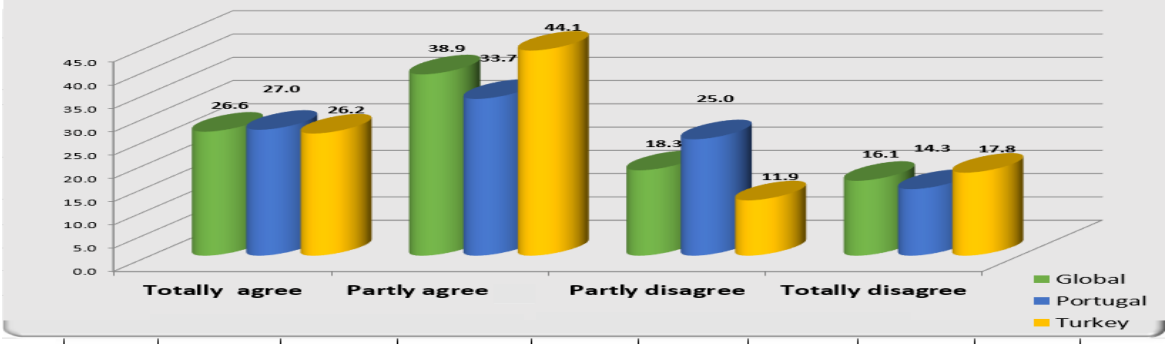
	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	38,1	151	43,4	172	11,1	44	7,3	29
Portugal	41,8	82	37,2	73	12,2	24	8,7	17
Turkey	34,5	69	49,5	99	10,0	20	6,0	12

This item seeks to inquire into the respondents' perception about whether health-relevant choice overload (the independent variable) influences the health-relevant indecisiveness (dependent variable). The results of the Q10 item support the results in Q1, Q2, Q5 and Q6, which indicate a possible relationship between CO and indecisiveness. The investigation about such a possible relationship through the sub-questions mentioned in G-5 and G-6 revealed an expected result. 38,1 percent of the respondents stated that they totally agree with the statement that an abundance in the health-relevant choices (information, pills, nutrients, therapies, techniques etc.) may result in an indecisiveness, 43,4 percent partly agree, 11,1 percent partly disagree and 7,3 percent totally disagree. No significant statistical difference was found between the data collected from respondents in Turkey and Portugal. The distribution of the responses from Portugal is as follows: totally agree (41,8 percent), partly agree (37,2 percent), partly disagree (12,2 percent), totally disagree (8,7 percent). The responses from Turkey are: totally agree (34,5 percent), partly agree (49,5 percent), partly disagree (10,0 percent), totally disagree (6,0 percent).

3.2.4. Indecisiveness constructed by the market and the implications

Until now, the results concerning the possible relationship between health-relevant choice overload which was presumed to be constructed by the market and society and indecisiveness was investigated through Q1, Q2, Q5 and Q10. Below, the readers will find the findings inquiring into the further implications of indecisiveness caused by CO and what kind of behaviors are observed in indecisiveness and how health-literate consumers overcome their indecisiveness.

Figure 12- (Q6)- When I cannot find a solution for my body/mental/skin health problems, choosing among a variety of solutions such as therapies, products, lifestyle changes etc. would make me feel uncomfortable

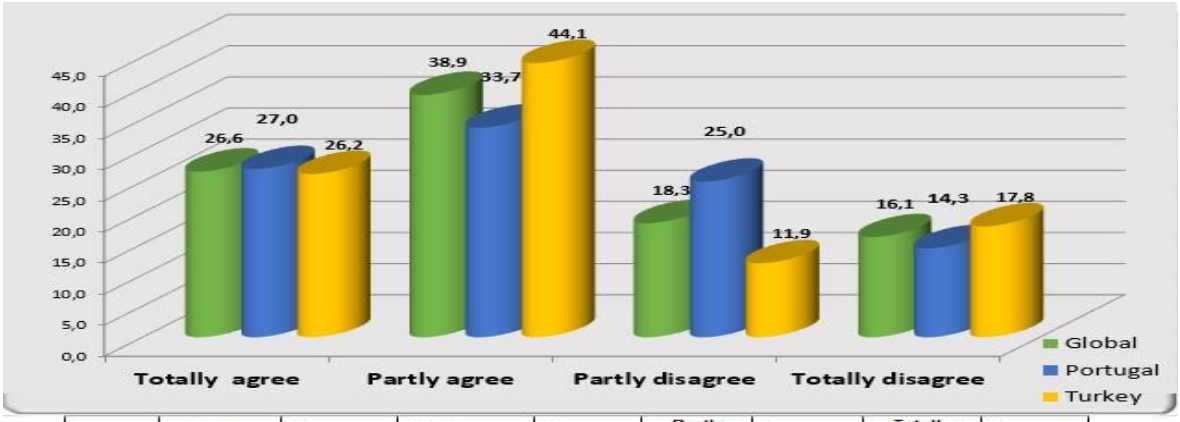


	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	26.6	106	38.9	155	18.3	73	16.1	64
Portugal	27.0	53	33.7	66	25.0	49	14.3	28
Turkey	26.2	53	44.1	89	11.9	24	17.8	36

This item seeks to inquire about whether information and choice overload lead to an increased indecisiveness when the health-literate consumers cannot find solutions to their personal health problems through the medicalized and exploited health-care consumption and behavior management systems. The inquiry in relation to the sub-question mentioned in G-9 revealed that consumers experience decision difficulties and indecisiveness when they feel that they cannot overcome the health-related problems through the existing choices that they have already tried and that they should try other alternatives. 26,6 percent of the respondents stated that they totally agree with the statement choosing among a variety of health-relevant choices when they cannot find solutions to their health problems would make them feel uncomfortable, 38,9 percent partly agree, 18,3 percent partly disagree and 16,1 percent totally disagree. 65.5 percent of the respondents consider such inefficient cycles of health-relevant decision-making in daily health care or serious health problems to be a negative experience. No significant statistical difference was found between the data collected from respondents in Turkey and Portugal. The responses for this statement from

Portugal are as follows: totally agree (27,0 percent), partly agree (33,7 percent), partly disagree (25,0 percent), totally disagree (14,3 percent). The responses from Turkey are: totally agree (26,2 percent), partly agree (44,1 percent), partly disagree (11,9 percent), totally disagree (17,8 percent).

Figure 13- (Q7)- When I feel uncomfortable in choosing among the health-relevant choices such as "therapy, doctor, pills etc.", I would post-pone buying-consuming relevant products-services



	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	26,6	106	38,9	155	18,3	73	16,1	64
Portugal	27,0	53	33,7	66	25,0	49	14,3	28
Turkey	26,2	53	44,1	89	11,9	24	17,8	36

This item seeks to inquire about whether the decision difficulty/indecisiveness leads to a postponement in such health-relevant behaviors as purchase and consumption or not. The uncomfortableness emerging in the decision-making process has been conceptualized as decision-difficulty/indecisiveness. As already mentioned in methodology section, some conceptualizations were made, in this regard, in the "Q6, Q7, Q8 and Q9" statements, the uncomfortableness (indecisiveness) in decision-making was assigned as the independent variable and there are other dependent variables to be inquired. For this statement, the dependent variable is consumption-purchase postponement concept. The findings obtained in the inquiry about the goal and sub-question mentioned in G-9 and G-11 revealed that a postponement is experienced as a result of indecisiveness and it may be a negative consequence both for the consumers and the market. The decision difficulty-indecisiveness discouraged the health-literate consumers in Portugal and Turkey from consuming or purchasing health products, services, therapies etc.. 21,4 percent of the respondents stated that they totally agree with the statement that decision difficulty-indecisiveness leads them to postpone the health-relevant purchase or consumption, 40,1 percent partly agree, 17,1

percent partly disagree and 21,4 percent totally disagree. No significant statistical difference was found between the data collected from respondents in Turkey and Portugal. The responses for this statement from Portugal are as follows: totally agree (23,5 percent), partly agree (42,3 percent), partly disagree (17,9 percent), totally disagree (16,3 percent). The responses from Turkey are: totally agree (19,4 percent), partly agree (37,8 percent), partly disagree (16,4 percent), totally disagree (26,4 percent).

In the indecisiveness literature, postponement behavior is defined as one of the consequences of indecisiveness, the findings in this statement converge with the definitions and findings in the literature. While the market offers a wide variety of alternatives to the health consumers, it is apparent from the findings that it also reduces the speed and frequency of consumption and purchases due to also producing postponement caused by indecisiveness.

Table 4- Cross table analysis – Postponement of health-relevant purchases and consumption according to indecisiveness levels

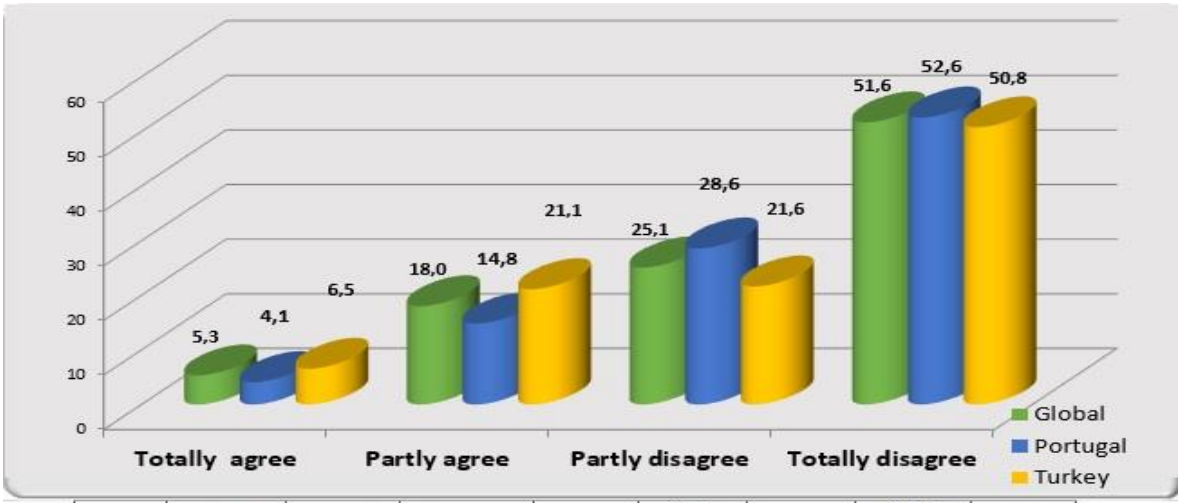
		When I feel uncomfortable in choosing among the health-relevant choices such as "therapy, doctor, pills etc.", I would post-pone buying-consuming relevant products-services			
Assume that you have a serious health problem (like heart disease or cancer). You search for relevant advices, information, therapies, doctors, hospitals, pills, products etc. You see that there is a great variety of these. You would find this variety		Totally agree	Partly agree	Partly disagree	Totally disagree
	Highly complex	31,5%	37,0%	11,0%	20,5%
	Partly complex	15,5%	46,0%	21,8%	16,7%
	Not or little complex	14,5%	32,9%	18,4%	34,2%

This item was important in that indecisiveness could have an impact on the consumption and purchase behaviors, so, it was subjected to a cross-tab analysis. As mentioned in the previous pages, the Q1 statement was the main tool to measure indecisiveness level. The cross-tab analysis was conducted to examine the consumption and purchase patterns and trends emerging according to indecisiveness levels of respondents. 31,5 percent of the highly indecisive respondents (Q1) totally agree with the statement "I would post-pone buying-consuming relevant products-services", 37,0 percent partly agree, 11,0 percent partly disagree and 20,5 percent totally disagree. 15,5 percent of the medium-level indecisive respondents totally agree, 46,0 percent partly agree, 21,8 percent partly disagree and 16,7 percent totally disagree. 14,5 percent of the low-level indecisive respondents totally agree, 32,9 percent partly agree, 18,4 percent partly disagree and 34,2 percent totally disagree. As it can be seen from the figures in table 4 presenting the results of the cross analysis, 68,5 percent of the high-level indecisive respondents, 61,5 percent of

the medium-level indecisive respondents and 47,4 percent of the low-level indecisive respondents totally or partly agree with the postponement of the relevant consumption and purchase behavior when they feel indecisive.

The distribution of the responses in cross analysis conducted for Portugal data is as follows: 35,2 percent of the highly indecisive respondents (Q1) totally agree, 39,4 percent partly agree, 9,9 percent partly disagree and 15,5 percent totally disagree. 14,8 percent of the medium-level indecisive respondents totally agree, 51,1 percent partly agree, 23,9 percent partly disagree and 10,2 percent totally disagree. 21,6 percent of the low-level indecisive respondents totally agree, 27,0 percent partly agree, 18,9 percent partly disagree and 32,4 percent totally disagree. As for the Turkey data, 28,0 percent of the highly indecisive respondents (Q1) totally agree, 34,7 percent partly agree, 12,0 percent partly disagree and 25,3 percent totally disagree. 16,3 percent of the medium-level indecisive respondents totally agree, 40,7 percent partly agree, 19,8 percent partly disagree and 23,3 percent totally disagree. 7,7 percent of the low-level indecisive respondents totally agree, 38,5 percent partly agree, 17,9 percent partly disagree and 35,9 percent totally disagree. The data obtained from the cross analysis revealed that postponement trends in higher indecisiveness level are more apparent in Portugal (74,6 percent) whereas this rate in Turkey is lower (62,7).

Figure 14– (Q8)- When I feel uncomfortable in choosing among the health-relevant choices such as "therapy, doctor, pills etc.", I would be totally blocked and stop searching.



	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	5,3	21	18,0	71	25,1	99	51,6	204
Portugal	4,1	8	14,8	29	28,6	56	52,6	103
Turkey	6,5	13	21,1	42	21,6	43	50,8	101

This item seeks to inquire about whether the decision difficulty or indecisiveness leads to a discouragement about further health-seeking behaviors in the form of stopping or abandoning the health-relevant practices. Findings for the sub-question mentioned in G-9 revealed that the postponement or discouragement do not stop health-literate consumers from searching for alternatives or further solutions, on the contrary, it encourages them to proceed with experimenting other choices. 5,3 percent of the respondents stated that they totally agree with the statement that indecisiveness causes them to stop further health-seeking behaviors, 18,0 percent partly agree, 25,1 percent partly disagree and 51,6 percent totally disagree. Majority of respondents (76,7 percent) stated that they are not totally blocked by indecisiveness and do not abandon their health and health-information seeking practices. These findings correspond to the increased search behavior associated with indecisiveness in the literature. The indecisive health-literate was found not to be blocked but they were found to be in further information-solution seeking as an indication of indecisiveness, another indication of the postponement of the decision-making, but not exactly abandoning it.

No significant statistical difference was found between the data collected from respondents in Turkey and Portugal. The responses for this statement from Portugal are as follows: totally agree (4,1 percent), partly agree (14,8 percent), partly disagree (28,6 percent), totally disagree (52,6 percent). The responses from Turkey are: totally agree (6,5 percent), partly agree (21,1 percent), partly disagree (21,6 percent), totally disagree (50,8 percent).

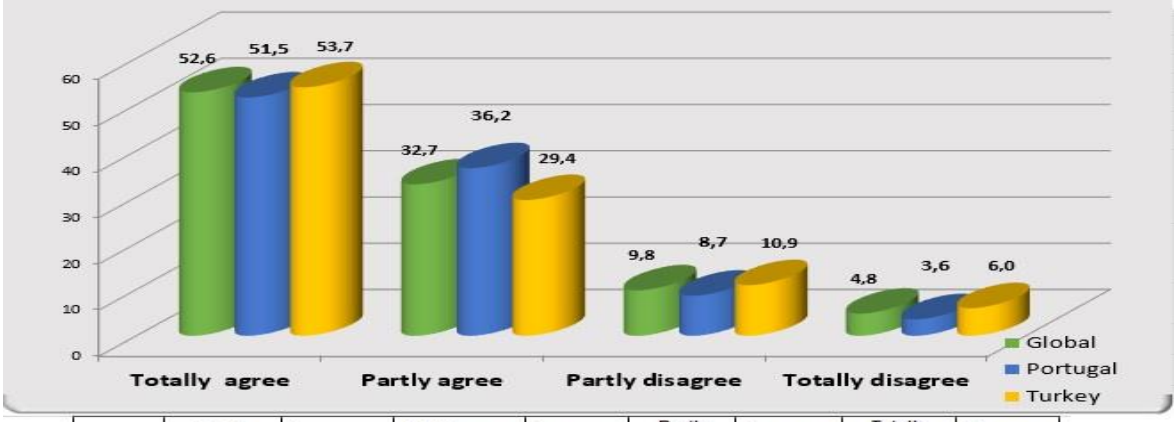
Table 5- Cross table analysis – Stopping health-relevant information seeking according to indecisiveness levels

Assume that you have a serious health problem (like heart disease or cancer). You search for relevant advices, information, therapies, doctors, hospitals, pills, products etc. You see that there is a great variety of these. You would find this variety	When I feel uncomfortable in choosing among the health-relevant choices such as "therapy, doctor, pills etc.", I would be totally blocked and stop searching			
	Totally agree	Partly agree	Partly disagree	Totally disagree
Highly complex	6,8%	21,2%	27,4%	44,5%
Partly complex	3,5%	16,8%	27,2%	52,6%
Not or little complex	5,3%	14,7%	16,0%	64,0%

According to the data, although only a small part of the respondents is totally blocked and abandons information-seeking practices, even these small figures are inclined to change according to indecisiveness levels. In higher levels of indecisiveness, higher rates of being

totally blocked and stopping search were obtained. 6,8 percent of the highly indecisive respondents (Q1) totally agree with the statement "I would be totally blocked and stop searching", 21,2 percent partly agree, 27,4 percent partly disagree and 44,5 percent totally disagree. 3,5 percent of the medium-level indecisive respondents totally agree, 16,8 percent partly agree, 27,2 percent partly disagree and 52,6 percent totally disagree. 5,3 percent of the low-level indecisive respondents totally agree, 14,7 percent partly agree, 16,0 percent partly disagree and 64,0 percent totally disagree. 28, 0 percent of those with higher indecisiveness, 20,3 of those with medium indecisiveness and 20,0 percent of those with lower indecisiveness were found to be blocked and this rate changes according to the indecisiveness level.

