Mari Wigaard

The HPV Vaccine Program in Zanzibar

A qualitative study of the current challenges regarding the HPV vaccination program in Zanzibar

Master Thesis in Social Work

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Abstract

The principal aim of this qualitative study is to gain a deeper understanding of the operating HPV vaccine system in Zanzibar and identify potential challenges within it. My goal has been to explore the current functioning of the vaccine system, which was introduced in 2018, and examine healthcare workers' and the general public's views on the vaccine to gain insights into its functionality.

The research follows a qualitative study design with 16 interviews conducted with healthcare workers and local people working outside the health sector in Zanzibar. My data shed light on how the system is not functioning optimally due to barriers like vaccine hesitancy, local misconceptions, parental actions, limitations in education and gaps in knowledge among local people and healthcare workers.

My objective has been to emphasise the importance of social work when integrating a vaccination program into a new context and examine how the system fails to account for culturally sensitive and context-specific perspectives. For my research, it has been important to emphasize and integrate a social work approach to the healthcare standards of the HPV vaccine.

Hence, I chose to apply theoretical concepts from critical social work, which has a long tradition of examining social justice, power dynamics and equality. By incorporating critical theory as a theoretical framework, this research will explore how decolonial and feminist social work perspectives provide necessary insights into the dynamics of the vaccination program to identify areas for improvement in Zanzibar's HPV vaccination system.

Acknowledgement

Through the recent years global female health has been a political topic that has been close to my heart. More specifically, the diagnosis of cervical cancer and the treatment to prevent the disease have been an important political issue that I care about. As a social worker, it has been important for me to communicate our role in the health system and shed light on why our profession is crucial in the health service. First, I would like to thank Knowledge for Change, for giving me the opportunity. This has been a journey of growth where I met challenges, I had to face head-on, with great support from the organization every step of the way. I especially want to thank my supervisor, Dr.James Ackers-Johnsen and Dr.Maaike Seekles, for their invaluable support during the qualitative research in Zanzibar.

In addition to this, I would like to thank my supervisors, Louise Ackers and Wenche Bekken from Salford University and Oslo Metropolitan University. Two ankers in this process, both during the fieldwork in Zanzibar, and in the aftermath of it all when I have been in the writing process at home in Oslo. I have always been passionate about academic writing and social work from a global health perspective, and I will forever be grateful for all the people I met through this research that I can pass on their knowledge from. I want to thank all the participants from Zanzibar who gave me insight and knowledge I would never be without, and all the beautiful people who have guided me and given me new perspectives on global women's health and life in general. I have done my best to write holistically and respectfully where I both follow the ethical guidelines of a research project and carry forward all the knowledge I have gained in the best possible way.

Best wishes,

Mari Wigaard

Dedication

I would like to dedicate this master's thesis to all the informants who participated in this project. I am forever grateful for the knowledge you have shared with me, and I thank you with sincere gratitude. This has given me the possibility to carry forward this project.

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List of abbreviations

GAVI	Global Alliance for Vaccines and Immunization
HPV	Human Papilloma Virus
IFSW	International Federation of Social Workers
K4C	Knowledge for Change
LGBTQ+	Lesbian, Gay, Bisexual, Transgender & Queer
MAC	Multi-age cohort vaccination campaign
NIPH	Norwegian Institute of Public Health
POI	Primary Ovarian Insufficiency
TM	Traditional Medicine
UNICEF	Unite Nations International Children's Emergency Fund
WHO	World Health Organization

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Chapter 1

The HPV Vaccination Program in the Context of Zanzibar

1.0 Introduction

Global healthcare and medical social work are closely intertwined and play an essential role in addressing healthcare challenges worldwide, especially in low—and middle-income countries. Global healthcare challenges are a central issue for social work and especially in the context of understanding the social determinants of health in a local, national and global context (Bywaters et al., 2009). The World Health Organization (WHO) described several critical social determents to health in their publication *Social Determinant of Health: The Solid Facts* (Wilkinson et al., 2003). Social gradient, early life, stress, social exclusion, poverty, unemployment and social support are social determinants that influence our health and medical conditions (Wilkinson et al., 2003). This approach highlights how social work is fundamental when addressing social welfare needs, which are crucial to solving global health issues.

In collaboration with the charity organization Knowledge For Change (K4C) I have conducted my research with an initiative to gain more knowledge about the existing HPV vaccine program in the context of Zanzibar. Knowledge for Change is an organization that works to improve the standard of healthcare and education provided to the poorest members of society in low-and middle-income countries (K4C, 2022). The initial plan was to conduct my research project in Uganda where K4C is running "The Cervical Screening Project". However, due to the enactment of the LGBT+ death penalty in Uganda, Oslo Metropolitan University decided to pause student placements in Uganda temporarily. To conduct my research somewhere else, K4C changed the destination to Zanzibar, Tanzania.

Tanzania is a republic on the coast of East-Africa (FN, 2023). The republic surrounds itself with Malawi, Mozambique and Zambia in the south and The Democratic Republic of Congo, Rwanda and Burundi in the West. The country borders with Uganda and Kenya in the north. The United Republic of Tanzania has a semi-autonomous region known as Zanzibar. The region consists of two main islands, Unguja (referred to as Zanzibar) and Pemba Island, and some smaller islands (Larsen, 2022). The islands have around 1,3 million residents, and the capital of Zanzibar, where I lived, Stone Town, stands on a peninsula (Larsen, 2022). Zanzibar has historically been a key trading centre in the Indian Ocean, attracting the interest of various global powers, including Europeans. Furthermore, it also harboured one of East Africa's most

infamous slave markets, marking a dark period in its legacy (WMF, 2020). Zanzibar has witnessed a series of power struggles among Arabs, the Portuguese and the British (Larsen, 2022). Predominantly Muslim, it is regarded as the Islamic Centre within the United Republic of Tanzania (Wikipedia, 2024).

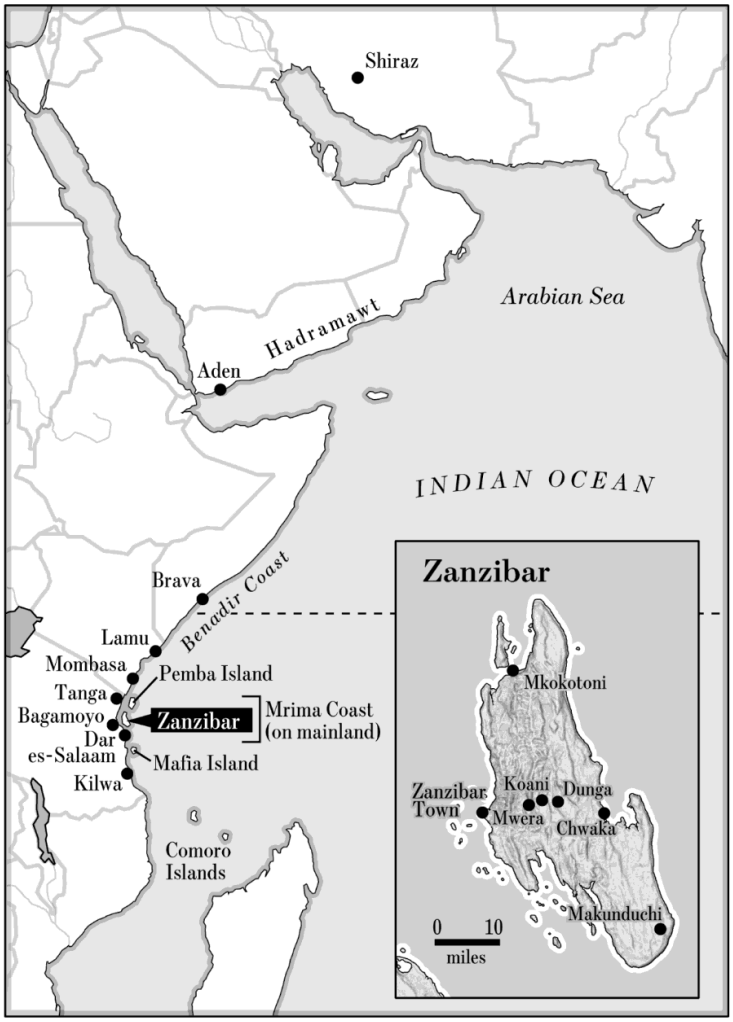

Figure 1. Map of Northwestern Indian Ocean and Zanzibar Island. From "Islamic law, gender, and social change in post-abolition Zanzibar" (Stockreiter, 2017).

My fieldwork in Zanzibar focused on understanding the functionality of the HPV vaccine system to identify potential barriers in the system. Human Papillomavirus (HPV) is a small double-stranded DNA virus that infects humans (De Sanjosé et al., 2018). The virus is highly infectious and the most common sexually transmitted infection in the world (NIPH, 2024). The virus' characteristic is genital warts and is known as a sexually transmitted virus that causes the most invasive cervical cancers (Baseman & Koutsky, 2005). However, most of the infected individuals eliminate the virus without ever developing clinical manifestations, and it is only a small fraction of HPV-infected individuals that develop invasive cervical cancer.

(Baseman & Koutsky, 2005). Cervical cancer is preventable with HPV vaccination and cervical screening. In 2018, WHO called for global action to eliminate cervical cancer as a global health problem. The global strategy and most important prevention against Human Papillomavirus is the HPV vaccine. WHO advises HPV vaccination for girls from 9 years old to 14 years old (Li et al., 2022). The following goal is 90% coverage of girls by the age of 15 (WHO, 2020). The reason for administering early vaccination is to ensure coverage before the onset of sexual activity where you are exposed to HPV (WHO, 2022, p. 653). All the licensed HPV vaccines provide high protection against the HPV virus and have clinical efficacy in preventing cervical cancer (WHO, 2022, p.661).

WHO stated that Tanzania is among the five countries with the highest rates of cervical cancer in Africa (WHO, 2023). Additionally, cervical cancer is the most frequently diagnosed cancer among women between 15 and 44 years old in Tanzania, and each year, there are 9,770 incidents of cervical cancer per 100,000 women (Henke et al., 2021). The mortality rate per 100,000 women is 6,695, and if no preventive actions are taken, Tanzania is estimated to have 12,416 new cases of cervical cancer per year in 2025 (Henke et al., 2021). Tanzania introduced the HPV vaccine nationally to 14-year-old girls in 2018 (Li et al.,2022). This means that the HPV vaccination has been present in the country for a limited time of 6 years. The strategy was vaccinating girls at school, health facilities and community outreach. This was with a two-dose, six-month interval schedule (Li et al., 2022).

The Tanzanian Ministry of Health established the HPV vaccine with what they called the Global Alliance for Vaccines and Immunization (GAVI). The GAVI's HPV vaccine program was implemented in 32 countries by 2022 (GAVI, 2024). After the demonstration program in Kilimanjaro, the national immunization program was decided to be introduced to address the country's high cervical cancer burden. Nonetheless, the limited HPV vaccine supply only gave Tanzania the capability to receive enough HPV vaccines for single-age cohort girls (Li et al., 2022). This is the reason why Tanzania, in the beginning, introduced their vaccination program to 14-year-old girls. The government wanted to choose a cohort of 14-year-old girls to guarantee the protection of as many girls as possible (Li et al., 2022).

The Zanzibarian government publicly announced the HPV vaccine's success in acceptability in Daily News. Dr. Salim Slim-Director, from the Department of Preventive Services and Health Education under the Zanzibar Ministry of Health, announced that the vaccination campaign to protect girls against cervical cancer had been highly accepted among the Zanzibar population after immunizing 100% of the 23 000 targeted girls (Daily News,

2023). Also noted in the article is that Dr. Slim attributed high acceptance among the population to increased public awareness and knowledge about the vaccine.

If cervical cancer is estimated both preventable and curable, why does it remain one of the leading causes of mortality for women worldwide? Approximately, 88% of all cervical cancer occurrences are diagnosed in low-resource countries where the prevention and treatment programs are poor (Bradford & Goodman, 2013). This involves low-resource countries where 5% of women have been to a screening for cervical cancer (Bradford & Goodman, 2013). This is closely related to lack of resources, poverty and disenfranchisement of women (Denny et al., 2006). The burden of cervical cancer is disproportionately high in low-income countries mainly because of absent resources to integrate vaccination, treatment programs and screening (Harden & Munger, 2017).

An additional reason for the low vaccine coverage is vaccine hesitancy, which has severe repercussions on the HPV vaccine all over the world. The Strategic Advisory Group of Experts on Immunization (SAGE) emphasizes that hesitancy is a behavioural phenomenon which is contextual and vaccine specific (MacDonald, 2015a). Along with people's behaviour towards the vaccine, an important field of study gaining knowledge about the reasons people either get the vaccine or not. Vaccine hesitancy against the HPV vaccine is known to be associated with a social stigma because the virus is sexually transmitted (Omayo et al., 2023). The factors that are contributing to vaccine hesitancy is a global issue that has a significant impact on the uptake in Sub-Saharan Africa (MacDonald, 2015).

Social work is articulated as a discipline that is anchored in "social justice, human rights, collective responsibility and respect for diversity (IFSW, 2014). The Global definition of the Social Work profession is defined as: "A practice-based profession and an academic discipline that promotes social change and development, social cohesion and the empowerment and liberation of people" (IFSW, 2014). The profession of social work endeavours to help and empower vulnerable individuals, families and groups in society (Dako-Gyete et al., 2018). Moreover, a crucial practice within this diverse profession is ensuring the welfare of individuals by managing individuals' health conditions.

A health condition has a huge impact on the individual itself, families, their social environment and society itself. This is where medical social workers have an essential role in helping to support the individual and their families to navigate the challenges associated with the plethora of conditions people face. This involves a holistic view of the person with solving

the social, emotional, contextual and practical challenges. The distinctive resource of social workers is how we "utilize the strength-based, person-in-environment perspectives to provide the contextual focus necessary for client family-centred care" (Dako-Gyete et al., 2018). To summarize, this explains the importance of social work from a healthcare perspective and how the welfare system is dependent on providing holistic healthcare. The professional practice itself is taken care of in mental health facilities, clinics, nursing homes and hospitals (Dako-Gyete et al., 2018). Social work has the possibility to investigate the social and cultural context in which it operates to address different stigmas and barriers connected to a system.

The history of Social Work as a profession is intrinsically tied to global legacies of imperialism and colonialism. Social work in countries in Africa has navigated itself through indigenous, colonial and independence epochs (Dako-Gyete et al., 2018). One of the key challenges facing the social work profession in countries in Africa has been limited recognition within the professional circles. In many African countries, the role of social workers in health services is not widely recognized, as formal social welfare services are a relatively recent development on the continent (Dako-Gyete et al., 2018). This is due to the socioeconomic and cultural challenges within many African countries. Another key challenge is the lack of relevance and effectiveness in addressing the continent's most pressing problems (Kurevakwesu, 2024). This stems mainly from the fact that social work practices were transferred wholesale from the West during colonial times. Since then social work practice has remained laden with Western practice, theories, models and intervention strategies (Kurevakwesu, 2024).

