HIV/AIDS in northern Tanzania
- An investigation of activity participant’s opinions on Kilimanjaro Aids Control Association (KACA) and their work on combating HIV/AIDS

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15 credits
Registered Nurse Program 180 credits
Spring semester 2009
Abstract

**Aim** The aim of this study is to investigate the activity participants’ opinions on Kilimanjaro Aids Control Associations’ (KACA) work in combating HIV/AIDS in Moshi, Tanzania, and to examine what they have learnt from participating KACA’s activities. The authors also examined whether the participants thought the activity has influenced on their behaviour.

**Method** The study is an explorative qualitative study with semi-structured interviews. The respondents (20) were purposively selected in order to get balanced representation.

**Results** The majority of respondents were very grateful after being in contact with KACA. According to some of the respondents, KACA supplies needy people with financial as well as mental support. Many of the respondents have been passing on their new knowledge about HIV/AIDS to others, and claimed that they have changed their behaviour.

**Conclusion** Our findings were that the majority of our respondents had positive experiences about KACA’s role in combating HIV/AIDS in the Kilimanjaro area. Almost every respondent claimed they had got new knowledge about HIV/AIDS. The new knowledge led to reduced risk taking behaviour, which we believe can reduce the spread of HIV. Since this study contains 20 respondents, the results can not be generalized.

**Keywords** Tanzania, KACA, HIV/AIDS, prevention
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Abbreviations

AIDS – Acquired Immunodeficiency Syndrome
ART – Antiretroviral Therapy
ARV – Antiretroviral
HAART – Highly Active Antiretroviral Therapy
HIV – Human Immunodeficiency Virus
KACA – Kilimanjaro Aids Control Association
MCTC – Mother to Child Transmission
MVC – Most Vulnerable Children
PLHA – People Living with HIV/AIDS
VCT – Voluntary Counselling and Testing

Introduction

HIV/AIDS
The Human Immunodeficiency Virus (HIV) infects cells which are important for the immune system and slowly destroys their function. Due to reduced capacity of the immune system, the body gets more vulnerable against “opportunistic infections”, like tuberculosis and pneumonia. HIV is spread between humans by body fluids, e.g. blood. Unprotected sexual intercourse, transfusion of contaminated blood or sharing of instruments, like needles, among drug abusers are factors that increase the spread of HIV. A mother can also pass on the virus to her child during pregnancy, childbirth or breastfeeding (World Health Organization [WHO], 2008). HIV is spread primarily through sexual intercourse and intravenous drug use, but in some areas the spread of HIV through Mother to Child Transmission (MTCT) and blood transfusion also contributes to the increasing number of infected people (Quinn, 2008). Acquired Immunodeficiency Syndrome (AIDS) is the most severe and very last stage of the HIV infection. The time between the infection of HIV and the occurrence of AIDS varies between individuals; it can take 10-15 years and sometimes even longer. The United States Centres for Disease Control and Prevention and the European Centre for the Epidemiological
Monitoring of AIDS defines AIDS as “the occurrence of any of more than 20 opportunistic infections or HIV related cancers” (WHO, 2008).

Prevalence and spread of HIV/AIDS in Africa/Tanzania

Approximately 33 million people in the world are living with HIV (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2008). Two thirds (67%) of the population who carry HIV/AIDS (22.1 million) live in Africa south of Sahara (Swedish International Development Cooperation Agency [Sida], 2008; UNAIDS, 2008). The prevalence of HIV/AIDS in the sub-Saharan Africa region is almost 6% (UNAIDS, 2008). Despite the retrogression of the epidemic in some countries, for example Senegal, Uganda and more recently Kenya and Zimbabwe the total number of infected individuals has increased (Sida, 2008). There is a need of much stronger technical and financial support for organizations and networks of People Living with HIV/AIDS (PLHA) (UNAIDS, 2008). Until the mid-1980 the average life expectancy was increasing in many African sub-Saharan countries, but now HIV/AIDS has decreased the life expectancy with approximately 15 years in many of these areas (Quinn, 2008).

Globally, the percentage of women among people living with HIV has remained stable at 50% over the last years. However, in sub-Saharan Africa, 60% of adults (15+) living with HIV are female (UNAIDS, 2008). Mothers who are living with HIV/AIDS have to prioritize every day to care for their own health and nutrition, but also their children’s health and nutrition (Piwoz & Bentley, 2005). The African women get infected at a younger age than men, and the difference in occurrence between genders continues to grow (Sida, 2008). In Moshi, northern Tanzania, an examination was made between November 2003 and December 2007, with the purpose of finding a relationship between the number of sexual partners and the risk of being HIV positive. Results indicated the risk was 19.05% for women with only one sexual partner, and 44.79% for women with five or more sexual partners. Among men, the numbers were 3.55% and 14.95% respectively. For that reason, the study showed a very high increase in the risk of HIV positively for every new sexual partner, especially among women (Landman et al., 2008).

The spread of infection has flourished in areas where the population is mobile and migrant. According to Sida (2008), the reason for this is that the social mobility often leads to lack of
common assessments and norms with social rejection as result; a situation where support and security from family and close friends is no longer available for the single individual (Sida, 2008). Tanzania has shown an increasing prevalence of HIV infections among adults (15-49 years), with 0 % in 1981 to a peak at 8.1 % in 1995. The prevalence has decreased since then to 6.5 % in 2004 (Somi et al., 2006). The Estimations and Projections Package (EPP) was created by UNAIDS in order to predict the national short-term HIV epidemic based on already existing data (Brown, Salomon, Alkema, Raftery & Gouwn, 2008). According to calculations by the EPP, the prevalence is estimated to stay stable at 6.5 % until 2010. The urban HIV epidemic in Tanzania has increased from 0 % in 1981 to a peak in 1992 with the prevalence 12.6 %. It is estimated to stay between 10.9-11.8 % from 2003 to 2010. To compare the urban with the rural areas, HIV epidemic increased with 0 % 1981 to 7.0 % in 1995 and the prevalence is expected to be stabilized at 5.2 % during 2003 to 2010 in the rural areas. The number of new infected people per year peaked in 1995 with 225 000 and decreased to 140 000 in 1997. However, the number of new infected is expected to rise again to 225 000 people in 2010. The number of deaths caused by HIV/AIDS has increased steadily from 1985, and it is expected to reach 120 000 people per year in 2010 (Somi et al., 2006).