Figure 15– (Q9)- When I feel uncomfortable in choosing among the health-relevant choices such as "therapy, doctor, pills etc.", even my indecisiveness would be temporary, I would immediately continue searching for further information and trying alternatives



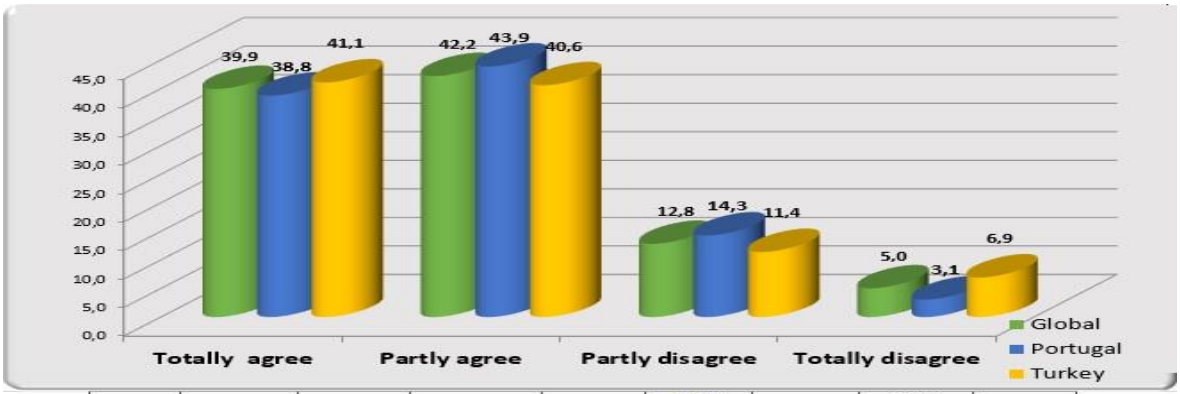
	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	52,6	209	32,7	130	9,8	39	4,8	19
Portugal	51,5	101	36,2	71	8,7	17	3,6	7
Turkey	53,7	108	29,4	59	10,9	22	6,0	12

This item seeks to inquire about whether the health-relevant indecisiveness is a temporary or permanent phenomenon, whether the further information and alternative seeking are deemed to be the key practice to overcome indecisiveness. Findings for the goal and the sub-question mentioned in G-9 indicated that little or no ignorance and discouragement emerge as a result of the "temporary" indecisiveness. The further seeking for alternatives and information were deemed to be the solution to overcome indecisiveness. 52,6 percent of the respondents stated that they totally agree with the statement that their health-relevant indecisiveness is usually temporary and that they continue searching for further information and choices, 32,7 percent partly agree, 9,8 percent partly disagree and

4,8 percent totally disagree. No significant statistical difference was found between the data collected from respondents in Turkey and Portugal. The responses for this statement from Portugal are as follows: totally agree (51,5 percent), partly agree (36,2 percent), partly disagree (8,7 percent), totally disagree (3,6 percent). The responses from Turkey are: totally agree (53,7 percent), partly agree (29,4 percent), partly disagree (10,9 percent), totally disagree (6,0 percent).

The findings also revealed that the health-relevant indecisiveness is usually temporary (85,3 percent totally and partly agree). This is supported by the findings in Q8, the health-literate consumers overcome the health-relevant indecisiveness through an increased search for information and experimenting more alternatives. This finding is also in the similar vein with the postponement result in Q7, "postponement in the form of an increased search". These results converge with the definitions and findings in the relevant indecisiveness literature. But it should be noted here that the results in Q8 and Q9 seem to disprove the argumentations made about "blasé attitude" in the text. Respondents do not feel that they are stuck due to indecisiveness, on the contrary, they continue further search and experiences with other choices and overcome the indecisiveness problem. The discrepancy between the expected decision-fatigue (Blasé attitude) and obtained results in Q7-Q8-Q9 revealed that such a decision fatigue in health-relevant indecisiveness process may not have a certain relationship between ignorance or stopping the health-seeking behavior.

Figure 16– (Q4)- Health-related decision-making is a confusing process in which I take action by taking many things into account



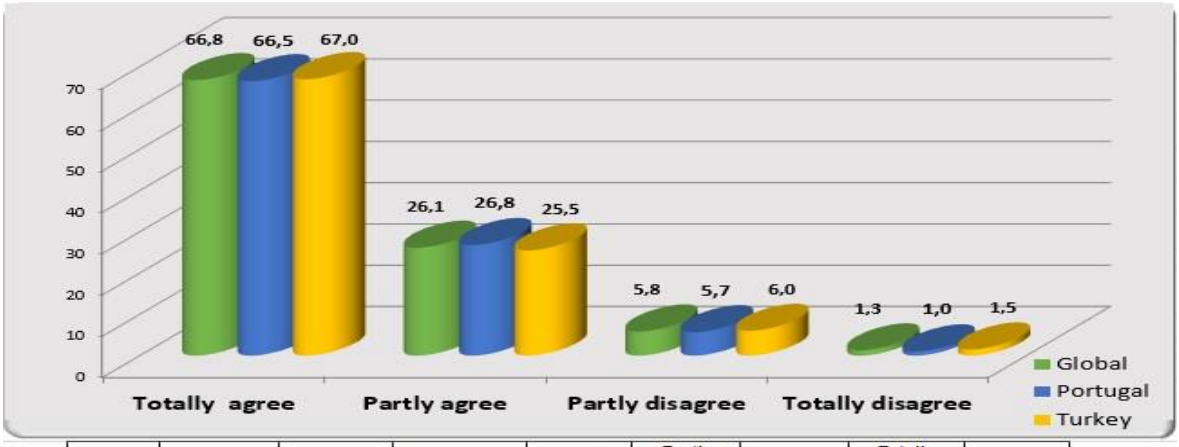
	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	39,9	159	42,2	168	12,8	51	5,0	20
Portugal	38,8	76	43,9	86	14,3	28	3,1	6
Turkey	41,1	83	40,6	82	11,4	23	6,9	14

This item seeks to inquire about whether the health-relevant decision-making has been perceived as more complex due to an imperative to pay attention to many factors or variables. Findings revealed that the health-relevant decision-making in Turkey and Portugal is considered as a confusing process by the majority of respondents. 81.1 percent of the respondents find the present health-relevant decision-making a totally or partly confusing process. 39,9 percent of the respondents stated that they totally agree with the statement "health-related decision-making is a confusing process in which they take action by taking many things into account", 42,2 percent partly agree, 12,8 percent partly disagree and 5,0 percent totally disagree. No significant statistical difference was found between the data collected from respondents in Turkey and Portugal. The responses for this statement from Portugal are as follows: totally agree (38,8 percent), partly agree (43,9 percent), partly disagree (14,3 percent), totally disagree (3,1 percent). The responses from Turkey are: totally agree (41,1 percent), partly agree (40,6 percent), partly disagree (11,4 percent), totally disagree (6,9 percent).

3.2.5. Conflicting Health Information (Advice) and Decision-Making

This study argued that conflicting health advice and information have relationships with health-relevant decision-making and indecisiveness, and a relevant inquiry was made with several sub-questions in the survey. The results of this inquiry were presented below.

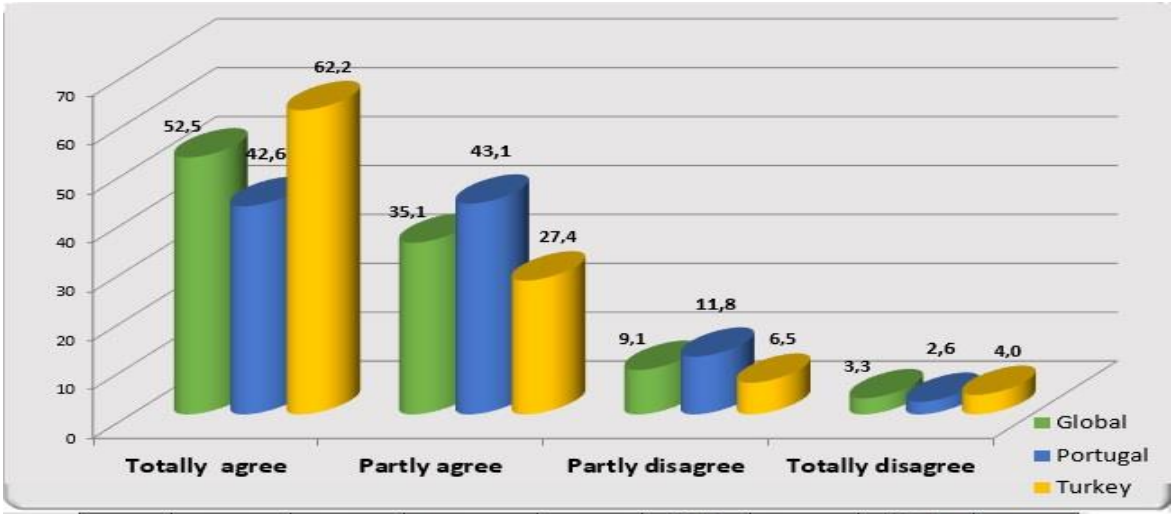
Figure 17- (Q13) - In media and internet sources, I come across health advice and information which are in conflict with each other



	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	66,8	263	26,1	103	5,8	23	1,3	5
Portugal	66,5	129	26,8	52	5,7	11	1,0	2
Turkey	67,0	134	25,5	51	6,0	12	1,5	3

This item seeks to inquire about whether internet and media are the main sources of conflicting health information and advice as it is one of the most important issues to be investigated in this study. Findings for the sub-question in G-5 revealed that these conflicting messages are encountered by a great majority of respondents (92,9 percent) upon the reception of the overload of advice through media and internet. 66,8 percent of the respondents totally agree with the statement that the they encounter conflicting health information and advice in internet and media sources, 26,1 percent partly agree, 5,8 percent partly disagree and 1,3 percent totally disagree. No significant statistical difference was found between the data collected from respondents in Turkey and Portugal. The responses for this statement from Portugal are as follows: totally agree (66,5 percent), partly agree (26,8 percent), partly disagree (5,7 percent), totally disagree (1,0 percent). The responses from Turkey are: totally agree (67,0 percent), partly agree (25,5 percent), partly disagree (6,0 percent), totally disagree (1,5 percent).

Figure 18– (Q14) - Various conflicting health information and advice lead to decision difficulties about the appropriate health behaviors

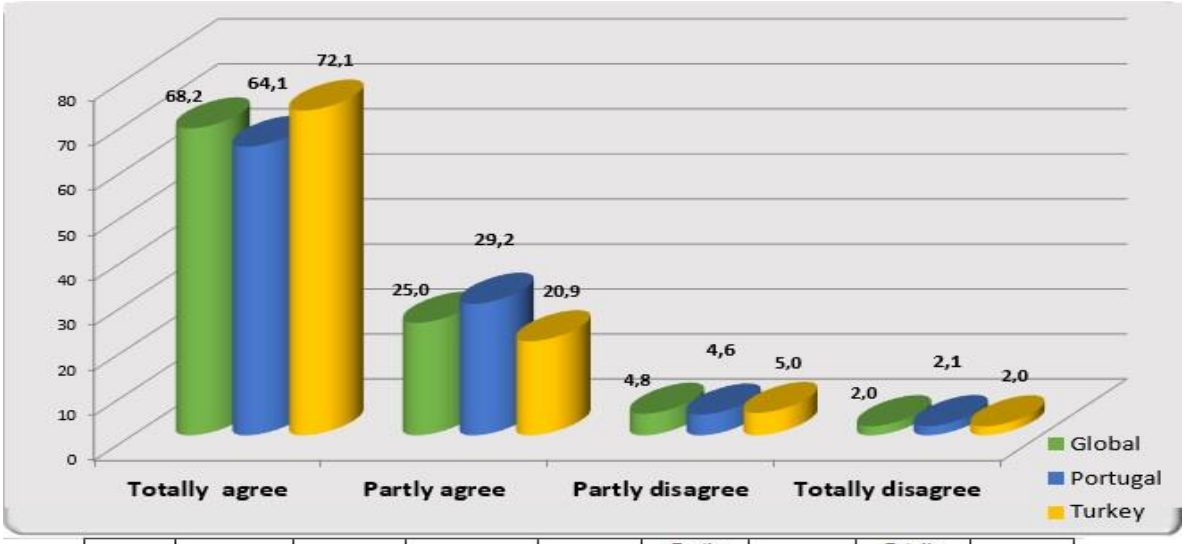


	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	52,5	208	35,1	139	9,1	36	3,3	13
Portugal	42,6	83	43,1	84	11,8	23	2,6	5
Turkey	62,2	125	27,4	55	6,5	13	4,0	8

This item seeks to inquire about whether the conflicting health information and advice (independent variable) lead to a decision difficulty-indecisiveness (dependent variable) about the appropriate health behavior. The findings for the sub-question in G-6 revealed that there may be a relationship between conflicting health information and indecisiveness about the appropriate behavior. According to the data, besides the choice

overload, the conflicting information was also found to be another factor contributing to the emergence of indecisiveness. 52,5 percent of the respondents totally agree with the statement that conflicting health information leads to health-related indecisiveness, 35,1 percent partly agree, 9,1 percent partly disagree and 3,3 percent totally disagree. The total and partial agreement rate is 87,6 percent whereas disagreement rate is only 12,4 percent. No significant statistical difference was found between the data collected from respondents in Turkey and Portugal. The responses for this statement from Portugal are as follows: totally agree (42,6 percent), partly agree (43,1 percent), partly disagree (11,8 percent), totally disagree (2,6 percent). The responses from Turkey are: totally agree (62,2 percent), partly agree (27,4 percent), partly disagree (6,5 percent), totally disagree (4,0 percent).

Figure 19- (Q15)- Internet and media distribute confusing health advice whether I like it or not

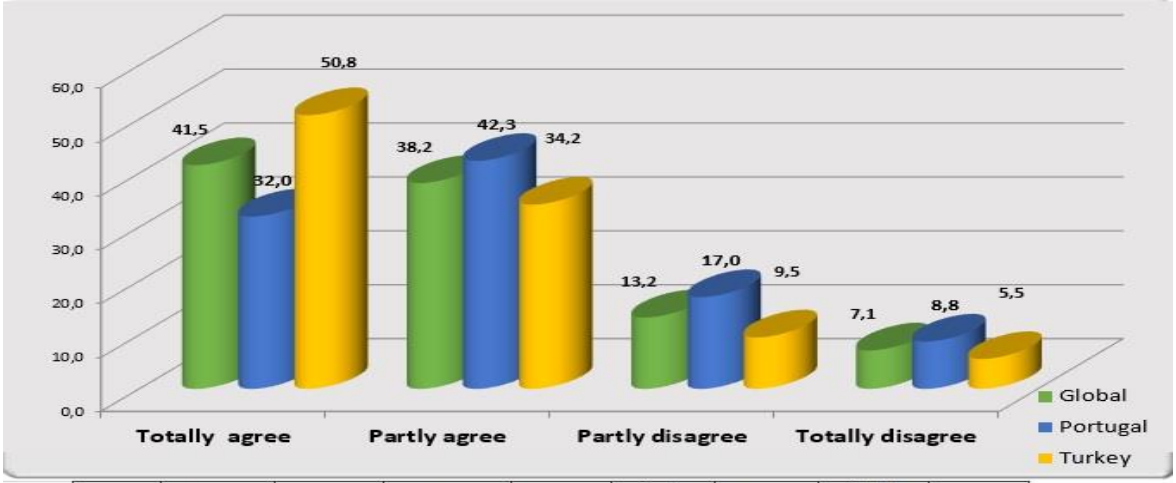


	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	68,2	270	25,0	99	4,8	19	2,0	8
Portugal	64,1	125	29,2	57	4,6	9	2,1	4
Turkey	72,1	145	20,9	42	5,0	10	2,0	4

This item seeks to inquire about whether internet and media disseminate the confusing health information and advice which may lead the respondents to indecisiveness. The findings for the sub-question mentioned in G-4 and G-5 revealed that the confusing messages were disseminated through internet and media. This result is in the same vein with the results in Q13. 68,2 percent of the respondents totally agree with the statement that internet and media distribute confusing health information, 25,0 percent partly agree, 4,8 percent partly disagree and 2,0 percent totally disagree. The total and partial agreement rate

is 93,2 percent whereas disagreement rate is only 6,7 percent. No significant statistical difference was found between the data collected from respondents in Turkey and Portugal. The responses for this statement from Portugal are as follows: totally agree (64,1 percent), partly agree (29,2 percent), partly disagree (4,6 percent), totally disagree (2,1 percent). The responses from Turkey are: totally agree (72,1 percent), partly agree (20,9 percent), partly disagree (5,0 percent), totally disagree (2,0 percent).