In pre-colonial times, addressing social issues was the responsibility of the traditional system, managed by figures such as queen mothers, community leaders, or family heads. Within African culture, the extended family played a central role, bearing primary responsibility for the welfare and support of its members. The extended family system has a caring role in terms of food, shelter, social education and insurance against old age, sickness and the consequences of death (Dako-Gyete et al., 2018). The colonialists from Britain, France and Portugal introduced the formal systems of social welfare into Africa (Dako-Gyete et al., 2018). The colonial administrators served, first and foremost, the needs of the European population in the colonies, which confirms that the social welfare was primarily for the benefit of the colonizers themselves and not for the African population. The welfare that was introduced for the people of the colonial power and the areas where the colonialists were concentrated was mainly to prevent crime and treat law and order in certain areas (Dako-Gyete et al., 2018). The rural areas

where Africans lived were left to fend for themselves during the colony time. This was with a small exception of voluntary organizations and the assistance of missionaries (Dako-Gyete et al., 2018).

Many social work practitioners are presenting an anti-colonial critique in response to the debate within the social work profession's entanglement with colonial and imperial ideologies (Caron & Ou Lin Lee, 2020). Mel Grey, John Croates, Michel Yellow Bird, and Tiani Hetherington (2016) reflect upon the effects of Western colonization on social work in *Decolonizing Social Work.* The authors recognize the way social work has been a part of colonization and discuss the tension within social work concerning what constitutes professional social work practice in an African setting. Africa's social problems are distinct from those in the West, hence the latter being more economically and politically developed but with huge diversity (Kurevakwesu, 2024). Modern social work practice in Africa has been shaped by colonial history and the charity work of previous missionaries, both pre- and post-colonial influences (Dako-Gyete et al., 2018). In my mind, this leaves social workers with a great responsibility to pave the way for ethical practice. This will entail that the practice is culturally grounded and locally relevant to impact local and Indigenous peoples positively.

This global initiative of the HPV vaccination program entails adapting a programme to different countries with diverse cultures and social practices. In this case, a social work approach can raise important questions about how to require a tailored approach to each unique context and area, navigating through different social practices. My aim has been to investigate the current functioning of the HPV vaccination system in Zanzibar. Furthermore, I have been exploring the context bound to the system around the HPV vaccination system and the multiple perspectives on it. I am positioned in the local context of Zanzibar, engaging with local participants, both healthcare workers and non-healthcare workers. This research aims to explore attitudes and identity potential barriers related to the HPV vaccine, highlighting the importance of understanding social and cultural factors to enhance the effectiveness of the healthcare system.

In conjunction with Knowledge for Change, this research has aimed to address challenges regarding the HPV vaccine program in Zanzibar. Furthermore, the objective was to integrate a holistic and contextual approach to the HPV vaccine and its program. I aim to investigate the attitudes and potential barriers associated with the HPV vaccine to emphasize how crucial knowledge is about these elements is for the system to achieve universal health coverage. In the next, I will introduce my theoretical framework for my master's thesis when

conducting qualitative research with 16 interviews about the HPV vaccine system in the context of Zanzibar. This is why I will, in the next, ask my research question for this master's thesis:

What are the current challenges regarding the HPV vaccination program within the context of Zanzibar?

Chapter 2

The theoretical framework

The aim of this study is to use critical social work as a theoretical framework for analysing my empirical data. Positioned in a local context and engaging with local participants, I am examining the functions and barriers surrounding the HPV vaccine system. I will focus on two central movements within critical social work that will provide me with the necessary tools to examine the current understanding of the HPV vaccine: Postcolonial Social Work and Decolonial Feminist Social Work. Both movements within the social work profession seek to critically examine social work education, practice, and research to decolonize the system of social work (Kleibl et al., 2019). These theoretical frameworks stand within the discipline, such as anti-racism, indigenisation, critical whiteness, intersectionality and ´learning to un-learn the Euro-American logic which has been imposed over centuries on non-Western cultures (Kleibl et al., 2019). Using postcolonial and decolonial feminist work approaches, I will allow an in-depth examination of how these elements manifest within my data. I will examine the language they use, as it serves as their means of communication. This will initially provide insights into the circulation of the current terms and understandings around the HPV vaccine. I will present theoretical concepts, such as biopolitics, governmentality and discourse theory and use them as analytical tools for understanding the complexities within my data.

2.0 Postcolonial social work

Decolonization is a critical, transformative process that originates in political discourse, focusing on the withdrawal of colonial power from the colonized countries (Kleibl et al., 2019). The critique has emerged in relation to structural discrimination during colonialism and its impact on society today. As Kliebl et al. (2019) articulates. "[...] decolonisation demand deep changes within postcolonial national, transnational, and international state–society relationships, the transformation of the global capitalist economy, and a revaluing of cultural and collective rights as well as feminisms within the international debates about sustainable development." (Kleibl et al., 2019). It has been argued that colonization was likely to be followed up by neo-colonialism as several countries got their independence, but the former colonizers were still in political, social and economic power (Kleibl et al., 2019). Ndangwa Noyoo (2019) describes how substantial entanglements persist, even though formal control ended with the transfer of sovereignty (Noyoo, 2020). Consequently, businesses, charities, European non-governmental organisations (NGOs), professional private soldiers and many

other actors now fill up the space that the colonial states were occupying, often replicating previous inequalities of power in other forms (Noyoo, 2020).

The decolonizing approach criticises social work for embodying Eurocentric ways of perceiving and understanding the world (Kleibl et al., 2019). Eurocentrism, a key element in the decolonizing perspective, is described as a 'superstructure that seeks to impose European consciousness onto other people's consciousness' (Kleibl et al., 2019). Decolonial social work asks critical questions regarding the structures and practices of social work, particularly questions such as *who exercises* the authority, *how* authority and power are exercised and if it is universally appropriate or a product of neo-capitalism (Kleibl et al., 2019). The decolonial approach asks critical questions about the internalised taken-for-granted assumptions and challenges all social workers to consider in which way colonial history impacts social work (Kleibl et al., 2019) .

The process of decolonization has segments relevant to social work in several ways. The social work lens captures resistance to colonisation often including rejecting Western values and lifestyles (Kleibl et al., 2019). Various anticolonial theorists have challenged prevailing discourses by developing theories around psycho-political trauma. Ngugi wa Thiong'o (1981) introduced a concept that deeply influenced social workers *Decolonising the mind*. This is an important contribution as the approach not only considers decolonization to involve the colonization of land, but also the people (Ngugi wa Thiong'o, 1986). To practise a decolonial approach in contexts where the experience of collective trauma is widespread, it is essential to recognize the remaining psycho-social consequences of colonization. These theorists have considered the collective trauma caused by colonialism, which includes experiences of dehumanization, abjection and loss of culture, history, and identity (Masson & Harms Smith, 2020). Social work must intervene with a decolonial approach in areas of identity, meaning, humanisation, dignity, and language (Masson & Harms Smith, 2020). By intervening in these areas, the social worker can use empowerment and critical conscientisation to examine power, being, and knowledge in depth.

2.1 Decolonial Feminist Social Work

Feminist analysis is a fundamental part of social work, considering women are overrepresented among social service users (Hosken & Vassos, 2022). Female social service users are, unfortunately, overwhelmingly oppressed, brutalised, marginalized and poor (Hosken & Vassos, 2022). In response to this, feminist social work aims to level out women's personal, cultural and structural injustices. This is why social work is affine to the development of critical

theory, with a mutual focus on promoting social justice and achieving liberation for women (Watts & Hodgson, 2019). The gendered lens is essential when social workers identify systemic inequalities, as it is critical to "challenge ideologies and power structures that disadvantage women, and advocate for changes in structural arrangements that impact so heavily on women's lives and wellbeing" (Alston, 2005).

Feminist social work appeared in the 1970s and 1980s and was centred around the foundation of Western feminist theory as it owed its allegiance to key European Enlightenment ideals such as universal respect, equality and freedom (E.Cree & Phillips, 2019). However, Western feminist social work has faced critique, especially since many Indigenous and black women wanted to dismantle and destabilise Western individualism with anti-colonial perspectives (Rodríguez Castro, 2021). As the American political activist and professor Angela Davis said: "Feminism involves so much more than gender equality. And it involves so much more than gender" (Rodríguez Castro, 2021). This means that Western feminism often focused on a Eurocentric perspective in feminism, which failed to represent women in communities around the world. Feminism should not be limited to everyday challenges only involving white women in Western countries. Unfortunately, although the feminist perspective has focused on addressing injustice, Caron & Ou Jin Lee (2020) argue that not all feminist approaches within social work have recognized how colonial legacies and contemporary coloniality create hierarchies between women (Caron & Ou Lin Lee, 2020). Therefore, they argue that social work would benefit from decolonising feminism, where we recognize that gender is shaped by various identities. Furthermore, this involved adopting a pluralistic understanding of feminism, instead of viewing women as a homogeneous group as decolonial feminist approach seeks to mask women's multiple lives.

In recent times, intersectionality has been a helpful lens in colonial feminist theory, which investigates contexts of oppression. Intersectional feminism primarily seeks to eliminate negative discrimination or oppression against people based on personal, social or other background characteristics (Hosken & Vassos, 2022). The term intersectionality highlights the many ways a woman can experience oppression or discrimination. If we did not take intersectionality into consideration, it would mean that discrimination regarding women of colour would be ignored. Intersectionality is crucial because it encompasses all types of discrimination. Women can experience multiple discrimination simultaneously, with factors such as colour, gender, sexual orientation, disabilities and socioeconomic background. Decolonial feminism advocates for viewing gender in its historical and geopolitical context.

Caron & Ou Jin Lee (2020) advocate for the importance of critically examining how colonial logics shape gender and always examine the social terminology and cultural contexts where identities are changed and challenge the tendency to make assumptions about groups. As a researcher this means decolonial feminism includes situating oneself and one's relationship to social work.

2.2 Discourse theory

When intervening with a decolonial approach, it has been crucial to examine the dynamic of language and power. If we see deconstruction in the eyes of our language, we aim to "*uncover the ways we talk about and choose to label experience, and how these shape experience*" (Fook, 2015). Deconstructing language means uncovering the way power operates in the language of our experiences. Michel Foucault (1926-1984) is one of the most influential social thinkers of our century and provides a toolbox for constructing and transforming public societal discourse and practices in critical social work (Motion & Leitch, 2007). Foucault questioned the role of language and communication in shaping our reality.

The term discourse can be related to practices in society, culture, interaction, and communication where language is central. Foucault (1972) describes discourses as "governed by analysable rules and transformations" that determine who can speak, what could be said, the position they speak from, interests, institutional domains, and acceptable viewpoints (Motion & Leitch, 2007). This basically means that language is determined by societal rules and practices and that the language itself is shaped by acceptable topics and underlying power dynamics. The term encompasses all types of discourses, from highly specific conversations in the legal system to general discourses on the street. According to Foucault, practices are embodied with discourses, that are produced in practice and affected by structures which must be understood historically.

Discourses are a way of exercising power. For political purposes, it relies on institutions to create cultural constructions of what is perceived as morally right. These discourses construct and transform societal practices. The Foucauldian discourse perspective explores the depth of and production of meaning that is communicated through the discourses and the power of knowledge within them (Motion & Leitch, 2007). Foucault's groundbreaking contribution was questioning how discourses and other social practices were accepted as legitimate or true in society. What is perceived as the truth is essential to characterize certain power relations. Additionally, Foucault integrated an understanding of how individuals develop a personal sense of ethics and subjectivity as a response to societal norms and normalizing institutional practice

(Motion & Leitch, 2007). Foucault is concerned with how society governs people, and how governmentality is practiced and expressed by people. In that way, resistance can be present in the practices of the people.

2.3 Biopower and Governmentality

The traditional and commodified view of power is that power is connected to a social position and that it is empowered by being transferred from a very powerful person to another less powerful person or group (Fook, 2015). This is problematic as it implies that empowering one person or group is inherently conflictual (Fook, 2015). Additionally, it suggests that empowering one person or group involves disempowering another person or group. Power does not necessarily need to be at the expense of the other group or lead to a conflict. If a marginalized group in a society gets more power, it does not mean that the dominant groups are losing theirs. Power is a concept which is seen as a dynamic force that can be shaped and constructed in various ways depending on the context (Fook, 2015). Therefore, it recognizes the potential for a mutual empowering and collective power. Furthermore, groups and people from different social positions can contribute to creating power in an empowering process together (Fook, 2015). Ultimately, power is relatively intertwined in all social interactions, which makes it context-dependent.

Foucault is famous for reconceptualizing power in a critical approach as he sees it as a productive force shaping our lives, not only as something static and controlling (Motion & Leitch, 2007). His concept of governmentality is a fusion of *government* and *mentality*, which explains actively, governing through mentalities (Clegg, 2019). Foucault argues that it is an "ensemble formed by the institutions, procedures, analysis and reflections, the calculations and tactics, that allow the exercise of the very specific albeit a complex form of power." (Jessop, 2007). In other words, governmentality means in which ways power is exercised over populations through direct control, but also combined with organizational governance and self-governance (Clegg, 2019).

The power goes through a wide range of strategies: institutions, social structures and political structures. Additionally, it includes the process of the individuals internalizing the forms of control and guiding it into their behaviours, thoughts, and actions. The institutions like schools, universities, prisons, hospitals, and court systems are administrating and regulating the populations. In this way, governance is indirect through institutions like the health system. Individuals in society shape their identity by being actors as *entrepreneurs of their selves* where their opinion (Clegg, 2019). Power can be diffused through individuals and be embedded with

cultural norms. Foucault's governmentality illustrates how governance influences a micro- and meso-level of disciplinary power. Furthermore, Foucault describes how there has been a shift in the exercise of power where power in its new form systematically regulates life through its term *biopolitics* (Kleibl et al., 2019).

Foucault introduced his concept of biopolitics in the first volume of *The History of Sexuality.* In this book, he introduces a new form of power that is different from sovereign power (Foucault, 1978). The concept has a three-tier structure that works on different levels. On a lower micro-level it is defined by individualization, as in producing individuality for monitoring the body politics (Nilsen & Wallenstein, 2013). On a micro-level, this discovers how individuals appear in a statistical phenomenon, as an entire population that works under collective terms (Nilsen & Wallenstein, 2013). Thirdly, there is a crucial connection between the production of sex in an individual term and in relation to the population, as in the construction of a family (Nilsen & Wallenstein, 2013).

