Hurdles to Health: An Exploration of the Social Determinants that Affect Attitudes toward HPV Vaccination in Salvador, Bahia, Brazil

Megan Rogers
SIT Graduate Institute - Study Abroad

Follow this and additional works at: https://digitalcollections.sit.edu/isp_collection
Part of the Public Health Education and Promotion Commons, Women's Health Commons, and the Women's Studies Commons

Recommended Citation
Rogers, Megan, "Hurdles to Health: An Exploration of the Social Determinants that Affect Attitudes toward HPV Vaccination in Salvador, Bahia, Brazil" (2015). Independent Study Project (ISP) Collection. 2261.
https://digitalcollections.sit.edu/isp_collection/2261
Hurdles to Health:
An Exploration of the Social Determinants that Affect Attitudes toward HPV Vaccination in Salvador, Bahia, Brazil
Rogers, Megan
Academic Director: Ventura, Gabriela
Project Advisor: Góes, Emanuelle, MS in Nursing with an emphasis in Women’s Health and PhD in Public Health, Instituto de Saúde Coletiva and Universidade Federal da Bahia
Brazil, Salvador, Bahia
Seattle University
Submitted in partial fulfillment of the requirements for Brazil: Public Health, Race and Human Rights, SIT Study Abroad, Fall 2015
Abstract

In 2014, the Brazilian government began supplying free, preventative human papillomavirus (HPV) vaccines for girls between the ages of 9 and 13. This public health campaign has the potential to greatly reduce the high HPV infection rate in Brazil, but without targeted education and information to supplement this medical intervention the program is predicted to have a smaller impact. This study aims to assess how well information about the HPV vaccine is currently reaching young Brazilian girls and their families.

Data was gathered by interviewing professionals who work in STD education, women’s issues, and healthcare advocacy, as well as one mother of a young girl. By speaking to this array of people a clearer picture of some of the major stumbling blocks that impede the realization of the government’s 80% HPV vaccination goal developed.

The current national healthcare campaign is highly focused on cancer-prevention, which provides a good incentive for many Brazilian families to vaccinate their daughters, but does not account for the relationship between HPV and sex. This study categorizes and explores some of the other social determinants, or factors, that contribute to a family’s decision to vaccinate and, therefore, the overall future sexual health of Brazil.

Resumo

Em 2014, o governo brasileiro começou a fornecer gratuitamente, papilomavírus humano (HPV) de prevenção vacinas para meninas entre as idades de 9 e 13. Esta campanha de saúde pública tem o potencial de reduzir significativamente a taxa de infecção pelo HPV alta no Brasil, mas sem educação orientada e informação para completar esta intervenção médica o programa está previsto para ter um impacto menor. Este estudo tem o objetivo avaliar como a informação bem sobre a vacina HPV está atingindo as moças brasileiros e suas famílias.

Os dados foram recolhidos por profissionais de entrevista que trabalham na educação das DST, as questões das mulheres, a defesa da saúde, assim como uma mãe de uma menina. Por falar para esse conjunto de pessoas uma imagem mais clara de alguns dos principais obstáculos que impedem a realização do objectivo de 80% de vacinação HPV do governo desenvolveu.

A campanha nacional de saúde atual é altamente focado on-prevenção do câncer, o que proporciona um bom incentivo para muitas famílias brasileiras para vacinar suas filhas, mas não leva em conta a relação entre HPV e sexo. Este estudo categoriza e explora alguns
HURDLES TO HEALTH

dos outros determinantes sociais, ou de fatores, que contribuem para a decisão da família para vacinar e, portanto, a saúde sexual futuro global do Brasil.

Keywords

*Human papillomavirus (HPV), cervical cancer, vaccination, sexuality, health education*
## Table of Contents

Acknowledgements ........................................................................................................ iv

Introduction .................................................................................................................. 1

- **Problem Statement**
- **Literature Review**

Methodology .................................................................................................................. 8

- **Research Location**
- **Data Collection and Analysis**
- **Limitations**
- **Ethical Concerns**

Results and Discussion ............................................................................................... 12

- **Evolution of Research**
- **Perceptions and Misconceptions of Sexuality**
- **Systematic Gaps**

Conclusion ..................................................................................................................... 22

- **Recommendations for Future Research**

References ...................................................................................................................... 25

Appendix

- **SIT Questions** ....................................................................................................... 27
- **Figures** .................................................................................................................. 30
- **Pre-Interview Statement** .................................................................................... 32
- **Informed Consent Form** ..................................................................................... 33
- **Interview Questions** .......................................................................................... 35
- **Interviews Conducted** ....................................................................................... 37
Acknowledgements

I would like to thank Emanuelle Góes who was my Project Advisor. Her help with interview contacts, her constant reassurance, and her willingness to answer my questions at any time of the day made this research possible.

Thank you to Gabriela Ventura, the Academic Director of the School for International Training (SIT) in Salvador, who aided me in crafting my original problem statement, and worked to make connections for me within SUS both for my research and my personal growth.

Many thanks to Rafaela Loureiro, the Program Assistant for SIT Salvador, who helped me make phone calls in Portuguese, and always made a tremendous effort to find answers to my technical questions.

I am also grateful to Paula Santos, Caroline Feitosa, and Juarez Dias for going out of their way to help me make connections to potential interview sources.

Thanks to Amanda Santos, my SIT Portuguese instructor, who was indispensible in making my interview questions intelligible in a language that was entirely foreign to me only months ago.

I greatly appreciate the patience and generosity of my host family in Salvador. They have always looked out for my wellbeing and their immense kindness for opening their home to me will not soon be forgotten.

I am incredibly thankful to all four of my interviewees who took time out of their busy schedules to meet with me and to give me thoughtful feedback on my research questions. This project would not exist without them.

Finally, my most sincere thanks to my friends and family for the emotional support and endless encouragement that they have provided, not only throughout the production of this paper, but over the last three months. You have been my lifeline.

Thank you.
Introduction

Problem Statement

The practice of preventative medicine, such as simple vaccine regimens, presents a unique opportunity for healthcare communities worldwide to outmaneuver many communicable diseases. Additionally, in this manner, government-run healthcare systems can save money by choosing to treat citizens before serious and costly medical conditions take root. In the United States, heated debate about the efficacy of economization through vaccine campaigns has been underway for years without result; Brazil, however, is setting a prime theoretical example of universal health care, including targeted vaccination efforts, through the public, government health organization Sistema Único de Saúde (SUS). The increased administration of the new human papillomavirus (HPV) vaccine means that the government of Brazil has the potential to greatly impact the sexual health of its public over coming generations. At the same time, education about the utility, safety, and function of the HPV vaccination needs to be available in order to entice willing patients, and their families, to participate in immunization campaign and to proactively maintain their health after vaccination.

In Brazil, vaccine refusal has led to less than target immunization rates. As the government cannot force compliance, people who are afraid of illness or side effects caused by the shots often go without (Souza, September 15, 2015). The human right of an individual to abstain from vaccination is clear, however, the health of a community as a whole rests on the collaboration of the entire population to create a healthy environment.

In the case of sexually transmitted diseases (STDs) some risk can be undertaken knowingly with the aid of physical protection, such as condoms. For HPV, however, the additional protection of a vaccination can stop not only the spread of an irksome STD, but also cancer. HPV is know to cause genital warts that can lead to abnormal tissue growth, and, eventually, the evolution of cervical and anogenital cancers through unmitigated cell division. This highly prevalent STD, which infects as many as 75% of sexually active individuals worldwide, manifests in more than 150 different strains, meaning that immunity or previous contraction of a less virulent form of HPV does not necessarily protect an individual from re- or more pronounced infection (Lima et al., 2013, p. 2; Villa, 2014, p. 1). This high rate of HPV is especially significant in Brazil, where “cervical cancer is the second most common cancer among women” and the “cervical cancer incidence rate is two to three times higher…than in North America and Europe” (Kawai, Branco de Araujo, Fonseca, Pillsbury, & Singhal, 2012, p. 250).
HURDLES TO HEALTH

In 2014 SUS stated that it would begin to combat the high HPV infection rate through a public health vaccination campaign. The stated goal for this effort is 80% vaccination for girls aged 9 to 11 (with a temporary catch-up campaign for 12 and 13 year-olds in the coming years), and to maintain or raise that proportion as the program continues (Figure 2; AFP News, 2014). A generic, quadrivalent vaccine, which protects against the four most common types of HPV (two which have been shown to cause cancer and two of which do not), was selected for use in Brazil because of its wide-reaching coverage.