Figure 20– (Q24) - The conflicts in the diet regimes imposed break my confidence in these information and advice



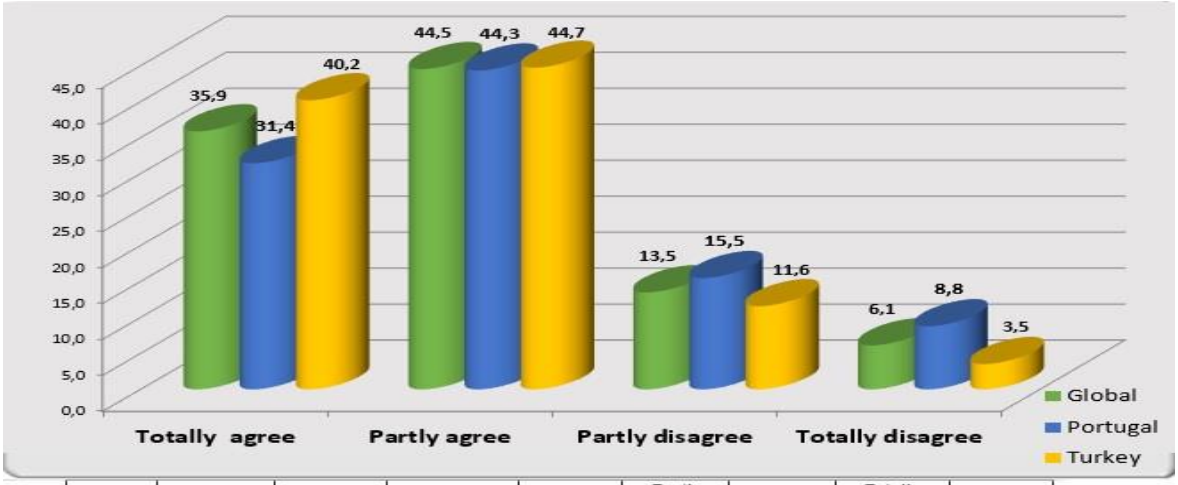
	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	41,5	163	38,2	150	13,2	52	7,1	28
Portugal	32,0	62	42,3	82	17,0	33	8,8	17
Turkey	50,8	101	34,2	68	9,5	19	5,5	11

This item seeks to inquire about whether the diet regimes, one of the most prominent issues of healthy life and disseminated mostly, contributing to an information and choice overload, cause any distrust in the relevant type of information and advice. Findings for the sub-question mentioned in G9 revealed that any discouragement and distrust in the health-care decision-making and the reception of advice impact further processes such as seeking information or choices. The dietary advice and philosophies are vastly disseminated on the internet and in media as well as in social interactions. Actually, these constitute a large part of the health-relevant information overload[81]. Within the context of this dietary

[81] Many kinds of dietary regimes offer conflicting nutritional advice. For instance, some diet regimes suggest the consumption of protein-based nutrients, some others carbohydrate-based or fat-based ones. Some regimes suggest having 3 meals a day, some others having 3 meals plus several snacks or 2 meals and having no food for 16 hours (such as intermittent fasting regimes vastly practiced recently). The conflicts by the propositions of these were found to lead to confusion according to the results of this statement and some others in previous pages.

information overload, many conflicting regimes and arguments are disseminated. This dissemination of the conflicting diet advice is perceived by a majority of the respondents. 41,5 percent of the respondents totally agree with the statement that the conflicting diet regime advice cause distrust in these kinds of information, 38,2 percent partly agree, 13,2 percent partly disagree and 7,1 percent totally disagree. The total and partial agreement rate is 79,7 percent whereas disagreement rate is only 20,3 percent. No significant statistical difference was found between the data collected from respondents in Turkey and Portugal. The responses for this statement from Portugal are as follows: totally agree (50,8 percent), partly agree (34,2 percent), partly disagree (9,5 percent), totally disagree (5,5 percent). The responses from Turkey are: totally agree (32,0 percent), partly agree (42,3 percent), partly disagree (17,0 percent), totally disagree (8,8 percent).

Figure 21– (Q25) - When my confidence in the conflicting advice is broken, I start ignoring these kinds of information



	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	35,9	141	44,5	175	13,5	53	6,1	24
Portugal	31,4	61	44,3	86	15,5	30	8,8	17
Turkey	40,2	80	44,7	89	11,6	23	3,5	7

This item seeks to inquire about whether the overproduced health information and advice produce any ignorance (like Blasé attitude) due to the over-stimulation with conflicting and unreliable information. Findings for the sub-question mentioned in G9 indicated that the conflicting information creates an unreliability about and an ignorance in the information and choices offered in the healthy life system. 35,9 percent of the respondents totally agree with the statement that the conflicting health advice and diet regimes lead to an ignorance about these kinds of information, 44,5 percent partly agree,

13,5 percent partly disagree and 6,1 percent totally disagree. The total and partial agreement rate is 80,4 percent whereas disagreement rate is only 19,6 percent. No significant statistical difference was found between the data collected from respondents in Turkey and Portugal. The responses for this statement from Portugal are as follows: totally agree (31,4 percent), partly agree (44,3 percent), partly disagree (15,5 percent), totally disagree (8,8 percent). The responses from Turkey are: totally agree (40,2 percent), partly agree (44,7 percent), partly disagree (11,6 percent), totally disagree (3,5 percent).

One further implication of this finding is that the alternatives provide relief and hope about finding the optimal solution for the health problems, however, the overload of choices and alternatives are also likely to eliminate the trustworthiness feeling by creating a confusing choice-decision-making system.

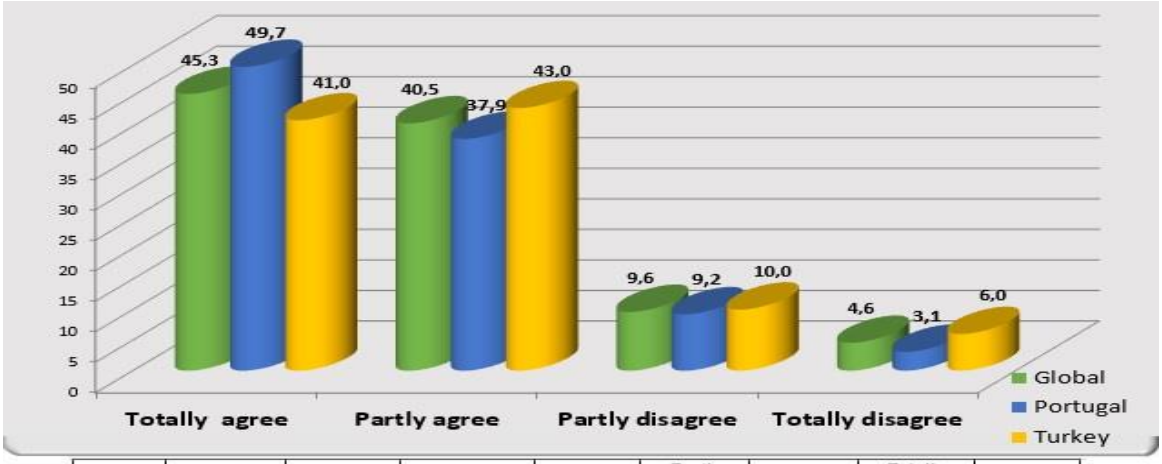
Table 6- Cross table analysis – Starting to ignore the conflicting information according to indecisiveness levels

		When my confidence in the conflicting advices is broken, I start ignoring these kinds of information			
Assume that you have a serious health problem (like heart disease or cancer). You search for relevant advices, information, therapies, doctors, hospitals, pills, products etc. You see that there is a great variety of these. You would find this variety		Totally agree	Partly agree	Partly disagree	Totally disagree
	Highly complex	42,0%	44,1%	10,5%	3,5%
	Partly complex	30,6%	49,7%	15,6%	4,0%
	Not or little complex	35,5%	34,2%	14,5%	15,8%

A cross-table analysis was made to examine the behavioral patterns according to each level of indecisiveness. In higher levels of indecisiveness, higher rates of ignoring the conflicting information were obtained. 42,0 percent of the highly indecisive respondents (Q1) totally agree with the statement “When my confidence in the conflicting advice is broken, I start ignoring these kinds of information”, 44,1 percent partly agree, 10,5 percent partly disagree and 3,5 percent totally disagree. 30,6 percent of the medium-level indecisive respondents totally agree, 49,7 percent partly agree, 15,6 percent partly disagree and 4,0 percent totally disagree. 35,5 percent of the low-level indecisive respondents totally agree, 34,2 percent partly agree, 14,5 percent partly disagree and 15,8 percent totally disagree. 86,1 percent of those with higher indecisiveness, 80,3 of those with medium indecisiveness and 69,7 percent of those with lower indecisiveness were found to start ignoring the information

type which were considered to have conflicts (such as diets). As it can be seen in the table 6, these rates of ignorance are inclined to change according to the indecisiveness level.

Figure 22– (Q17) - I prefer not to apply the conflicting health information in which I have no trust



	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	45,3	179	40,5	160	9,6	38	4,6	18
Portugal	49,7	97	37,9	74	9,2	18	3,1	6
Turkey	41,0	82	43,0	86	10,0	20	6,0	12

This item seeks to inquire into what kind of health-relevant decisions and behaviors accompany the distrust in the conflicting health information, whether health-literate consumers take these information and advice seriously and apply these or not. The findings reveal that distrust in the conflicting information discourage the respondents from following this piece of advice. 45,3 percent of the respondents totally agree with the statement that they do not apply the conflicting information in which they do not trust, 40,5 percent partly agree, 9,6 percent partly disagree and 4,6 percent totally disagree. The total and partial agreement rate is 85,8 percent whereas disagreement rate is only 14,2 percent. No significant statistical difference was found between the data collected from respondents in Turkey and Portugal. The responses for this statement from Portugal are as follows: totally agree (49,7 percent), partly agree (37,9 percent), partly disagree (9,2 percent), totally disagree (3,1 percent). The responses from Turkey are: totally agree (41,0 percent), partly agree (43,0 percent), partly disagree (10,0 percent), totally disagree (6,0 percent). All these findings indicate that the conflicting information reproduces distrust and this can be considered to bring the further processes to standstill.

Table 7- Cross table analysis – Abandoning the application of conflicting information according to indecisiveness levels

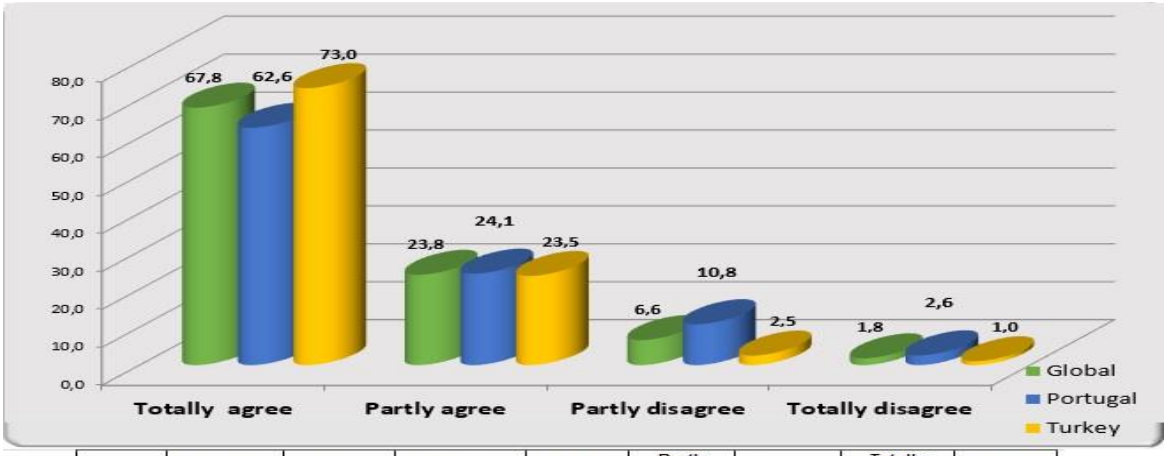
Assume that you have a serious health problem (like heart disease or cancer). You search for relevant advices, information, therapies, doctors, hospitals, pills, products etc. You see that there is a great variety of these. You would find this variety		I prefer not to apply the conflicting health information in which I have no trust.			
		Totally agree	Partly agree	Partly disagree	Totally disagree
	Highly complex	51,4%	41,0%	4,9%	2,8%
	Partly complex	42,0%	43,7%	10,9%	3,4%
	Not or little complex	40,8%	32,9%	15,8%	10,5%

A cross-table analysis was made to examine the behavioral patterns according to each level of indecisiveness. In higher levels of indecisiveness, higher rates of not applying the conflicting information were obtained. This indicates that the health-literate respondents are inclined to abandon applying any kinds of advice when they find conflicts in these and distrust. 51,4 percent of the highly indecisive respondents (Q1) totally agree with the statement "I prefer not to apply the conflicting health information in which I have no trust", 41,0 percent partly agree, 4,9 percent partly disagree and 2,8 percent totally disagree. 42,0 percent of the medium-level indecisive respondents totally agree, 43,7 percent partly agree, 10,9 percent partly disagree and 3,4 percent totally disagree. 40,8 percent of the low-level indecisive respondents totally agree, 32,9 percent partly agree, 15,8 percent partly disagree and 10,5 percent totally disagree. 92,4 percent of those with higher indecisiveness, 85,7 of those with medium indecisiveness and 73,7 percent of those with lower indecisiveness were found to abandon applying the conflicting information when they lose their trust in these information type. As it can be seen in the table 7, these rates of ignorance (abandoning) are inclined to change according to the indecisiveness level.

3.2.6. Health-Relevant Information Overload and Relevant Perception

Below, the results targeting to investigate the process of health-relevant information dissemination and perception of this volume of information as an overload were presented. The main inquiry focuses on the main sources of information overload: internet and media.

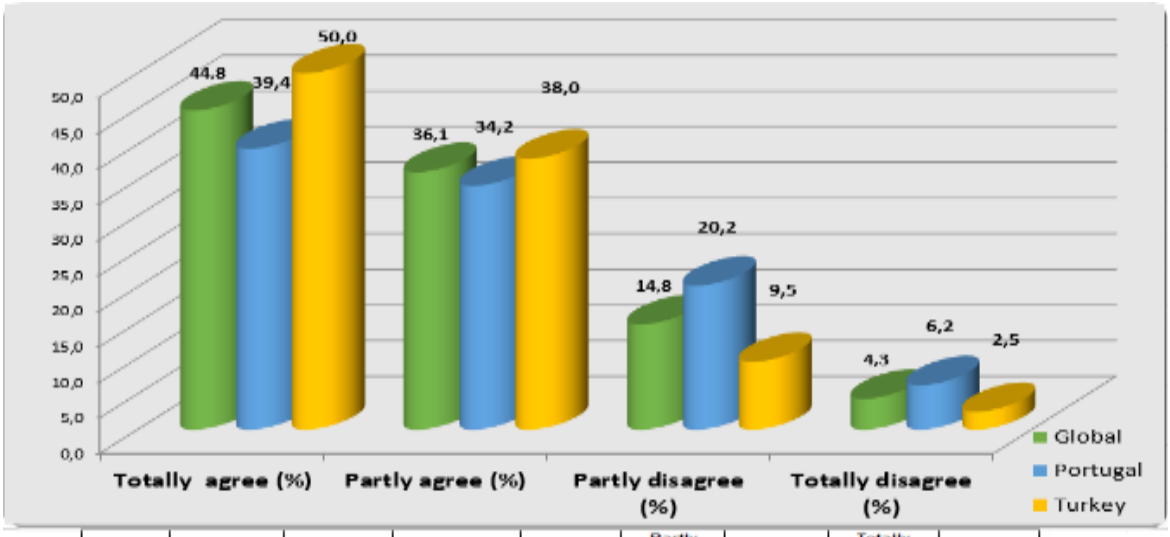
Figure 23– (Q26)- There is too much information pollution about healthy life in internet and media



	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	67,8	268	23,8	94	6,6	26	1,8	7
Portugal	62,6	122	24,1	47	10,8	21	2,6	5
Turkey	73,0	146	23,5	47	2,5	5	1,0	2

This item seeks to inquire about the health-literate consumers' perception about the existence of conflicting, confusing and low-quality information dissemination in media and internet. Findings for the sub-questions mentioned in G4 and G5 revealed that the media and internet can facilitate the dissemination of the conflicting health-information. 67,8 percent of the respondents totally agree with the statement that they encounter too much health-relevant information pollution in media and internet, 23,8 percent partly agree, 6,6 percent partly disagree and 1,8 percent totally disagree. The total and partial agreement rate is 91,6 percent whereas disagreement rate is only 8,4 percent. The responses for this statement from Turkey are as follows: totally agree (73,0 percent), partly agree (23,5 percent), partly disagree (2,5 percent), totally disagree (1,0 percent). The responses from Portugal are: totally agree (62,6 percent), partly agree (24,1 percent), partly disagree (10,8 percent), totally disagree (2,6 percent). This data indicates that information pollution is produced and observed a bit more in Turkey or controlled less due to a lack of protective measures by relevant organizations. This was an expected result. This phenomenon was one of the most important issues that establish the theoretical and empirical framework of the inquiry of this study. The findings concerning the perception about the existence of information pollution converge with the findings concerning the perception about information overload, conflicting information and indecisiveness.