The concept of biopolitics refers to the political discourses regarding administrating life and populations. In that way, biopolitics refers to the process of subjectivization and state formation (Lemm, 2014). Biopolitics is mainly how the government manage and controls life and death in a society. Ultimately, this also involves how the government promote health and safety and gets to determine who will live and who will die. Totalitarianism illustrates the most extreme form of biopolitics today. This can be illustrated by China's one-child policy. A biopolitical lens is important in examining current health systems and challenges today, such as the COVID-19 pandemic or the current HPV vaccination system.

The government insert biopolitical technology used to control life, death and bodies. This is what Foucault calls the *biopower. Biopower* consists of two basic models: The regulatory control of the population and the discipline of the individual body (Lemm, 2014). This means that biopower is a technique used to control populations and subjugate bodies naturalized by discourses (Foucault, 1978). In this way, biopower is working on individuals really and directly, and is an ascendant type of power that is cantered upon life (Lemm, 2014). Biopower can be policies and regulations regarding health interventions as reproducing technologies, control of sexual behaviour, family planning, vaccine politics or other public health campaigns.

Chapter 3
Methodology

In this chapter, I will introduce my methodological approach to the research project about the challenges around HPV vaccination in the context of Zanzibar, Tanzania. The project follows a qualitative study design by conducting 16 interviews with local people from Zanzibar. It has been important for my research to emphasize and integrate a social work approach to the healthcare standards of the HPV vaccine. Hence, I chose to apply theoretical concepts from critical social work, which has a long tradition of examining social justice, power dynamics and equality (Fook, 2015).

To be able to point out the current challenges regarding the HPV vaccination system in Zanzibar, the critical examination of power has helped me uncover the challenges that must be addressed for the HPV vaccination system to operate in a better way. For the system to improve its effectiveness, the critical perspective has revealed power dynamics within the language, culture and knowledge that create barriers to vaccine uptake.

Additionally, this approach encouraged me to be mindful of my own presence as a co-producer of knowledge, as critical social work explores how knowledge is produced and how knowledge is inextricably linked to power (Fook, 2015). The critical social work approach includes a perspective that enables a nuanced understanding of local perspectives when looking into the context in an open and culturally appropriate way that embraces multiple perspectives. This perspective is crucial, considering that the research is done in an African context, where colonial histories and power imbalances are still present.

3.0 Scientific Position

This qualitative study is based on a scientific position rooted in critical theory, which focuses on reflexivity in examining the knowledge produced. The critical approaches to social work were born in the 1970s, rooted in the Frankfurt School which was seeking to challenge social oppression, empower disadvantaged groups and work towards change (Fook, 2015). It has been crucial for this research to use a social constructionist perspective, which examines how knowledge is constructed. My epistemological position during this research has been grounded in the critical social work perspective, which is an approach that primarily "*involves understanding how structures dominate and also how people construct and are constructed by*

changing social structures and relations, recognizing that there may be multiple and diverse constructions of ostensibly similar situations." (Fook, 2015).

The critical approach has been efficient when examining the current challenges in Zanzibar. The challenges that stood out for me in the interviews are in many ways intertwined with the local production of knowledge and multiple power structures within the community. Engaging with critical theory helped me uncover power structures within the community manifested in different aspects such as language, cultural practices, and gendered societal norms. Furthermore, this approach illuminated how different power structures influenced the acceptance of the HPV vaccination program. The critical perspectives discuss how knowledge is never entirely value-free, as it is influenced by the one who constructs it (Fook, 2015). Knowledge is a contextually produced practice that is shaped by the environment where it exists.

By using critical theory, I examined the local production of knowledge, which in this context were several misconceptions of the HPV vaccine. During some of the interviews, I learned about two myths, in particular, that challenged my own values and beliefs, which also made me aware of my own biases and preconceptions. Critical theories involve recognizing reflexivity and self-reflection on dominant structures and relations that affect people's daily lives. Reflexivity enables us to recognize how aspects of ourselves and our context influence the kinds of knowledge we produce and value (Fook, 2015). It is important that the researcher is aware of and able to identify their own preconceptions, motives, and values that could potentially influence the research process. Enacting some sort of self-interrogation is crucial before entering a different context and conducting qualitative research. In the next, I will present several layers of my own position, which comes with the fact that I am a thirty-year-old female-identifying and non-indigenous researcher from Norway.

3.1 Positionality

In what way could these identity markers potentially affect my research project? One of the most important contextual approaches is "positionality", which involves being able to identify how we are inextricably a part of every situation (Fook, 2015). This relies on the researcher adopting a consciously aware stance, where the professional is mindful of the situation from both an internal and external perspective. This allows the social worker to use a dual awareness, where the practice seeks to aim for consciously being sympathetic to any resistance to change and additionally have an approach of courage to seek change (Fook, 2015).

Growing up in Norway has afforded me a range of privileges. First and foremost, it is essential to recognize the inherent power and responsibility that comes with conducting research in a different cultural context. By reflecting back on my interviews, I realized that my own positionality might have subtly influenced the interaction between me and the participants. In the following, I will analyse how this may have played out. For example, many of my participants thought I was a doctor. When I explained that I was a social work student, many of them questioned what that would entail. I sensed that my role as a researcher gave me more authority than my role as a student.

I do not think my age provided me with a level of authority, considering I am just 30 years old, but my gender, on the other hand, could potentially have benefited me, considering I was conducting interviews with female participants about a female-health-related topic. Given that the interview was centred around female health issues, I think that my gender might have created a safe space for women to share their thoughts regarding the HPV vaccine. Furthermore, I believe my gender might have given me access to more information with the female participants, whereas a male researcher could have met different barriers than me.

My position as a white and non-indigenous person is perhaps the dynamic that I see as the most complex during the interviews. My whiteness can symbolize power in many ways. Entering an African context as a white person carries Europe's historical legacy of colonialism and a history of research with several ethical concerns. Firstly, it symbolizes a lingering colonial perspective that can create associations like authority or privilege. This was something that I experienced, and that made me feel uncomfortable in some situations. In some ways, I experienced being “othered” with categories that were new to me. In Zanzibar, I was frequently called “Mzungu”. If I walked down the streets, the children would call me “Mzungu”; at the hospitals, I heard “Who is the Mzungu?” wherever I went, this was a fact I could not hide.

This fact illustrates how my whiteness was a part of every situation, including my interviews. This ‘mzungu’ perspective is a popular Swahili term for “White people” or Europeans (Spitzer, 2019). The term derives from the Swahili verb *Kuzungua* which means ‘to go around’. The term has many linguistic and historical connotations, as it means the high level of mobility associated with light-skinned foreigners (Spitzer, 2019). Additionally, I think whiteness in a Zanzibar context is seen as a symbol of wealth because white tourists frequently come to the island to travel and enjoy their holidays. I never experienced any negative attention like discrimination, but I experienced that my whiteness made people assume that I was rich. One of the things I encountered during my interviews regarding this exact topic was during the

interview, where the participant asked me if I could offer to pay to buy more equipment, in this case, a scapula, so they could conduct cervical screening on multiple women a day. They could not conduct as many cervical screenings as they wanted to because of a lack of equipment and antibacterial fluid to clean them with. The preconceptions about 'Mzungus' led them to the assumption that I had enough resources to supply them with equipment. The mzungu perspective made me think about my own Eurocentric bias and made me critically reflect upon own cultural background. This awareness serves as a foundation when researchers enter a different cultural context.

Given this position, I frequently tried to build trust within the interview situation when intentionally taking an interview approach that was transparent, open, and interested in their perceptions and stories. It has been important for me to question the motivation behind my work and question the "helping imperative", which is a professional appendix connected to the profession's entanglement with the colonial civilisation mission (Kleibl et al., 2019). It is mainly entitled to the white colonial subjectivity that wants to help the "other" or colonised and is attached to the idea of progress as a universal value from the West (Caron & Ou Lin Lee, 2020). Personally, it has been important for me to position myself away from a helping imperative where I am projecting my own personal beliefs around the work towards the elimination of the HPV vaccine. I would rather understand the underlying structures of power in the knowledge and language that are present around the HPV vaccine system in Zanzibar. To do this, I think it was crucial that I, as a researcher, had an approach that was genuinely open and sought to understand the context of their beliefs on their terms and conditions.

3.2 Conducting Interviews

The qualitative research design chosen in this study is centred on in-depth interviews to explore the challenges regarding the HPV vaccine program in Zanzibar. To gain a deeper understanding of the challenges of the operating HPV vaccination system in Zanzibar, I decided to conduct interviews with healthcare workers and local people working outside the health sector. In preparation for my research, I decided to use an inductive approach in my interviews. This involved creating an interview guide that was as open as possible to capture the voices of my participants in the most authentic way. Additionally, it allowed me to fully focus on my participants' experiences without a preconceived scientific or theoretical framework.

I decided to interview healthcare workers mainly for two reasons. First, they are a valuable resource for gaining a deeper insight into patients' perceptions and assumptions regarding the HPV Vaccine. Second, listening to their perspectives on the infrastructure and

functioning of the HPV vaccine is invaluable, as they bring firsthand experience with local perceptions and the practical realities of HPV vaccine uptake. That means they would possibly know the current functioning and challenges regarding the HPV vaccination program.

I decided additionally to interview local members of society because I saw it as a way of learning about their perceptions regarding the HPV vaccine. I thought this could give me insights into how the HPV vaccine system was implemented in the local community. It was a crucial choice to include local people, as this would enable me to identify how the communities perceive and interact with the HPV vaccination program. These grassroots perspectives provided me with valuable insights, enabling a deeper understanding of local perceptions surrounding the HPV vaccine. Conducting interviews with both local residents and healthcare workers was essential to gaining a nuanced and comprehensive understanding of the current functioning of the HPV vaccine system. This broad approach allowed me, as a social worker, to identity existing barriers within the context of HPV. Incorporating these two distinct viewpoints enabled a comparative analysis. Only by conducting interviews with both local people and healthcare workers would I be able to truly find a complex and holistic understanding of the current functioning of the HPV vaccine system. This broad approach enabled me, as a social worker, to access the current barriers in the context of HPV.

3.3 Research Method

For my research, I conducted interviews with a total of 12 healthcare workers and four residents who worked outside the formal healthcare sector. Qualitative interviewing is a form of professional conversation that requires a theme, a researcher and a research participant. The core of qualitative interviews is how interviews highlight our access to realities (Silverman, 2011). The interviews themselves entail interpersonal interaction, situating subjects in their lifeworld's and their own social and cultural context (Moen & Middelthon, 2015). I focused on conducting interviews in a tradition of qualitative research methods because of its strength in revealing practices and dynamics within different sociocultural contexts.

My aim was to conduct interviews with an account for integrated *intersubjectivity*, which allows for dialogic moments in communication (DeTurk & Foster, 2008). During the interviews, I actively tried to listen and generate a mutual understanding with the participants on their terms and conditions. In some situations, I could follow up with questions regarding what they said or shift the conversation to the element that was important to them. By using active listening, I founded the interviews with a dialogic approach where I followed the participant's contribution but also continued asking questions from my interview guide when there was a mutual

understanding. In some situations, it could be a language barrier which was prohibiting me from getting an accurate understanding. I always tried to repeat the questions or ask them in another way if there were any barriers I picked up on. Another reason for a dialogic approach was that I wanted the participants to answer as authentic as possible and not feel pressured in any way to respond based on what they assumed was favourable or expected.

Although I conducted interviews abroad, this is not an ethnographic study, but rather a qualitative exploration aimed to understand specific challenges regarding the HPV vaccine system in the context of Zanzibar. Conducting qualitative interviews gave me insights into the context, situation and experiences regarding the functioning of the HPV vaccine programs in Zanzibar. The interviews with both groups lasted from 25 minutes to 60 minutes. I used a semi-structured interview guide to be prepared and carry out the interviews sufficiently. Methodologically, the semi-structured interviews provided flexibility, as this approach did not require adhering to a strict question order. Equally important was the strategy of engaging participants in a way that allowed them to share their beliefs and knowledge on their own terms, within their context, and at their own pace.

3.4 Sampling and Recruitment Strategies

My initial goal prior to the qualitative interviews was to execute focus group interviews with two different groups: healthcare workers and residents who worked outside the formal healthcare sector. My experience was that people's perception of time was very different from what I was used to. As some of the participants seemed to arrive several hours later than initially agreed upon, I found it challenging to coordinate group interviews. I soon realised that it would be more convenient and efficient to conduct individual interviews, allowing for greater flexibility, which is crucial in qualitative research. Therefore, I decided to execute my interviews individually. This method seemed to work out better both for the participants and for me as a researcher.

This qualitative research began with connecting with two nurses from the local hospital through a staff member of Knowledge for Change. This social process was the start of what is commonly referred to as the snowball method (Skilbrei, 2023). This method involves using connections with individuals already involved in the study to establish contact with new informants. The snowball effect naturally took shape after meeting a member of staff and getting connections in the hospital. Additionally, this brought me to a local running group, which connected me with residents who had different kinds of jobs outside the healthcare sector. The ambition was to get in contact with as many people as possible to connect with local

people's perspectives on the system of the HPV vaccine as well as healthcare workers. The interviews took place in the office of Knowledge For Changes House and at two local hospitals in Zanzibar.

3.4.1 Healthcare Workers

I interviewed a collected group of 12 healthcare workers, including doctors, nurses, midwives and health officers. The initial aim was to find healthcare workers who were working with the HPV vaccine program. I started by interviewing five healthcare workers from the local hospital in Zanzibar. They provided me with prominent information about the different perceptions of the HPV vaccine, but they were not directly involved in the HPV vaccine system. One day another member of staff from K4C introduced me to a local maternity hospital where their healthcare workers were conducting cervical screening and handing out vaccines. The local maternity hospital proved to be an invaluable source of insights into the HPV vaccine system, offering information on vaccine distributing, education initiatives, and its handout proves within schools. Luckily, a member of staff from K4C, was able to translate at the Maternity Hospital, as most healthcare workers did not speak English, but Swahili. I could see that my translator genuinely was committed to ensuring the translations were accurate even though the English from time to time lacked fluency. If there were any language barriers, we made sure to ask each other again or repeat our words. This did not post itself as a big issue, as I think our English was sufficient to convey the necessities. While I trust her to translate the participant's narratives and perspectives accurately, my lack of Swahili fluency means I'm not fully able to verify the precision of the translations made by my translator.