In 2009, Tanzania is estimated to have 2.2 million adults infected with HIV, of whom 15 % (330 000) are between 18-24 years old. The majority of all new infections also occurs in this age group (Charles et al., 2009). There is a need of education and information about HIV/AIDS among people in Tanzania, to change the individual attitude against risk taking behaviour (WHO, 2008). In the early 1990s, a dramatic reduction in the prevalence of HIV was seen in Uganda. According to Kirby (2008) the most importance factor behind the decrease in HIV transmission in Uganda was changes in sexual behaviours among the inhabitants; having less sexual partners and then using condoms when having sexual intercourse. These changes in behaviour could contribute a lot in preventing the spread of HIV (Kirby, 2008). The most effective way to avoid getting infected by HIV/AIDS (when having sexual intercourse) is to use protection. However, excepting abstinence from sexual intercourse, no protective method is 100 % safe (WHO, 2008). Since there is no cure for HIV, people are often unwilling to get tested. This leads to increased spread of infection, since the lack of knowledge makes people less careful and less willing to protect themselves during intercourse (Sida, 2008).
A big problem caused by HIV/AIDS that also contributes to the spread of the disease is the growing amount of orphans. In sub-Saharan Africa, approximately 12 million children (under 18 years old) have lost one or both of their parents to AIDS, and the number of children orphaned continue to rise. Tanzania was estimated to have 930,000 orphans in 2005, from whom only 51% were being supported (UNAIDS, 2008). Orphans are more exposed to situations that may result in being infected, as poverty, insecure environments and lack of self confidence. This can bring them into drug abuse and prostitution. The sharing of needles when using drugs and unprotected sexual intercourse puts them in the risk zone of getting infected with HIV (Sida, 2008).

**Traditional healers and available healthcare in managing HIV/AIDS in Tanzania**

In Dar es Salaam and Arusha in Tanzania, the public health services do not always have adequate drugs and health facilities for the patients they are suppose to serve (Kayombo et al., 2007). For many people, traditional healthcare practitioners are the only option for various treatments, including HIV/AIDS; more than 60% of Tanzania’s population depends on traditional medicines provided by traditional healers for treatment of diseases such as HIV/AIDS (Kayombo et al., 2007; Kisangu, Lyarru, Hosea & Joseph, 2007). Many of the Tanzanian people are also scared of taking modern medication and therefore prefer traditional medicines (Kisangu et al., 2007). In Dar es Salaam and Arusha, 192 traditional healers were interviewed, of whom 110 claimed to be treating HIV/AIDS. Only 75% of traditional healers who claimed to be treating HIV/AIDS knew some HIV/AIDS symptoms as defined by WHO. In addition, 10% of the total respondents claimed to have cured HIV/AIDS patients, i.e. HIV positive patients became negative, became healthy and gained weight or gave birth to a healthy child after treatment. Fair familiarity about HIV/AIDS symptoms might be reflecting the low understanding of the traditional healers who are attempting to manage HIV/AIDS in Tanzania. More knowledge about HIV/AIDS and especially on prevention and caring for the patients should be imparted (Kayombo et al., 2007). There are a good number of reports on traditional medicine to treat various diseases, but these are not well documented. The reports are also often very small and generalized, in particular those made on treating HIV/AIDS (Kisangu et al., 2007). Despite lack of documentation, the traditional medicine unfortunately sometimes is the first (and maybe the only) option when it comes to treatment of HIV/AIDS in Tanzania (Kayombo et al., 2007; Kisangu et al., 2007).
Voluntary counselling and testing

Voluntary counselling and testing (VCT) started in Tanzania 1997 and with approximately 5.3 million clients testing and 1,643 VCT-centres around the country by the end of April, 2008, it is one of the biggest strategies to slow the spread of HIV infections in Tanzania. VCT includes information spreading such as condom promotion and provision, safer sex and risk reduction counselling and HIV testing (Charles et al., 2009). To get tested, the individuals must actively ask for a HIV test. The opportunities and willingness to get tested have been limited by fear of discrimination and stigma, low coverage of services and the perception by many people that they are not at risk of being infected (WHO, 2009; Matovu & Makumbi, 2007). People who came up with a positive HIV test result after undergoing VCT showed reduced risk taking behaviour and thereby decreased risk of spreading the disease.

Approximately 10% of the population in the sub-Saharan areas know their HIV-status, but many people claimed they would undergo HIV testing if the access were better. Therefore, an increased amount of VCT-centres will lead to that more people get tested (Matovu & Makumbi, 2007).

VCT is perceived to have good effects in risk reduction among sexually active youth. However, few students (34.6%) from the study population among young health care professional students at KCM College of Tumaini University and Allied health schools in the region of Moshi had previously done a VCT. The majority (63.8%) of the students were supportive of VCT, but the uptake and the risk perception was low.) The conclusion from Charles et al. (2009) was that the VCT-centres should be more youth friendly to attract this group for HIV testing. The youth also need more information about the benefits from VCT (Charles et al., 2009).