Figure 24– (Q27)- There is too much information pollution about healthy life in face-to-face social interactions and relations

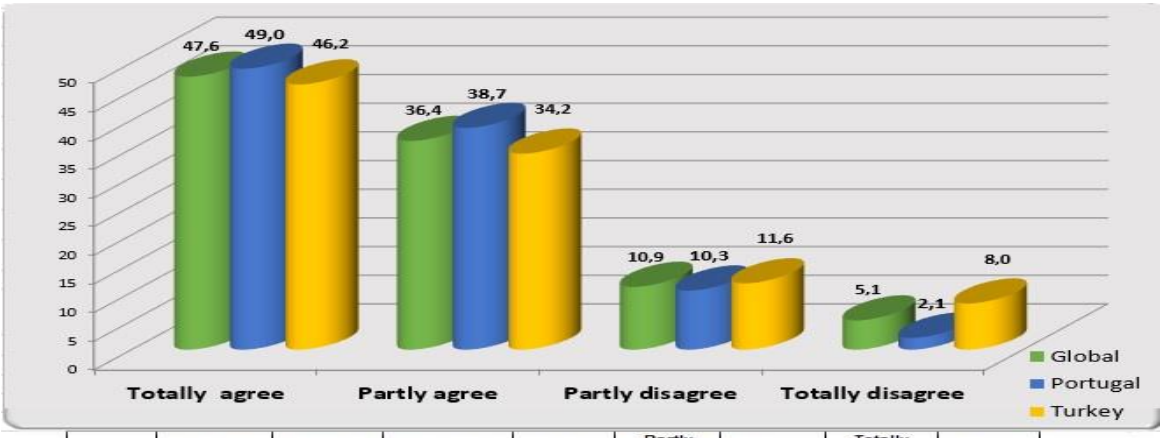


	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	44,8	176	36,1	142	14,8	58	4,3	17
Portugal	39,4	78	34,2	68	20,2	39	6,2	12
Turkey	50,0	100	38,0	76	9,5	19	2,5	5

This item seeks to inquire about the health literate consumers' perception about the dissemination of conflicting, confusing and low-quality information in the social relationships and interactions. The findings for the sub-question mentioned in G4 and G5 indicated that the social network and capital can also facilitate the dissemination of the conflicting health-information. 44,8 percent of the respondents totally agree with the statement that they encounter too much health-relevant information pollution in social interactions, 36,1 percent partly agree, 14,8 percent partly disagree and 4,3 percent totally disagree. The total and partial agreement rate is 80,9 percent whereas disagreement rate is only 19,1 percent. The responses for this statement from Turkey are as follows: totally agree (50,0 percent), partly agree (38,0 percent), partly disagree (9,5 percent), totally disagree (2,5 percent). The responses from Portugal are: totally agree (39,4 percent), partly agree (34,2 percent), partly disagree (20,2 percent), totally disagree (6,2 percent). In Turkey, the rate of the responses confirming information pollution is a little more than Portugal and this was an expected result. We can say that we have an evidence indicating that information pollution is produced and observed more in the social relations in Turkey. There, word of mouth health-communication phenomenon can be easier to be observed in the daily conservations of health-literate consumers. The data also reveals that the information pollution is

considered to be a bit less in the social interaction (80,9 percent) than in media and internet (91,6 percent).

Figure 25– (Q18) - In internet and media, there is a redundancy of healthy life advice



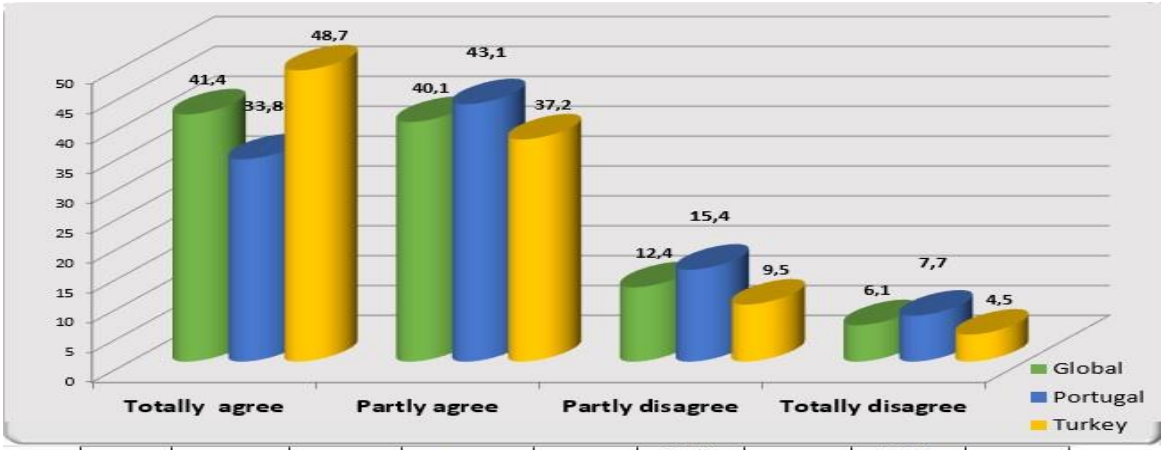
	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	47,6	187	36,4	143	10,9	43	5,1	20
Portugal	49,0	95	38,7	75	10,3	20	2,1	4
Turkey	46,2	92	34,2	68	11,6	23	8,0	16

This item seeks to inquire about whether the health-literate consumers perceive the volume of health information disseminated in internet and media as an abundancy or overload. The findings for the sub-questions mentioned in G4-G5 support the argument that the health-relevant information volume disseminated in the media and internet can be considered as an overload, overproduction or over-dissemination. 47,6 percent of the respondents totally agree with the statement that they consider the volume of health information disseminated in media and internet as an abundancy and overload, 36,4 percent partly agree, 10,9 percent partly disagree and 5,1 percent totally disagree. The total and partial agreement rate is 84,0 percent whereas disagreement rate is only 16,0 percent. No significant statistical difference was found between the data collected from respondents in Turkey and Portugal. The responses for this statement from Portugal are as follows: totally agree (49,0 percent), partly agree (38,7 percent), partly disagree (10,3 percent), totally disagree (2,1 percent). The responses from Turkey are: totally agree (46,2 percent), partly agree (34,2 percent), partly disagree (11,6 percent), totally disagree (8,0 percent). These findings are strong supportive data concerning one of the fundamental arguments of this study, the extent of the healthy life advice dissemination in internet and media platforms.

3.2.7. Social Capital, Decision-making and Indecisiveness

In this section, the findings about the social health regulation; the dissemination of the health advice within the social sphere and networks; the interaction taking place; and most importantly about the impact of the social groups on health-relevant perception, decision-making and behaviors are presented.

Figure 26– (Q20) - Members of my family/social circle share health information and advice that they have learnt from media/internet/publications

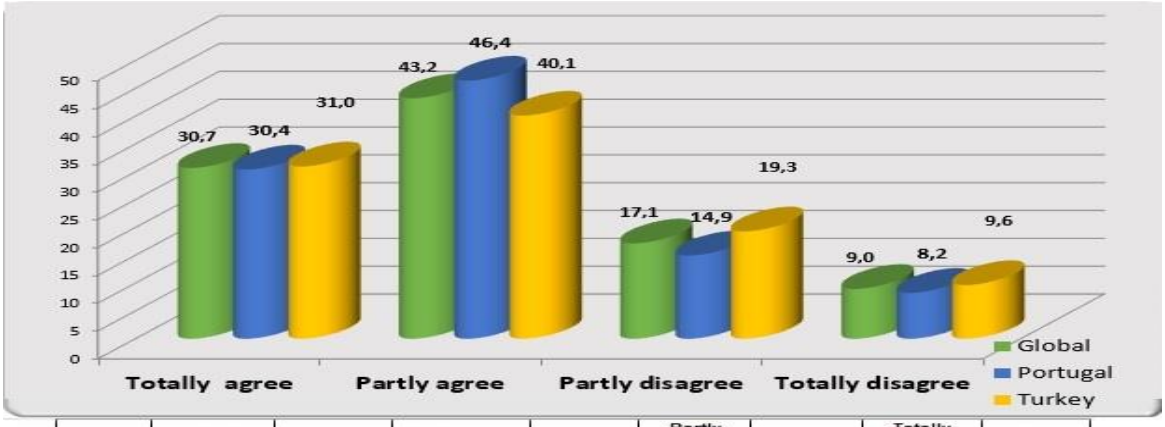


	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	41,4	163	40,1	158	12,4	49	6,1	24
Portugal	33,8	66	43,1	84	15,4	30	7,7	15
Turkey	48,7	97	37,2	74	9,5	19	4,5	9

This item seeks to inquire about whether social capital has a relationship with health-relevant decision-making or not. The findings for the sub-questions mentioned in G4 and G5 revealed that the health-relevant information acquired through media and internet is disseminated through social relations and interactions, impacting the health-relevant decision making through the use of social capital. 41,4 percent of the respondents totally agree with the statement that the social circle disseminates the health-relevant advice and information acquired through media, internet and other publications, 40,1 percent partly agree, 12,4 percent partly disagree and 6,1 percent totally disagree. The total and partial agreement rate is 81,5 percent whereas disagreement rate is only 18,5 percent. No significant statistical difference was found between the data collected from respondents in Turkey and Portugal. The responses for this statement from Portugal are as follows: totally agree (33,8 percent), partly agree (43,1 percent), partly disagree (15,4 percent), totally disagree (7,7

percent). The responses from Turkey are: totally agree (48,7 percent), partly agree (37,2 percent), partly disagree (9,5 percent), totally disagree (4,5 percent). This finding is another indication of the strong impact of social capital on the health-relevant information dissemination and decision-making.

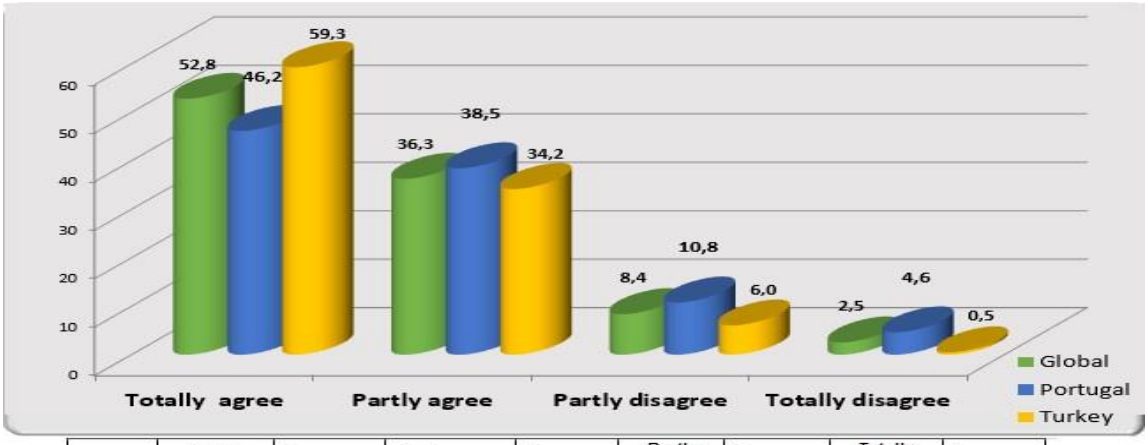
Figure 27– (Q22) - My family/social circle share conflicting health information and advice with me whether I like it or not



	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	30,7	120	43,2	169	17,1	67	9,0	35
Portugal	30,4	59	46,4	90	14,9	29	8,2	16
Turkey	31,0	61	40,1	79	19,3	38	9,6	19

This item seeks to inquire into the perception of the health-literate consumers about the conflicting health information disseminated by their social circle, whether their social circle disseminates conflicting information or not. The findings for the sub-questions mentioned in G4 and G5 revealed that the social actors and social capital, besides media and internet, can also cause the dissemination of the conflicting health-information. 30,7 percent of the respondents totally agree with the statement that the social circle disseminate hearsay health advice and information and this is not a well-informed dissemination, 43,2 percent partly agree, 17,1 percent partly disagree and 9,0 percent totally disagree. The total and partial agreement rate is 73,9 percent whereas disagreement rate is only 26,1 percent. No significant statistical difference was found between the data collected from respondents in Turkey and Portugal. The responses for this statement from Portugal are as follows: totally agree (30,4 percent), partly agree (46,4 percent), partly disagree (14,9 percent), totally disagree (8,2 percent). The responses from Turkey are: totally agree (31,0 percent), partly agree (40,1 percent), partly disagree (19,3 percent), totally disagree (9,6 percent).

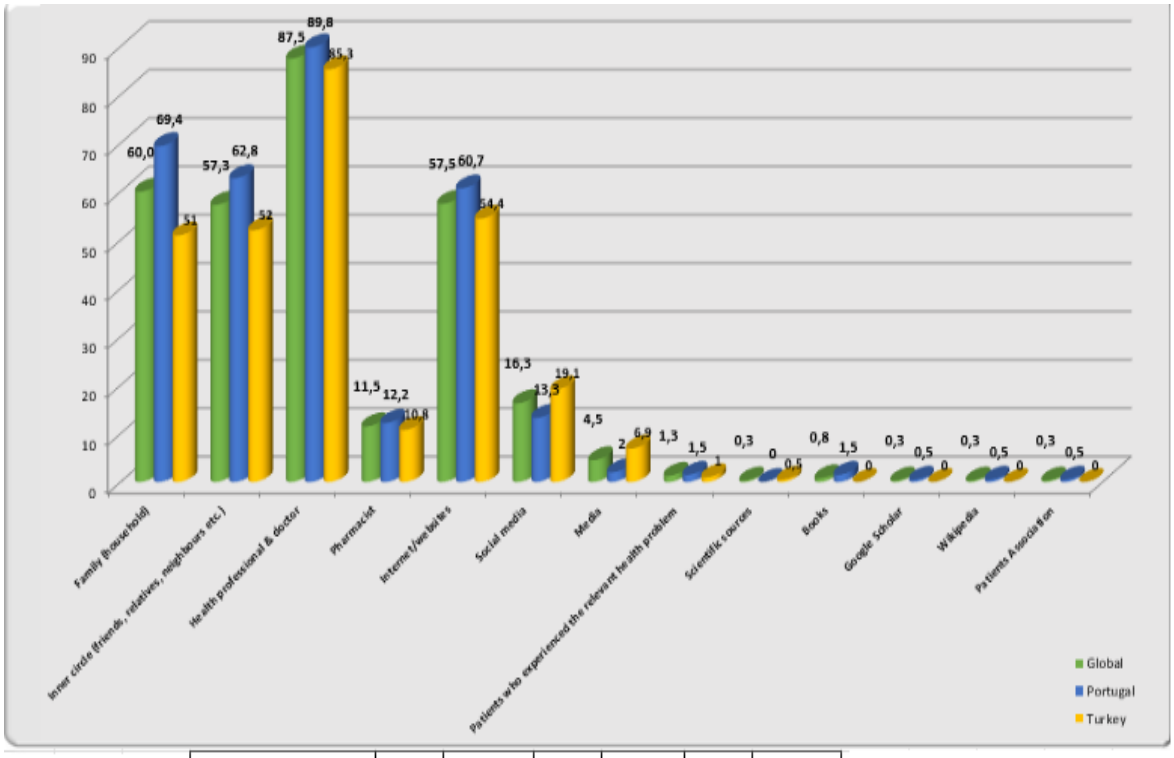
Figure 28– (Q19)- "I hear such health-relevant quick tips and advice as "if you experience this, you should do this".



	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	52,8	208	36,3	143	8,4	33	2,5	10
Portugal	46,2	90	38,5	75	10,8	21	4,6	9
Turkey	59,3	118	34,2	68	6,0	12	,5	1

This item seeks to inquire about the use of quickie health concept in the social and public health regulation and the extent of the exposure to such quick tips and advice received through social circle, media and internet. The findings for the sub-question mentioned in G-3 supported the possible role of quickie health in health-care management, at least, the dissemination of the quick tips is confirmed by the respondents. 52,8 percent of the respondents totally agree with the statement that they come across quick tips instructing them to behave in any specific manner in their health problems, 36,3 percent partly agree, 8,4 percent partly disagree and 2,5 percent totally disagree. The total and partial agreement rate is 89,1 percent whereas disagreement rate is only 10,9 percent. No significant statistical difference was found between the data collected from respondents in Turkey and Portugal. The responses for this statement from Portugal are as follows: totally agree (46,2 percent), partly agree (38,5 percent), partly disagree (10,8 percent), totally disagree (4,6 percent). The responses from Turkey are: totally agree (59,3 percent), partly agree (34,2 percent), partly disagree (6,0 percent), totally disagree (0,5 percent).