3.4.2 Residents of Zanzibar

I conducted interviews with a selected group of four local women from Zanzibar, each working outside the healthcare sector. This choice was intentional, as the HPV vaccine in Tanzania is administered exclusively to girls. By speaking with women, I aimed to gather insights from individuals who had personal experience with the decision of whether or not to receive the vaccine, offering perspective rooted in firsthand choices and cultural context. This consideration was particularly important given that HPV disproportionately affects women in Tanzania, increasing the likelihood of encountering individuals with personal or community experiences related to the virus. The women I interviewed held various roles within society, including tour guides, secretaries and cleaners. My interview approach and guiding questions evolved after an initial conversation with one of the local participants, as I will elaborate in the following section.

In the initial interview with a local participant, I encountered challenges in following my interview guide, as they did not have answers to my questions. I realised the questions I had made were designed for health workers, rather than for people without 'expert' knowledge. During the interview, I encountered a local participant who lacked awareness about the HPV virus and filled the silence with knowledge about the research, virus and HPV prevention. This unintentional shift could not only influence her answers but also diminish her opportunity to express her own beliefs and knowledge. I quickly understood that this approach was not giving me the answers that I wanted and raised ethical concerns. This made me reflect on my methodology and develop a revised interview guide for the subsequent local participants. This adjustment proved successful, as it allowed participants to express their beliefs and understanding on their own terms, fostering a more authentic and respectful dialogue.

I was supposed to interview a local resident I had contacted through another local resident from Zanzibar. Unfortunately, when I got to the person's office, the person did not want to be interviewed or recorded for several reasons. I found this meeting important to write about as the non-participant had several crucial sayings. The non-participant began by explaining how a friend had been killed after participating in a recorded interview. This highlighted the potentially severe consequence of participating in such research, underscoring that, as an outsider, I could not fully grasp the actual danger present in the local context. The person mentioned that he would never have his personal opinion about the HPV vaccine recorded, especially if he was critical to the system.

3.5 Analysing Strategy

The analysis is an integral part of the qualitative research and is a reflexive activity and process from the beginning to the end (Moen & Middelthon, 2015). It is a cyclical process that includes elements like pondering which themes to pursue, choosing research methods, making decisions about who to talk to, searching for patterns and selecting what to write about, and how (Moen & Middelthon, 2015). When I got back from Zanzibar at the end of March, I started organizing my interviews. This involved transcribing each one using the Transcribing OpenAI named "Whisper." I chose to listen through all the interviews while correcting the data Whisper transcribed for me, as I wanted all the data to be accurate and correct. After I used Whisper and additionally transcribed myself, I started the process of coding the transcribed interviews.

Throughout my analysis process, I organized my transcribed and coded data material, including my notes from before and after the interviews, and identified the key themes that emerged as prominent data for my research. By transcribing my data and analysing my

material, I found several interesting findings that had potential for a thesis, but in the end, I landed on four distinct themes. Themes such as gaps in knowledge, vaccine resistance, parents' resistance and local myths emerged as prominent data because they spoke to the root causes of community resistance, challenges and barriers regarding the HPV vaccine system in Zanzibar. The reason I selected some of the themes was because the data felt unexpected and, in certain cases, profoundly surprising to me. When I was reflecting on the process of analysing my data, the findings I found interesting and wanted to communicate through my thesis were the findings that were new to me and where I sought to find answers. This specific data required me to reevaluate my own preconceptions and fully see the participant's view, which challenged my own perspectives of what I perceive as “true”.

I decided that my main strategy would be to present my prominent findings in different themes and analyse them in the eyes of my theoretical framework. To be able to analyse my data, I analysed them themes through a two-stage analysis. The way I wanted to design the analysis was to see my findings in the eyes of documented studies, and then identify the misconceptions and barriers to the HPV vaccine in the eyes of critical theory. The analysis was therefore designed to understand the findings through the lens of previous research to evaluate the contemporary relevance and, secondly, examine the findings through postcolonial theory and the different elements of theory I find relevant from critical social work.

3.6 Ethical Considerations

The moment a person enters a research process, the main person managing the research is responsible for protecting the rights of the participant (Vivek, 2022). This underscores the importance of following ethical guidelines to ensure the participants are protected during research. Ethical considerations are especially crucial in qualitative research, particularly when disadvantaged participants are involved (Vivek, 2022). An ethical safeguard becomes even more critical when face-to-face interviews are conducted, as the interaction can potentially put the participants in a vulnerable position. In my research, the participants did bring up sensitive information about themselves, their families or communities in some contexts. This was brought up regarding questions about their perception of the vaccine. Considering Zanzibar is a small community, I did not want them to be concerned with confidentiality around their answers in the interviews. This is why I wanted to protect their privacy and prohibit any breach that could potentially lead to social repercussions. This is why I ensured that the data remained protected and confidential throughout the research process.

This makes securing sensitive information essential in qualitative research. To address these concerns, I applied for ethical clearance and got it approved through “The Norwegian Agency for Shared Services in Education and Research " prior to the research. I also took other considerations during the research time in Tanzania, which I will explain in the next section. Prior to the interviews with both healthcare workers and local people, they received a consent sheet which entailed information about the study, regarding what questions I would ask and how the data would be collected and stored. I also informed that they could pull them self out at any time if they regretted and that I would delete all the information that they had given. During the transcription process the participants where all given a pseudonym to keep their information protected in the process.

3.7 Reliability, Validity & Transferability

In qualitative research, the researcher needs to be involved to produce knowledge. An important question that the concept of *reliability* asks, is if the study results are free from biases (Fook, 2015). My personal conviction of the HPV vaccination system is an integrated part of my biases and preconceptions regarding the vaccine. The National Surveillance Program in Norway is monitoring the safety and effectiveness of the HPV Vaccination Program. Since 2009, the HPV vaccine has been offered to girls in 7th grade as a part of the childhood immunization programme (NIPH, 2024). The national surveillance program shows high vaccine efficacy and a significant reduction in HPV infections (NIPH, 2024). According to a study published in 2021, cervical cancer could nearly be eradicated in Norway by 2039 thanks to the high vaccination coverage by the childhood immunization program (Portnoy et al., 2021). Even though my biases and preconceptions about the vaccine were clear, my goal was not to project my own beliefs onto the participants but rather investigate their belief.

As previously mentioned, some of the myths certainly stood out to me and felt unexpected in the way of really challenged my own beliefs. When the healthcare workers addressed certain perceptions, it struck me as devastating. During the interview, I had to make sure that my personal reaction was not visible. I did not want to project my own preconceptions on the participants but rather understand what made these myths be perceived as true. During the interviews, my mind worked hard to ask the right questions that would provide me with the most accurate information about the information they shared. This did not mean I did not ask critical questions, but rather that I followed up with a response to seeking more local knowledge about the topic. Some of the participants did ask questions regarding the HPV vaccine system in Norway, research on it and my perceptions of the vaccine. I shared my thoughts on it if they

were interested to know, but I experienced that I had to do this at the end of the interview, as I did not want their answers to be influenced by my thoughts.

Additionally, qualitative research asks if the research is replicable, which means if the findings are reliable and as independent from the researcher as possible (Fook, 2015). The contradictory aspect in a qualitative matter is how the researchers need to be involved for knowledge to be produced. In a qualitative study, we are dependent on the context, as researchers and participants are coproducers of knowledge (Fook, 2015). However, it is important to ask if the qualitative study is the extent to which they are positioned to transcend singular perspectives (Moen & Middelthon, 2015). This is why researchers need to strive to observe, describe, and analyse the world in a way that is understandable and transcends the perspectives of the study participants and the researcher in a reliable way (Moen & Middelthon, 2015). To practice transcendence within the perspectives, I focused on avoiding leading questions to maintain ethical integrity and best transcend the participants' singular perspectives. Additionally, I focused on giving the participants time to express themselves and reflected on my own responses during the interviews to reduce the risk of the participants not expressing their authentic voices.

Relevance, transferability and validity are essential standards in qualitative research. The importance of sampling is closely intertwined with *validity.* The term is divided into *external validity* and *internal validity* (Malterud, 2001). External validity asks in what contexts the findings can be applied which means the representations are relevant across different groups (Malterud, 2001). Internal validity, on the other hand, asks whether the study investigates what it is meant to, which means if it actually reflects the reality of what the participants have said (Malterud, 2001). These elements will ensure that the research is accurate, but it is crucial that the researcher adheres to these standards. I have been consistent in collecting information in the interviews and have reflected on utilizing the information I have collected in a way that aligns with the expectations of validity. This means that I have been genuinely consistent with using elements from interviews that highlight their beliefs and perceptions. My goal was not to try to fit the participant's beliefs, perceptions and knowledge into a preconceived framework but rather communicate a representative reality of the participant's views by addressing validity. This means being truthful about the process, including how my first interview with a local person outside the healthcare sector did not meet the ethical guidelines and how this made me change my interview approach.

Transferability refers to the “The range and limitations for application of the study findings, beyond the context in which the study was done” (Malterud, 2001). Although this research includes a group of healthcare workers and residents living in Zanzibar, it does not mean these represent healthcare workers and non-healthcare workers in other areas of the country. This group may have different understandings than others. No study in this methodological tradition can provide findings that are universally transferable (Malterud, 2001). However, some of my findings may, for instance, be transferable to previous research I have found on the topics.

Chapter 4

Presenting data and analysis

In this chapter, I will present a comprehensive view of the HPV vaccine system from the eyes of all the healthcare workers and the local people I interviewed. I will summarize the prominent findings from my research. The analysis is based on the experience, perspectives and narratives of the healthcare workers and local people addressed in their interviews. I have collected the data from these interviews and identified multiple patterns in different challenges around The HPV vaccine. Furthermore, I will highlight the insights into the HPV vaccine that emerged from the patterns I have observed across the 16 participants.

Through my interviews, I have gained insight into the challenges the participants associate with the system. I will get deeper into these different assumptions, narratives, and perceptions that were working as a barrier to vaccine uptake. This includes vaccine hesitancy, local misconceptions, a large knowledge gap, parental resistance, and important barriers to vaccine education. Using a postcolonial feminist approach, I will interrogate my research's prominent findings. I will interpret theoretical concepts such as governmentality, biopolitics, and discourses and allow an in-depth examination of how these elements manifest within my data.

4.0 Vaccine Hesitancy in the Context of Zanzibar

Vaccine hesitancy proved to be a particularly severe issue continually mentioned by the healthcare workers I interviewed in Zanzibar. This was a deeply entangled challenge among the various challenges emphasized by the healthcare workers. Hadyia articulated it like this:

> *"So sometimes when the patient come, they didn't even take a vaccine. Even one in their life. Because of their knowledge. So, it's like all vaccines. All vaccines. It's not only HPV. Even BCG. They didn't take it"*

In Zanzibar, 10 of 12 healthcare workers I interviewed addressed observing scepticism, resistance, misconceptions, or hesitancy within the local community and with patients in their medical practice regarding all types of vaccines. Zulfa described it like this:

> *"In Zanzibar they have the conception like that on all vaccines. It will destroy our future and our kids. Even in the corona virus."*

The Strategic Advisory Group of Experts on Immunization (SAGE) by WHO, which advises global vaccine policies and strategies, has developed a model to systemize the determinants of vaccine hesitancy. SAGE emphasizes that hesitancy is a contextual and vaccine-specific behavioural phenomenon (MacDonald, 2015). SAGE Working Group on Vaccine Hesitancy defines it as "the delay in acceptance or refusal of vaccination despite the availability of vaccination services." (WHO, 2023). Vaccine hesitancy is complex and context-specific, varying across time, place and vaccines (MacDonald, 2015). It is crucial to point out that vaccine hesitancy may be present in a context where the vaccine uptake is generally low because of supply difficulties, inadequate funding, or other system failures. Khadija who was conducting cervical screening at the maternity hospital described the issue of supply difficulties with the treatment of cervical cancer:

> *"There's no equipment. There's lack of equipment. Sometime if they already have been contaminated. Other women still wait. So you, and after that, you cannot use them the same day. You have to tell them to come tomorrow…Because after you use this(speculum), you should not use this on someone. Because, of course, it can be contagious. So you have to make sure you sterilize it. So they need more equipment.»*

The biggest challenges concerning the elimination of cervical cancer as a global health problem are vaccine manufacturing, supply issues, delivery of cervical screening in low and lower-middle-income countries and adequate funding of both vaccination programs and cervical screening (Canfell, 2019). This means that vaccine uptake is low due to system failures and limited vaccine service availability. Considering that vaccine hesitancy is not the main explanation for the presence of an under-vaccinated population, it could be a barrier to a low vaccine uptake. Nonetheless, it is important to differentiate hesitancy from other reasons for a low vaccine uptake to be able to address the right measures needed for an improved vaccine system (MacDonald, 2015). Systematic research conducted with 13 studies included in the study from 2007 until 2021 found determinants of Human Papillomavirus (HPV) vaccine hesitancy in Sub-Saharan Africa (Omayo et al., 2023).

4.1 Hesitancy in the eyes of imperial occupation

> *"So, she said to the community, they don't want their kids to be vaccinated. So she said to the place she is staying, they don't want to hear about any vaccination, even if it's Corona, it's Corona, but any, they don't want to hear. So it's like Western people, they want to kill them, reduce their number, that's why they say they don't want." (Zulfa).*

Zulfas's words underscore how “Western people” are seen as threats and those who want to kill them. The perception that “Western” individuals pose a threat to society is a mistrust I came across several times in my interviews. The legacy of Western governments had an underlying mistrust. Considering vaccine hesitancy is both a contextual and a vaccine-specific behavioural phenomenon, it is important to analyse vaccine hesitancy in the historical context of Africa. Especially since Western medicine has held a dominant and problematic role on the continent since the era of imperialism. Colonial history shows several examples of colonial projects that undermined the health of the Indigenous populations in Africa, frequently based on unequal treatment of Europeans and Africans, and justified through racial ideologies (Greene et al., 2013). Jeremy Green et al. (2013) argue that colonial medicine shows that the sites of imperial occupation served as laboratories for medical strategies and a source of testing subjects for medical health research (Greene et al., 2013). There were no ethical standards for the African population involved. This often meant that Africans were exploited as “guinea pigs” for the European colonizers.

Regarding sleeping sickness research, medical experts conducted painful lumbar punctures to detect parasites and provide drugs that are managed to save lives. Unfortunately, 10 and 20 % of the people tested led to brain damage or blindness (Tilley, 2016). Additionally, there were instances where Africans were intentionally infected with a specific illness to evaluate the medicine's effect (Greene et al., 2013). Several invasive body practices like forced blood draws, collecting stool samples, and forced removals or vaccinations led to protests and opposition among Africans (Tilley, 2016). Protesting was one of the ways the Africans could resist the brutality of the colonial racist project. The historical consciousness of the colonial roots can be argued is present today, especially regarding vaccine hesitancy.