This project attempts to better understand the ways in which social determinants affect the attitudes of young girls and their families towards vaccination. I will identify specific reasons for vaccine refusal, define the role of supporting organizations in promoting sexual health, and create a context for cultural norms that negatively impact the public’s view of and access to the vaccine. The public health of all communities rests on the quality of the resources provided, and a well-formulated HPV campaign could have a significant impact on the overall health and wellbeing of the population of Salvador, Brazil. Each community faces different health challenges, but the newness of the HPV vaccine in Brazil presents a unique opportunity to understand this population’s relationship with sexual health and prevention strategies.

Literature Review

Brazil has an extremely high rate of HPV infection, which is “the primary cause of cervical cancer...causing approximately 70% of cases” of that disease (Kawai et al., 2012, p. 250). Currently, between 9 and 10 million Brazilians are infected with the virus, which leads to an annual tally of “17,540 new cases of cervical cancer” (Kury et al., 2013, p. 19). Additionally, due to poor screening and a lack of sexual health knowledge in the general population more than 4,000 Brazilian women die each year from HPV-caused cervical cancer (Kury et al., 2013, p. 19). Because of discrepancies in the availability of care and other social determinants that hinder the health of minoritized populations, Brazil, and other Latin American countries, suffer from “large within-country variation in cervical cancer incidence and mortality” (Villa, 2012, p. 1409).

Inequalities within the Brazilian healthcare system include both racial and socioeconomic discrimination, which make the incidence of disease more likely in an already marginalized population (Travassos, Laguardia, Marques, Mota, & Szwarcwald, 2011, p. 41). HPV strikes darker-skinned communities more forcefully than others (Silva, et al., 2009, p. 888). Many health professionals feel uncomfortable speaking to the existence of this discrimination, but SUS acknowledges its existence through a reporting campaign (Figure 1).
In fact, “around 10% of subjects who used health services...reported some form of discrimination,” and people with darker skin reported multiple types of discrimination at higher rates than other groups (Travassos, et al., 2011, p. 41; Travassos, et al., 2011, p. 39). Recognition of this potential prejudice, and the related lack of treatment, is the first step to equalizing the Brazilian healthcare system, as, currently, a large part of the problem of disproportionate HPV infection lies in the social set-up of that system. These forces come together to make access to relatively cheap and effective sexual health tools difficult for certain pockets of the population.

Simple diagnostic techniques, such as Pap smears, and prevention strategies like “the use of condom[s] and also HPV vaccination are the current state of the art of prevention” against HPV infection and its evolution into cervical cancer (Kury et al., 2013, p. 20). As the new HPV vaccine comes into greater use in Brazil it will remain important to take advantage of Pap smears and condom use because of factors that may lower the effectiveness of the prophylactic immunization. Although “cervical cancer is more common in women aged 40–60 years,” the best time to prevent the initial HPV infection is prior to the beginning of sexual activity (Kury et al., 2013, p. 20). It has been reported that, “the highest incidence of infection occurs soon after the onset of sexual activity,” which may be before the vaccine is even offered (Kury et al., 2013, p. 20).

In Brazil “36% of young people between 15 and 24 say they had their first sexual intercourse before the age of 15” (Costa et al., 2014, p. 640). This early sexual debut means that a third of the population remains at heightened risk for HPV infection, especially as many of the interviewed subjects explicitly indicated that they had “engaged in sexual behaviors placing them at risk of HPV acquisition before HPV vaccination” (Hofstetter et al., 2014, p. 1943). Because of this early and risky sexual experience it appears necessary to engage young people and their families in greater sexual health education. This can increase their knowledge about the effectiveness of the HPV vaccine and, while possibly encouraging them to abstain from dangerous exposure prior to full vaccination, teach about reasons for, and methods of, safe sexual activity.

Even after vaccination, the use of condoms to protect against infection remains an effective measure (Costa et al., 2014, p. 635). Current HPV vaccines are only formulated to prevent infection by the four most common types of HPV, but over 150 strains exist (Lima et al., 2013, p. 2). HPV vaccination has the potential to be an especially important intervention in Brazil because: “condoms are still underutilized, especially among teenagers. [The] Ministry of Health data show condom use rates as around 0.2 to 1.4 percent by the age group
15-19 years” (Costa et al., 2014, p. 635). Part of this trend is likely due to that fact that this population considers the prevention of pregnancy, rather than the prevention of disease, to be the main reason for condom use, but additionally, “forgetfulness, cost, and reports of impairing pleasure in the sexual intercourse” all conspire to produce astronomically low condom use rates (Costa et al., 2014, p. 642; Borges et al., 2010, p. 286). Additionally, “sexually experienced respondents were more likely to feel a lower need for safer sex if they had not used a condom the last time they had had sex with their main partner,” indicating that there is a cyclical pattern of behavior, beyond the aforementioned external factors (Doskoch, 2012, p. 70). The overall lack of education about the utility of condoms has led to a lackadaisical mentality that continues to put young Brazilians at extremely high risk for HPV and other STDs.

Even when education about condom use has been taught, the gender dynamics within a partner relationship may complicate the logical use of such protection. A study done on Brazilian couples showed that “men, exercising hegemony in gender relations, end up determining the contraceptive method that women will use” because “[i]t is not yet accepted that a woman takes the initiative in this matter” (Marchi, de Alvarenga, Osis, & Bahamondes, 2008, p. 103; Marchi, et al., 2008, p. 107). This situation illustrates how, when the balance of power inside a relationship is unequal, the external factors of access to, and education about, STDs can cease to have an effect on the choices that the female partner can make, or feels that she can make. Additionally, should one of the partners propose the use of protection against STDs they potentially “acknowledg[e] the possible existence of infidelity”—an insinuation that could have a variety of consequences (Gomez & Marin, 1996, as cited in Marchi, et al., 2008, p. 107). However, if infidelity does occurs, the individual with less control in an unbalanced relationship could suffer the harmful consequences of exposure to an STD because they felt that cultural gender expectations held them back from using protection. The long-abided norm of female submissiveness reduces a woman’s agency and creates opportunities for the spread of disease.

As young girls start to receive the new HPV shot throughout Brazil, the country is presented with a unique opportunity to actively educate the next generation about sexual health and STD prevention in a new way. Currently, “ignorance with regard to the forms of transmission, signs and symptoms caused by HPV may suggest gaps in preventive strategies of health services” (Costa et al., 2014, p. 635). Although prior to this vaccination campaign it may have been difficult to reach out to pre-adolescent and adolescent girls about sexual health, the SUS, and other organizations that provide STD education and treatment, may start
to make up for the current lack of knowledge as 9 to 13 year-olds come to get their three-shot series.

An education program through the universal health system would be extremely beneficial to girls from lower socio-economic families. People with “higher educational attainment” have, statistically, shown more “knowledge on HPV transmission as compared to those less educated”; however, regardless of this divide, in one recent study, “[o]nly a minority of the women interviewed were able to quote correctly the transmission mode of the HPV and identify the signs and symptoms of the infection caused by this virus” (Moreira et al., 2006, p. 601; Lima et al., 2013, p. 4). Without baseline knowledge about how a disease is acquired it is nearly impossible to combat the spread of infection. A SUS sexual health curriculum could help to remedy this lack of knowledge and help women stay healthy. The findings from another study report that, “more than two thirds of the women…did not know the potential consequences of HPV and less than 10% knew that it might lead to cervical cancer,” but, it can be assumed that if information was more readily available and more widely known, more people would be careful about protecting themselves from infection (Moreira et al., 2006, p. 602). Indeed, once interviewees were made aware of the consequences of HPV and the existence of a vaccine against it 88% to 100% of women (from various studies) said that they would agree to receive the immunization if it was offered (Rama et al., 2010, p. 39).