Figure 29– (Q3) - If I am told to have a surgery about my serious health problems and I feel uncomfortable about the choices relevant to therapies, doctors or hospitals etc., I would get the support from the resources & people below



	Global (%)	Frequency (n)	Portugal (%)	Frequency (n)	Turkey (%)	Frequency (n)
Family (household)	60	240	69,4	136	51	104
Inner circle (friends, relatives,	57,3	229	62,8	123	52	106
Health professional & doctor	87,5	350	89,8	176	85,3	174
Pharmacist	11,5	46	12,2	24	10,8	22
Internet/websites	57,5	230	60,7	119	54,4	111
Social media	16,3	65	13,3	26	19,1	39
Media	4,5	18	2	4	6,9	14
Patients who experienced the	1,3	5	1,5	3	1	2
Scientific sources	0,3	1	0	0	0,5	1
Books	0,8	3	1,5	3	0	0
Google Scholar	0,3	1	0,5	1	0	0
Wikipedia	0,3	1	0,5	1	0	0
Patients Association	0,3	1	0,5	1	0	0

This item seeks to inquire about social capital's impact on the health-relevant decision-making and perception in serious health-relevant decision-making situations. According to the data collected, health professionals and doctors are the most important sources of information in the serious health-relevant decision-making. Health-literate consumers view the doctors (87,5 percent) by far as the most reliable and valuable sources in their social capital. The second most consulted group is the family (household) members (60,0 percent). The third is internet/websites (57,5 percent). The fourth is inner circle (friends, relatives, neighbors etc.), (57,3 percent). When we look at the distribution of the sources to be consulted, we see that respondents in Portugal are inclined to get social support

from the family/household (69,4 percent) more than Turkish respondents (51,0 percent). Similarly, support from inner circle is a bit higher in Portugal (62,8 percent) than Turkey (52,0 percent), from health professionals/doctors (89,8 percent) in Portugal and (85,3 percent) in Turkey. The internet/websites have become one of the most important resources of support for both countries: (60,7 percent) in Portugal and (54,4 percent) in Turkey. Social media and conventional media usage in Turkey for support was found to be higher. Social media (19,1 percent) in Turkey and (13,1 percent) in Portugal, media (6,9) in Turkey and (2,0 percent) in Portugal.

4.Conclusion

In this final chapter, the overall evaluation of the whole research process, findings and arguments is attempted with reference to what extent the data collected corresponded to and supported the arguments and expected results. The results of the survey study are evaluated, interpreted and explained critically and these are done in the light of the actual theories in the literature. The reader will also find an updated review of the findings from survey, arguments from literature and the research questions. In addition to these, suggestions for further researches and implications for policies and practices are presented.

The majority of the findings of the survey and cross analysis conducted on some specific results helped me with answering the research question and sub-questions. The main findings are found to be consistent with my expectations. In the findings section, the findings were not subjected to a critical evaluation as I planned to do the cricital evaluation of these with the arguments from the literature in this last chapter. Below, you can find the most important findings and some updated review of the arguments supported with data.

In the coronavirus pandemic, we have witnessed a legacy of 1930's modernist ideology: "the nationalist idea of stronger generations for a stronger economy and welware of the society". This ideology could be observed in the decision-making and discourses of the Portuguese and Turkish states and their body and health politics during the pandemic. Salazar's body and health organizations are still used, though not as much as they were used in the past, but the ideology founded the base of the mind and body relationship which is still appreciated today, which was also encouraged in the discourses presented to the public and actions to be taken. Atatürk's sayings are also still commonly followed in the daily body and health behaviors, gymnastic activities and discourses.

A wide variety of respondents (81 percent) were found to think that they would experience indecisiveness when exposed to health-relevant information/choice overload constructed by the market and society. This data supports the arguments in this study and the relevant arguments in the literature (Schwartz, 2006: 12; Fielding, 1994; Tolon and Ozkan, 2015:33; Malhotra, 1982: 419; Fletcher and Wald, 1987; Kuo, 2010: 38; Iyengar and

Lepper, 2000: 995-1004) and responds to the research question with concrete evidence. The results obtained through several items in the scale indicated that a great majority of the respondents have a perception that the health-relevant information and choice overload lead to indecisiveness. These findings are also in line with some of the most significant studies in the literature, even though these are not studies conducted on health-relevant decision-making. This finding obtained in this study may be an important point of departure for some microsociological health-relevant decision-making studies and may have some further implications for studies to be conducted in health psychology discipline.

In addition to the arguments shown in the Coleman's Boat diagram (image 1) in introduction and mentioned in Chapter 1, supportive data were obtained through the survey about the influence of indecisiveness on the health-relevant consumption, purchases and on the relevant economic activities in the health market. However, it was also revealed that the indecisiveness is not permanent and that it is overcome mostly through increased search activity in the process of problem-solving. We can say that the health activities and practices can be postponed at the micro level but with consequences on the health economy at the macro level. It should also be noted that increased search activity can be associated with increased consumption and experimenting the alternatives. The theoretical framework that I developed to inquire into the micro, meso and macro levels of processes and to bridge these helped me uncover some phenomena which contribute to the health-relevant PDB and indecisiveness. The findings from the survey in the Chapter 3, the visual data and document analysis provided in the Chapter 1 and Chapter 2 supported the arguments provided within the context of the theoretical framework of this study. Market, media, social structure (in the form of social network and social and cultural capital), health organizations, body and health politics, religion, culture, economy and information production technologies were all found to contribute to the emergence of information and choice overload and to the health-relevant PDB and indecisiveness.

The ignorance or blasé attitude was not found to be correlated with indecisiveness. This result refuted the arguments in this study and in the literature asserting that indecisiveness stops or leads to a blockage in the health-information and solution seeking. This was the only unexpected result obtained in the survey. According to the findings, respondents in Portugal and Turkey are not blocked in the health-relevant decision-making

and behavior processes. Even though it was found that they experience decision-latency, it does not surely indicate ignorance or a blasé attitude caused by indecisiveness.

According to the survey results, health-relevant decision-making has turned out to be a more difficult practice at the present time. It has been complexified by information and choice overload emerging in social interaction (word-of-mouth communication), the internet and media. In addition to these factors, the limited temporal capital and socio-economic conditions were also found to complicate the health-relevant decision-making when the health-literate consumers experience health problems. During the Coronavirus pandemic process, we witnessed a process in which some experts who were trained and educated to be neutral in scientific aspects however acted with specific agendas not serving scientific or social purposes but contributing to the misinformation due to their desire to attract more attention. They are powerful actors and can find places in the media coverage, however, such scientific discussions or statements should be made in the relevant scientific activities such as conferences and not in mass media, because, the contradictory information, data or findings can be in the nature of the scientific studies, however, they may not serve the social causes if they are disseminated in an overload and presented to the lay people who will be confused. We can say that the rapid dissemination fo misinformation by lay people as well as health authorities and experts during Coronavirus pandemic had some impacts on the emergence of the conspiracy theories appreciated by a wide majority in society. This process has also been defined as COVID-19 infodemic[82]. A very recent study by Bozkurt (2021) revealed that the misinformation and conspiracy theories which were the products of the infodemic contributed to the hesitation, indecisiveness and distrust about the vaccination against Covid-19 virus, which is likely to impact (at least considered so by some authorities) the group immunity in the country.

[82] World Health Organization defined infodemic an overabundance of information in both online and offline environments. According to WHO (2020), "it (infodemic) includes deliberate attempts to disseminate wrong information to undermine the public health response and advance alternative agendas of groups or individuals. Mis- and disinformation can be harmful to people's physical and mental health; increase stigmatization; threaten precious health gains; and lead to poor observance of public health measures, thus reducing their effectiveness and endangering countries' ability to stop the pandemic… Misinformation costs lives. Without the appropriate trust and correct information, diagnostic tests go unused, immunization campaigns (or campaigns to promote effective vaccines) will not meet their targets, and the virus will continue to thrive".

A great majority of the respondents in Turkey and Portugal were found to encounter conflicting health information in media and internet as well in word-of-mouth health communication. The cross-check of the results also indicated that conflicting health advice leads to indecisiveness and distrust. Although no relationship between indecisiveness and ignorance was found, the results indicated that distrust has a relationship with ignorance of this kind of information, products and services. The same conclusion can be made for the ignorance of products and services perceived as unreliable. In further studies, the relationship between conflicting choices/information and distrust and their impacts on the health economy and social management of health behavior can be investigated. Further data is needed to shed light on the possible relationship between choice/information overload and resistance against these. In the literature, there are many studies indicating that the information and choice overload lead to indecisiveness. However, the distrust in and resistance against both the accurate and inaccurate methodologies, drugs, vaccines, therapies or lifestyles should also be underscored with references to the social aspects (word-of-mouth health communication), health-behavior management, decision-making and health economy. Anti-consumerism and resistance against the relevant-information and actors should be investigated thoroughly so that the impacts of such movements may be revealed with references to social and economic aspects.

A majority of the respondents stated that they are exposed to health-relevant information pollution in media, internet and social interaction. Findings were obtained about the fact that information pollution in internet and media was not questioned through a critical health-literacy perspective and that this pollution was proliferated without such a critical questioning. We may conclude that formal and informal health education in Turkey and Portugal do not produce efficient outputs in terms of critical health-literacy. Further studies may also investigate the impacts of the social interaction and word-of-mouth health communication (dissemination of fads, fallacies and hearsay information which are all far from reality) on health-relevant PDB and distribution of misinformation. As indicated in Coleman's boat (image 1), the distribution of misinformation, information overload and application of these may lead to a reduction in the health-behavioral and economic activities due to distrust and indecisiveness. Although we cannot assert that it is a permanent phenomenon, we may say that it will be perceived as a negative condition by the market and individuals in the health-problem solving process.

The results indicated that social capital has an impact on the health-relevant PDB and indecisiveness. In this context, supportive data was obtained about the fact that the social circle and family shared the health information (advice) they acquire through the internet and media with the respondents. A majority of the respondents were found to perceive the dissemination of the conflicting information through social network. This data also provided implications about the proliferation of information pollution. Results suggested that the conflicting advice were perceived both as an "information pollution" and an "information overload" disseminated in internet and word-of-mouth health communication. The relationship between these and the quick tips disseminated through the internet, media and word-of-mouth health communication should be investigated in further studies, because the usage of quick tips in health behavior management was found to be perceived by a majority of respondents. As such, more data should be obtained about the possible impacts of the proliferation of quickie-disposable health (about such possible relationships between quickie-disposable health and information pollution and overload).

As mentioned in the Chapter 2 and Chapter 3 and shown in empirical findings and survey results, health communication is carried out in a more unorganized and exploited manner in Turkey. The Turkish media has adopted a morality-based health communication strategy as in the magazine-like tendencies in British media (for instance, "Daily Mail" articles and news about health). Even the well-organized mass communication organizations carry out the editorial tasks with negligence and the information and content accuracy and quality are well below the level of the information provided in formal education. Beyond the risk posed by media, one can also easily observe information overload and pollution emerging on the internet upon which the content and knowledge management cannot be easily undertaken. The deeper investigation of the impact of social media and internet upon information overload sources, indecisiveness and social regulation of health-relevant decision-making through word-of-mouth communication taking place in these platforms is suggested as issues to be investigated in further studies.

This study revealed the negative impacts of health-relevant information and choice overload on decision-making, individual behavioral practices and economic activities as a result of the decision latencies. Besides this, it provided data about the relationship between

information/choice overload and indecisiveness and on the reproduction of these through social capital. The relevant theoretical arguments and data from survey and empirical investigation have been synthesized.

This study is one of the limited number of studies conducted in the fields of sociology of medicine and micro-sociology on health-relevant PDB and targeted to fill in a gap in its specific context. Accordingly, it will be logical to offer regulatory, editorial and communication-related suggestions to be implemented in health policies and applications in Turkey and Portugal. In this context, the minimalization of the health-relevant information overload and pollution is suggested by developing projects in which experts from relevant industries, academic, governmental and non-governmental organizations collaborate, make investigations and create decision-support systems through social organizations and use of internet filtering technologies and media ethic regulations. The commissions composed of the actors mentioned above can conduct investigations to prevent the proliferation of inaccurate applications, policies and information. Such decision-making support systems can contribute to a better management of the health communication that produces an overload of pseudo-scientific discourses, applications, messages, inaccurate information, myths and the social distribution of these. If such problems are not solved, exploitation and ineffective health-relevant marketing and information pollution may lead to negative experiences in the economic, individual and health-relevant levels. Below, some specific suggestions that can be of use for the establishment of a more efficient health-relevant decision-making process are presented. These suggestions are not based on the findings but on the observations made throughout this study. These are not moral lessons but structural practical recommendations for different stakeholders contributing to health-relevant decision-making process.

Specific suggestions

- The inspection of the activities by those claiming to be healthy life experts in social media and distributing practices, applications and discourses.
- Reeducating authors writing health-advice columns in national newspapers and journals.
- Developing decision-support systems and projects to measure the accumulative impacts of choice and information overload on indecisiveness.

- The inspection of the procedures followed in manufacturing the replications of original health products and methodologies, the routine inspection of alternative products about which the state organizations produce public spots instructing the careful use and consumption of these.
- Reeducating authors writing health-relevant news and articles in terms of producing responsibly and ethically, not only to capture the attention of the audience.
- Developing systems that inspect and detect the unhealthy products, ineffective choices and information pollution.
- Providing a standardized health education in the curriculum starting from pre-school education until the end of university education, even after formal education through public education centers within the context of life-long learning projects.
- Standardizing health information-advice provided in health technologies with reference to the norms of the World Health Organization and national organizations as these technologies are worn on the body or even inserted into the body.
- Preventing the assumption of health-expert titles without license on the internet and social media. Instagram, Facebook and Twitter provide titles with blue labels that indicate whether this user is officially recognized person or not. For people involved in health-relevant issues, a label or symbol can be added to their profile so that consumers see that this person is a licensed expert.

Today, the internet reproduces commodification, cyberlibertarianism, prosumption and anti-consumerism together. It can illuminate, liberate or enslave and produce illiberality in any given subject. Hence, the investigation of the new internet-based health information dissemination and reception habits and systems (such as social media pages, forums, digital health tracking applications integrated with social networks) is crucial. The internet has emerged as the most utilized source of healthy life cultural capital due to the facilitated access to health information in Turkey and Portugal (Abel, 2003, Gorkemli, 2017, Comissão de Tecnologias de Informação em Saúde do Health Parliament Portugal, 2017, Ritzer and Jurgenson, 2010: 18).

The perception of the health-relevant choices as commodities in Turkey and Portugal is likely to stem from the lack of decision-support systems regulating and investigating health-relevant complications and decisions to make. At least, we can say that the relevant

councils or organizations are not efficient enough to prevent information pollution and low-quality and unlicensed health products. Such mechanisms could operate more effectively in regulating the proliferation of information, services and products in a more organized way. The positive impacts of such regulations will be probably seen in the health-relevant PDB levels of the society members, with less reference to indecisiveness due to improved decision-making support systems.

Such protective measures and warnings such as “low quality information” in search engines should be introduced. Through the use of artificial intelligence in social media and search engines, the low-quality information can be ranked and specified with specific labels showing authenticity. At least this can be implemented for health information. The accumulative impact of the health-relevant information/choice overload ignored in many arguments and studies should be studied by the relevant organizations and academics. States and health-policy makers could and should the cumulative effect of information overload by taking requirements of the advertisements in the markets into consideration. Constraining counterfeit products, the advertising and marketing activities by unlicensed and unprofessional professionals and with unlicensed, unprofessional methodologies and discourses and inspecting their marketing activities could result in positive outcomes concerning the cumulative effect and indecisiveness. Health care policies and health communication can be organized in a fashion that not only boosts production of commodities but also provides dependable information about how to use them. In organizing regulations, applications and strategies suggested above and protecting consumers from indecisiveness and ineffective consumption, civil society organizations should become involved in the process of producing and distributing the health-relevant product information and services to prevent negative experiences on behalf of consumers.

This study argued that biopsychosocial models and social models should be employed in defining and handling issues instead of biomedical models. Health-relevant issues and problems will not be successfully resolved through the scientific and politic approaches based on individualistic neoliberal morality. We can see that the biomedical orthodoxy failed in the Coronavirus pandemic when even the international and national authorities experienced indecisiveness and increased pressure due to information and choice overload. These times may be an opportunity for a transition to a social model by abolishing the orthodoxy in the biomedical approach. In this regard, a micro-sociological approach was

developed here with the goal of demonstrating the biomedical orthodoxy in both the dissemination of health-relevant information and the marketing of products. Transforming the individualist/biomedical model to a social model and developing a more holistic sociological approach is essential for investigating the health-relevant decision-making in all individual, social and organizational levels. This is because, as Augusto stated, life, mental and physical capacities of individuals are not only determined by biological or psychological facts, but also deeply influenced by the social circumstances in which they live (Augusto, 2018). In this regard, a social model for health-relevant decision-making could work well in the explanation of the relevant issues.