Vaccine hesitancy, examined through the lens of postcolonial theories, can provide insights into the current circulation of understandings around the HPV vaccine in Zanzibar. A decline in trust towards Western countries can play a role in vaccine hesitance and, additionally, the vaccine uptake today (Falade, 2024). In a postcolonial tradition, examining the history of the systematic racism that was executed during colonial times is crucial to understanding the context of vaccine hesitancy today. In the eyes of postcolonial theory, it can be claimed that African countries are sceptical about European medicines because of these colonial practices that left mistrust in the communities when implementing new health interventions like the HPV vaccination program. In the following, I will introduce the concrete misconceptions and myths circulating in Zanzibar today through the eyes of the 12 healthcare workers.

4.2 The myth of infertility

> *"Most of them, they think it can bring bad reproductive health. It can lose number of getting back children, so their perception. So, most of them, this vaccine maybe is a problem in their life, so they didn't take any vaccine" (Hadiya)*

A perspective that continuously emerged through my interviews with the healthcare workers was the belief that receiving the HPV vaccine could lead to infertility, in other words, being unable to receive children. In my interviews, I asked what the most common reason why people did not want to receive the vaccine. Another participant, Imani, defined it like this:

> *"The biggest reason is that they will not be able to conceive babies"*

Several participants, mostly the health workers, communicated this attitude when they frequently met working with local people in the health service. The assumption that vaccines cause infertility can be dated back decades. Misinformation and conspiracy theories are the underlying factors of vaccine hesitancy, and female infertility is prominent as a repeated false claim and target of antivaccine misinformation (Smith & Gorski, 2024). In research conducted cross-sectionally with in-person surveys among health workers, community leaders, school personnel and council leaders in 18 council areas in Tanzania (2019), approximately half of the informants stated that they had come across misinformation about the HPV Vaccine (Li et al., 2019). 91% of the respondents indicated that the most common misinformation was that the HPV vaccine would affect girl's fertility (Li et al., 2019).

> *"People, they perceive vaccine differently because most of them, they think vaccine can affect their life. They can cause to be infertility in their perception. So, they are very fear, they're very fear to take vaccination." (Hadyia)*

Particularly, the Human Papilloma Virus (HPV) has been incorrectly blamed for infertility and primary ovarian insufficiency (POI) (Smith & Gorski, 2024). Hadiya is elucidating the underlying fear of not being able to have children, which was also brought to light by one of my local informants, Maryam, who said she was scared of the vaccine. Nine healthcare workers referenced the myth of infertility regarding the vaccine during the interviews, indicating a prevalent concern regarding misinformation about the HPV vaccine in Zanzibar. Perhaps such information may significantly influence the public discourse and acceptance of the vaccines, including the HPV vaccine itself.

The concept of biopolitics is closely intertwined with the HPV vaccine program. Foucault's theories suggest that the HPV vaccination program is one of the current biopolitical actions taken by the government in Zanzibar. The government exercises control over life and

death through the current biopolitics, which governs health and human bodies. It is implemented into politics and societal institutions and refers to the governance of human life. Therefore, biopower is regulating the population through the biopolitical goals that are reflected in the vaccine campaign. In this way, the government is executing power over human bodies with the goal of trying to reduce the high death rates of women.

However, since the vaccination program is voluntary, it means the government is not only executing power but also giving the residents of Zanzibar bodily autonomy. The initial goal of the vaccine implementation is to influence personal health decisions. With the HPV vaccination program, the government aim to reduce mortality among women in Tanzania by eliminating the HPV virus. You can, therefore, argue that the HPV vaccination system is a biopolitical decision conducting biopower to the country's residents as there is an infrastructure in place to implement this in the country and as the Department of Preventive Services and Health Education under the Zanzibar Ministry of Health is highly recommending the vaccine. Through a Foucauldian analysis, the vaccination program has the power to shape societal norms and behaviour of the residents of Zanzibar. Questions that are important to ask are how it is contributing to societal norms and discourses. The contradiction in this matter is how the health ministry’s efforts to address women’s mortality rates and improve their health in terms of not getting cancer, and the myths are fuelling a perception that it is doing the opposite – it is taking away their ability to renew life.

Foucault’s biopolitical intervention suggests that the HPV vaccine campaign is perceived by local people in the communities as a barrier to their ability to continue the lineage of reproduction. Additionally, infertility threatens the culture of Zanzibarians, leading to a sufficient misconception that it is threatening their lives instead and is seen as a biopolitical action that will prohibit them from renewing life and being able to reproduce themselves. You could argue that the fear of infertility challenges their culture and the significant importance of having children. Bearing in mind the societal expectations of having children are strong in Zanzibar, the consequences of taking the vaccine could potentially be stigmatizing if you believe in the misinformation and false claims of infertility.

4.3 The myth of "becoming gays"

The myth of "becoming gay" after receiving the vaccine continuously came up during my interviews. Mwahija described it in this way:

> *"Because they say they change their hormone they will they change your hormones okay let's say if you're a girl you will just like to they they mention gay in general like to female to but the female you say lesbian like you will like to have affairs with your fellow girls want to have appetite with boys you know what i mean like yeah"*

Six healthcare workers utilized the myth of "becoming gay" if you had the vaccine. This concerned 50% of the health workers I conducted interviews with. This argues that there is a prevalent concern that one might "turn gay" if one receives the vaccine. Therefore, this misconception may consistently influence the public discourse surrounding the HPV vaccine in Zanzibar. This misconception of "turning gay" appears to be a prevalent belief in the same way as the concern about infertility. Unfortunately, I have not encountered any research on the myth of "people are turning gay", unlike the studies on the myth of infertility. However, there has been a spread of misconception regarding the turning into "homosexuals" on the COVID-19 vaccine in the social media platform Telegram. Ayatollah Abbas Tabrizian made the claim to his followers that the COVID-19 vaccination turns people into "homosexuals", bearing in mind that this is punishable with death in Iran (O'Neill, 2021). The cleric in the Iranian regime has a history of promoting false information about Western medicine (O'Neill, 2021). This perception can be connected to the broader societal tendency of blaming the LGBTQ+ community or using their legacy in a discriminating manner. My informant Amina who was a midwife at the local hospital described it in this way:

> *"Because if you tell her about vaccines, there is also now this thing called "gay things". So, people will be like, these people want to inject us so that we become gays. (She smiles and lauges). It's crazy. It's very crazy. When you go to the community, you hear a lot of things and be like, what? You see? So it's like, ah, no, me, my man, my man cannot get vaccine. No, no, no. They become gays."*

The misconception of LGBTQ+ people is present in a lot of African countries today. In Tanzania, LGBTQ+ people face severe challenges as same-sexual acts are criminal offences and you can be punished with life imprisonment (Wikipedia, 2024). Therefore, one could argue that homosexuality is a present social taboo in Zanzibar, which potentially makes the efficiency of the myth efficient as people are already scared to discuss such a big taboo. The Government of Tanzania is known for using homophobic rhetoric by saying that homosexuality is "un-African" (Wikipedia, 2024). Intersectional feminist social work perspective seeks to eliminate

negative discrimination and oppression based on, for example, colour, gender, and sexual orientation. Considering, that LGBTQ+ people are experiencing discrimination and oppression on a legal level, the local discourse about LGBTQ+ people is most likely marginalizing. An intersectional feminist social work approach could identify the factors among how the terminology around the discriminating discourse around LGBTQ+ people. Homophobia is not only used as a weapon against marginalization and discrimination but additionally used to reinforce misinformation and impose fear surrounding the HPV vaccine. This approach can help with understanding how misconceptions and controversies tied to a public health narrative are contributing to a joint stigma regarding the HPV vaccine. Additionally, when Amina described how "these people want to inject us, so we become gay", she was speaking about what she called "the Western people", as in Europeans. Once again, postcolonial history could be argued visible through the myth of "becoming gay", as mistrust of Western individuals underscores the misconceptions regarding the HPV vaccine as homosexuality is seen as something the Western people want to impose on Africans. The HPV vaccination system is seen as a biopolitical health intervention imposed by Western governments to make Africans gay and not as an action that wants to reduce the number of mortality against women suffering from cervical cancer.

4.4 Gap in knowledge

A pattern that drew my attention was the gap in knowledge between the healthcare workers and the local community members around the HPV virus and the HPV vaccine. While the HPV vaccine knowledge among healthcare workers was adequate on the HPV virus, cervical cancer and the treatment and prevention, the knowledge among the local community members outside the healthcare sector was rather non-existent. In the following I will introduce the local community members perceptions on the HPV vaccine. Furthermore, Dayana, answered the questions in this way:

> *Me: Do you remember the first time you heard about the human papillomavirus?*
> *Participant: Papilloma?*
> *Me: Yeah. Human Papilloma Virus. You remember?*
> *Participant: I don't hear that.*

The four local residents of society who had professions outside the healthcare sector that I interviewed had limited knowledge about the HPV vaccine or the virus itself. Three of four members of society had never heard about the HPV vaccine, nor the HPV virus or the fact that it causes cervical cancer. Furthermore, one of the participants, whom I refer to as Maryam,

explained when I asked when she first heard about the HPV vaccine*:*

"Today"
So, you don't know anyone who's had the vaccine? Have you gotten the vaccine in the school that you have been to?
"No, I was scared. (...) I've never taken any vaccine in school."
What is your community saying about the vaccines?
"Some of them they accept, they say okay you should take vaccine, like corona you could die. But some of them, they sometimes, they ask for diseases. Oh, you should, when you take vaccine, it will give you the source of getting more diseases."

She had never heard about the HPV virus, nor had she heard about anyone in her community who had taken the HPV vaccine. Grace, the third participant who grew up in Zanzibar, explained how she had never heard about the HPV vaccine, but how she received the coronavirus vaccine even though her parents encouraged her not to take it. Apparently, they told her that bad things could happen to her and that she would get a disease. Interestingly, the belief that vaccination, in general, could lead to getting a disease surfaced through my participants. Dayana's exact words about how vaccines could lead to diseases were:

"We feel so bad. Like to get some new disease. They know what it is. They learn to know what about this. Yeah, because a lot of them, we don't have enough knowledge.."

None of these four women knew anyone in their community who had taken the HPV vaccine, and they had never heard about it. When asked Dayana, do you think most people in your local community know about the vaccine, or do you think they don't know?

"I think they don't know because I live in the village. (...) At the first time, it's so difficult for them to understand or to believe in what you're talking about. But as soon as you give them knowledge, as I told you, they are not in knowledge.

A cross-section survey in two regions in Northern Tanzania called "Tanzanian Women's Knowledge about Cervical Cancer and HPV and their Prevalence of Positive VIA Cervical Screening Results" (2017-2019) utilized questionnaires and clinical data. This research demonstrated a significant lack of knowledge on cervical cancer regardless of educational level, resident status and number of children (Henke et al., 2020). Additionally, there was a widespread lack of knowledge on HPV in all groups, but especially in urban areas, where misconceptions were dominating (Henke et al. 2020). With a number of 2,192 women interviewed, 731 women reported never having heard of cervical cancer. That is a result of 33% This was relatable to the lack of knowledge I met in the interviews with people who worked

outside of the healthcare sector in Zanzibar. The lack of knowledge was interestingly high among the local people I interviewed outside the healthcare sector compared to the healthcare workers. I began to see patterns of the term discourses revealing themselves in my data in relation to the lack of knowledge. This could manifest insights into the current circulation of understandings around the HPV vaccine, which I will explain in the next section.

> *Me: So, you have heard about the HPE vaccine there?*
> *Participant: "From nurse."*
> *Me: Can you tell me a little bit about what you know about the vaccine? Or the virus?*
> *Participant: "No." (Aadila)*

The fourth local participant outside of the health sector, Aadila, mentioned she had heard about the virus when she was working at a local hospital for a period. When I asked her what she knew about the HPV she was unable to give further details. With three of my local participants being unaware of the HPV virus, and the fourth having only a limited understanding despite the fact that she encountered it in a medical setting, it suggests that the opportunity to learn about the HPV virus largely exists within what I call the healthcare-related discourse. We could argue that the current knowledge about the HPV vaccine mainly belongs to the discourses related to the medical institutions and not the discourses that are dominating in the societal practises within the residents. This could also argue that the biopolitical decision of the HPV vaccine is integrated into two of the hospital's institutions and that the biopower is visible throughout the healthcare-related discourse. It does not seem to work as a biopower in the societal communities as the residents perceive it as something that prohibits them from renewing life and being able to reproduce themselves. It seems like the common parlance or the word on the street is both misconceptions and narratives that do not work in favour of the HPV vaccine system.

4.5 Two different discourses

> *"(..) Simple. I got to know about HPV and vaccine when I was in med school, almost 24 years, at the age of 24. Throughout my life, I've haven't heard about HPV or anything like that. You can hear about other vaccines, but specifically for HPV, not until I reached the med school. (..) " (Baraka)*

During the interview, I realised the gap in knowledge and beliefs between healthcare workers and local people. Several of my healthcare workers had first heard about the HPV virus and the HPV vaccine when they were in the university studying medicine to become a doctor or nurse.

The healthcare workers explained how they first heard about the HPV virus in a medical setting, which perhaps illustrates once again how there are two separate discourses within the people in Zanzibar. Based on these findings, it could be argued that the people who knew about the HPV virus largely exist within the healthcare-related discourses. Many of the healthcare workers I interviewed were taught about the HPV virus, its role in causing cancer, and the vaccine either when they were in medicine school or in the hospital.