Until recently, VCT was the primary model for providing HIV testing and counselling. A new guidance was prepared by WHO/UNAIDS in May 2007. This guidance is called provider-initiated testing and counselling and involves every patient who is in contact with health facilities to specifically get recommended to make a HIV test. Unless the patient declines, the test will be performed. This method has shown an increased uptake of HIV testing, and it may create new opportunities for HIV prevention. The new method has already been implemented in some countries, however, not yet in Tanzania (WHO, 2009).
Antiretroviral Therapy

There is no cure for HIV/AIDS, but there are antiretroviral (ARV) drugs. Antiretroviral Therapy (ART) decreases the viral load in the body and in that way the progression of the disease (WHO, 2008). There is also highly active antiretroviral therapy (HAART) which consists of three or more highly potent anti-HIV drugs to prevent the virus to become drug-resistant (Maggiolo, 2009; Stowell, 2006). People diagnosed with AIDS live longer since HAART was introduced; an estimation suggest that in 2006, 85-90 % of people living with AIDS in the United States will live more than six years after being diagnosed, while in the first years of the HIV/AIDS epidemic, the median time of survival in the same country was approximately 12 months after being diagnosed with AIDS. HAART has also shown good effect on MTCT in Europe and the United States; without any treatment the risk of MTCT was 15-30 %, while with the advent of HAART it was only 1-2 %. Unfortunately, ARV drugs are not widely available in the developing world, where MTCT remains a major cause of HIV transmission (Quinn, 2008).

The world has recognized the HIV pandemic as a big problem that needs to be taken seriously; the total annual financial resources accessible for HIV care rose from 1.6 billion US dollars in 2001 to 8.2 billion US dollars in 2005. The assessment of ARV drugs increased fivefold worldwide and up to eightfold in southern Africa during the same period (Quinn, 2008). WHO and UNAIDS set a goal in 2001; three of five (three million) people who need ARV drugs should have it in year 2005 (Dlamini et al., 2009; Quinn, 2008). Despite this global effort to give infected people adequate care, only one in six people in sub-Saharan Africa who needed ARV drugs in 2005 was receiving them (Quinn, 2008). In Tanzania, the goal was to treat about 44 000 patients by the end of 2005, according to a signed three years agreement 2005-2007 between Tanzania and Sweden on the implementation of the National HIV/AIDS Care and Treatment Programme. The goal was proved to be difficult to meet since only 25 840 patients were on ARV drugs by the end of 2005 (Sida, 2006). According to the chairman of KACA, F. Swai (information meeting, September 29, 2009), ART is free for HIV infected inhabitants in Tanzania.

HIV/AIDS related stigma and its effects on VCT uptake and ART

The Holzemer study (2007, according to Dlamini et al., 2009) developed a theoretical model of stigma, which focused on HIV/AIDS related stigma in Africa. The study described
HIV/AIDS related stigma as a process that begins with a trigger, such as a positive HIV test or getting an ARV drug refill, and progresses to stigmatizing, for example accusing or avoiding someone. Eventually, the stigma behaviours can lead to outcomes like violence or even homicide; behaviours which also can become new stigma triggers. Anything that can identify a person as being infected with HIV can be a stigma trigger, according to the theoretical model (Dlamini et al., 2009). Even religious views have a strong impact on HIV related stigma; some strongly religious people think that HIV is a punishment from God or that PLHA has not followed the word of God (Zou et al., 2009).

Stigma is still one of the central barriers when it comes to successful prevention and management of HIV/AIDS in Africa (Uys et al., 2009). Fear of stigma and discrimination have limited the willingness to get tested (WHO, 2009; Matovu & Makumbi, 2007). Triggers initiating stigma behaviour also have a negative effect on ART, such as poor adherence and hiding medications. The stigma model also hypothesizes that ART itself is a trigger for stigma behaviours (Dlamini et al., 2009). Despite this, as a result of ART, burden-related stigma due to their inability to manage everyday activities has decreased among PLHA in Kisesa (a ward in northern Tanzania) (Roura, Urassa, Busza, Mbata, Wringe & Zaba et al., 2009a; Roura, Wringe, Busza, Nhandi, Mbata & Zaba et al., 2009b). Even though religious views are strongly associated with HIV related stigma, the attitudes towards ART among religious people depend more on education level and knowledge about ART rather than the religious factors (Zou et al., 2009).

The increasing availability of ART has turned HIV into a manageable condition. The majorities of community leaders in the region of Kisesa are worried that PLHA might increase their amount of sexual partners thanks to their improved condition after initiating ART, and therefore enhance the spread of HIV. In fact, recent studies in sub-Saharan Africa have documented increased sexual risk taking behaviour for those who came out HIV negative after undergoing VCT and PLHA after initiating ART (Roura et al., 2009a).

**Kilimanjaro Aids Control Association**

Kilimanjaro Aids Control Association (KACA) is an organization which is active in the region of Kilimanjaro, northern Tanzania, head quartered in Moshi. The organization was created in 2003, and it is autonomous, non-political and not for profit. KACA was formed to
create or improve the existing awareness on sexual behaviour, especially among sexual active people in the age group 15-49 years. They also want to strengthen the capacity to care for the “Most Vulnerable Children” (MVC) among families and communities. One central vision of KACA is to achieve a society that is free from HIV/AIDS pandemic. To reach this vision, KACA organize innovative activities with the aim to decrease the number of new HIV infections and to battle HIV/AIDS epidemic (Kilimanjaro Aids Control Association [KACA], 2009).

KACA has a number of specific objectives. Some of them are to fight HIV/AIDS related stigma and discrimination, to encourage voluntary HIV testing, to preserve the rights of the PLHA so as to improve the quality of their lives, and to advocate on application of “ABC” strategy (Abstinence, Be faithful to the same partner and consistence use of Condoms). In KACA’s work with the MVC, the objectives are to make communities aware of the problem with the MVC and to collaborate with other stakeholders to provide basic needs to the MVC and their families (KACA, 2009).

At KACA’s head quarters in Moshi there are voluntary working nurses who provide VCT for the locals. According to the chairman of KACA, F. Swai (information meeting, September 29, 2009), people from other districts and regions also come to Moshi in order to get tested, even if there is a VCT-centre closer to their residence, due to fear of stigma and being recognized. KACA cooperates with Mawenzi Hospital and Kilimanjaro Christian Medical Centre (KCMC); if someone is tested positive for HIV/AIDS at KACA’s VCT-centre, the patient get an admission note to one of these hospitals (the patient can choose which one). KACA also educates Traditional Healers to become promoters of behaviour change and condom use, in order to reach out to a greater amount of inhabitants in Kilimanjaro region (information meeting, September 29, 2009).