In short, the arguments and data presented in this study may refer to globalized decision-making, although the study specifically targets two countries: Portugal and Turkey. Although they are geographically far from each other, have limited economic, social and cultural relations, many cases, historical narrations, health-communication processes and survey results were found to be similar. Further studies may be conducted with data collection from more countries and test whether or not the arguments presented in this study indicate globalized trends in PDB.

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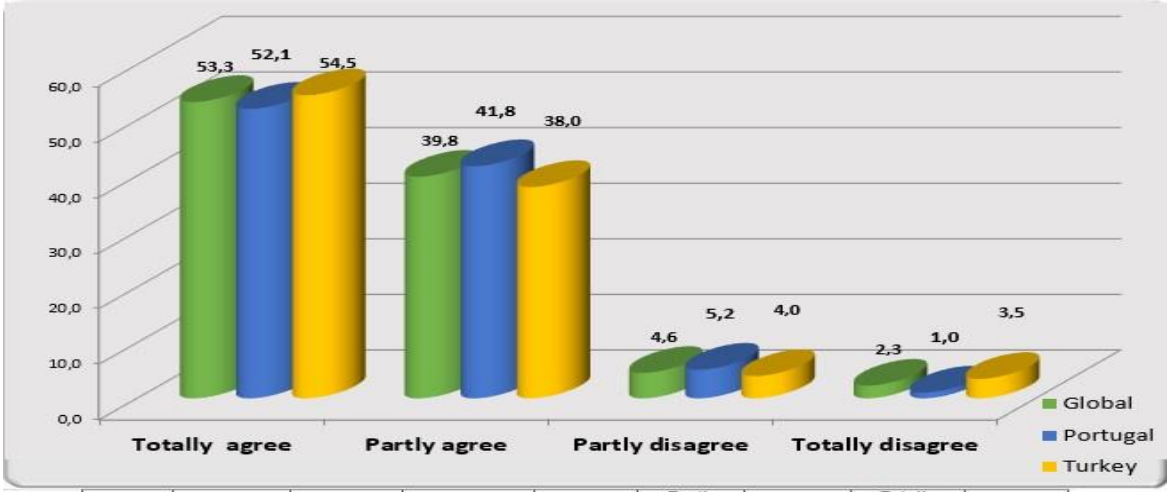
Annex

In the annex, the remaining and less-relevant survey data and figures, the questionnaire in Turkish and Portuguese languages and my resume were presented. Firstly, the findings were presented as below:

Conflicting Health Information (Advice) and Decision-Making:

Figure 30– (Q29)- When I apply the healthy-life advice but feel that this is not useful for my health, I continue searching for and applying other advice



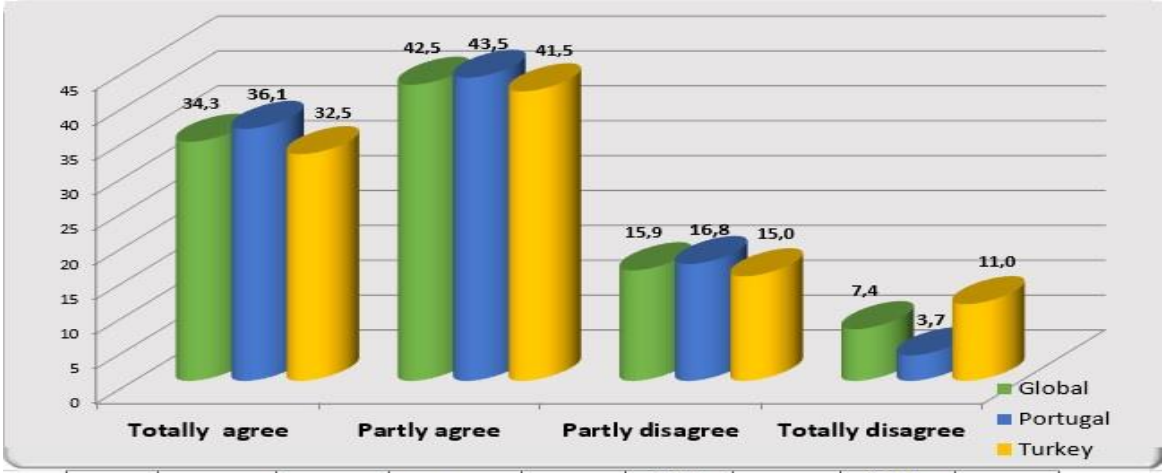
	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	53,3	210	39,8	157	4,6	18	2,3	9
Portugal	52,1	101	41,8	81	5,2	10	1,0	2
Turkey	54,5	109	38,0	76	4,0	8	3,5	7

This item seeks to inquire about whether respondents continue seeking for further health advice and information and applying these after unsuccessful or inefficient experiments with some advice and products. The findings for the sub-question mentioned in G9 revealed that any discouragement emerging in health-care management due to inefficient practices caused by the application of advice impacts further processes such as seeking information or choices. 53,3 percent of the respondents totally agree with the statement that they continue searching and applying other alternatives or choices (information, products or services) when they apply these but cannot find a solution to their health problems, 39,8 percent partly agree, 4,6 percent partly disagree and 2,3 percent totally disagree. The total and partial agreement rate is 93,1 percent whereas disagreement rate is only 6,9 percent. The responses for this statement from Portugal are as follows: totally agree (52,1 percent), partly

agree (41,8 percent), partly disagree (5,2 percent), totally disagree (1,0 percent). The responses from Turkey are: totally agree (54,5 percent), partly agree (38,0 percent), partly disagree (4,0 percent), totally disagree (3,5 percent).

Commodification of health and commodified health decision-making

Figure 31– (Q11)- The health-related decisions are investment decisions. Healthiness can be achieved when the anticipated investment is made

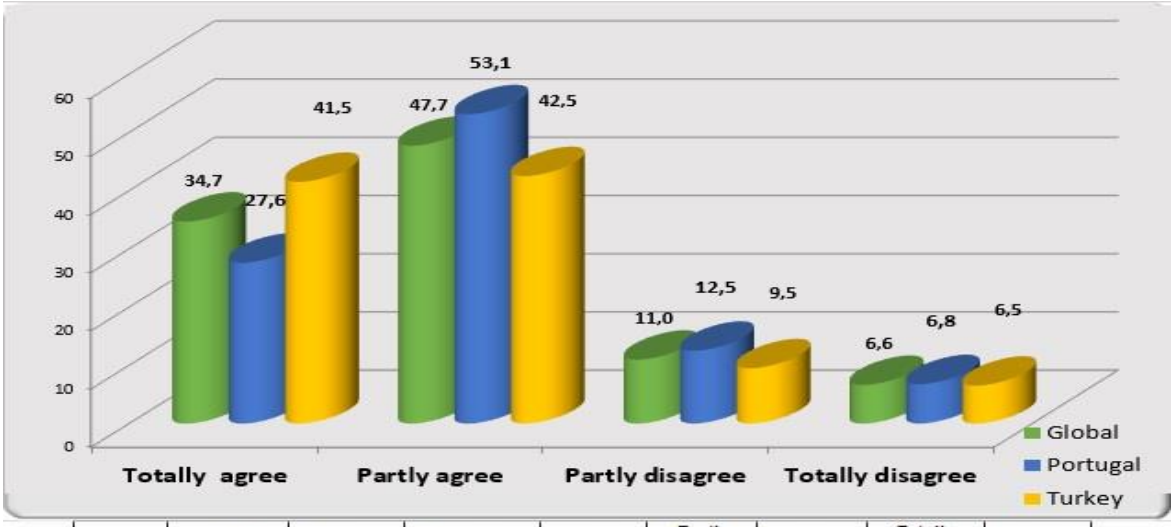


	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	34,3	134	42,5	166	15,9	62	7,4	29
Portugal	36,1	69	43,5	83	16,8	32	3,7	7
Turkey	32,5	65	41,5	83	15,0	30	11,0	22

This item seeks to inquire about the perception of health as a commodified concept, whether the present health-relevant decision-making is a commodified construct or not, whether its results, a better health status expected as a consequence of health seeking is seen as a human capital or not. The findings for the sub-question mentioned in G-7 indicated that the health-relevant decision-making of the present time has been commodified with references to investment concept, like the constructible body of Giddens. 34,3 percent of the respondents totally agree with the statement that health-relevant decision-making is a commodified personal investment decision, 42,5 percent partly agree, 15,9 percent partly disagree and 7,4 percent totally disagree. The total and partial agreement rate is 76,8 percent whereas disagreement rate is only 23,2 percent. No significant statistical difference was found between the data collected from respondents in Turkey and Portugal. The responses for this statement from Portugal are as follows: totally agree (36,1 percent), partly agree (43,5 percent), partly disagree (16,8 percent), totally disagree (3,7 percent). The responses

from Turkey are: totally agree (32,5 percent), partly agree (41,5 percent), partly disagree (15,0 percent), totally disagree (11,0 percent).

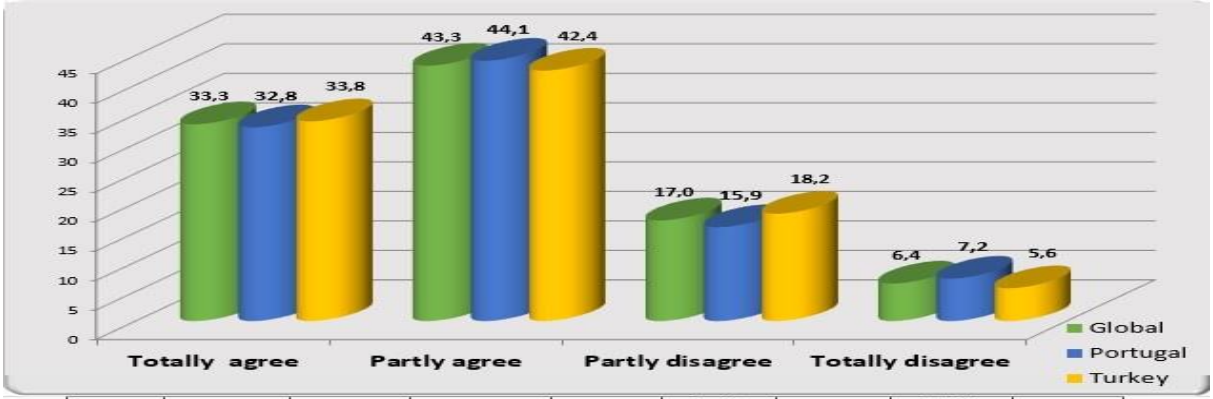
Figure 32– (Q12)- The health-relevant drugs, behaviors, therapies, doctors, hospitals and services are suggested as if they are ordinary consumer products or services



	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	34,7	136	47,7	187	11,0	43	6,6	26
Portugal	27,6	53	53,1	102	12,5	24	6,8	13
Turkey	41,5	83	42,5	85	9,5	19	6,5	13

This item seeks to inquire about whether health-relevant choices are perceived as commodified and suggested as a commodity by lay people with no regards to a serious contemplation about the side effects of health-relevant services or products. The results are in the same vein with the data obtained in Q11, supportive of the existence of commodification in health-relevant decision-making and social marketing. 34,7 percent of the respondents totally agree with the statement that health-relevant drugs, behaviors, therapies, doctors, hospitals and services are suggested like commodified goods or services, 47,7 percent partly agree, 11,0 percent partly disagree and 6,6 percent totally disagree. The total and partial agreement rate is 82,4 percent whereas disagreement rate is only 17,6 percent. No significant statistical difference was found between the data collected from respondents in Turkey and Portugal. The responses for this statement from Portugal are as follows: totally agree (27,6 percent), partly agree (53,1 percent), partly disagree (12,5 percent), totally disagree (6,8 percent). The responses from Turkey are: totally agree (41,5 percent), partly agree (42,5 percent), partly disagree (9,5 percent), totally disagree (6,5 percent).

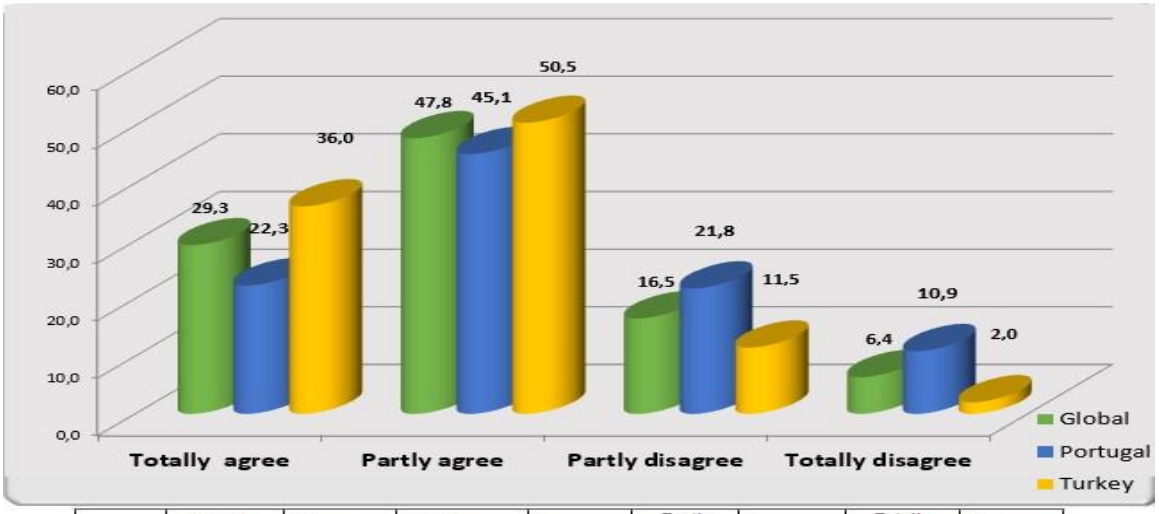
Figure 33– (Q21) - Members of my family/social circle share hearsay health information.



	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	33,3	131	43,3	170	17,0	67	6,4	25
Portugal	32,8	64	44,1	86	15,9	31	7,2	14
Turkey	33,8	67	42,4	84	18,2	36	5,6	11

This item seeks to inquire into how much the health literate consumers trust in the health information and advice disseminated by their social circle, their perception about the quality of information disseminated by their social circle, whether they are well-informed people or not. The findings for the sub-questions mentioned in G4 and G5 revealed that the information pollution in the media, internet and social relations can have impact on the health-relevant decision-making through social interaction, through word-of-mouth health communication. 33,3 percent of the respondents totally agree with the statement that the social circle disseminate hearsay health advice and information and this is not a well-informed dissemination, 43,3 percent partly agree, 17,0 percent partly disagree and 6,4 percent totally disagree. The total and partial agreement rate is 76,6 percent whereas disagreement rate is only 23,4 percent. No significant statistical difference was found between the data collected from respondents in Turkey and Portugal. The responses for this statement from Portugal are as follows: totally agree (32,8 percent), partly agree (44,1 percent), partly disagree (15,9 percent), totally disagree (7,2 percent). The responses from Turkey are: totally agree (33,8 percent), partly agree (42,4 percent), partly disagree (18,2 percent), totally disagree (5,6 percent).

Figure 34– (Q28)- When I have health problems, someone in my family/social circle shares advice with me for me to solve this problem and to recover with short-cut methods

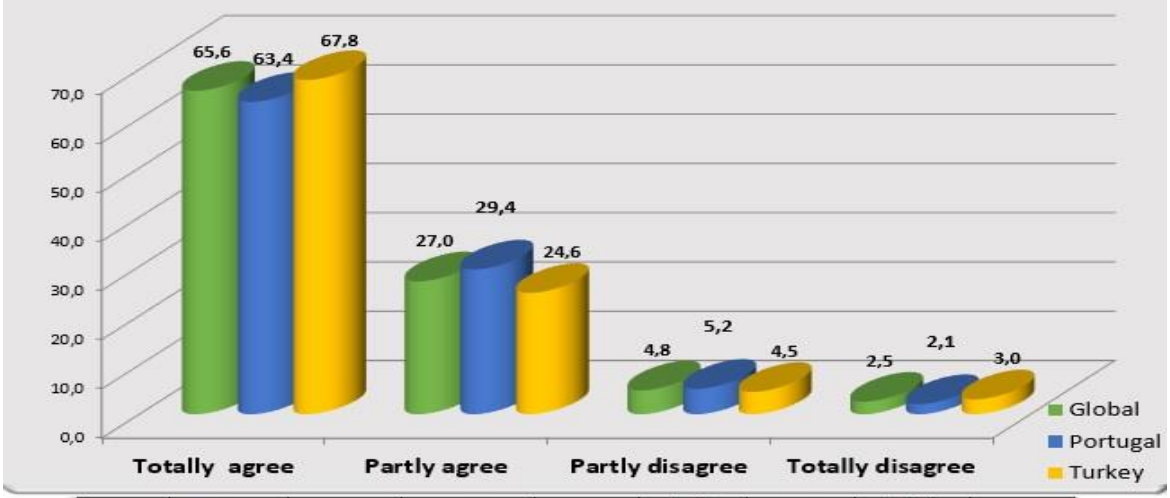


	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	29,3	115	47,8	188	16,5	65	6,4	25
Portugal	22,3	43	45,1	87	21,8	42	10,9	21
Turkey	36,0	72	50,5	101	11,5	23	2,0	4

This item seeks to inquire about whether the quickie health advice is disseminated and utilized within the context of social regulation practices to solve the health problems, whether these short-term trends produced in media and internet are reflected in the social interaction, reception and perception levels. The data obtained are supportive of the existence of a "quick health tips" culture and quickie health concept. 29,3 percent of the respondents totally agree with the statement that their social circle disseminates quick health tips, 47,8 percent partly agree, 16,5 percent partly disagree and 6,4 percent totally disagree. The total and partial agreement rate is 71,1 percent whereas disagreement rate is only 28,9 percent. The responses for this statement from Turkey are as follows: totally agree (36,0 percent), partly agree (50,5 percent), partly disagree (11,5 percent), totally disagree (2,0 percent). The responses from Portugal are: totally agree (22,3 percent), partly agree (45,1 percent), partly disagree (21,8 percent), totally disagree (10,9 percent). The trends in the data collected in Turkey (86,5 percent) revealed that the social health regulation through these kinds of short cut tips is more apparent than Portugal (67,4 percent).