The healthcare workers had a genuine belief in the research regarding the HPV virus, and the importance and effect of the HPV vaccine. There was not a single healthcare worker presenting any arguments opposing the HPV vaccine. The local people, on the other hand, seemed to have limited knowledge about the HPV vaccine itself. One of the questions I asked the healthcare workers after these interviews was in which ways there was a difference between the perspectives on the HPV vaccine and local people's perceptions. Regarding the knowledge gap, one of the healthcare participants I named Baraka, articulated it in a clear and comprehensive manner:

> *'"(..)Talking about HPV. So, I'm like, if you ask any person randomly in the street, do you know anything? I think if you ask 10 people, I'm sure 10 out of 10, maybe they might have no understanding of what you're talking about. So, I think it's more awareness rather than just people maybe they feel something not worthy to screen or to check or vaccinated about HPV (...)*

Seven of my healthcare participants acknowledged a gap in knowledge between healthcare professionals and local members of society. Another of my informants explains it in this way (Zulfa):

> *"So, I should say they're different because people in the community, they have negative perception toward the vaccination. They say if you are going to vaccine, you won't get, you won't conceive, you won't have a baby. So that's the difference. Health workers they know, the importance of having vaccination. (..) But people from the community, they are not aware about it. They have perception within have already been feed lies, you know, so it's also, that's the difference. That's the, yes, because you know, the advantage of the community, some, they don't know"*

In summary, many of the healthcare workers addressed an alarming lack of knowledge about the HPV vaccine and cervical cancer among the local people they knew and met through work. My findings from the interaction with the local individuals aligned with the experiences reported by the healthcare workers regarding the lack of knowledge. The healthcare workers

also encountered widespread misconceptions circulating in Zanzibar:

> *"To the health workers, I can say like, there's no problem of it because they know how serious it is. But to the normal people, maybe they can doubt, because remote people, they have those particular, ah, vaccine, vaccine is not a good thing, it's coming from Western unions, so it can cause this, sometimes they just want to kill us, you know, they have those minds in their mind. They won't understand much about the vaccines. (..) But for them, they don't have knowledge. They don't know. They are not aware of vaccine. They have been feeding these lies about vaccinations. So, yeah, that's, I think the difference." (Amina)*

After interacting with the healthcare workers highlighting the knowledge gap, it seemed like there was a critical need for health education about the HPV vaccines in the community. With limited knowledge about the HPV virus and the HPV vaccine, it appears to me that the local discourse is surrounded by another meaning of production. The discourse among community members outside the formal health sector from Zanzibar was rather dominated by other health-related practices than biomedical approaches. I will, in the following section, illustrate this by presenting data from the common alternative practices that my non-health worker participants referred to. The societal practices that were the primary source of medical treatment seem to be involving other practises than biomedicine.

4.6 Traditional medicine in the eyes of residents

Traditional medicine seems to be a fundamental part of the culture and history of local people's treatment of different health issues in Zanzibar. Two out of four of the individuals shared a common interest in alternative forms of healthcare practices. To them, a common part of life and taking care of their own health, was the important belief in traditional medicine. In one of these interviews, a woman I named Grace explained how people treat their health problems with traditional medicine. She had never heard about the HPV vaccine, but she communicated her perspectives and her beliefs in traditional medicine. Grace had grown up in a rural community in Zanzibar and explained their treatment of different health issues like this:

> *"When you have pain, then you treat it with traditional medicine. During corona, they use different leaves. And they treat themselves through leaves. Leaves from different tree. Like lemon leaves, black pepper leaves, cinnamon leaves, they mix together, boil. (...) If you feel heavy, you just take the root of cinnamon, boil it with water, then you go was your hands, and you'll be fine for one time at least. Also, if you feel fever, just we mix different leaves of different trees, mixing with the root of cardamom, cinnamon, boil*

together, then you drink a little water with it, and those water that you made, you go was your body, and then you feel fine. That's how we do it. "

In this context, Grace explained how the community treated Corona with a traditional Zanzibarian approach. Furthermore, the second participant, Dayana, born and raised in Zanzibar was contributing to the narrative of the importance of traditional medicine in the local communities. Dayana explains how local people use traditional medicine for a wide range of health concerns:

"Sometimes people, take medicine to stop getting pregnant. So they take to the vagina. They go to the doctor. Sometimes when they get pregnant, they abolish. They eat something like poison. So they abolish from the vagina. (...) They're using henna, henna is the tree. They have the leaves, they have the roots, so they take back all the used leaves. They boil and then they drink. (...)"

According to a mixed-methos study in Northern Tanzania on traditional medicine (TM), TM is a critical component of the healthcare system in big parts of sub-Saharan Africa (Stanifer et al., 2015). This study characterized the reasons for the use of traditional medicine among the general population, where 70% of people frequently access healthcare through traditional healers. This is all intertwined with cultural beliefs, perception of TMs as being more effective, disease understanding, safety concerns on biomedicine and high cost and limited access to biomedicine. The study identifies five essential determinants for traditional medicine use in the North of Tanzania. This included biomedical healthcare delivery, strong cultural identities, the credibility of traditional practices, disease understanding and individual health status (Stanifer et al., 2015).

None of these four individuals expressed how traditional medicine was specifically utilized for the HPV virus or cervical cancer, as they had never previously heard about it before. However, two of them emphasized the importance of TM in the treatment of general health issues within the local communities of Zanzibar. This argues that traditional medicine practice has a crucial role in the discourse among community members outside the formal health sector from Zanzibar. This confirmed the local tradition that travels far back in time and gives answers to the production of meaning that is integrated into the discourse. The discourse around traditional medicine communicated both the power of cultural and societal practises. The knowledge of traditional medicine was accepted by the locals and seen as legitimate knowledge to treat health issues, which argues that the traditional interpretation was bound to several

elements: history, identity, culture and language. If we examine these findings from the premise that two separate discourses operate regarding health and treatment, it seems like the two discourses were colliding. The discourse the local communities had was dominated by traditional health treatment, but the discourse among health workers was based on the advice from WHO regarding HPV vaccination. This raises the question of whether following the WHO guidelines would require people to act at the expense of their own beliefs and culture. Several of the healthcare workers were accepting the vaccine and were still a part of the Zanzibarian community on their premises.

In the lens of postcolonial critical theory, an important topic in this context would be looking at the term "othering", which means categorizing or "labelling" people, their behaviour, and culture. This is typically when they do not fit the standards and are "othered" as problematic and abnormal. For social workers to avoid this, our aim is to approach the issues from the perspective of the people experiencing them (Fook, 2015). Stereotyping and portraying African individuals as "uneducated" is an easy conclusion to jump to for people who do not understand why people who have free access to the vaccine do not want to receive it. These stereotypes reinforce racial biases, and it is important in this discussion to address the complex dynamic behind why people are not choosing the HPV vaccine. This chapter emphasises the power and cultural importance of traditional medicine. It can be argued that traditional medicines serve as a form of protection against the "Western values" that are "projected" on African values. In this way, traditional medicine works as an important cultural and symbolic stance in defending the African cultural values not to be overstepped again.

4.7 Parents views

> *"So, she said the problem they face is with the challenges with the parents. Sometimes the parents, they told their children they should not get vaccination because they want to deliver babies, because it will cause side effects on them. So they stop, they build that fear in their heart. So sometimes we can find like when they go today, the students are not coming to school."(Cathrine)*

Nine of the healthcare workers discussed the fact that parents, in some cases, prevented their children from receiving vaccination. This involved both the HPV vaccines and all vaccines in general. The parents had the power to influence their children's possibility of receiving vaccines. As we previously mentioned, the local woman, Grace, was transparent regarding her

parents' hesitance towards the vaccines, as they did not want her to receive the COVID-19 vaccine. As she was an adult now, she did have the choice herself of receiving it or not. Unfortunately, children or youth who are between the ages of 12 and 14 years old could potentially have their parents denying them the HPV vaccine. Imani explains the key challenges regarding the parents like this:

> *"So, she said the most challenge they face, other children they deny to be vaccinated because they told us the parents should not do vaccine. So, it's also a challenge because they can't force. If she said no, it's no. Yeah, so she said that's the challenge because of the negative mood they have about it. Like, we are going to be gay or we're not going to have kids. They're not going to. So other they say if you inject it's painful for one week, you can feel it. Pain in the head. So the other child will be like, ah, they told me it's so painful in here, so I don't want. (..)"*

The healthcare professionals who were directly working with vaccine uptake pointed out that this was the main challenge to vaccine uptake. Four out of four healthcare professionals working with HPV vaccination in the maternity hospital communicated the system's challenges with the parents' acceptability. A question that occurred in my mind in the interview where they told me about the challenges regarding the parents was: Why did they not hold meetings with the parents to provide information about the HPV vaccine alongside the information shared with the kids? Cathrine's answer to this was:

> *"So she said that to get the parents is hard, but when they come to the clinic, they give them education and protection."*

The healthcare workers painted a wide and complex picture of parent's views on HPV views. The narrative conveyed from my informants was how some of the parents served as a barrier, as they were depriving the children of protection from the virus. This did not imply that all parents deprived their children of getting the vaccine, but that some did. One of the healthcare workers explained this by suggesting the differences might stem from parents and uneducated parents. Additionally, Zulfa described how it was not only the parents that could work as a barrier:

> *"So, she said this current testing is there, but it's not going like in a high progression because most of the people until now, even the teachers, they deny. So they can even influence the parents or the students to refuse getting vaccination due to the bad perception they have of getting vaccinated. So it's also a challenge. So she said, like, if they can keep educating them, educating them, but that's the challenge. They try a lot to give them education, but they still have that perception. So it's so hard to change their mentality, what they think about vaccination."*

Zulfa informed how it was not only the parents who could deny the HPV Vaccination for their children, but also the teacher. This was an interesting matter to me, and I was intrigued to know how their team would meet this challenge. In such cases, Zulfa described how they would address the situation:

> *"So, they say sometimes if they deny, they call the Sheha. The Sheha is like a leader of the street. Okay, the community leader. Then we will come and explain to them, like, this is from the government. There's no negative sign from it. So, it also helps for other parents to agree. Yeah, after getting information from Sheha. She said it also helps them to agree to get the vaccine. To accept the vaccine."*

Foucault's concept of *governmentality*, emphasizes how the government can control residents by shaping their mentalities and behaviour, which is exactly what manifests when parents actively engage in their children's opportunity to have the vaccine. The parents are advocating for self-regulation and the right to decision-making on behalf of them self and their children. The parental actions show how their autonomy is crucial to them. The parental choice to decline indicates resistance to the leading authority. The parental resistance upholds a sense of act to protect their children from external influences the government is imposing on them. This can reflect a mistrust in Zanzibar's leading health intervention regarding the HPV vaccine. This argues that the government has not been able to internalize and guide parents into behaviours, thoughts and actions that are accepting the vaccine and that the biopower the government is trying to integrate into the local communities is ineffective.

4.8 Education about the HPV vaccine

Children were educated regarding the HPV vaccine before receiving the vaccine, and the education was limited to girls only:

> *Translator: She said they mostly give education to girls because that's who they want to vaccinate.*
>
> *Me: So when you're teaching about it in the classroom, then it's only girls?*
>
> *"Yeah, it's only girls."*
>
> *Okay. And when you give out the vaccine, the boys are not there either? It's only the girls? Okay, I didn't know that. So... How do boys get to know then that they can be carriers of the virus?*
>
> *Translator: I think they are not aware. Because according to the answer they say, they only base on females. (Sara)*

Potentially, this could be a significant factor for the barriers upheld in the community. In a feminist postcolonial social work approach, involving men in discussions about female health is elementary, especially given that men are occupying many positions of power today. In the context of Zanzibar, I reflected on how educating boys could be a crucial step toward implementing the vaccine system into the culture, norms, social discourse and common knowledge. Engaging the men in this discussion would provide men with more knowledge about how they could participate in spreading the virus, and what would be necessary to support initiatives for women health. Additionally, it would be important for the men to receive knowledge about how the HPV virus could cause anus cancer, throat cancer and penis cancer. Engaging the men could gain a broader understanding in the communities and lead to a strengthened HPV vaccine system. I was particularly interested in knowing what knowledge the education regarding the HPV vaccine was based on. This was something that came up in my last interview with the healthcare worker on the HPV vaccines I call Mwahija:

> *"So she said like when they when they go there they give education about being clean like the girls to clean themselves and also they tell them about vaccination they if they are not going to get vaccine of HPV how effective are they going to get. So they say in general they tell the girls like they should not engage in sexual affairs so that to prevent also sexual transmittet disease so even if they are getting approaches the boys they should not be easy to get they should know their standard they should avoid those sexual affairs. "*
>
> *(..) so they and are saying that they should not interfere in sex. And what do they say about the vaccine?*
>
> *"So they also say like they give them education about the side effects of the vaccination if they feel sometimes you can inject the people and can swell or sometimes she can faint it depends on the reaction of the body toward vaccination so she said like. They tell them if you feel this sign, you should come to us, to the clinic of the hospital."*

One of the key elements of the education about the HPV virus in Zanzibar was to instruct girls to avoid engaging in sexual affairs to prevent sexually transmitted diseases. From a feminist postcolonial perspective, it was notable that the way the girls would prevent getting the virus was with abstinence rather than the protection in the vaccine itself. In my eyes, the point of receiving the vaccine was that it was safe to have sex because they would be protected from the virus afforded by the vaccine itself. This approach appears in the eyes of critical social work to execute power and control over the girl's sexuality, by framing their choices with behaviour constraints over their body. The HPV vaccine was supposed to offer safe sex in the future, not

restrict them from sexual freedom. In a critical and holistic approach, this education revealed the power dynamics that were present in the culture, as the education involved direct control of female sexuality. The biopower integrated by the government was conducting power over female bodies, and additionally, it was excluding males from getting knowledge about the HPV vaccine.

One of the things that characterize the vaccine hesitancy against the HPV vaccine is that it is associated with a social stigma. The social stigma is unique in the sense that the HPV vaccine is related to being a sexually transmitted infection (Omayo et al., 2023). Smith and Gorski (2024) explore the complex pushbacks that have been used against the vaccine in conservative religious groups. This involves the argumentation that vaccination against a sexually transmitted disease would inspire promiscuity and risky sexual behaviour in teenagers (Gorski & Smith, 2024). “Is there a more productive way for us to spend the money that may help someone who is in a health situation that has nothing to do with their personal choices?” asks George Runner (Gorski & Smith, 2024). This misconception was communicated by the Republican California State Senate in the mid-2000s, who, in an article in the Los Angeles Times, argues that cervical cancer is a result of lifestyle choices.

Several initial anti-vaccine campaigns spread incorrect and misleading information and are being selectively spread on social media following algorithms keyed to this exact engagement on social media (Gorski & Smith, 2024). Research has found no risk or evidence regarding HPV vaccination or risky sexual behaviour (Smith & Gorski, 2024). In the context of Zanzibar where Islam was central in their society, I could picture this promiscuity discouraging the parents from vaccinating their children. If the HPV vaccination carries the social stigma of leading to promiscuity, it would be an efficient way of preventing this from happening by teaching girls not to engage in sexual affairs. Unfortunately, it seemed like the government were restricting female sexuality rather than offering protection with the HPV vaccine, as a solution to this.

5.0 Conclusion

To be able to examine the current challenges regarding the HPV vaccination program within the context of Zanzibar, I conducted interviews with 12 healthcare workers and four local people who worked outside the health sector. Writing about the difficulties regarding the HPV vaccination problem made me reflect on how important it is to examine the social and cultural context before implementing a global vaccination system in a country. It also made me proud and aware of how important social work is when implementing a vaccination program, and why it is essential to engage with the communities' values and beliefs to be able to implement a HPV vaccination system that works efficiently.