KACA has a way of spreading information which focuses on every participant’s contribution of ideas and thoughts about the issue. They are educating communities about HIV/AIDS epidemic through distribution of posters, brochures and flyers, but also with public meetings and mass media, like radio and newspapers. KACA organizes activities as study circles and theatre performances to spread information about HIV/AIDS. They also started a football club, Machava FC, in order to keep youth and adults active and give them a chance to meet new people and exchange thoughts about HIV/AIDS. Active members of KACA have been
trained in study circle methodologies by Studiefrämjandet in Uppsala. KACA claims to have achieved adapting study circle methodologies in the communities as an important tool for development. The study circle is a group of approximately 5-12 participants (including the circle leader who is a member of KACA) which are studying and discussing a specific subject or question, like HIV/AIDS related stigma. KACA’s theatre group is also cooperating with Studiefrämjandets theatre group in Sweden (KACA, 2009).

**Statement of the problem**

No earlier study has been performed in order to find out what participants of KACA’s projects in preventing HIV/AIDS in northern Tanzania think about the activity they have been attending, and what they have learnt from participating. Therefore, the authors would like to investigate what activity participants think about KACA’s work and what they have learnt from participating in at least one of KACA’s activities. The authors also want to examine whether the participants thought that the activity has influence on their behaviour.

**Aim**

The aim of this study was to investigate the activity participants’ opinions on Kilimanjaro Aids Control Associations’ (KACA) work in reducing the incidences of HIV/AIDS in Moshi, Tanzania, and to examine what the participants have learnt from participating in at least one of KACA’s activities. The authors also examined whether the participants thought that the activity has influenced on their behaviour.

**Research questions**

1. What are the activity participants’ opinions on the work performed by KACA?
2. What have the participants learnt from attending at least one of KACA’s activities?
3. Have the activities, according to the participants self-reports, in any way influenced on their behaviour?
Method

Study design
Explorative qualitative study with semi-structured interviews.

Sample
The inclusion criterion for this study was that respondents should have participated in at least one activity organized by KACA, to be able to give the authors valuable and subjective answers. Exclusion criterion was membership of KACA, since the answers from KACA members might be influenced by their affiliation which could make them unwilling to express some of their thoughts. To ensure balanced representation, the authors wanted both male and female respondents from different age groups. Also, KACA is working in different geographical areas, so the authors wanted respondents from both rural and urban areas. The authors shared their request of suitable respondents with the chairman of KACA, on which he got in contact with 20 purposively selected candidates who had given out their phone number or address after participating an activity arranged by KACA. The contact was either performed as a phone call or a home visit. The selected people were asked by the chairman of KACA to participate (after given a short summary of the aim of the study), on which all 20 agreed. Beyond 3000 Tanzanian shilling (approximately 16 SEK) to compensate for their transport costs and time, the study participants were not offered any economic incentive. 15 respondents (seven men, eight women) were residents of urban areas in the district of Moshi. Further, five respondents (two men, three women) were residents of Embukoi masai village (rural area in Moshi district). The respondents were from different age groups (18-53 years) (see Table 1).

Table 1. The respondents’ gender, age and area of residence.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age group</td>
<td>18-29</td>
<td>30-41</td>
</tr>
<tr>
<td>Residence in rural area</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Residence in urban area</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>
Data collection
The interviews contained six semi-structured questions according to an interview guide which was developed by the authors (see Attachment 1). The interview questions were tried out before the data collection started; a pilot interview was performed at KACA’s head quarter with a member from KACA’s theatre group. After answering all six questions the test respondent was asked if there was something he did not understand, but he claimed to have understood all questions on which the authors approved the interview guide. Before every interview started, the respondent was asked to reveal his/her age, which was documented by the authors. The interview started off with the authors asking what kind of activity the respondent had attended. Further on, the interview contained questions regarding the respondent’s opinion about the activity, what the respondent might have learnt from participating, whether the activity has influenced on the respondent’s opinion about HIV/AIDS or/and whether it will influence the respondent’s behaviour. Last of all, the respondent was asked if he/she thought KACA should improve anything in their activity. All six questions were asked to every study participant, but occasionally the interviewer had to clarify a question, or ask follow-up questions if he/she thought a development of the answer was necessary. No follow-up questions were prepared; the interviewer came up with suitable follow-up questions in order to make the respondent develop his/her answer during the interview.

Procedure
The 20 interviews were held over four days; the first three days (15 interviews) the interviews were held in the chairman’s office at KACA head quarter in Moshi. The chairman of KACA gathered five respondents the first day (time duration for the interviews were 4 to 10 min, including the translation), six respondents the second day (time duration: 5 to 21 min) and four respondents on day three (time duration: 4 to 7 min). The fourth day, the authors went to Embokoi masai village where the last five interviews were held in a secluded room (time duration: 7 to 10 min). A Swahili-English interpreter (a member of KACA’s theatre group) and the two authors were attending every interview; the authors were acting as interviewers two days each. On the first three days, a Swahili-English control interpreter was attending the interviews to make sure the interpreter did not miss any information. If the interpreter missed
some information or did not know the English translation of the answer from the respondent, the control interpreter added this to the interview. One of the respondents knew English, but the Swahili-English interpreter was still present during this interview and clarified one of the questions to the respondent in Swahili. Three respondents in Embukoi masai village did not know Swahili or English. Therefore, a second interpreter (the chief of Embukoi masai village) had to be present, to translate the question from Swahili into the masai language the respondent spoke, and also translate the respondents’ answers back into Swahili. The interviews were recorded by the author who did not act as interviewer.