One significant reason for the lack of public knowledge about HPV, and sexual health in general, may be due to the way that information is passed down. Although the main source of knowledge about sexual health is usually healthcare staff, it may be that patients—particularly young girls—internalize health education more readily when it comes from a family member (Lima et al., 2013, p. 4). In a study of HPV risk perceptions if was found that “poor maternal knowledge and/or communication [about sexual health] were related to inaccurate or poor articulation of risk perceptions [in daughters]” and vice versa (Mullins, Widdice, Rosenthal, Zimet, & Kahn, 2015, p. 3907). “Girls whose mothers demonstrated higher knowledge and/or communication about HPV vaccination tended to articulate accurate risk perceptions” (Mullins et al., 2015, p. 3909). In either case, “the vaccination visit was an opportunity [for the mother] to talk about their family’s values related to sex and provide sexual health education to their daughter,” potentially with the medical guidance of the health professionals on hand (Mullins et al., 2015, p. 3910).

The vaccination visit can also be an opportunity for mothers to check in with their daughters and learn more about their children’s understandings of sexual health and the need
HURDLES TO HEALTH

for protection. Before vaccination some parents believe that “vaccination may lead to inaccurate risk perceptions…and subsequent riskier sexual behaviors”; however, recent studies suggest that this is not necessarily true (Mullins et al., 2015, p. 3907). Generally, girls who receive the HPV vaccination become “less likely to practice riskier behaviors due to the education that girls received with vaccination” (Mullins et al., 2015, p. 3910). Education is the key in this equation because other “[v]accine recipients perceived less need for safer sex if they were less knowledgeable about HPV and the HPV vaccine” (Doskoch, 2012, p. 70). As long as the immunization and education are provided together the end result tends toward safer sexual practices.

For some young people, the idea of sexual education may be a new topic altogether. People who come from more socially conservative families may not have had educational conversations about sex or sexuality and could, therefore, have little frame of reference when the subject HPV vaccination is first broached. Social conservatism that limits the acceptability of openness about sexuality has been linked to a “religious environment at home,” which, in turn, has been shown to be “one of the main determinants of adolescent attitudes toward sexuality” (Thoraton & Camburn, 1987, as cited in Hoga, et al., 2010, p. 703). Some deeply religious parents are more concerned with upholding “the image of ‘good girl,’” not wanting their daughter to be perceived as having low “moral value” by associating with issues of sexuality, even those that promote health (Hoga, Tibúrcio, Borges, & Reberte, 2010, p. 709). Therefore, as young people and their families form views about the role of sex, healthcare providers may, unwittingly, be insufficiently prepared “to deliver care when religious needs are involved” (Salgado, Rocha, & Carvalho, 2007, as cited in Hoga, et al., 2010, p. 714). Despite a healthcare provider’s best intentions, it may simply not be possible to give adequate health care, including knowledge about sexual health, to all patients by utilizing a universal method. Differing views and backgrounds must be taken into account in order to overcome cultural barriers that prevent the utilization of all the tools that a healthcare system has to offer.

The importance of HPV education, along with diagnostic testing and vaccination, is evident in the high incidence of infection in the Brazilian population. The SUS has started an important campaign to immunize the up-and-coming generation, but medical interventions alone will not be enough to adequately protect the young girls currently eligible for the vaccine. Without education that can rise above issues of race, systemic access, education, religion, and gender and family dynamics, the campaign for HPV prevention will almost certainly struggle to meet its 80% vaccination goal. As the president of Brazil, Dilma
HURDLES TO HEALTH

Rousseff, stated when she announced the commencement of the HPV vaccination program, “[t]he state has an obligation to protect all girls”; however, to be truly effective, the program must expand beyond the utilization of vaccination alone (AFP News, 2014).
HURDLES TO HEALTH

Methodology

Research Location

The research for this project was conducted in the city of Salvador, Bahia, Brazil, which is in the northeast region of the country. The city of Salvador was the original colonial capital and served as the main entry point for most of the African slaves brought to Brazil throughout the 16th to 18th centuries. Today, approximately 80% of the Bahian population is of African ancestry, a legacy that gives the area a signature culture and ambiance, but also creates social issues that are unique to this area (Duffy, 2009). Racial and class dynamics compound disparities in health and socioeconomic status in a way that makes the perspective of public health in Bahia different than in other parts of Brazil. By conducting fieldwork in Bahia, the results of this study evaluate the perceptions of the HPV vaccine in this region. The observations and patterns discussed here are specific to the campaign of HPV vaccination in this state.

Data Collection and Analysis

I gathered data from four interviews conducted over the month-long course of the research period. Three of the interviewees work in public health related fields at local organizations that promote sexual health and women’s rights. Each woman had a slightly different area of expertise and perspective on sexual health, but their varying arenas of work each addressed the topic of HPV vaccination in a way that was valuable to my research. The fourth interviewee is a community member with a young daughter who has not yet received the HPV vaccine. These four interviewees were selected because of their experiences with, and understandings of, the SUS HPV vaccination campaign, but also because of my access to them as a student researcher. More information about the interviewees is provided in the Appendix.

I conducted one-on-one meetings with each of the four women at times and locations that were mutually convenient, therefore, they varied from case to case. I used a list of pre-prepared questions, which can be found in the Appendix, as the backbone of my semi-structured interviews with each of the three organizational professionals. The fourth interview was conducted as a conversation, and flowed from the interviewee’s personal experiences and observations; that interview did not address the same questions that I posed to the public health professionals because they were not applicable.

Before each interview I read each interviewee a list of statements that included their right to skip any uncomfortable questions or terminate the interview at any time. Additionally, each interviewee signed an informed consent form and verbally agreed to the
use of their legal name before the interview began. All of the interviews were conducted in Portuguese and were recorded with the verbal consent of each subject. Materials outlining the exact questions asked before the interviews and a copy of the informed consent form can be found in the Appendix.

During the interviews I took the most detailed notes I was able to while still engaging in the conversation. These notes, taken in a mix of English and Portuguese, highlighted the insights that seemed most important at the time, as well as words that I would need to translate later. After each interview session I analyzed the voice recordings, and wrote summarized transcripts in English that also included my initial notes. As I collected more data I coded the pertinent information as that I could have an easier time identifying and analyzing trends.

My research was conducted by interviewing key informants, most of whom I connected with through my Project Advisor. I made this choice because of time constraints and the amount and type of resources I had to make connections with sources. I chose to conduct my research through semi-structured interviews because of the level of detail I felt that I could obtain through this qualitative method. A more uniform method of data gathering, such as a survey, would not have allowed for personalization of pre-structured questions, embellishment of answers, or follow-up inquiries when needed. The semi-structured interview format allowed for me to shift the conversation towards topics that seemed more promising and for me to respect the boundaries of my interviewees. This flexibility became a vital element in my research because, although I was initially looking for information about SUS-based HPV and STD education, I learned about the myriad social determinants that affect sexual health in Salvador in a much greater way.

Limitations

Prior to starting my research I identified ethical considerations that prohibited me from interviewing subjects under the age of 18. This factor limited my field research because I was unable to gain the perspective of the girls receiving the vaccine, which could have provided more information about HPV and the HPV vaccine reaches, or does not reach, its intended public.

One limitation I had not expected to encounter was the newness of the HPV vaccine. I had expected to readily find new data tracking the use of the immunization and a budding education program to supplement and support the medical treatment, but I did not. Although I was not able to extensively scour the state for educational programs, my sources informed me
that the type of information I was originally looking for was not available at this early stage in the vaccination implementation process.