Understanding vaccine hesitancy in Zanzibar requires viewing it through the lens of colonial history. Postcolonial theories offer valuable insights, illustrating how misconceptions and mistrust surrounding vaccines can be traced back to the systemic racism and injustices perpetrated during colonial times. The historical injustices continue to shape lived experiences and influence attitudes toward health interventions in the present day. By engaging with the concepts of biopolitics, I have addressed how colonial times introduced racial hierarchies, especially considering the racist mistreatment and use of African bodies. By engaging with postcolonial theory, this research has given insights into how mistrust towards Western individuals and governments is still present today in Zanzibar.

It can be argued that African countries are sceptical about European health interventions because of the colonial practices that left mistrust in the communities. These findings underscore that we need interdisciplinary approaches to raise health competence in local communities with a focus on overcoming the foundational mistrust in the communities. Involving social workers in this process could be essential for the government to address community-specific concerns and introduce initiatives to rebuild trust in the communities regarding vaccines.

In this research, I have examined how the local misconceptions regarding infertility and "becoming homosexual" are highly present in the local perceptions of the HPV vaccine in Zanzibar today. This analysis has argued that the HPV vaccination program is a biopolitical decision from the government to address women's mortality rates and improve their health in terms of not getting cancer. Unfortunately, the local myths are fuelling a perception that the health intervention is doing the opposite – it is taking away their ability to reproduce reproductive health and freedom. The postcolonial history informs these misconceptions, as the

HPV vaccination system is seen as a biopolitical health intervention imposed by Western governments. In Zanzibar, homosexuality is a deeply entrenched taboo, making it an effective tool for fuelling misconceptions, as the topic already evokes fear and apprehension among the population. This is exacerbated by the government's use of homophobic rhetoric, often framing homosexuality as "un-African", further entrenching stigma and misinformation. The myth surrounding homosexuality are often linked to European colonial history, as its legality in many European countries is perceived by some as an imposition of European values onto African societies. This association reinforces the idea that homosexuality is a foreign concept, further fuelling resistance and misconceptions within local communities. This fact underscored the importance of trust in society and how important it is to address the reasons for mistrust to be able to meet the insecurities and fears related to the HPV vaccination.

One of my most prominent findings was the big gap in knowledge about the HPV vaccine among healthcare workers and local community members outside the healthcare sector. Based on these findings, my analysis argues that current knowledge about the HPV vaccine mainly belongs to discourses related to medical institutions and not to discourses among the local communities. Furthermore, these separated discourses could reflect a very medicalised agenda in the GAVI vaccination program, where a social work perspective is needed. My research argues that the biopolitical decision surrounding the HPV vaccine is integrated into two of the hospital's institutions and that the biopower is visible throughout the healthcare-related discourse, but rather not working as a biopower in the societal communities. On the opposite, the local discourse is reproducing knowledge about traditional medicine and not working in favour of the HPV vaccine system. Therefore, one could argue that government biopower is not as efficient in the local communities and that there is a need to implement measures that resonate with the daily discourse in Zanzibar. It would potentially be a strategic move to implement health campaigns that speak the local language and make knowledge about the HPV vaccination system more accessible. From a social work perspective, it would be crucial to implement initiatives that would bridge the knowledge gaps highlighted throughout this master thesis, by applying a multifaced approach highlighting historical contextualization, community engagement and healthcare system dynamics.

An important finding regarding the educational system around the HPV vaccine was how the education was limited only to girls. The decolonial feminist social work argues that implementing boys and men in the discourse around the HPV vaccine would be crucial for the system to develop. To break through the circulating misconceptions, it would be a strategic

move to include boys in the education, and additionally, local figures such as the Sheha, religious leaders, teachers, and other essential figures in the local societies. From a feminist postcolonial perspective, it is notable that the education regarding the HPV that the government was giving out was restricting female sexuality rather than offering protection with the HPV vaccine. In my research project, I discussed how the government was executing biopower over female sexuality when advocating abstinence for the girl's sexuality. The framing of girls' choices with behavioural constraints reflects, through postcolonial feminist social work, as a regulation of female bodies, potentially stemming from the fear of the girls becoming promiscuous.

Another important finding within the Zanzibarian community was how parents and some teachers were preventing the children from receiving vaccinations. In this context, the concept of governmentality provided us with useful insights. The term emphasizes how the government can control residents by shaping their mentalities and behaviour, which is exactly what manifests when parents actively engage in their children's opportunity to have the vaccine. This analysis has argued that the parents are advocating for self-regulation and the right to decision-making on behalf of themself and their children, which reveals a distrust and resistance to the leading HPV vaccination program. Furthermore, the government is not succeeding in internalizing an acceptance of the HPV vaccine, and through the eyes of a social worker, it would be necessary for parents to be guided through the process of HPV vaccination.

This leaves social workers with a great responsibility to reveal the cultural and societal factors that work as barriers and threaten HPV vaccine uptake. A social worker can contribute by advocating for what the broader social environment would need for the vaccination system by integrating a context-specific and culturally sensitive perspective into a standardized vaccination program. This is why it is crucial to advocate for an interdisciplinary approach and integrate a social work perspective when raising health awareness.

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7.0 Interview Guides

7.1 Healthcare Workers in Zanzibar

1. Kindly ask everyone to introduce themselves, where they work and where they are from?
2. Where did you get your education?
3. How old are you?
4. Which department in the hospital do you work in?
5. Where and when did you first hear about the HPV vaccine?
6. How do you perceive the HPV vaccination?
7. Do you hand out any vaccines in the hospital where you work?
8. What kind of experience do you have regarding the HPV vaccine program in Zanzibar?
9. Can you tell me a bit about your involvement in the HPV vaccine program?
10. Do you think there is a difference in the HPV-vaccine handout in private and public schools?
11. How do you perceive the current functioning of the HPV vaccination program?
12. How to you think the local people view the HPV vaccine compared to health workers?
13. What are your experiences with meeting women throughout different stages of cervical cancer?
14. Have you had any experience with men throughout different stages of penis, anus or throat cancer?
15. Do you know anyone that has taken the vaccine? In your local community? Friends, nabours, family?
16. Does the fact that the virus is a sexual transmitted virus have anything to say of their perception of it?
17. Have you ever seen any information about the HPV vaccine given out by the government? In the public space, tv, radio or anything?
18. Do you know anyone that has taken the vaccine? In your local community? Friends, nabours, family?
19. Do you think religion can have anything to do with how people perceive the vaccine?
20. How would religion affect the vaccination program?
21. How do you think parents perceive the vaccine here?

Challenges:

1. What are the challenges the program faces?
2. Are there any differences between private and public schools in how they hand out the HPV vaccine? Is that only an issue in your hospital/school, or is it all over the country?
3. How do the parents of the girls getting the vaccine perceive the need of the vaccine?
4. How would religion affect the vaccination program?

Different perception:

5. How do people working in the school perceive the vaccine?
6. How is the teachers perceiving the vaccine?
7. How do you perceive the HPV vaccine?
8. What do you think is the common knowledge about the vaccine among the girls?
9. Is it any girls or parents who don't want to vaccinate? Why?
10. Nurses: Do you think people know about the HPV-vaccine and what it is for?

Girls out of school/Boy's vaccination

11. We know a lot of children don't go to school in Zanzibar. Do you have any idea how they reach out to the girls who is not getting the vaccine at school?
12. Do you think boys will get vaccinated?

7.2 Interview Guide for Local People Outside the Health Sector in Zanzibar

1. Where are you from?
2. How old are you?
3. Where do you work?
4. Are you religious?
5. Where and when did you first hear about the HPV vaccine?
6. Do you know how it is transmitted?
7. Do you think it is normal to know about the vaccine?
8. What kind of experience do you have with the HPV vaccine program in Zanzibar?
9. How is the vaccine given out? Where, when, and how?
10. How do you perceive the HPV vaccination?
11. How do you perceive vaccination in general?
12. How to you think the local people view the HPV vaccine?
13. Have you ever seen any information about the HPV vaccine given out by the government? In the public space, tv, radio or anything?
14. Do you know anyone that has taken the vaccine? In your local community? Friends, nabours, family?
15. How do you think parents perceive the vaccine?
16. Do you think religion affects the way that people perceive the vaccine?

Challenges:

17. What are the challenges the program faces?
18. Are there any differences between private and public schools in how they hand out the HPV vaccine? Is that only an issue in your hospital/school, or is it all over the country?
19. How do the parents of the girls getting the vaccine perceive the need of the vaccine?
20. How would religion affect the vaccination program?

Different perception:

21. How do people working in the school perceive the vaccine?
22. How do you perceive the HPV vaccine?
23. What do you think is the common knowledge about the vaccine among the girls?
24. Is it any girls or parents who don’t want to vaccinate? Why?

25. Nurses: Do you think people know about the HPV-vaccine and what it is for?

Girls out of school/Boy's vaccination

26. We know a lot of children don't go to school in Zanzibar. Do you have any idea how they reach out to the girls who is not getting the vaccine at school?
27. Do you think boys will get vaccinated?

8.0 Appendixes

8.0 Letter from Knowledge for Change

Knowledge for Change

11 Newmarket Street, Skipton, North Yorkshire, UK, BD23 2HX

Kibokoni, House No. 1814B

Zanzibar

E: info@knowledge4change.org
W: www.knowledge4change.org
P: +44 (0) 7928 009 363

Date: 30/08/2023

Faculty of Social Sciences
Department of Social Work
Oslo Metropolitan University
Pilestredet 46, 0167 Oslo, Norway

Re: Study placement with Knowledge for Change, in Partnership with Mnazi Mmoja Referral Hospital and the University of Salford (UK).

Dear ,

Knowledge for Change (K4C) is delighted to be able to offer you a 16-week student placement from 13/01/2024 - 04/05/2023. K4C represents a long-term international collaboration between Mnazi Mmoja Referral Hospital and the University of Salford (UK). This relationship is governed by a Memorandum of Understanding and the organisations agree to be jointly responsible for the negotiation, organisation and management of the placement.

The placement being offered is practice and study focused and will involve close collaboration with staff and students from the above-mentioned partners and additional stakeholder organisations in Zanzibar. During your placement, you may be based with one or multiple organisations, all of which focus on community development activities which are aligned to your programme of study at Oslo. These include organisations focusing on women and children's empowerment, protecting vulnerable populations (particularly those with a disability or HIV, sex workers or

victims of domestic violence) and improving children's (particularly girls') education.

During your placement, you will be supervised by an appropriate professional, either from within K4C or from one of our partner organisations.

Students are responsible for making their own flight, travel, accommodation, and subsistence arrangements in Zanzibar and must also ensure they have appropriate insurance cover(s) for the duration of their placement. K4C and its constituent partners will assist students wherever possible in making these arrangements. Pastoral and academic support will be provided jointly by K4C and the University of Salford.

The tuition fee chargeable for the above placement will be GBP 1,200.00

For any questions or queries please contact Knowledge for Change using the details provide below.

Yours Sincerely,

Mr Ndawula Allan
Project Manager (K4C, Uganda)
Address: Knowledge for Change (Uganda)
Plot 39, Saaka Road
P.O Box 392, Fort Portal
Kabarole District, Uganda
Email: garyallan46@yahoo.com
Phone: +256 (0) 774 671 007

Dr James Ackers-Johnson
Project Manager (K4C, UK)
Project Manager (University of Salford, UK)
Address: Room L530, Allerton Building, School of Health & Society Salford, United Kingdom
Email: J.Ackers@Salford.ac.uk
Phone: +44 (0) 161 295 2823

7.4 Agreement Knowledge for Change

Name: Mari Wigaard
Date of Issue: 31/09/2023

11 Newmarket Street, Skipton, BD23 2HX
Telephone: +44 (0) 161 295 2823
Email: info@knowledge4change.org
Website: www.knowledge4change.org
Registered Charity Number: 1146911

Terms of Agreement

This agreement confirms that you have been accepted to undertake a voluntary or elective placement in **Zanzibar, Tanzania** through Knowledge for Change (K4C). Your agreed placement dates are as follows:

13/01/2024 - 04/05/2023 (16 weeks)

The total tuition fee for this placement will be **GBP 1,200.00**.

Item	**Cost (GBP)**
Tuition fee	1,200
Accommodation	1,280
Airport transfer	20
Total	**2,500**

The above costs include provision of the following items:

- ✓ Accommodation in Zanzibar (incl. gas, water, electricity, Wi-Fi) for 12 weeks
- ✓ Private transfer from Zanzibar to Accomdation
- ✓ In-country travel for placement purposes
- ✓ Placement supervision
- ✓ Minimum GBP200 sustainable investment into our hosting partner facilities

The above placement costs do not include provision of the following items*:

- × Flights
- × Vaccinations or anti-malarial prophylaxis
- × Covid-19 testing
- × Food or drink
- × Personal/tourist activities undertaken whilst on placement
- × Domestic travel in Norway
- × Insurance

*note: this list is indicative and is not exhaustive.

Placement Evaluation and Review

Through project evaluation, we aim to create a rolling record of your experience and learning whilst on placement. All students / volunteers are asked to comply with the Project Evaluation processes designed by Knowledge for Change which may include surveys, interviews, focus groups and written reports/blogs. You may also wish to develop a personal or public blog detailing the activity on your placements, but please be aware of ethical considerations and confidentiality.

Code of Conduct

Placement Hours:

- Students are expected to 'work' for an average of 32 hours per week whilst on placement
- Students are expected to 'work' regular hours each day. The timing of these hours can be discussed with the placement manager and may be subject to flexibility.
- Students may spend their evenings and weekends as they please (within certain limitations).
- Students will be required to advise their Placement Manager of where they are travelling to if moving outside of the town or city in which they are placed. No student will be allowed to travel outside of their placement country during their placement without prior written consent from their Placement Manager.

Conduct:

Students are reminded that whilst they are on placement, they are representing Knowledge for Change, their respective University and/or their professional body. Students are required to behave in a manner that reflects the professional standing of both the UK and Norwegian institutions and the hosting organisation(s). Any behaviour that brings Knowledge for Change or any of our partner organisations into disrepute will be dealt with through our Disciplinary Policy and may result in termination of the placement and escalation to the respective University or professional body. Students must also adhere to the risk assessment guidance, and any deviation may imply a breach of the terms of their insurance. Students should be aware that if they do deviate from the assessment/guidance that they do so at their own risk.

The following are examples of offences that, having given due consideration to all of the circumstances, may be regarded as Gross Misconduct. It is possible that a student could be dismissed without previous warnings. This list is indicative; it is not to be regarded as exclusive or exhaustive:

- Misuse of drugs, e.g. through misappropriation of drugs or being under the influence of illicit drugs.
- Criminal conduct.
- Sexual offences or sexual misconduct.
- Conduct likely to offend decency (students need to be aware of and observe cultural differences).
- Violence or other exceptionally offensive behaviour.
- Discrimination of any kind against a member of staff or public, including on the grounds of sex, race, colour, nationality, marital status, sexual orientation, religion, disability or social background.
- Breaches of safety regulations endangering oneself or other people including deliberate damage to, neglect of, or misappropriation of safety equipment.
- Reckless behaviour which constitutes a danger to health or safety of any person.
- Breaches of confidentially relating to patients, staff or other persons.