Data analysis

The interviews were transcribed by the authors shortly after the interviews were held (maximum two days). The authors could not hear some words properly on the recording. Therefore, the interpreter was asked to listen to the recording in order to clarify what word was meant. Only the parts of the interview that were in English were transcribed. The transcribed recordings constituted the unit of analysis. To analyze the transcribed interviews, qualitative content analysis according to Graneheim and Lundman (2004) was used. The interviews were read through to find the sense of the whole. Then, meaning units that correlated to the aim of the study were sorted out by the authors. Thereafter, these meaning units were condensed by the authors. The authors compared the condensed meaning units, and sorted them under appropriate abstractive codes (see Table 2). Further on, the codes were compared in order to find similarities. The codes were listed under eight sub-categories and finally linked together to form five broader categories (see Table 3) (Graneheim & Lundeman, 2004).

Table 2. Example of meaning units, condensed meaning units and codes.

<table>
<thead>
<tr>
<th>Meaning units</th>
<th>Condensed meaning units</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>“...when I was in... like... sex... with a girl... I didn’t use condom... mhm... after getting the information that HIV/AIDS and this and this... I discovered that it is much important to use</td>
<td>The respondent has discovered that it is important to use condom.</td>
<td>Knowledge about the importance of condom use.</td>
</tr>
</tbody>
</table>
condom..” (R4: Male, 18)

“I have learnt that I have to use protection when I’m doing sex..”
(R9: Female, 29)

The respondent has learnt that she has to use protection (condom) when having sex.

“..when I didn’t know the information, I thought that AIDS is a big problem and we thought that if someone has AIDS he just die.. so at last I came to know that you can have medical processes and you live well..” (R15: Female, 33)

The respondent now knows that there is treatment for those who have HIV/AIDS.

Knowledge about ART.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Sub-category</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge about the importance of condom use</td>
<td>Received knowledge about HIV/AIDS from KACA</td>
<td>New knowledge about HIV/AIDS</td>
</tr>
<tr>
<td>Knowledge about ART</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3. Example of codes sorted under sub-categories and categories.

**Ethical consideration**

The respondents took part of an information letter, which was worked out according to Codex guidelines for informed consent, in which the aim of the research was shortly described (see Attachment 2). The information letter had been translated by KACA’s coordinator into Swahili (see Attachment 3), and was read out loud to the respondent before the interview started. The interviewers only asked the respondent to reveal his/her age, and the respondents are therefore impossible to identify. The respondents were due to the information letter aware of the possibility to discontinue the interview at any time without any given reason. All respondents agreed to procedure after taking part of the information letter (Codex, 2009).
**Results**

The authors identified the following five categories with eight underlying sub-categories (see Table 4):

*Table 4. Identified categories with underlying sub-categories.*

<table>
<thead>
<tr>
<th>Categories</th>
<th>Sub-categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received support from KACA</td>
<td>Financial support from KACA</td>
</tr>
<tr>
<td></td>
<td>Mental support from KACA</td>
</tr>
<tr>
<td>New knowledge about HIV/AIDS</td>
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<td></td>
<td>Sharing information/education given by KACA</td>
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<td>Changed behaviour</td>
<td>Reduced amount of sexual partners</td>
</tr>
<tr>
<td></td>
<td>Using condoms and avoiding sexual contacts when</td>
</tr>
<tr>
<td></td>
<td>being drunk</td>
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<tr>
<td>New knowledge about entrepreneurship</td>
<td>-</td>
</tr>
<tr>
<td>Perceived limitations in KACA’s work</td>
<td>Perceived lack of funds and donors</td>
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<td>Perceived lack of transport possibilities and working equipment</td>
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**Received support from KACA**

*Financial support*

The majority of the respondents were very grateful after being in contact with KACA; they think they have benefited a lot. KACA is donating food, useful materiel and money to needy people, often people who in any way struggle with problems that comes along with HIV/AIDS. Some of the respondents gave examples of donations they have received from KACA.
“..KACA have bought school bags to my kids.. my children.. exercise books… uniforms..” (R16: Male, 44)

Many of the respondents were also aware of KACA’s limited financial resources, but they found that KACA always tried to help in the best possible way.

“..if they (KACA) have money they give me a little..” (R10: Female, 46)

**Mental support**
The results showed that KACA does not only sustain people by donations, they also supply needy people with mental support. According to a few respondents, KACA yields hope among People Living with HIV/AIDS (PLHA), so they can maintain their motivation to live and also to find joy in their lives. One respondent living with HIV said KACA has given him hope and support.

“..even if you are infected with HIV/AIDS.. KACA gives you hope.. so that you don’t lose hope. You still a living man.. and I have seen a lot that have HIV/AIDS and KACA have tried to help them and they live in a happy way..” (R5: Male, 38)

**New knowledge about HIV/AIDS**

*Received knowledge about HIV/AIDS from KACA*
KACA spreads a lot of information about HIV/AIDS through their different activities. For example, the respondents have due to KACA’s activities learnt things such as the importance of getting tested for HIV.

“..I went and test my blood for HIV/AIDS, because of the education I’ve got through KACA..” (R18: Female, 33)

One respondent also said she has learnt about antiretroviral therapy (ART). Some said they had been encouraged by KACA to go and test themselves, even though they were afraid of

---1 Respondent
what the test might show. After being tested, they felt relief when they found out they were HIV negative.

A good number of the respondents thought that their new knowledge had shed light on the seriousness of the disease (i.e. that there is no cure). One described her feelings after she met a person who had AIDS. He was in a really bad condition, which gave the respondent a lot of perspective, thinking she did not want to end up like him. Further, one respondent reported an awareness that lack of knowledge about the disease can make you more vulnerable to HIV/AIDS.

“...and also they give the people the information that if you don’t know the information about HIV/AIDS it is easy for you to catch the infect.. to be infected..” (R5: Male, 38)

KACA provides information about condom use. One respondent has learnt that there are condoms for women and for men. A few respondents said they have received information about how to use condoms. Some of the respondents mentioned that they through KACA have learnt that condoms are an important protection when it comes to spread of HIV/AIDS.

“..when I was in.. like... sex.. with a girl.. I didn’t use condom.. mhm.. after getting the information that HIV/AIDS and this and this.. I discovered that it is much important to use condom..” (R4: Male, 18)

One respondent also reported that he had learnt about HIV related stigma. A few said that they are not ashamed to talk about HIV/AIDS anymore, after being in contact with KACA.