This study was also limited by access to potential interviewees and difficulty contacting people of interest. It was hard to identify people who could provide accurate and helpful information about the HPV vaccination campaign because of my limited knowledge of public health professionals in the area. With the assistance of my Project Advisor I successfully contacted four interviewees, but, in an effort to gain a perspective from the SUS, I contacted the Immunization Coordinator for the Bahia State Secretary of Health, and enlisted the help of the School for International Training’s (SIT) Academic Director in contacting the management of the Centro Especializado em Diagnóstico, Assistência e Pesquisa (CEDAP), a governmental health organization that works specifically with STDs. Although I had some promising initial contact with both of these sources, I was not able to interview either of them for this project. Therefore, none of my sources work directly for the SUS HPV vaccination campaign, which may affect my findings concerning the government program.

The small sample size that I obtained also limits my study. More perspectives and additional validation of the perspectives outlined here are necessary to corroborate my findings. I have attempted to focus on the most obvious similarities between the statements of the three public health professions I interviewed, and to show support for those accounts with testimony of the mother I interviewed. The themes I found seem to be well-supported, but a larger sample size could have helped to identify more social determinants of sexual health in Salvador, or bolster the evidence for those stated in my research.

Additionally, my imperfect Portuguese-language skills likely affected the research because the flow of conversation was less fluid than it would have been in my native English. Although I understood the answers that I gathered well, I missed the opportunity to ask some potential questions because the subtlety of the interviewee’s answer did not fully register at the time of the conversation.

**Ethical Concerns**

Before I started my interviews I explained the purpose of my research and my intentions with the materials that I collected. I obtained legal consent to record all of the interview sessions and to use the information I gathered through the signing of the SIT consent form, and I made every effort to respect the boundaries and privacy of my research subjects throughout the interviews that I conducted. I assured my interviewees that I will continue keep their personal information secure and I gave them the option of making
themselves anonymous with a pseudonym. I never pressured any of my interviewees for an answer they were unwilling to give.

Other ethical concerns for this research relate to the over-generalization of particular community. I have not, in any way, aimed to stereotype or pigeonhole the experience or beliefs of any group or people, but this is possible due to the low number of interviews I was able to perform and the similarities between many of the perspectives gathered from those encounters. I have done my best to correctly attribute and contextualize quotations throughout my Results and to provided as much framework as possible when explaining sensitive topics in my Discussion.
Results and Discussion

Evolution of Research

When I began this project I set out to understand the ways in which HPV education has changed since the implementation of the HPV vaccine in Brazil in 2014. In crafting my original question I made many assumptions that limited my ability to see the larger picture of sexual health policy, education, and access in Salvador. Even after my extensive initial literature review, I had a hard time placing my topic within the wider scope of STD education and treatment in Brazil; there are many studies that report staggering HPV infection rates and cancer statistics, but not many that speak to advances in prevention outside of increased vaccine administration. With little information about the quality of sexual health education in Brazil I felt uncertain about what my finding may be. This uncertainty lead me to write and rewrite my research questions before my first interview, trying to keep in mind the many potential directions that my research might possibly take.

I was, therefore, surprised when, after my first interview, I did not feel the need to significantly alter my questions or the way that they were asked. Among the three sessions for which I used my prepared questions, I received different, interesting, and relevant answers to various parts of each item. When I first became interested in delving into the HPV vaccine as a research topic I considered it from a strictly medical point of view. In my mind I saw the issue in blanket terms, which lead me from acknowledging that HPV is a disease, to understanding that vaccination is a good prevention strategy, to the idea that education about sexual health and STDs could help young women stay healthier throughout their lives. In my research I learned that not everyone is aware of STDs in the same way, that vaccination can be a frightening prospect, and that many building blocks need to be in place for any type of education to be effective. In the end, I saw a much different picture of sexual health in Salvador than I originally thought was possible. Through the filter of the HPV vaccine, I came to better understand the systemic deficiencies that make sexual health education and STD prevention a bigger issue than any one disease.

My research aims to identify the main social determinants that affect the universal application of HPV vaccination in Salvador, and to lay the groundwork for those hoping to further sexual health in the region.

Perceptions and Misconceptions of Sexuality

The HPV vaccine is an extremely new tool in Brazil. It has only been universally offered through the SUS for one year, and because of that, the public has had limited information about its efficacy. Rosa, a coordinator for a sexual health support organization in
Salvador, explained that, regardless of the type of vaccine, safety and helpfulness needs to be believable and believed before people are willing to receive it (R. Marinho, personal communication, November 24, 2015). The public is also not convinced that there are no adverse effects, said Emanuelle, a clinician and researcher at a Salvador health institution (E. Góes, personal communication, November 27, 2015). The general skepticism about HPV vaccination was new to me when I began researching this topic, and I found that it revealed a different attitude towards medical interventions than I expected or had even encountered before.

In order to delve into this research I needed to overcome my personal misconception that the main focus of HPV vaccination was health because I discovered very different expectations in the Brazilian context. My misguided belief had originally been enforced by SUS materials, and by news and scholarly articles about the HPV vaccination campaign in Brazil. Posters promoting the HPV vaccine specifically highlight its cancer-preventing potential, and academic reports on the subject center on the prospect of reducing Brazil’s high infection and cancer rates through vaccination (Figure 2). In practice, the people of Salvador experience HPV vaccination as way that is much more related to sex and sexuality than to disease.

**Age at Vaccination**

Because HPV, and therefore its prevention, is so closely associated with sex, the age at which the vaccination is administered can be controversial. For many parents the idea of vaccinating a 9 to 11 year-old daughter against an STD is uncomfortable because they do not feel ready to think of their daughters as sexual beings (E. Góes, personal communication, November 27, 2015). Amanda, the mother of an 11 year-old daughter, explained that there is debate about the timing of vaccination even within her own family: her mother believes that the vaccine should be administered after the start of “vida sexual,” or sexual life, while Amanda thinks that the vaccine should be given to girls before they become sexually active. Because of the unpredictable timing of sexual initiation, Amanda agrees with the idea that the HPV shot should be administered sometime during early adolescence, but she still feels that 11 is too young for her daughter to receive the vaccine. (A. Santos, personal communication, December 1, 2015)

This sexual activity–based interpretation of the best time to initiate vaccination is logical based on the transmission method of HPV, however, it is contestable based on medical evidence. The early administration of the HPV shot has been proven beneficial because the protection provided by the vaccine grows over time. The SUS vaccine regimen
is, accordingly, spaced out over a total of five years to maximize the protection benefits of the immunization (Figure 2). Therefore, the reluctance of some parents to give the HPV shot to such young girls indicates that the SUS has not properly educated potential vaccine recipients and their families about the medical reasoning behind such early vaccination initiation.

Another worry related to the age of girls at vaccination is a misconception that many parents have about the effect that the vaccine itself could have on their daughter’s sexuality and desire for sexual activity. Two of the public health professionals I interviewed touched on this sentiment. Emanuelle stated that, in her experience, parents can be worried that the vaccine will awaken their daughter’s sexuality and this will, in turn, lead to teenage pregnancy, or relations with multiple young men (E. Góes, personal communication, November 27, 2015). Sandra, a feminist activist and coordinator for the lesbian, gay, bisexual, and transgender movement in Salvador, has experienced similar reactions in schools where, she reports, she has been approached by parents who think that her teachings about reproductive and sexual health amount to encouraging the students to engage in sexual activity (S. Muñoz, personal communication, November 27, 2015). According to Emanuelle, parent’s anxiety about increased sexuality arising from HPV vaccination stems from the same sentiment that these parents hold for the availability of condoms in schools (E. Góes, personal communication, November 27, 2015). Many parents are skeptical of the psychological effect that contraceptives could have on their children; they worry that, by addressing sexual health, sexual activity will occur.