Social class and decision-making practices

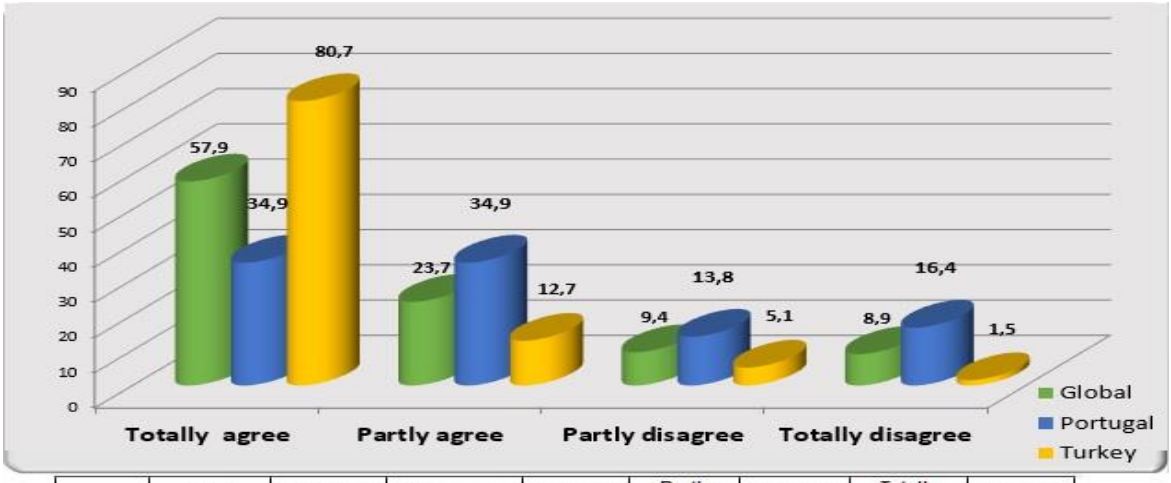
Figure 35– (Q23) - Having more financial means may facilitate having more temporal opportunities and physical energy opportunities for applying the healthy life advice



	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	65,6	258	27,0	106	4,8	19	2,5	10
Portugal	63,4	123	29,4	57	5,2	10	2,1	4
Turkey	67,8	135	24,6	49	4,5	9	3,0	6

This item seeks to inquire into the perception of the health-literate consumers about the possible impact of socio-economic conditions (economic capital-independent variables) on the application of healthy life advice and information, about how it influences the applicability of advice (dependent variable). A great majority of the respondents contemplate that the financial means facilitate having physical energy and time to apply the health advice as well as the capacity to purchase the relevant products, services and therapies. 65,6 percent of the respondents totally agree with the statement that the financial means facilitate the applicability of the healthy-life advice, 27,0 percent partly agree, 4,8 percent partly disagree and 2,5 percent totally disagree. The total and partial agreement rate is 92,6 percent whereas disagreement rate is only 7,3 percent. No significant statistical difference was found between the data collected from respondents in Turkey and Portugal. The responses for this statement from Portugal are as follows: totally agree (65,6 percent), partly agree (27,0 percent), partly disagree (5,2 percent), totally disagree (2,1 percent). The responses from Turkey are: totally agree (67,8 percent), partly agree (24,6 percent), partly disagree (4,5 percent), totally disagree (3,0 percent). A cross-tab analysis was made for this question to see whether the levels of income and socio-economic status impact their perception about this statement and no significant statistical difference was found.

Figure 36– (Q16)- I think the state and health institutions should control the dissemination of the very different health-related information, product, service choices and be consistent in this control



	Totally agree (%)	Frequency (N)	Partly agree (%)	Frequency (N)	Partly disagree (%)	Frequency (N)	Totally disagree (%)	Frequency (N)
Global	57,9	227	23,7	93	9,4	37	8,9	35
Portugal	34,9	68	34,9	68	13,8	27	16,4	32
Turkey	80,7	159	12,7	25	5,1	10	1,5	3

This item seeks to learn whether the choice variety about the health-related information, product and service which are shaped by the neoliberal market norms are considered to be quality and efficient, whether health-care management should be regulated by the states and public organizations or not. 57,9 percent of the respondents totally agree with the statement that public organizations should control the dissemination of the variety of products, information and services, 23,7 percent partly agree, 9,4 percent partly disagree and 8,9 percent totally disagree. The total and partial agreement rate is 81,6 percent whereas disagreement rate is only 18,3 percent. The responses for this statement from Portugal are as follows: totally agree (34,9 percent), partly agree (34,9 percent), partly disagree (13,8 percent), totally disagree (16,4 percent). The responses from Turkey are: totally agree (80,7 percent), partly agree (12,7 percent), partly disagree (5,1 percent), totally disagree (1,5 percent). A significant statistical difference was found between the results of Turkey and Portugal for the Q16. The Turkish respondents feel that the state and public health organizations should regulate the relevant dissemination as they feel that the neoliberal economy and social media exploit the health information and consumer's hopes for a better health status. As a consequence of this, the lower quality of information, products or services may have become more visible in Turkey. According to the results of this statement, the state and relevant organizations in Turkey are expected to control healthy life system

whereas the rates in Portugal are lower. In Portugal, it is also expected by a majority of people, but, still much lower than Turkey.

Table 8– (M1)-How often do you use the social media platforms listed below

	Everyday (%)	Frequency (N)	2-3 times per week (%)	Frequency (N)	Once in a week (%)	Frequency (N)	2-3 times a month (%)	Frequency (N)	Once a month (%)	Frequency (N)	Less than a month (%)	Frequency (N)	Never (%)	Frequency (N)	Frequency (N) TOTAL	
Facebook	51,5	203	15	59	5,6	22	2,3	9	2,3	9	5,1	20	18,3	72	394	
Instagram	48,3	189	13,3	52	3,6	14	1,8	7	1,3	5	6,4	25	25,3	99	394	AIDED
YouTube	51,3	202	29,2	115	7,4	29	4,8	19	3	12	3,8	15	0,5	2	391	
Websites	78,1	304	15,9	62	1,8	7	2,1	8	0	0	1,5	6	0,5	2	389	CHOICES
Twitter	69,1	38	21,8	12	1,8	1	1,8	1	3,6	2	1,8	1	0	0	55	
Academic journals	33,3	1	33,3	1	0	0	33,3	1	0	0	0	0	0	0	3	
WhatsApp	90	18	0	0	5	1	0	0	5	1	0	0	0	0	20	
Newspaper Websites	40	4	20	2	10	1	10	1	0	0	10	1	10	1	10	
Ekşisözlük	100	16	0	0	0	0	0	0	0	0	0	0	0	0	16	
LinkedIn	60	3	40	2	0	0	0	0	0	0	0	0	0	0	5	
Professional websites	100	1	0	0	0	0	0	0	0	0	0	0	0	0	1	
Academia	50	1	50	1	0	0	0	0	0	0	0	0	0	0	2	
Snapchat	100	4	0	0	0	0	0	0	0	0	0	0	0	0	4	
Telegram	0	0	0	0	0	0	0	0	0	0	0	0	100	1	1	
Journals	0	0	0	0	100	1	0	0	0	0	0	0	0	0	1	
Google Scholar	100	1	0	0	0	0	0	0	0	0	0	0	0	0	1	
YOK Thesis Database	100	1	0	0	0	0	0	0	0	0	0	0	0	0	1	
Yandex	0	0	0	0	0	0	0	0	0	0	100	1	0	0	1	
Google	83,3	5	0	0	0	0	0	0	0	0	0	0	16,7	1	6	
Game Related Sites-pages	0	0	0	0	0	0	0	0	0	0	0	0	100	1	1	
Pinterest	80	4	20	1	0	0	0	0	0	0	0	0	0	0	5	
Tv-sites	33,3	1	33,3	1	0	0	33,3	1	0	0	0	0	0	0	2	
Spotify	66,7	2	33,3	1	0	0	0	0	0	0	0	0	0	0	3	UNAIDED
Health-related blogs	100	2	0	0	0	0	0	0	0	0	0	0	0	0	2	CHOICES
Researchgate	0	0	100	1	0	0	0	0	0	0	0	0	0	0	1	
Bundle	100	1	0	0	0	0	0	0	0	0	0	0	0	0	1	
Patients Association, Doctor and Hospital Instructions	100	1	0	0	0	0	0	0	0	0	0	0	0	0	1	
Paleo90	0	0	100	1	0	0	0	0	0	0	0	0	0	0	1	
Online Literature	100	1	0	0	0	0	0	0	0	0	0	0	0	0	1	
E-learning	100	1	0	0	0	0	0	0	0	0	0	0	0	0	1	
Reddit	62,5	5	25	2	0	0	12,5	1	0	0	0	0	0	0	8	
Sapo.pt	60	3	40	2	0	0	0	0	0	0	0	0	0	0	5	
Tumblr	50	1	50	1	0	0	0	0	0	0	0	0	0	0	2	
Gmail.com	100	1	0	0	0	0	0	0	0	0	0	0	0	0	1	
Wikipedia	50	1	50	1	0	0	0	0	0	0	0	0	0	0	2	
OLX	50	1	50	1	0	0	0	0	0	0	0	0	0	0	2	
Noticiasaominuto Website	0	0	100	1	0	0	0	0	0	0	0	0	0	0	1	
Correio da Manhã Website	100	1	0	0	0	0	0	0	0	0	0	0	0	0	1	
RTP Site	100	1	0	0	0	0	0	0	0	0	0	0	0	0	1	
Imgur	100	1	0	0	0	0	0	0	0	0	0	0	0	0	1	
eNewsletters	100	1	0	0	0	0	0	0	0	0	0	0	0	0	1	

This item seeks to learn the respondents' main sources of information, which are usually their sources of health information. In this inquiry, 4 aided choices were provided and an open-ended blank space was left to the respondents for them to write other sources information and to select how often they use these sources to collect information. As it can be seen from the table, people's main internet sources of information are Facebook, Instagram, YouTube, Websites and Twitter. According to this frequency table, when the number of respondents and the percentage of daily and weekly usage, the internet websites were found to be the most frequently used, YouTube is the second, Facebook is the third, Instagram is the fourth and Twitter is the fifth. Other frequencies for each internet platforms and applications are listed in the table.

Questionnairre in Turkish

Tez araştırması için anket:

Bu çevrimiçi anket çalışması, Coimbra Üniversitesi Ekonomi Fakültesinin Sosyoloji bölümünde doktora çalışmalarını sürdüren Okan Baldil'in doktora tez araştırması kapsamında yapılmaktadır.

Bu ankette, düşüncelerinize en uygun olanı seçenekleri işaretlemeniz beklenmektedir. Bu araştırmanın temel amacı, günlük yaşamınızda karşılaştığınız sağlıklı yaşam önerileri, sağlıkla ilgili verdiğiniz kararlar hakkındaki deneyimlerinizden ve görüşlerinizden faydalanmaktır. Paylaştığınız görüşler ve sınırlı kişisel bilgiler gizli tutulacaktır ve bu akademik çalışmaya katkıda bulunan isimsiz bir katılımcı olacaksınız.

https://www.uc.pt/feuc/eea/doutoramentos/sociologia/estudantes/OBaldil adresinde çalışmamın içeriği anlatılmaktadır. Eğitim durumu, meslek, yaş ve gelir gibi demografik bilgiler dışında size ait kişisel veya özel hiçbir bilgi talep edilmemektedir.

S0-Günlük bedensel ve sağlık ihtiyaçlarınızı karşılayacak kadar sağlık önerisi ve bilgisine sahip olduğunuzu düşünüyor musunuz?

Evet	1	Hayır (Anket sonlandırılacak)	2

Sosyal medya ve internet kullanım alışkanlıkları							
M1- Aşağıdaki sosyal medya platformlarını ne sıklıkla kullanmaktasınız?	Her gün	Haftada 2-3 Kez	Haftada 1 kez	Ayda 2-3 Kez	Ayda 1 kez	Ayda 1 kezden daha az	Hiç-Asla
Facebook	1	2	3	4	5	6	7
Instagram	1	2	3	4	5	6	7
YouTube	1	2	3	4	5	6	7
Diğer (Üstte yer alanlar dışında en çok kullandığınız sosyal medya platformunu belirtin) ➡	1	2	3	4	5	6	7

S1-Ciddi bir sağlık sorununuzun (kalp hastalıkları veya kanser gibi) olduğunu düşünün. Bu konuda önerileri, bilgileri, tedavileri, doktorları, hastaneleri, ilaçları ve ürünleri araştırmaktasınız ve bu konularda çok fazla çeşit ve alternatif olduğunu farketmektesiniz.

Bu seçenek çeşitliliğini

Hiç karmaşık bulmazdım veya sadece biraz karmaşık bulurdum	Kısmen karmaşık bulurdum	Çok karmaşık bulurdum

S2- Kişisel koşullarımı (zaman, bütçe, duygular vb.) gözönünde bulundurarak bu tür konulardaki alternatifler (öneriler, tedaviler, doktorlar, hastaneler, ilaçlar, ürünler vb.) arasında seçim yapmayı

Hiç karmaşık bulmazdım veya sadece biraz karmaşık bulurdum	Kısmen karmaşık bulurdum	Çok karmaşık bulurdum

Q3- Ciddi sağlık sorunlarım için bir operasyon geçirmem söylenseydi ve bu sorunların çözümü için tedavi, doktor veya hastane tercihleri arasında kalıp içim rahat etmeseydi, aşağıdaki kaynaklardan ve insanlardan destek alırdım (birden fazla seçenek işaretleyebilirsiniz)

Aile (Hanehalkı)	1
Yakın çevre (arkadaşlar, akrabalar, komşular vb.)	2
Sağlık uzmanları ve doktorlar	3
Eczacı	4
İnternet/web siteleri	5
Sosyal medya	6
Medya	7
Diğer (lütfen belirtin)	

	Tamamen katılıyorum	Kısmen Katılıyorum	Kısmen Katılmıyorum	Hiç Katılmıyorum
Q4- Sağlıkla ilgili karar alma süreci birçok şeyi göz önünde bulundurarak harekete geçtiğim karmaşık bir süreçtir	1	2	3	4
Q5-Ciddi bir sağlık sorunu yaşasaydım, sınırlı zamanım, bütçem olsaydı ancak önümde çok sayıda seçenek duruyor olsaydı (tedavi, doktor, hastane, ilaç, ürün, öneriler gibi), bunların arasında tercih yapmak daha zor bir görev olurdu	1	2	3	4
Q6-Beden/zihin/cilt sağlığıyla ilgili sorunlarıma çözüm bulamadığımda tedavi, ürün, yaşam tarzı değişiklikleri gibi çözüm seçenekleri arasında tercih yapmaya çalışmaktan rahatsızlık duyardım.	1	2	3	4
Q7- Sağlıkla ilgili "tedavi, doktor, ilaç vb." konularda tercih yapma aşamasında sıkıntı hissettiğimde bu konularda ürün ve hizmet satın almayı ertelerim.	1	2	3	4
Q8- Sağlıkla ilgili "tedavi, doktor, ilaç vb." konularda tercih yapma aşamasında sıkıntı hissettiğimde söz konusu durum beni hareket etmekten alıkoyar ve araştırma yapmayı bırakırım.	1	2	3	4
Q9- Sağlıkla ilgili "tedavi, doktor, ilaç vb." konularda tercih yapma aşamasında sıkıntı hissettiğimde kararsızlığım geçici olur, daha fazla bilgi araştırmaya ve alternatifleri denemeye devam ederim.	1	2	3	4
Q10- Sağlıkla ilgili seçeneklerin çokluğu (bilgi, ilaçlar, besinler, tedaviler, teknikler vb.) uygun seçim konusunda kafa karışıklığı/kararsızlığa sebep olabilir	1	2	3	4
Q11-Sağlıkla ilgili kararlar yatırım kararlarıdır. Sağlık öngörülen yatırım yapıldığında ulaşılabilen bir şeydir.	1	2	3	4
Q12-Sağlıkla ilgili ilaçlar, davranışlar, tedaviler, doktorlar, hastaneler ve hizmetler sanki bunlar sıradan tüketici ürün ve hizmetleriymiş gibi önerilmektedir.	1	2	3	4
Q13- Medyada ve internet kaynaklarında çelişen sağlık önerilerine ve bilgilerine denk gelirim.	1	2	3	4
Q14-Çelişen sağlık bilgileri ve önerileri uygun sağlık davranışı konusunda karar vermeyi zorlaştırmaktadır	1	2	3	4
Q15) İnternette ve medyada istesem de istemesem de kafa karıştırıcı sağlık önerileri paylaşılmaktadır.	1	2	3	4
Q16) Devletlerin ve sağlık kurumlarının çok farklı sağlık bilgi, ürün ve hizmet seçeneklerinin dolaşımını control etmesi ve bu kontrolde tutarlı olmaları gerektiğini düşünüyorum	1	2	3	4
Q17) Çelişen sağlık bilgilerine güvenmediğim için bunları uygulamıyorum.	1	2	3	4
Q18) Medyada sağlıklı yaşamla ilgili haber ve önerilerin gereğinden fazla yer almaktadır.	1	2	3	4