Sharing information/education given by KACA

The majority of the respondents mentioned that they have been passing on the information they have received from KACA to other people in the society and to their friends. Many of the respondents claimed that they spread on general information about HIV/AIDS.

“...inform our friends and others about HIV/AIDS.. and continue to take the message and education to the society..” (R8: Female, 39)
Some of the respondents said that they have been educated in study circle methods by KACA. This made them able to arrange their own study circles, in order to discuss questions concerning HIV/AIDS and also to forward the information they have received from KACA. One respondent said that she has been educating other people about how to protect themselves from HIV/AIDS. Another respondent reported that she has been spreading on information about the importance of getting tested for HIV/AIDS.

**Changed behaviour**

**Reduced amount of sexual partners**

One important knowledge a lot of the respondents brought up is that multiple partners increase the risk of getting infected with HIV. KACA has started a football team (Machava FC) with the aim to educate the players about HIV/AIDS, but also in order to give them a chance to take care of their physical health. One respondent, who was a member of Machava FC, said that the football makes them focus on such things as sport, which can keep them off risk taking behaviours.

“...**KACA is telling us to protect ourselves from HIV/AIDS... to do a lot of exercises.. so that they can not feel like going to somewhere to find a woman or a baby girl. [...] doing practice, exercises, can build you to not think about sex.**” (R5: Male, 38)

Many of the respondents who were in a marriage brought up the importance of not having sexual intercourse outside the marriage, due to the risk of getting infected with HIV.

“...**before I got the information I was having more than one women.. more than one partner.. but after that, after that and after I've been given the information now I stay with only two wives.**” (R12: Male, 43)

One of the respondents also said that she and her husband had gone and tested their blood for HIV together, and when they found out they were HIV negative, they made sure they would stay with each other.
Using condoms and avoiding sexual contacts when being drunk

Another change in behaviour many of the respondents brought up was that they have started to use condoms when having sexual intercourse after taking part of the information and education that KACA provides.

“..I don’t do sex, intercourse without using condom..” (R7: Female, 39)

A few also said there is a risk of forgetting to use condom if having intercourse when being drunk, so now they do not have sex if they have been drinking.

“..don’t be drunk and if you do sex because you might forget to use condom..” (R11: Female, 53)

New knowledge about entrepreneurship

KACA does not only provide information about HIV/AIDS, they also try to help people gain a better life through educating them in how to earn their own money. Many of the respondents said that KACA has helped them a lot by providing them different kind of education about entrepreneurship, for example to make good quality ornaments, run a farm in a proper way, and also to do business by selling and buying cattle. KACA has given some of the respondents the opportunity to learn how to sew and make batiks.

“..I can do my own shops work.. and KACA has taken me to place that I got certain education that helps me until now.. to go and learn how make batik.. eeh and to sew..” (R10: Female, 46)

The respondents believed that the education they have received from KACA has been a big profit for them, and that they now can earn an income.

Perceived limitations in KACA’s work

Perceived lack of funds and donors
Almost all of the respondents did agree that the main problem KACA is facing is lack of money, i.e. funds and donors. To be able to keep up their work to help and reach a lot of people, the respondents thought KACA needs more financial support.

“...it’s important to keep more effort to save KACA.. so that KACA can save people.”  
(R1: Male, 49)

“...if they have a lot of founds who can give support to KACA, then KACA will reach a lot of people..” (R8: Female, 39)

Perceived lack of transport possibilities and working equipment

KACA is performing their work in both urban and rural areas. One thing that most of the respondents thought could help KACA is improved transport possibilities. When KACA is going to villages where the public transport does not go, they have to rent a vehicle which is very expensive for them. If they could get their own transport it would simplify their work in informing and educating those who are living in rural areas.

“...I have opinion that if KACA would be supported and enabled.. if they get financially and transports so that they can go and give the information in different places, in rural..” (R9: Female, 29)

A few of the respondents suggested that KACA should improve the equipment for their activities. They mention lack of funds and donors as the underlying reason for KACA’s poor facilities.

“..KACA should improve in the equipments, working equipment..” (R13: Female, 40)

“..KACA should be given support to get equipments for doing, for running the activities..” (R12: Male, 43)
Discussion

Summary of results

The aim of this study was to investigate the opinion of respondents on KACA’s work in reducing the incidences of HIV/AIDS, and to examine what they have learnt and whether their behaviour has changed after being in contact with KACA. No earlier study has been performed in order to find out what participants of KACA’s activities think about the work performed by the organization. Five categories were identified: received support, new knowledge about HIV/AIDS, changed behaviour, new knowledge about entrepreneurship and perceived limitations in KACA’s work.

The majority of respondents were very grateful after being in contact with KACA. According to some of the respondents, KACA supplies needy people with financial as well as mental support. Several respondents said that through KACA they have received a lot of useful information and education about HIV/AIDS. For example, respondents have learnt how to protect themselves from getting infected. Furthermore, many of the respondents have been passing on their new knowledge received from KACA to their friends and the society. A good number of the respondents claimed that they have changed their behaviour, such as decreased their sexual risk taking behaviour by always using condoms when having sexual intercourse and avoiding multiple sexual partners. KACA has also taught several respondents about entrepreneurship and how to earn an income. However, many respondents also mentioned that KACA has a small amount of financial resources limiting their ability to obtain transportation, better activity equipment and ultimately reach more people.

Discussion of the results

Received support from KACA

A few of the respondents said that KACA have donated money, food and school equipment to People Living with HIV/AIDS (PLHA). One respondent who was living with AIDS also said KACA has given him mental support. Financial and mental support might increase the quality of life, which supports KACA’s objective to improving the quality of life among PLHA (KACA, 2009).
New knowledge about HIV/AIDS

The majority of the respondents said they have received general information about HIV/AIDS through KACA. One respondent also believe that the lack of knowledge about HIV/AIDS makes you more vulnerable to the disease. They have learnt that HIV/AIDS is a very serious disease, which correlates to the fact that there is no cure for HIV/AIDS (Sida, 2008; WHO, 2008). We think that understanding the seriousness of the disease can reduce the risk of getting infected, by reducing risk taking behaviour. Many respondents said that they have been forwarding information about HIV/AIDS to their family and the society. A few of the respondents said that KACA have been educating them in study circle methodologies. After getting the education, the respondents were able to arrange their own study circles, in order to discuss questions concerning HIV/AIDS and also to forward the information they have received from KACA. This strengthens KACA’s statement of having adapted study circle methodologies in the communities (KACA, 2009).