On the other end of the spectrum, some parents have expressed concerns that the HPV vaccine could have negative effects, such as sterilization, on their daughters’ reproductive systems (S. Muñoz, personal communication, November 27, 2015). For the parents who are convinced of these beliefs vaccination presents a significant risk either way. The misconceptions about the HPV vaccine that inform a social climate of fear contribute to making universal sexual health education by the government health authority difficult to achieve.

Religious Sentiments

Another such factor is vaccine refusal due to religious morals; the resistance to vaccination can be more pronounced when conservative religious morals are integrated into a family’s values and understandings of sexuality and sexual health. All four of my interviewees said that they have seen religious conservatism influence a family’s decision to vaccinate, and that this has led to lower vaccination rates among, primarily, Evangelical and
HURDLES TO HEALTH

Catholic religious groups. (R. Marinho, personal communication, November 24, 2015; S. Muñoz, personal communication, November 27, 2015; E. Góes, personal communication, November 27, 2015; A. Santos, personal communication, December 1, 2015) Sandra specifically noted the role that the teachings of the church have on whether a mother decides to vaccinate her child (S. Muñoz, personal communication, November 27, 2015). Amanda described her personal experience of speaking to the parents of her daughter’s friends, some of who relayed their choices not to vaccinate due to religious beliefs (A. Santos, personal communication, December 1, 2015).

The reasoning behind religious parents’ decision not to vaccinate can be related to their desire to perpetuate the virgin image of their daughter. If a young girl asks to be vaccinated her family may assume that she is having sex or is planning to have sex (E. Góes, personal communication, November 27, 2015). In this scenario, not vaccinating a daughter both preserves her image in the eyes of the parents, and the family’s image in the eyes of their like-minded community.

Gender Dynamics

Because the HPV vaccine is offered to young girls who are closely influenced or controlled by their families, who are nearing an age when sexual activity and the exploration of sexuality statistically begin, and who live in a culture that strongly delineates the role of a female in society, the issue of preventative medicine becomes extremely politically charged. All three of the public health professionals whom I interviewed shared their strong views about the violation of women and girls’ human rights in the Brazilian healthcare system. According to Rosa, gender remains a problem for sexual health because women and girls are not able to stand up for themselves or to demand the protections that are their right (R. Marinho, personal communication, November 24, 2015). Emanuelle agreed with this statement, adding that female autonomy should be universal and upheld by the government as a human right; girls must have the right, and the ability, to protect themselves from disease, and that, to do so, they must have control over their own bodies (E. Góes, personal communication, November 27, 2015). Sandra explained that women’s rights—the rights of those in less socially powerful positions—in actuality do not leave paper, not because of the services provided, but because of the way that they are provided (S. Muñoz, personal communication, November 27, 2015).

The healthcare system falls down on providing adequate human rights to girls who want the HPV vaccine because, as young adolescents, they are dependent upon their parents for permission to receive the vaccine (S. Muñoz, personal communication, November 27,
HURDLES TO HEALTH

2015; A. Santos, personal communication, December 1, 2015). The family’s control of a girl’s choice to receive HPV vaccination is a clear example of the way that female sexuality and gender subjugates women in Brazil (E. Góes, personal communication, November 27, 2015). The general discomfort of parents with the idea of vaccination, and its relationship to sexuality, is understandable, but denying their daughters the opportunity to protect themselves has the possibility to lead to detrimental future health outcomes for Brazil’s young women and can severely limit the effectiveness of the country’s HPV vaccination campaign as a whole.

The socially constructed role of women in Brazil also limits their ability to advocate and defend themselves once they enter into relationships with men. Women can easily end up in compromised positions, without the ability to advocate for themselves or their health (R. Marinho, personal communication, November 24, 2015). Rosa and Sandra both relayed the experiences of women they have worked with who have struggled to maintain their sexual health within relationships. Rosa talked about the attitudes of men towards their own sexual health, as well as their partner’s, saying that, in some cases, a woman might be proactive about her health and receive testing and treatment, but that her partner may not share her concern nor receive treatment for himself. Because of the gap in coverage created by the male partner’s choice to go untreated, the female partner can become re-infected multiple times. Rosa said that this cycle, which leaves the female partner without capacity in the relationship, can lead to her giving up on her health and autonomy over her body. (R. Marinho, personal communication, November 24, 2015) Sandra told a similar story about the way that partners view fidelity, and the ways that this trust can lead to negative health outcomes for women. She said that everyone wants to believe that their partner is clean and faithful, but that this belief is causing more occurrences of STDs in Brazil. Additionally, she has seen this same mentality lead to less treatment once STDs are diagnosed. (S. Muñoz, personal communication, November 27, 2015)

Rosa spoke specifically about the positive role of good communication in understanding sexual health and combating STDs. She highlighted the ways in which communication can alter the compromised position in which women may find themselves in their relationships to their families or male partners. Instead of resigning to a silent position, she advocates for open communication, which, she believes, can create more dialogue about health in general. (R. Marinho, personal communication, November 24, 2015) If a more open climate of communication about sexual health can be fostered in the private relationships between men and women there is a higher chance that sexual protection, both in and out of
relationships, will come to be accepted. Rosa says that, because gender is the current foundation of many relationships where women have little power, talking openly about that dynamic is the only way to improve health outcomes (R. Marinho, personal communication, November 24, 2015).

The current SUS HPV vaccination campaign does not explicitly account for the complicated gender dynamics that have been observed by Rosa and Sandra in their community work. Therefore, by focusing specifically on the prevention of cancer in promotional materials, the SUS is avoiding a conversation that could bring more young women into health clinics to receive the HPV shot. The vaccination campaign is inextricably tied to human rights, which are women’s rights, because of the officially unrecognized link between sexual health and female autonomy (E. Góes, personal communication, November 27, 2015). Equality in sexual health represents a forceful first step towards the empowerment of women in a community.

Systematic Gaps

The social perceptions and misconceptions that inform the cultural climate around the HPV vaccine in Salvador present unique issues not only in familial relationships, but also within the governmental system. The goals and priorities of the SUS have created many small gaps in STD coverage and access to existing healthcare services, which combine to elevate the community’s sexual health risk. Education and empowerment present two fronts on which the prevailing system and outside organizations can come together to increase their positive impact and improve the sexual health of the community. (R. Marinho, personal communication, November 24, 2015)

Misunderstanding of Coverage

Although the promotional materials that I have seen for the SUS HPV vaccination campaign clearly explain the vaccine regimen, Emanuelle told me that only a small number of girls are currently finishing the series to the third dose. She reports that a much higher number of girls have received the first vaccination than the second. (E. Góes, personal communication, November 27, 2015; Figure 3) Because the HPV vaccination program is new to Brazil this skewed rate of return could be the result of timing, as girls must wait six months to receive their second shot (Figure 2). However, the data from the National Immunization Program (NIP) shows that some girls are already eligible for, and have received, the third shot, which, in Brazil, is given five years after the first dose (Figure 3). It is possible that the girls counted in the third dose category for the 2014 results received the vaccine prior to the five-year mark; in other countries the vaccine is administered over the course of
approximately one year, therefore, it is medically conceivable that all participants did not follow the timing of the SUS vaccination regimen. The statistical drop-off that Emanuelle has observed has the potential to cause significant problems for those girls who only receive the first dose. Emanuelle indicated that this population believes themselves to be protected against infection, when in fact they are not (E. Góes, personal communication, November 27, 2015). It seems unlikely that a girl who has invested time and effort in obtaining the first dose would ignore the second if she knew that she was not yet protected from infection. Therefore, this noticeable decline suggests that the SUS is not adequately educating young girls who receive the first dose of the HPV vaccination about the vaccine schedule and the reasoning behind it.