Q19) İnsanlardan "Şöyle bir sorun yaşarsan şu şekilde hareket etmelisin, şunu yapmalısın" gibi sağlıkla ilgili ipuçları ve önerileri duyuyorum	1	2	3	4
Q20) Aile bireylerim/sosyal çevremdeki kişiler medya/internet veya diğer yayınlardan edindikleri sağlık bilgileri ve önerilerini benimle paylaşır.	1	2	3	4
Q21) Aile bireylerim ve yakın çevrem kulaktan dolma sağlık bilgilerini benimle paylaşırlar.	1	2	3	4
Q22) Ailem/sosyal çevrem benle istesem de istemesem de çelişen sağlık önerileri/bilgileri paylaşmaktadır	1	2	3	4
Q23) Daha fazla maddi imkanlara sahip olmak sağlıklı yaşam önerilerini uygulamak için daha fazla zaman ve fiziksel enerji sahibi olmayı imkanı sağlar.	1	2	3	4
Q24) Dayatılan çeşitli diyetlerin birbiriyle çelişmesi bu bilgilere ve önerilere duyduğum güveni kaybetmeme sebep olmaktadır	1	2	3	4
Q25) Çelişen sağlık önerilerine güvenimi kaybettiğimde artık bunları görmezden gelmeye başlıyorum.	1	2	3	4
Q26) Medyada ve internette sağlıklı yaşam konusunda çok fazla bilgi kirliliği bulunmaktadır	1	2	3	4
Q27) Yüzyüze sosyal etkileşimde ve ilişkilerde çok fazla bilgi kirliliği bulunmaktadır	1	2	3	4
Q28) Sağlık sorunları yaşadığımda ailemden/sosyal çevremden birileri bunları çözebilmem için kısayoldan iyileşme adına önerilerde bulunur	1	2	3	4
Q29) Sağlıklı yaşam önerilerini uyguladığımda eğer bunların işe yaramadığını hissedersem başka önerileri araştırmaya ve uygulamaya devam ederim.	1	2	3	4

Demografik Bilgiler:

D1-Kaç yaşındasınız? (Sadece 1 seçenek)	
12 - 24 yaş	☐ 1
25 - 34 yaş	☐ 2
35 - 44 yaş	☐ 3
45 - 54 yaş	☐ 4
55 - 64 yaş	☐ 5
64 yaş ve üzeri	☐6
Cevapsız	☐99
D2- Hanehalkının aylık toplam net geliri nedir TRY/EURO? (Sadece 1 seçenek)	
1000 TL'den daha az	☐ 1
1001 -2000 TL	☐ 2
2001 - 3000 TL	☐ 3
3001 - 4000 TL	☐ 4
4001 - 5000 TL	☐ 5
5001 -10000 TL	☐6
10001 TL ve üzeri	☐ 7
Gelir yok	☐ 10
Cevap yok	☐ 99

D3-Cinsiyet					
Kadın	☐ 1	Erkek	☐ 2	Diğer	☐ 3

D4 – Eğitim seviyesi

D5– Meslek durumu

MESLEK	Eğitim Seviyesi / Eğitim Süresi / Meslek	1		2	3		4		5	6	7
		Okur-yazar		İlkokul	Ortaokul		Lise		Ön-lisans-	Lisans	MASTER Doktora
		1 yıl	2-4 yıl	5 yıl	6-7 yıl	8 yıl	9-10 yıl	11 yıl	12-14 yıl	15 yıl	17 yıl
İşsiz	01. Ev hanımı	E	D	D	C2	C2	C1	C1	B	B	A
	02. Emekli	E	D	D	C2	C2	C1	C1	B	B	A
	03. Öğrenci										
	04. Geçici süreliğine işsiz	E	E	E	D	D	C2	C2	C1	C1	C1
Serbest Meslek	05. Nitelikli serbest meslek	-	-	-	-	-	-	-	-	A	A
	06. 0-5 çalışanı olan tüccar	E	E	D	D	C2	C2	C1	C1	B	B
	07. 6-20 çalışanı olan tüccar	C2	C2	C2	C2	C1	C1	C1	B	B	A
	08. 20+ çalışanı olan tüccar	C1	C1	C1	C1	B	B	B	B	A	A
	09. 1-9 çalışanı olan şirket/fabrika sahibi	C2	C2	C2	C2	C1	C1	C1	B	B	A
	10. 10-25 çalışanı olan şirket/fabrika sahibi	C1	C1	C1	C1	B	B	B	B	A	A
	11. 25+ çalışanı olan şirket/fabrika sahibi	B	B	B	B	B	B	A	A	A	A
Maaşlı çalışan	12. Kıdemli yönetici	C1	C1	C1	B	B	B	B	A	A	A
	13. 10'dan daha az sayıda çalışanı olan orta kademe yönetici	C2	C2	C2	C2	C2	C1	C1	C1	B	B
	14. 10'dan daha fazla sayıda çalışanı olan orta kademe yönetici	C2	C2	C2	C2	C1	C1	C1	B	B	A
	15. Nitelikli uzman, mühendis, teknik personel	D	D	D	C2	C2	C2	C1	C1	B	B
	16. Memur	D	D	D	C2	C2	C2	C1	C1	B	B
	17. Ofis çalışanı	D	D	D	C2	C2	C2	C1	C1	B	B
	18. İşçi	E	D	D	D	C2	C2	C2	C1	-	-

Değerli vaktinizi ayırdığınız için çok teşekkür ediyorum. Anketle ilgili eleştirilerinizi, önerilerinizi veya merak ettiğiniz konuları aşağıdaki metinde paylaşabilirsiniz. Anket sonuç raporunu edinmek isterseniz, e-posta adresinizi yazabilirsiniz ve raporu adresinize gönderebilirim.

Questionnairre in Portuguese

Pesquisa para pesquisa de dissertação:

Este estudo de pesquisa on-line é conduzido no contexto da pesquisa de dissertação de doutoramento de Okan Baldil, um estudante de doutoramento que estuda no Departamento de Sociologia da FEUC, Coimbra.

Nesta pesquisa, o questionário solicitará que selecione as opções mais adequadas que correspondem à sua opinião. O principal objetivo desta pesquisa é aprender com as suas experiências e opiniões sobre os conselhos de vida saudável que encontra em sua vida diária e as decisões que toma.

O contexto do meu trabalho é descrito na https://www.uc.pt/feuc/eea/doutoramentos/sociologia/estudantes/OBaldil. Exceto pelas informações demográficas, como educação, ocupação, idade e renda, nenhuma informação pessoal ou privada é necessária.

P0-Acha que possui conhecimento suficiente em saúde para atender às suas necessidades físicas e de saúde diárias?

Sim	Nao (Continue with finish the survey)

M1-Com que frequência usa as plataformas de social media/rede social indicadas abaixo	Todos os dias	2-3 vezes por semana	Uma vez por semana	2-3 vezes por mês	Uma vez por mês	Menos de um mês	Nunca
Facebook	1	2	3	4	5	6	7
Instagram	1	2	3	4	5	6	7
YouTube	1	2	3	4	5	6	7
Sites	1	2	3	4	5	6	7
Outras	1	2	3	4	5	6	7

Espera-se que escolha a opção que melhor se adequa à sua opinião em relação às seguintes expressões

P1 – Imagine que tem um sério problema de saúde (como doença cardíaca ou câncro) e procura conselhos relevantes, informações, terapias, médicos, hospitais, pílulas, produtos etc. Percebe que existe uma grande variedade deles. Você encontraria essa variedade de opções

Altamente complexa	Parcialmente complexa	Não ou pouco complexa

P2- Escolher entre as alternativas relevantes (conselhos, terapias, médicos, hospitais, pílulas, produtos etc.) de acordo com todas as minhas condições (tempo, orçamento, emoções etc.) sobre esta situação seria

Altamente complexa	Parcialmente complexa	Não ou pouco complexa

P3- Se me disserem que vou ter uma cirurgia sobre aos meus problemas de saúde sérios e me sinto desconfortável sobre as escolhas relevantes para as terapias, médicos ou hospitais etc., gostaria de obter o apoio dos recursos e pessoas abaixo (Pode selecionar mais de um escolha)

Família (família)	1
Círculo interno (amigos, parentes, vizinhos etc.)	2
Profissional de saúde e médico	3
Farmacêutico	4
Internet/sites	5

Social media/rede social	6
Meios de comunicação	7
Outro (por favor escreva)	

Espera-se que escolha a opção que melhor se adequa à sua opinião em relação às seguintes expressões

	Concordo totalmente	Concordo parcialmentee	Discordo parcialmente	Discordo totalmente
P4 - Tomar decisoes relacionadas com a saúde é um processo dificil que obriga a uma decisão tendo muitos aspetos em consideração.	1	2	3	4
P5- Se eu tiver um sério problema de saúde, tenho tempo e orçamento limitados, mas uma grande variedade de opções (terapias, médicos, hospitais, medicamentos, técnicas, conselhos), escolher entre elas se torna uma tarefa mais complexa.	1	2	3	4
P6-Quando não consigo encontrar uma solução para os meus problemas de saúde corporal / mental / pele, escolher entre uma variedade de soluções, como terapias, produtos, mudanças de estilo de vida etc., isso deixa me desconfortável	1	2	3	4
P7 - Quando não sei que fazer para a minha saúde, como “terapia, médico, medicamentos etc.”, adio a compra e o consumo de produtos e serviços relevantes	1	2	3	4
P8 - Quando não sei que fazer para a minha saúde, como “terapia, médico, medicamentos etc.”, fico totalmente bloqueado e deixo de procurar	1	2	3	4
P9 - Quando não sei que escolha fazer para a minha saúde, como “terapia, médico, medicamentos etc.”, mesmo que a minha indecisão seja temporária, continuo a procurar mais informações em busca de alternativas	1	2	3	4
P10 - Acho que a abundância de opções sobre saúde (informações, medicamentos, nutrientes, terapias, técnicas etc.) pode levar a confusão / indecisão sobre a melhor escolha	1	2	3	4
P11 - As decisões relacionadas com a saúde representam um investimento. Uma vida saudável só se alcança quando o investimento é feito	1	2	3	4
P12-Os medicamentos, comportamentos, terapias, médicos, hospitais e serviços relevantes para a saúde são sugeridos como se fossem produtos ou serviços comuns de consumo.	1	2	3	4
P13 - Nos e media e na internet, encontram-se conselhos e informações contraditórios sobre saúde.	1	2	3	4
P 14-Várias informações e conselhos contraditórios sobre saúde aumentam a dificuldades de decisão sobre os comportamentos adequados de saúde.	1	2	3	4
P 15) A Internet e os media apresentam conselhos confusos sobre saúde.	1	2	3	4
P 16) Acho que o estado e as instituições de saúde devem controlar a difusão das informações, produtos e opções de serviços diferentes relacionados com a saúde.	1	2	3	4
P 17) Prefiro não usar informações e concelhos contraditórios sobre saúde, porque não confio nesses.	1	2	3	4
P 18) Na internet e nos media, há uma grande redundância de conselhos sobre vida saudável.	1	2	3	4
P19) Eu atendo a sugestões e conselhos rápidos sobre saúde como "se sentir isso, deve fazer aquilo".	1	2	3	4

P 20) Os membros do meu círculo familiar / social partilham informações e conselhos sobre saúde que retiram da media / internet / publicações.	1	2	3	4
P21) Os membros do meu círculo familiar / social partilham informações e concelhos de saúde sem fundamento comigo.	1	2	3	4
P22) Os membros do meu círculo familiar / social partilham informações e conselhos contraditórios sobre saúde comigo.	1	2	3	4
P23) Ter mais meios financeiros pode facilitar obter mais disponibilidades de tempo e de energia física para aplicar os conselhos de vida saudável	1	2	3	4
P24) Os vários regimes de dieta contraditórios impostos reduzem a minha confiança nessas informações e conselhos.	1	2	3	4
P25) Quando a minha confiança nesses conselhos é reduzida, começo a ignorar esses tipos de informações	1	2	3	4
P26) Há demasiado ruído na informação sobre vida saudável na Internet e nos media	1	2	3	4
P27) Há demasiado ruído na informação sobre a vida saudável nas interações e nas relações sociais cara a cara.	1	2	3	4
P28) Quando tenho problemas de saúde, alguém do meu círculo familiar / social compartilha comigo conselhos e ajuda-me a melhorar usando expedientes sobre esse problema.	1	2	3	4
P29) Quando aplico os conselhos de vida saudável, mas sinto que eles não são úteis para a minha saúde, continuo a pesquisar e a aplicar outros conselhos	1	2	3	4

Informação demográfica:

D1-Que idade tem?	
Entre 12 e 24 anos	☐ 1
Entre 25 e 34 anos	☐ 2
Entre 35 e 44 anos	☐ 3
Entre 45 e 54 anos	☐ 4
Entre 55 e 64 anos	☐ 5
64 anos ou mais	☐6
Sem resposta	☐99
D2- Qual é o rendimento mensal líquido da sua família em EUROS?	
Menos de 600 €	☐ 1
600 a 700 €	☐ 2
701 a 800 €	☐ 3
801 a 900 €	☐ 4
901 a 1000 €	☐ 5
1001 a 1100 €	☐6
1101 a 1200 €	☐ 7
1201 a 1300 €	☐ 8
1301 € ou mais	☐ 9

D3-Sexo					
Feminino	☐ 1	Masculino	☐ 2	Outro	☐ 3

D4 – Profissão

D5- Habilitações literárias – escolaridade concluída

PROFISSÃO	Nível educacional DURAÇÃO DA EDUCAÇÃO PROFISSÃO	1		2	3		4		5	6	7	
		Apenas sabe ler e escrever		Escola primária	Ensino secundário		Ensino médio		Licenciatura		Master	PHD
		1 ano	2-4 anos	5 anos	6-7 anos	8 anos	9-10 anos	11 anos	12-14 anos	15 anos	17 anos	
Desempregado	01 Doméstica	E	D	D	C2	C2	C1	C1	B	B	A	
	02. Reformado/a	E	D	D	C2	C2	C1	C1	B	B	A	
	03. Estudante											
	04. Desempregado/a temporário/a	E	E	E	D	D	C2	C2	C1	C1	C1	
Trabalhador independente	05. Trabalhador/a independente qualificado	-	-	-	-	-	-	-	-	A	A	
	06. Comerciante com 0-5 trabalhadores	E	E	D	D	C2	C2	C1	C1	B	B	
	07. Comerciante com 6-20 trabalhadores	C2	C2	C2	C2	C1	C1	C1	B	B	A	
	08. Comerciante com 20+ trabalhadores	C1	C1	C1	C1	B	B	B	B	A	A	
	09. Proprietário/a da empresa / fábrica com 1-9 trabalhadores	C2	C2	C2	C2	C1	C1	C1	B	B	A	
	10. Proprietário/a da empresa / fábrica com 10-25 trabalhadores	C1	C1	C1	C1	B	B	B	B	A	A	
	11. Proprietário/a da empresa / fábrica com 25+ trabalhadores	B	B	B	B	B	B	A	A	A	A	
Trabalhador de salário	12. Gestor/a sênior	C1	C1	C1	B	B	B	B	A	A	A	
	13. Gestor/a de nível médio com menos de 10 trabalhadores	C2	C2	C2	C2	C2	C1	C1	C1	B	B	
	14. Gestor/a de nível médio com mais de 10 trabalhadores	C2	C2	C2	C2	C1	C1	C1	B	B	A	
	15. Especialista qualificado, engenheiro, equipe técnica	D	D	D	C2	C2	C2	C1	C1	B	B	
	16. Funcionário público	D	D	D	C2	C2	C2	C1	C1	B	B	
	17. Empregado de escritório	D	D	D	C2	C2	C2	C1	C1	B	B	
	18. Trabalhador	E	D	D	D	C2	C2	C2	C1	-	-	

Muito obrigado pela sua disponibilidade do seu tempo precioso. Pode compartilhar as suas críticas, sugestões ou perguntas sobre a pesquisa espaço abaixo. Se quiser receber o relatório de resultados da pesquisa, pode escrever seu endereço de e-mail e receberá o relatório final quando estiver terminado.