Some respondents reported they have learnt about the importance of testing their blood for HIV/AIDS, and that they now have got tested. KACA encourages voluntary HIV testing (KACA, 2009). As seen in the Matovu and Makumbis (2007) study, people who were found to be HIV positive after testing for HIV/AIDS showed a reduced risk taking behaviour and thereby decreased risk of spreading the disease. The unawareness of one’s HIV-status also leads to increased spread of infection, since it makes people less careful and less willing to protect themselves during intercourse (Sida, 2008). This confirms the value of informing people about the importance of getting tested for HIV/AIDS. Even though recent studies in sub-Saharan Africa have shown increased sexual risk taking behaviour for those who came out HIV negative after undergoing VCT (Roura et al., 2009a), HIV testing is not likely to increase the spread of HIV (Matovu & Makumbi, 2007; Sida, 2008).

A few of the respondents have also learnt about HIV/AIDS related stigma and no longer feel ashamed to talk about HIV/AIDS since they have been in contact with KACA. A positive HIV test or getting an ARV drug refill can be triggers for stigma (Dlamini et al., 2009). According to Matovu and Makumbi (2007) and WHO (2009), the opportunities and willingness to get tested have been limited by fear of discrimination and stigmatisation. Stigma is considered one of the central barriers when it comes to managing HIV/AIDS in Africa (Uys et al., 2009). One of KACA’s objectives is to fight HIV/AIDS related

**Changed behaviour**

Many of respondents reported that they now do not have sexual intercourse without using a condom. A few also claimed that they do not have sex when they are drunk, since there is a risk they might forget to use condoms. Since the most effective way to avoid getting infected by HIV/AIDS when having sexual intercourse is to use protection (WHO, 2008), the respondents reduce the risk of getting infected or spreading HIV by using condoms when having sexual intercourse. There is a need to change the individual attitude against risk taking behaviour among people in Tanzania (WHO, 2008). KACA is working in order to create or improve the existing awareness on sexual behaviour (KACA, 2009). Staying with one partner and not having sex outside the marriage are two examples of change in behaviour a good number of the respondents brought up. Since every new sexual partner shows a very high increase in the risk of getting infected by HIV (Landman et al., 2008), these behaviour changes probably contributes to a decreased spread of HIV/AIDS. Reduced amount of sexual partners in combination with condom use was according to Kirby (2008) the most important factor behind the dramatic decrease in the prevalence of HIV in Uganda in the early 1990’s. Further, Kirby believes that these behaviour changes will decrease HIV transmission (Kirby, 2008).

**New knowledge about entrepreneurship**

Many of the respondents said that KACA has helped them a lot by providing them education about different kinds of entrepreneurship in order to earn more money. According to Sida (2008), poverty is one of the factors that make people more vulnerable to conditions that might increase the risk of getting infected by HIV. By helping people stay out of poverty, KACA might decrease the amount of new HIV infections.

**Perceived limitations in KACA’s work**

We found that the opinion among many of the respondents was that KACA is helping a lot of people, but their work is limited by small financial resources. There is a need of much stronger financial support for organizations and networks of PLHA (UNAIDS, 2008). Many of the respondents said that KACA could reach more people in rural areas if KACA had better transport possibilities. According to Somi et al. (2006), the estimated prevalence of HIV in
Tanzania during 2003 to 2010 in rural areas was 5.2 %, while it would stay between 10.9 - 11.8 % in the urban areas. The lack of resources could possibly be a reason for KACA to consider focusing their work on combating HIV/AIDS in urban areas. According to respondents, lack of transport to reach rural areas is a problem for KACA, but there is a lot of work to do in urban areas where the prevalence of HIV/AIDS is twice as big (Somi et al., 2006).

**Method discussion and suggestions of further studies**

The selection was appropriate in order to represent different age groups, gender and areas of residence, which strengthen the credibility of this study. Also, we find that our identified categories are covering all relevant data. However, we did not select the respondents ourselves; we presented our request of distribution among the respondents, on which the chairman of KACA made the final purposively selection. This was the only possible way to get in contact with our respondents; due to secrecy we could not get access to the lists of activity participants. As a result, there is a risk that the selection consisted of people who were mostly satisfied with KACA, which might have created a bias in the results. All interviews were used in this study, even though some had very poor information. We had hoped for longer interviews over all; however only a few fulfilled the suggested time for each interview. The reason why the interviews were short could be out interpreter’s limited vocabulary. We also got the impression that there was a lack of interest among our respondents. They were gathered all at the same time and had to wait for their interview, which could result in them being a little bored and restless. During the shorter interviews we felt that the respondent just wanted to get it over with. Some respondents did not seem to understand the questions properly, although we did perform a pilot interview in order to evaluate our interview questions on which no changes were made. Sometimes we repeated the questions with other words to make the respondent understand the meaning of the question, but still a few respondents did not give reasonable answers to some of the questions. These answers were not used in the content analysis. In future studies, it might be better to use more specific interview questions so that there is less possibility for the respondents to misinterpret. However, broad, open interview questions reduce the risk of affecting the respondents’ answers.
No specific follow-up questions were prepared, since we thought we got adequate answers during the pilot interview. At times, the interviewer came up with suitable follow-up questions in order to make the respondent develop his/her answer during the interview. We did ask more follow-up questions during the last performed interviews compared to the first interviews. Since we are inexperienced interviewers we did not always reflect over the given answers during the interview. It was first in the end of the transcribing we discovered that it would have been appropriate with more follow-up questions. We think that too few follow-up questions in combination with a number of respondents not understanding the meaning of some questions can be the reason why some interviews were shorter than expected. Due to our inexperience the interviews would probably have been more exhaustive if follow-up questions had been prepared.