Rosa linked the misconception that may lead to imperfect vaccination rates to the same feeling many Brazilians have about Polio and the immunization for that disease. She said that, because people are uneducated about HPV as a disease, they believe that the eradication of cancer is eminent. People think that, with vaccination against HPV, they will be free of cervical cancer in the same way that they are free from the threat of Polio. Although the HPV vaccination can be effective at stopping a cancer-causing HPV infection from taking root, it is far from a cure-all. Rosa added that the trusting attitude that she has observed when people assume that cervical cancer will be eradicated through HPV immunization can lead to a lack of other protection during sexual encounters. (R. Marinho, personal communication, November 24, 2015)

Racial Factors

Throughout my interviews I had difficulty obtaining specific answers about the role of race in health care and sexual health in Brazil. Two of the public health professional I interviewed only felt comfortable speaking in extremely general terms about racial issues in health care. Even though SUS acknowledges that discrimination exists within its system, these women, who work as the direct support system for marginalized communities in need of access to public health care, could not bring themselves to specify the role that race plays in that very system (Figure 2).

Sandra was the only interviewee who explicitly linked racism against darker-skinned people to poorer healthcare treatment in those populations. She said that doctors view black women differently—as dirty—and that they will not perform as many diagnostic or medical procedures when treating patients of color. (S. Muñoz, personal communication, November 27, 2015)
Emanuelle did speak to her observation of a higher incidence of disease in the black population of Salvador. She said that STDs and teen pregnancy are more common in black women, possibly because of lower condom use rates than the general population. In her view, these problems are related to the dual inequality faced by black women. She concluded that, for black women, the situations of both race and gender are heavy, but she did not specify what those situations might be in relation to health. (E. Góes, personal communication, November 27, 2015)

Priorities of the Healthcare System

Emanuelle also stated that she thinks the priorities of the SUS do not pay attention to the importance of the entire population in equal measure (E. Góes, personal communication, November 27, 2015). Even when special interest groups demand attention and action from the government, only those organizations with control over significant sums of money make progress, Sandra contended (S. Muñoz, personal communication, November 27, 2015). Both Emaunelle and Sandra said that, in general, care is not evenly spread between demographic groups, while Rosa said that she sees more variation according to geography, than social differences (E. Góes, personal communication, November 27, 2015; S. Muñoz, personal communication, November 27, 2015; R. Marinho, personal communication, November 24, 2015).

Rosa explained that the government does not seem to have a specific focus outside of targeted vaccination for 9 to 11 year-olds; therefore, she said, the programming varies by location. Rosa also said that, because there is not enough money in the government for universal support or education, the job falls to organizations like hers. She observed that the SUS presence is greater in some rural places around Salvador where she has worked. These pockets of education provided by the government include work by Community Health Agents (CHA), who go door to door to educate parents about the vaccine. She has also observed programs taught by medical professionals that target young girls in schools. She has only seen this action effectively employed in rural areas and could not say whether this tactic has been utilized in the city, possibly because the large population of Salvador has made efforts to reach full coverage by CHAs difficult. (R. Marinho, personal communication, November 24, 2015)

Sandra expressed her view that the lack of consistent sexual health education by SUS is related to a dysfunctional chain of communication between the various levels of the system’s administration, and that this problem is compounded by political issues outside of the healthcare arena. She observed that the national, state, and municipal offices of the SUS
HURDLES TO HEALTH

all do different things in different ways and that this isolation of work significantly affects the way that services are provided to the public in different regions. (S. Muñoz, personal communication, November 27, 2015)

Vaccine Education

In Emanuelle’s observation, SUS education about HPV in Salvador is non-existent and, because of this, girls and their families do not understand the importance of the vaccine (E. Góes, personal communication, November 27, 2015). Amanda’s personal experience mirrors this conception; she said that her initial introduction to the HPV vaccine was through a television report, not through any official information provided by SUS. Amanda said that after she watched the report she spent some time researching the HPV vaccine online using the Ministry of Health website and women’s health group site. She does not think many parents do as much independent research as she did. While she is now, arguably, more informed than most parents, Amanda still does not feel like she has gained enough information to be confident in giving the vaccine to her daughter. (A. Santos, personal communication, December 1, 2015)

Because SUS engagement with the population is inconsistent, even when information is received by parents, it is often inadequate, and, therefore, confusing (S. Muñoz, personal communication, November 27, 2015). This disconnect makes it more difficult for parents to pass relevant facts along to their daughters or to verify the information that their daughters bring home from friends or educators at school. Sandra commented on the need to mend this broken system and suggested a family re-education campaign that could help to dispel rumors and misconceptions about the HPV vaccine (S. Muñoz, personal communication, November 27, 2015).

A more comprehensive SUS STD education program could be utilized in many ways; besides HPV education for families, there is a general need for greater precaution in sexual health (E. Góes, personal communication, November 27, 2015). Because of the ways that STDs spread the infection rates can quickly become amplified. Conducting education today about methods of transmission can help to prevent disease in currently at-risk populations and it also can initiate the conversation for future generations (S. Muñoz, personal communication, November 27, 2015).

Diagnosis

Sandra said that there is a wide lack of ability to recognize STD infection in the populations she works with, and that this is a significant issue tied to both knowledge about STDs and access to health care (S. Muñoz, personal communication, November 27, 2015).
HURDLES TO HEALTH

Rosa explained that one large gap in access to the SUS sexual health system is the screening and diagnosis of STDs. Many people are uneducated about the role of clinical visits in their sexual health and do not know about their right to utilize such services. Additionally, she reported that only 18-20% of people show symptoms related to STD infection, which means that people are not always aware that they are infected or are transmitting an infection. Because of this lack of knowledge and perceived lack of access to treatment, women who do not get regular gynecological exams often rely on prenatal care to cover their sexual healthcare needs as well as their concerns about pregnancy. (R. Marinho, personal communication, November 24, 2015) This method of addressing STDs and sexual health is ineffective because not all women become pregnant, only about 40% of women who do become pregnant go to a clinic for prenatal care, and it is often too late to cure or entirely treat an STD by the time it is diagnosed at a prenatal visit (R. Marinho, personal communication, November 24, 2015; S. Muñoz, personal communication, November 27, 2015).

Access to Health Care

All three of the public health professionals I interviewed consistently and adamantly repeated sentiments that socially marginalized groups, including young women eligible to receive the HPV vaccine, face issues accessing health care because of both cultural and systemic norms (R. Marinho, personal communication, November 24, 2015; S. Muñoz, personal communication, November 27, 2015; E. Góes, personal communication, November 27, 2015). Rosa explained that her employer, like many other non-governmental organizations, works to increase access to otherwise universal health services for those without institutional knowledge. She explained that not everyone knows that they have a right to the healthcare services they are entitled to by law. (R. Marinho, personal communication, November 24, 2015)

Rose talked about the need for access-focused organizations outside of SUS because of the depth and breadth of the problem. She said that the model of her organization is to work with the community, SUS, and other organizations so that they can fill the gap in access from many different angles. She does not think that it is possible for one single group to provide all of the resources that are needed within a community and that collaboration between various groups is necessary. (R. Marinho, personal communication, November 24, 2015)

The SUS is not currently providing information and services to everyone who requires this type of assistance, but, considering Rosa’s proposed organizational set-up, it
HURDLES TO HEALTH

may be better to allow some outside groups to enter the equation and facilitate the relationship between the community and the government (R. Marinho, personal communication, November 24, 2015). Due to social and political controversy the SUS HPV vaccination campaign is not yet reaching its entire target population and it may, therefore, have quite a bit of catching up to do, especially as the need for education becomes more apparent, but, overall, the program is seen as a positive healthcare intervention for the country (E. Góes, personal communication, November 27, 2015).
Conclusion

My research shows that there is a strong correlation between feelings about sexuality and reluctance for the parents of Salvador, Bahia, Brazil to vaccinate against HPV. This socially constructed relationship bleeds into conceptions about age-appropriate milestones, conservative religion, and gender. The association created by socially manifested perceptions between early adolescent HPV vaccination and sexuality draws on fears, moral values, and stereotypical ideas of the role of women in a way that makes vaccination against HPV an unappealing option. The parents of Salvador remain skeptical of the benefits of vaccination because the government Ministry of Health has yet to directly educate them about the HPV vaccine.