Listed below are examples of offences of Misconduct, other than Gross Misconduct, which may result in disciplinary action and/or counselling in the light of the circumstances of each case. This list is to be regarded neither as exclusive nor exhaustive. Other forms of misconduct may give rise to disciplinary action:

- Failing to observe, without sufficient cause, operational regulations whilst on placement.
- Where any member of the team renders themself unfit, through the use of alcohol or illicit drugs, for duties which they are, or will be required to perform, or which they may reasonably foresee having to perform. E.g. unfit to conduct project work due to use of drink/drugs on the previous day/night.
- Smoking within the workplace, in public areas or while in the company of community officials, local workers and patients (this can cause offence). This also includes smoking within student accommodation or within 5 metres of entrances.
- Failure to adhere to the risk assessment guidelines without good reason.

Emergency Contact Details

Please provide details below of 2 family members or close friends that we could contact in the case of an emergency. These people need to be contactable using the details you provide whilst you are on placement, so do not use someone who may, for example, be on holiday or working abroad during this time.

Emergency Contact 1:

Full name: Bente Wigaard

Phone Number(s): +47 934 07 196

Email address: bente.wigaard@gmail.com

Address: St. Edmunds vei 39 E

Relationship to you: Mother

Emergency Contact 2:

Full name: Liza Wigaard

Phone Number(s): +47 928 824 05

Email address: liza.w.johansen@gmail.com

Address: Båhusveien 14, 0573 Oslo

Relationship to you: Sister

Declaration

In signing this Placement Agreement; you are acknowledging that you have read and understood the content within the Agreement and the Risk Assessment document. You are also agreeing that you have undergone (or will undergo prior to your placement) any necessary health checks, are up to date on all required inoculations, have made arrangements to ensure you have a supply of anti-malarials for the duration of your placement, and will comply with Knowledge for Change's project/placement evaluation activities.

I confirm that I am accepting this offer of a placement with Knowledge for Change. Upon signing this document, I accept that I may not be able to reclaim any donations/transactions made to Knowledge for Change should I later decide to withdraw from the placement.

Name (print): Mari Wigaard

Signature: _____Mari Wigaard_____ **Date:** 31/08

Placement Fees

To confirm acceptance of your placement, we ask that you transfer the required fees to Knowledge for Change. On receipt of your fees, your placement logistics will be arranged. We cannot guarantee that fees can be returned to you should you decide to cancel your placement; however a decision will be made depending on the circumstances and any costs already incurred by the charity. If you, for any reason, decide to withdraw from your placement, please inform us as soon as possible.

Fees can be paid to Knowledge for Change by International Bank Transfer or by Credit/Debit card. Please reference your name on any transfers and forward any transaction confirmations to K4C. To make a transfer by **international bank transfer**, please use the following details:

Name of Account:	Knowledge for Change
Sort Code:	08-92-99
Account Number:	67215744
IBAN:	GB88CPBK08929967215744
BIC:	CPBK GB22
Name of Bank:	The Cooperative Bank Plc.

Please note: it is the responsibility of the sender to ensure all relevant international banking fees are paid.

To make a transfer by **bank-to-bank transfer**, please visit our 'Wonderful' donation platform: **https://wonderful.co.uk/pay?ref=1146911**

If this does not work, then please visit our 'Kindlink' donation platform where you can make a transfer by credit/debit card (fees may apply): **https://donate.kindlink.com/knowledge-for-change/2197**

Overseas Travel Health Questionnaire

Knowledge for Change (K4C) has a duty of care to all students, and this extends to any travel for or on behalf of the charity either for business purposes, study or work placement. Some individuals with health problems or disabilities who cope without difficulties in the UK encounter significant problems when travelling internationally or in unfamiliar environments. All students are asked to complete this short health questionnaire. Please complete the boxes below to the best of your knowledge:

Surname: Wigaard	**First Name: Mari**	**Title: Miss**
Date of Birth: 09/07/94	**Male/Female/Other:Female**	**Phone no:+47 46415817**
Home address: Urtegata 36 F, 0187		**Email address: mariwigaard@gmail.com**
Destination: Oslo		**Date of departure: 13/01/23**

	Please tick the appropriate box:	**Yes**	**No**
1	Are you currently unwell or have you suffered from any physical or mental health issues or required hospital treatment in the last 12 months?		X
2	Do you have a disability or has anyone advised you that you might have a disability/medical condition that could affect your fitness to travel?		X
3	Have you ever been refused travel insurance on health grounds or had special conditions imposed?		X
4	Has anyone advised you to take special precautions or advised against travel to certain areas of the world on health grounds?		X
5	Are you allergic to any particular materials, medications or foods or have any other allergies?		X
6	Have you received at least 2 doses of a Covid-19 vaccine recognised by the UK and/or Norwegian government?	X	

If you have ticked 'yes' to questions 1-5, or if you are unsure about any of these answers, K4C may contact you for clarification. The aim of this questionnaire and any resulting assessment is to identify any support that may be required for travelling or for the duration of your visit. Advice against travel would only be given in very exceptional circumstances and once all other options had been exhausted.

This questionnaire will be held in Knowledge for Change's records until any placement is completed; it will not be shared with any external parties. In signing this declaration, you agree to notify K4C if there are any changes in your health between completing this questionnaire and the day of travel. Failing to inform K4C of a pre-existing health condition can hinder the organisation's ability to provide any necessary support, should it be required. It may also jeopardise your insurance cover and could result in your travel being cancelled.

I declare that I have provided full and honest answers to all questions. I understand that travelling abroad against the advice of a qualified medical practitioner, or knowingly giving a false declaration of health, could invalidate my travel insurance policy and/or result in my travel being cancelled.

Signature: Mari Wigaard University/Organisation: Oslo Met

Date: 31/08/23

7.5 Notification from the Norwegian Social Science Data Services

Sikt

Notification Form

Reference number
753770

Which personal data will be processed?

- Name
- Voice on audio recordings

Project information

Title
HPV-vaksinen i Zanzibar

Summary
Jeg har planlagt å gjøre intervjuer for mitt masterprosjekt i min periode på Zanzibar 15.januar til 15.mai. Tema er så langt HPVvaksinering, og hvordan jenter får denne i skolesystemet. Jeg har til nå avgrenset temaet til hvordan vaksineringen fungerer på private muslimske skoler versus offentlige skoler. Finnes lite informasjon om HPV vaksinen i Zanzibar, imens det er mer om vaksineprogrammet i Tanzania. Jeg vil gjøre intervjuer på sosialarbeidere eller nøkkelpersoner som jobber på skolene, dvs. ikke målgruppen av ungdommer, men heller de som gir ut vaksiner og kan noe om vaksinering i landet.

Describe what you will research and why it is necessary to process personal data to achieve the objective
Jeg skal skrive om gruppen unge jenter og deres tilgang til HPV-vaksinen, men vet ikke om jeg trenger personnonopplysninger om dem da da jeg ikke skal intervju dem.

Project description
Do you want to participate in the research project titled The HPV Vaccine in Zanzibar.docx

External funding
Ikke utfyllt

Academic level
Master's

Contact information, student
Mari, mariwigaard@gmail.com, tlf: 46415817

Data controller

Institution responsible for the project
OsloMet – storbyuniversitetet / Fakultet for samfunnsvitenskap / Institutt for sosialfag

Project leader
Wenche Bekken , wenche.bekken@oslomet.no, tlf: +4767236313

Do multiple institutions share responsibility (joint data controllers)?
No

Sample

1

Describe the sample
Sosialarbeidere/nøkkelpersoner som kan noe om jenter som får/ikke får HPV-vaksine.

Describe how you will identify or contact the sample

Skal snakke med sosialarbeidere/nøkkelpersoner på skolene som gir/gir ikke ut HPV-vaksinen slik at jeg kan innhente informasjon om gruppen uten å intervjue noen av ungdommene i aldersgruppen.

Age group
25 - 70

Which data relating to sample 1 will be processed?
- Name
- Voice on audio recordings

How will data relating to sample 1 be collected?

Personal interview

Attachment

Interview guide for focus group interviews .docx

Legal basis for processing general personal data
Consent (General Data Protection Regulation art. 6 nr. 1 a)

Information for sample 1

Will the sample receive information about the processing of personal data?
Yes

How does the sample receive information about the processing?
Written (on paper or electronically)

Information letter

Do you want to participate in the research project titled The HPV Vaccine in Zanzibar.docx

Third persons

Will the project collect information about third persons?
No

Documentation

How will consent be documented?
- Manually (on paper)

How can consent be withdrawn?
Muntlig eller skriftlig

How can data subjects get access to their personal data or have their personal data corrected or deleted?
Kontakte meg.

Total number of data subjects in the project
1-99

Approvals

Will any of the following approvals or permits be obtained?
Ikke utfyllt

Security measures

Will the personal data be stored separately from other data?
Yes

Which technical and practical measures will be used to secure the personal data?
- Continuous anonymisation

Where will the personal data be processed
- Hardware

Recipients

Who has access to the personal data?
- Project leader

Will personal data be transferred to a third country?
No

End of project

Project period
15.01.2024 - 15.11.2024

What happens to the data at the end of the project?
All data will be deleted (deleting raw data)

Will the data subjects be identifiable in publications?
No

Additional information

7.6 Assessment from Norwegian Social Science Data Services (SIKT)

Sikt

Assessment of processing of personal data

Reference number
753770

Assessment type
Standard

Date
27.11.2023

Title
HPV-vaksinen i Zanzibar

Institution responsible for the project
OsloMet – storbyuniversitetet / Fakultet for samfunnsvitenskap / Institutt for sosialfag

Project leader
Wenche Bekken

Student
Mari

Project period
15.01.2024 - 15.11.2024

Categories of personal data
General

Legal basis
Consent (General Data Protection Regulation art. 6 nr. 1 a)

The processing of personal data is lawful, so long as it is carried out as stated in the notification form. The legal basis is valid until 15.11.2024.

Notification Form

Comment
Personvernтjenester har vurdert endringene registrert i meldeskjemaet.

Det er vår vurdering at behandlingen av personopplysninger i prosjektet vil være i samsvar med personvernlovgivningen så fremt den gjennomføres i tråd med det som er dokumentert i meldeskjemaet med vedlegg. Behandlingen kan fortsette.

OPPFØLGING AV PROSJEKTET
Vi vil følge oppved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet.

Lykke til videre med prosjektet!

7.7 Informed Consent Form for participants in the research

Do you want to participate in the research project

"The HPV Vaccine in Zanzibar"?

This inquiry extends an invitation to your participation in research with the principal aim of gaining a deeper understanding of the infrastructure, deployment and functionality of the HPV vaccine in Zanzibar. Within the framework of this master's project, I intend to investigate the experiences related to the implementation of the vaccine program in educational institutions. Social workers or other key figures that are surrounded by vaccination program will be subjects of the interviews. A part of the project also aims to interview people in the local community to understand more of the common knowledge about the vaccine. An essential aspect of this research is to examine their perspective and knowledge about the vaccine to be able to identify potential challenges, barriers or opportunities regarding the vaccine program. Interviews will be conducted at the house of the organisation Knowledge for Changes.

Why are you being asked to participate?

Due to your involvement in or knowledge about the vaccine programs, we are requesting your participation. The research itself will focus on the experiences or knowledge of common people, but also influential key figures concerning the planning, execution, and follow-up of vaccination procedures.

Project responsibility

Oslo Metropolitan University is responsible for the personal data processed in this project. My supervisor Wenche Bekken has the responsibility for this project. I will also be collaborating with Knowledge for Change, an organization affiliated with the University of Salford, where my contact person is Louise Ackers.

Voluntary Participation

Participation in this project is entirely voluntary. There will be no negative consequences if you choose not to participate or decide to withdraw from the project later. If you wish to withdraw, please contact mariwigaard@gmail.com. All information about you will be made anonymous.

What does participation entail for you?

Participation in the project involves taking part in individual interviews or group interviews. No private personal information will be collected from anyone. All that this requires is your job description and professional background. I will record audio and video during the group interviews and transcribe these later.

Bried overview of privacy

We will only use your information for the purpose outlined in this document. We handle personal data confidentially and by privacy regulations. More privacy information can be found below*.

Further details on privacy – How we collect and use your information

This study will not have access to any personal data. What I need to know is your name, contact information, and work experience. To safeguard this information, I will create a code that will be associated with a list of names in other data. My data will be restored on a research server where the entire interview will be transcribed, and it will be deleted after work is completed.

What gives us the right to process your personal data?

We process your information based on your consent. On behalf of Oslo Metropolitan University, privacy services at Sikt – Norwegian Agency for Shared Services in Education and Reasearch, have assessed that the handling of personal data in this project aligns with privacy regulations.

Your rights

As long as you remain identifiable in the data, you have the right to:

- Request insight into the information we process about you and receive a copy of said information.
- Request correction to any erroneous or misleading information about you.
- Request the deletion of personal data pertaining to you.
- Lodge a complaint with the Data Protection Authority regarding the handling of your personal data.

We will provide you with an explanation if we deem you cannot be identified, or if the rights cannot be exercised.

What happens to your personal data when research project concludes?

The project is slated to conclude on May 15, 2024. The data on the server will be deleted at that time.

Questions

If you have any questions about your rights, please contact:

- Project coordinator: Mari Wigaard mariwigaard@gmail.com Phone: +47 46 41 58 17
- Supervisor Norway: Wenche Bekken wenche.bekken@oslomet.no
- Supervisor in England: Louise Ackers h.l.ackers@salford.ac.uk
- Our Data Protection Officer: Ingrid Jacobsen personvernombud@oslomet.no

For inquiries related to Sikt's assessment of the project, you can contact via email: personverntjenester@sikt.no, or by phone: +47 73 98 40 40.

I have received and understood the information about the project "HPV Vaccine in Zanzibar" and have had the opportunity to ask questions. I consent to:

☐ Participate in interviews

☐ Share my thoughts, ideas, and knowledge about the HPV vaccine in Zanzibar.

☐ Allow project coordinator Mari Wigaard to provide information about my name, job title and work experience on my behalf of the project.

☐ Allow my personal information to be stored after the project's conclusion on May 1 15.

☐ I consent to the processing of my information until the project is concluded.

X_____

Particant:

Signature: _____

Sincerely Mari Wigaard and Wenche Bekken.