There is a risk of sources of errors when using two interpreters as we did in Embukoi masai village. Despite this, we chose to include the three interviews with the respondents who neither spoke English nor Swahili, since we wanted to ensure the distribution of residence. The English-Swahili interpreter we used for all our interviews had quite a limited English vocabulary and probably could not interpret everything the respondent said word for word. This might have been reflected in the transcribed answers. The English-Swahili interpreter was involved in KACA’s theatre group, which might have had an effect on his supposed role as independent interpreter. Due to limited time for data collection and practical reasons, the chosen Swahili-English interpreter was still the best possible option for this study. Considerations should be given to using an educated and more experienced interpreter, who is completely independent of the organization under evaluation. Also, there is a risk that the Swahili-Masai language interpreter (who was the chief of the masai village) affected the respondents. Since he had high authority in the village, the respondents might not want him to know about their personal thoughts. We find that our categories constitute the manifest content, and are well representing the relevant data. Even though a balanced representation of study participants was achieved, this study contents limitations wherefore the credibility can be questioned.

All research contains a certain amount of subjectivity. It is impossible for a researcher not to be influenced by her/his own pre-understandings when accomplishing a qualitative content analysis, which could have an effect on the results. In attempt to receive objectivity, an open discussion within the research team and an active questioning of the preconceived meaning
was maintained. All interviews were held over a short time period, and the same questions were asked to all respondents. For these reasons, we think that the dependability of this study is reliable.

This is a qualitative study with relatively few respondents; further and more comprehensive studies have to be performed in order to be able to generalise the results. However, due to the limited time for data collection, we could not have extended this study much. Even though our results can not represent everyone who have participated any of KACA’s activities, they could give a hint about common thoughts about KACA among people in Kilimanjaro region. We believe our results can well represent the opinions of our respondents. Hence, the transferability can be considered high for this limited group of respondents, but not for Tanzanian people in general.

**Ethical considerations**

This study was voluntary and the respondent could choose to discontinue the interview at any time without giving reason. Beyond 3000 Tanzanian shilling (approximately 16 SEK) to compensate for their transport costs and time, the study participants were not offered any economic incentive. This excludes the possibility of having respondents participating for economical reasons. HIV/AIDS can be a sensitive subject to discuss, but we found that all respondents were comfortable and able to answer our questions in an open way. Since the only personal information revealed were age and gender, all respondents are impossible to identify. The recorded interviews were kept in a locked room and destroyed after finishing the study. Our interpreters were informed about the secrecy, and their presence was accepted by all respondents.

**Practical implementation of the study**

This study shows that KACA is successful in order to spread information about HIV/AIDS according to our respondents. Our results might be valuable to KACA, since they show that the participants think KACA’s work is very important. Our results indicate that people who have not been directly in contact with KACA also have gained knowledge and education through the activity participants. This could encourage other NGO’s to adapt KACA’s methodologies in order to reach a greater amount of people.
Conclusions

Our findings were that every respondent had some positive experiences about KACA’s role in combating HIV/AIDS in the Kilimanjaro area. Almost every respondent claimed they had received some kind of new knowledge about HIV/AIDS. The new knowledge also led to reduced risk taking behaviour among some of the respondents, which we believe can reduce the spread of HIV. Many respondents brought up their awareness of KACA’s limited financial resources. Due to the fact that this study only involved 20 respondents, the results cannot be generalised.

Acknowledgements

The authors would like to thank KACA for helping us with the logistics. We also want to thank all of our respondents for attending this study. Further, we also send our thanks to Seynab at Studieförmedjandet in Uppsala for helping us getting in contact with KACA.

References


**Attachment 1. Interview guide.**

**Interview guide**

1. What kind of activity/activities arranged by KACA have you attended?
2. What is your opinion about the activity/activities you attended?
3. What do you find most important among what you have learnt from the activity/activities you attended?
4. Has the activity/activities you attended in any way influenced your opinion about HIV/AIDS?
5. Do you think the activity/activities you attended will influence your behaviour?
6. Is there anything you think KACA should improve in their activity/activities?

**Interview guide (translated into Swahili)**

1. Je umewahi kushiriki kwenye shughuli zipi za KACA?
2. Je una maoni gani kuhusu shughuli ulizoshiriki KACA?
3. Je ni mambo yapi muhimu uliyojifunza uliposhiriki kwenye shughuli za KACA?
4. Je mtazamo wako kuhusu VVU/UKIMWI ulibadilika ulipohudhuria kwenye shughuli zinazofanywa na KACA?
5. Je unafikiri kwamba shughuli ulizoshiriki KACA zinaweza kubadilisha tabia yako kuhusu VVU/UKIMWI?
6. Je una maoni yoyote yatakayoweza kusaidia kuboresha shughuli za KACA?
Dear activity participant,

We hereby want to ask you to participate in an interview study about KACA’s (Kilimanjaro Aids Control Association) work. The aim of this interview is to get a reflection of your opinion about KACA’s activities, what you have learnt through the activity and if the activity has influenced on your opinion of HIV/AIDS and/or will influence your behaviour. It contains six main questions and is designed by two nurse students at Uppsala University, Sweden. You are one of 20 persons who have been chosen to participate in this interview. The investigators want to include people from different ages and genders.

The investigators will only reveal your age and gender, no more information about your identity will be asked. It is a voluntary interview, and you are allowed to discontinue whenever you like without any given reason. The interview will be recorded and last for approximately 10-15 minutes. The recording will be transcribed and later presented in an attachment to the finished essay. The recording will be saved in a locked room and destroyed after the transcription is finished. A copy of the essay will be sent to KACA, where it will be available for you to read.

Thank you for your shown interest.

Best regards,

Stina Persson
stpe6256@student.uu.se
Nurse students at Uppsala University, Sweden.