My results illustrate the ways in which girls are barred from accessing sexual health care and education because of impediments to their autonomy and systemic failures. The near-constant presence of one or the other of these barriers means that many of the girls who could benefit from HPV vaccination the most are not able to access it. Non-governmental organizations are able to patch some of this gap, but they cannot be expected to reach everyone.

The lack of uniform education on the part of the SUS has compromised the HPV vaccination campaign from two angles: through the girl and through her family. Increased knowledge about the safety and purpose of the HPV vaccine among community members can only serve to strengthen the sexual health of all social groups in Bahia, and could lead to developments in the position of women at the same time.

This extremely new vaccination effort on the part of the government presents an opportunity to expand health and health knowledge within Brazil, and to create a new kind of relationship to medicine and the unique, universal medical system that is SUS. Using the social determinants identified here, an image of the way that the campaign for HPV vaccination functions within a much larger system of cultural norms and stigmas can be deciphered. The path toward sexual health is not straightforward; instead, it involves the careful consideration of many social factors and the implementation of strategies for universal coverage within the constraints of those factors.

The equality of access to HPV vaccination is, at some point, directly related to the amount of knowledge that is delivered to families and communities. The people of Salvador have expressed that they are unsure about what the HPV vaccine means to them; now is the time for SUS and other allies of sexual health to use this new window of opportunity to show the public what is possible.
Recommendations for Future Research

This study provides room for much further investigation into the perceptions of these specific social determinants. To continue research in this vein I would suggest finding support of the effect of certain social determinants expressed in this paper through data collection based in the community. I think that gaining the perspective of more community members, namely parents, who could corroborate or refute the proposed position of the social determinants in this paper would provide a much better picture of the ways that HPV, and other, vaccination campaigns could be improved.

Additionally, at a later date, the SUS HPV vaccination campaign education program could be reevaluated. The creation of a standardized education plan appears extremely vital to the perpetuation of good sexual health practices in Salvador and Brazil, but a follow-up study could show whether this conclusion is accurate.
References


HURDLES TO HEALTH


Appendix

SIT Questions

I believe that the original question I set out to answer could have been researched in the US. Similar sources to those used in Salvador could have been utilized in the US to find out about HPV education for young girls. I am positive, however, that the results of my research would be quite different, firstly, because I could not predict how my research would change in the Brazilian context, and secondly, because the social dynamics of the US are different than those of Salvador or Bahia. I cannot speculate about how those results might differ, but I feel sure that they would not be the same in any two states anywhere in the world. Perceptions of race, gender, sexuality, autonomy, health, religion, and human rights all influenced the answers I received in Salvador, and those factors would undoubtedly result in varying responses in different cultural climates.

I do not think that my learning style changed, but I did learn more about myself and the way that I process information. I like to have everything laid out so that I can process my results in an organized way. This method of analysis was hampered by the form that some of my notes took and the fact that I had to wait for one of my transcriptions to be completed before I could truly analyze and cross-reference all of my data.

Ten pages of my final project is taken from primary sources, my interviews. I used less secondary data to back up my findings. I feel that this is a good balance of information.

I looked for responses to my interview questions that addressed why not all eligible girls receive the HPV vaccine. This data ranged from directly related issues, like lack of education about HPV, to more tangential and structural topics, like the perception of female sexuality in Brazilian culture.

I utilized some of the interviewing and observation skills that I had practiced during the community project and field activities. I was thrown off guard by how different my ISP experience was from what I expected, partially because not many of my pre-ISP SIT field activities were applicable. My entire ISP consisted of interviews and I feel like before that time I had mostly be doing observation.

I was extremely aware of respecting my interviewees’ privacy and making sure that I did not cross any ethical boundaries in the course of my research. I also kept in mind the idea of coding and cataloguing the information I gathered so that I would be better able to analyze it later.

I feel that my main issue had to do with organizing my ideas around a differently framed research question as I was writing my final paper. This occurred because of time
HURDLES TO HEALTH

constraints due to scheduling interviews and the curving path that my research took from one side of STD education to another.

   I did feel constrained for time. It would have been helpful to have interviews scheduled earlier in the ISP period, but that is dependent upon other peoples’ schedules and cannot necessarily be helped. This could have been avoided by choosing an ISP topic that would have directly paired me with an organization where I could have started observations and interviews at the beginning of the ISP period.

   Yes, my topic, or rather the way that I address my topic shifted significantly. The available resources had a huge influence on how my topic was addressed because I got the perspectives of strong female activists who work outside of the government system, rather than the more SUS-focused perspective I had expected to get. This made my paper more centered on the community and social factors of HPV vaccination, which I feel is an extremely valuable perspective.

   I started out by meeting with my advisor, but that did not result in many sources, so I began reaching out to everyone I could think of who might have connections within the fields of public health and sexual health. This involved many emails, phone calls, and even trips to addresses found online. I found all of my literary sources through the library of my home institution.

   I used semi-structured interviews with public health professionals and with one community member to collect the data for my research. I chose to speak with public health professionals because I knew that their perspectives and expertise would give me a wider view of trends within the local population. Additionally, I decided to interview a member of the community (at the suggestion of one of my interviewees) because I wanted to corroborate what I was hearing from the organizational professionals about the general populations’ experience of HPV vaccination and education.

   My advisor was helpful in finding me some sources to interview and in calming my nerves when I was sure that I would end up with no data. We were not able to meet as often as I would have liked and we did not get a chance to talk about the results of my research because of the late date at which I finished all of my interviews. I do not think that we were necessarily on the same page as to what we should be expecting from each other in the advisor-advisee relationship.

   I ended up changing the focus of my research because of the availability of my research subjects and the types of answers that I received to my research questions. One of my interviews was significantly less focused than the others because the interviewee was
very concentrated on telling me what she thought I should know rather than answering the specific questions that I asked, but I still found many things she said helpful and relevant to my topic.

I feel that I learned more about how some of the themes we learned about in lecture manifest in people’s, especially women’s, daily lives. Even though I didn’t “see” these principals in action, the examples and context of my research gave new meaning to what it means to be a woman in Brazil.

Because I was not placed in a site where I had repeated contact with any person or group of people I do not think that this project helped with my adjustment to the culture. I do, however, feel that my Portuguese language skills improved, which has helped, and will continue to help me, in my conversations and relationships with people in Brazil.

I learned that I am not a fan of working sources and attempting to set up meetings, especially when I feel great pressure to produce something worthwhile. At the same time, I did learn the value of persistence in following up on leads and going back to the source of a lead in order to make further and more productive contact.

If they were working with the same Human Subjects Review and time constraints, I would suggest that they do their best to find parents in the community and build more on the view of the vaccine from that perspective. If I had more time, I would have liked to learn more about how the principles that I found by interviewing public health professionals manifest in reality.

I would be interested in doing more research like this. I think that it was a very interesting way to learn about a topic and a culture at the same time.
HURDLES TO HEALTH

Figures

Figure 1. This SUS-endorsed poster that asks patients to report acts of discrimination by healthcare professionals. This copy was posted in the Instituto de Saúde Coletiva at the Universidade Federal da Bahia in Salvador, Bahia, Brazil.

Figure 2. This poster promotes the SUS HPV vaccination campaign in health posts and health offices around Brazil. It explains the cancer-preventing benefits of the vaccine and the schedule of shots (0 months, 6 months, and 60 months). This copy was seen at a community health clinic in Cachoeira, Bahia, Brazil.
Figure 3. This chart was created using data obtained from Emanuelle Góes. The original source is the Programa Nacional de Imunizações (PNI), or National Immunization Program. The original document states that this is only partial data for the year 2014. Information about governmental vaccines is available through the PNI databases, APIWEB and SIPNI Web. Data about the HPV vaccination program can be accessed at:

http://pni.datasus.gov.br/consulta_hpv_14_selecao.php
Pre-Interview Statement

I read this list of statements to each interviewee in Portuguese prior to the presentation of the informed consent form. I obtained verbal consent to record each conversation in the third question, and use each interviewee’s name in response to the fourth question.

- If you do not want to respond you can skip a question or stop the interview.
  *Se você não quiser responder pode pular uma pergunta ou encerrar a entrevista.*

- Is it alright if I record this interview?
  *Está bem para você se eu gravar esta conversa?*

- I assure you that your personal data will be kept confidential.
  *Eu asseguro que seus dados pessoais serão mantidos em sigilo.*

- If you do not want to use your name, I can create a pseudonym, a fake name, for you.
  *Can I use your name?*
  *Se você não quiser usar seu nome, eu posso criar um pseudônimo, um nome falso.*

- If you understand all of this you can sign here.
  *Se você entende tudo pode assinar aqui.*

- This part of the form is for you to keep.
  *Este parte do formulario é para você guardar.*
Informed Consent Form

This consent form as presented to each interviewee, and was signed prior to the start of each interview. The bottom portion of the form was kept for the researcher’s records, while the interview subjects kept the top section. The forms that were presented to the interviewees were signed by the student researcher, the Academic Director of SIT, and the Project Advisor.

Rua dias D’Ávila, 109, - Barra, CEP: 40.140-270 Salvador, Bahia, Brasil
Tel / Fax: (71) 3032-6009 www.sit.edu/studyabroad | www.worldlearning.org

Termo de Consentimento Livre e Esclarecido

Prezado(a) Senhor(a)
Gostaríamos de convidá-lo(a) a participar de nosso estudo: Educação sobre HPV, que tem como objetivo obter maior entendimento sobre DSTs e educação sexual no Brasil.

A pesquisa, consistirá na realização de entrevistas, observações e/ou participações junto aos participantes do estudo e posterior haverá a análise do conteúdo destas entrevistas e/ou observações. Será conduzida dessa forma, pois pretendemos trabalhar com a experiência de vida dos(as) participantes da pesquisa.

Trata-se de um estudo, desenvolvido por Megan Cole Rogers orientada pela Sra. Emanuelle Goes.

Garantimos que, a qualquer momento da realização desse estudo, qualquer participante da pesquisa e/ou estabelecimento envolvido, poderá receber esclarecimentos adicionais que julgar necessários. Qualquer participante selecionado(a) tem o direito de recusar-se a participar ou retirar-se da pesquisa em qualquer fase da mesma, sem nenhum tipo de penalidade, constrangimento ou prejuízo. O sigilo das informações pessoais dos participantes será preservado, especificamente, quanto ao nome, à identificação de pessoas ou de locais. Todos os registros efetuados no decorrer desta investigação científica serão usados para fins acadêmico-científicos e serão inutilizados após a fase de análise dos dados e de apresentação dos resultados finais na forma de monografia ou artigo científico.

Em caso de concordância com as considerações expostas, solicitamos que assine este “Termo de Consentimento Livre e Esclarecido” no local indicado abaixo. Desde já agradecemos sua colaboração e fica aqui o compromisso de notificação do andamento e envio dos resultados desta pesquisa.

Qualquer dúvida ou maiores esclarecimentos, entrar em contato com a responsável pelo estudo:
e-mail: gabriela.ventura@sit.edu Telefone: (71) 99719.6010 (do SIT Study Abroad: Brasil-Saúde Pública, Raça e Direitos Humanos).

Aluno: Megan Cole Rogers
Estudante no Programa do SIT Study Abroad: Brasil-Saúde Pública, Raça e Direitos Humanos
___________________________, _______ de ________ de 2015.
(cidade)

Orientador(a): Gabriela Ventura

Orientador(a): Emanuelle Goes
HURDLES TO HEALTH

Eu, ____________________________________________________________, assino o termo de consentimento, após o esclarecimento e da concordância com os objetivos e condições da realização da pesquisa “Educação sobre HPV”, permitindo, também, que os resultados gerais deste estudo sejam divulgados sem a menção dos nomes dos pesquisados.

__________________________, _____ de ________________ de 2015.
(cidade) ____________________________________________________________________

Assinatura do Pesquisado(a)
HURDLES TO HEALTH

*Interview Questions*

These questions constitute the backbone of the three interviews that were conducted with public health professionals. During the interviews these questions were asked in Portuguese with slight modifications depending on the context of the conversation and the question’s relevance to the experience of the interviewee.

1) Can you tell me about your work with STDs, specifically HPV?

_Pode diga-me sobre seu trabalho com DSTs, especificamente HPV?

2) Do you teach about STDs and sexual health or just provide treatment?

_Vocês ensinam sobre DSTs e saúde sexual ou só dar tratamento?

3) Who comes to you for treatment and/or educational information about health? Do you focus on a specific group?

_Que vem aqui para tratamento e/ou informação de educação em saúde? Vocês focam um grupo específico?

4) Did your HPV educational program change after the introduction of the HPV vaccine?

_Seu programa de educação de HPV se modificou depois do lançamento da vacina de HPV?

5) How do you understand human rights in sexual health?

_Como você entende direitos humanos na saúde sexual?

6) Have you seen differences in treatment or knowledge of STDs resulting from race [or discrimination based on race]?

_Você viu diferenças em tratamento ou conhecimento de DSTs resultando de acordo com a raça?

7) Do you think that the young girls who receive the HPV vaccine understand the importance of the vaccine and other ways in which they should protect themselves?

_Você acha que as meninas que recebem a vacina de HPV entendem a importância da vacina e de que outras maneiras elas precisam proteger-se?

8) In your opinion, is the HPV vaccine a good idea for Brazil at this time? Do the people
understand the reasons for immunization and other precautions?

Em sua opinião, a vacina de HPV é uma boa idéia para a saúde do Brasil neste momento?
As pessoas entendem as razões para imunização e outras precauções?

9) Do you know if there are conflicts in families when you ng girls say that they want to get the HPV vaccine? Can their parents stop them from getting it?

Você sabe se há conflitos nas famílias quando uma moça diz que ela quer receber a vacina de HPV? Os pais podem impedi-la?

10) In your opinion, what is the most important part of your work?

Em sua opinião, qual é a coisa mais importante de seu trabalhando?

11) If you could change anything about SUS, what would it be?

Se você puder modificar alguma coisa da sistema de saúde no Brasil, o que será?

12) Is there anything that I didn’t ask that you think I should know for my research or my own knowledge?

Há alguma coisa que eu não perguntei que você acha é importante para minha pesquisa ou conhecimento?
HURDLES TO HEALTH

Interviews Conducted

Rosa Marinho
Social Project Coordinator at the Grupo de Apoio à Prevenção à Aids
Salvador, Bahia, Brazil
Interview conducted at 11:15 AM on Tuesday, November 24th, 2015

Sandra Muñoz
Feminist, and General Coordinator at Casa Cristal Lilás da Bahia and at Movimento de Lésbicas e Mulheres Bissexuais da Bahia
Salvador, Bahia, Brazil
Interview conducted at 9:00 AM on Friday, November 27th, 2015

Emanuelle Góes
Coordinator of Health Programming for Black Women at Odara-Instituto da Mulher Negra, Member of MUSA—Program to Study Gender and Health at the Instituto de Saúde Coletiva, the Group for Health Research of Women, Nursing, Gender, Race, and Ethnicity
Salvador, Bahia, Brazil
Interview conducted at 2:00 PM on Friday, November 27th, 2015

Amanda Santos
Portuguese professor at SIT Salvador. Mother with personal experience deciding whether to vaccinate her daughter and personal observation of the decisions made by other parents
Salvador, Bahia, Brazil
Interview conducted at 11:00 AM, December 1st, 2015