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A descriptive study of self-perceived attitudes  
regarding HIV/AIDS in Cambodia

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## **Abstract**

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Cambodia is the most HIV-afflicted country in Southeast Asia. The level of knowledge about the virus among the people is low and because of the poor conditions few people have access to testing and treatment. The HIV/AIDS epidemic has been followed by a stigmatization against people living with the disease and negative attitudes are common. The aim of this study was to identify self-perceived attitudes experienced by people living with HIV/AIDS in Lvea Em, Cambodia.

In this study, a qualitative interview method was used. Ten interviews were conducted with ten Cambodian men and women, aged 25-48 years. They lived in different villages in the district of Lvea Em, outside Phnom Penh. The contact-organization Asian Outreach Cambodia (AOC) provided us with the informants. Most interviews were conducted in the informant's own homes. One of the staff from the AOC also worked as an interpreter during the interviews. Since HIV/AIDS can be a sensitive topic, particular consideration was given to ethical considerations. To evaluate the results from the study a content analysis was used.

The results showed that there are several negative attitudes connected to people living with HIV/AIDS. The main reason for negative attitudes seems to be fear of contagion. The result also showed some positive attitudes that derive from having HIV, like the discovery of love and care from family members and strengthening of the relationship to them. The results indicate that it is important to target the main underlying causes for stigmatization against people living with HIV/AIDS, but also that it is necessary to focus on the positive attitudes that do exist towards them. We wish that this study may contribute a little in the future work to eliminate the stigma and negative attitudes and also in the work to bring forward and increase the positive attitudes.

Keywords: attitudes, HIV/AIDS, Cambodia

## Sammanfattning

Kambodja är det mest HIV-drabbade landet i Sydostasien. Kunskapsnivån om viruset bland människor är låg och på grund av de fattiga förhållandena har få människor möjlighet att testa sig och få tillgång till behandling. HIV/AIDS-epidemin har följts av en stigmatisering av de personer som lever med sjukdomen, och negativa attityder är vanliga. Syftet med denna studie var att identifiera självupplevda attityder uppfattade av personer som lever med HIV/AIDS i Lvea Em, Kambodja.

I denna studie användes en kvalitativ intervjumetod. Tio intervjuer genomfördes med tio kambodjanska män och kvinnor i åldern 25-48 år. Dessa personer bodde i olika byar i distriktet Lvea Em, utanför Phnom Penh. Kontaktorganisationen Asian Outreach Cambodia (AOC) försåg oss med informanterna. De flesta intervjuer genomfördes i informanternas egna hem. En av de anställda på AOC fungerade även som tolk under intervjuerna. För att utvärdera resultaten från studien användes en innehållsanalys. Eftersom HIV/AIDS kan vara ett känsligt ämne, togs speciell hänsyn till de etiska aspekterna.

Resultatet visade att det fanns flera negativa attityder gentemot personer som lever med HIV/AIDS. Den främsta orsaken till dessa negativa attityder tycks vara rädsla för smitta. Resultatet visade även att det fanns positiva attityder kopplade till att leva med HIV/AIDS, såsom upptäckten av kärlek och omsorg från anhöriga och stärkta relationer till dem. Resultatet pekar på att det är viktigt att angripa de största bakomliggande orsakerna till stigmatisering av personer som lever med HIV/AIDS, men även att det är nödvändigt att fokusera på de positiva attityder som faktiskt finns gentemot dem. Vi hoppas att denna studie kan bidra med en liten del i det fortsatta arbetet med att eliminera den stigmatisering och de negativa attityder som finns, samt i arbetet med att locka fram och öka de positiva attityderna.

Nyckelord: attityder, HIV/AIDS, Kambodja

## **The author's thanks**

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## **Introduction**

The first case of AIDS (Acquired Immunodeficiency Syndrome) was encountered in 1980-81 among homosexual men in the U.S. (Gisslén, 2007). In retrospect, the first case of HIV (Human Immunodeficiency Virus) could be traced back to 1959. The HIV/AIDS-disease can be found in any country of the world, but it is more common in poorer regions. Southeast Asia has one of the highest rates of new cases, and in Cambodia the HIV/AIDS-problem is relatively new. The first case of HIV infection in Cambodia was reported in 1991, and the first cases of AIDS were diagnosed in late 1993 (Geurtsen, 2005). Today Cambodia is Southeast Asia's most HIV/AIDS-afflicted country with almost 123 000 people infected with HIV (World Health Organization, 2009). The level of knowledge about the virus is low and because of the poor conditions few people have access to testing and treatment. In 2001, 12,000 people died from AIDS (UNAIDS, 2002). A study that examined the health status in the Lvea Em district, which is a rural area located about 70 km east of Phnom Penh, showed that HIV/AIDS was reported as one of the most common causes of mortality in the area (Mar, 2008). Among people aged 31 – 45, HIV/AIDS was reported as the major cause of death.

## **HIV/AIDS**

HIV infection is caused by Human Immunodeficiency Virus (Smittskyddsinstitutet, 2008). This is a retrovirus, meaning that the virus is stored in the infected person's gene pool for the rest of her life and in the long run the risk of developing AIDS is high. HIV virus exists in the infected person's blood- and body fluids, such as sperm, vaginal secretion and nerve tissue. Sexual intercourse is the primary way of contagion but the virus can for example be transmitted by the sharing of unclean needles, during pregnancy, childbirth and breast-feeding. The time period from HIV-infection to developing the chronic disease AIDS can be as long as 20 years (Gisslén, 2007). AIDS is a state of immunodeficiency and the patient is likely to catch other diseases, such as tuberculosis, due to the lack of immune defence.

## **Attitudes towards HIV/AIDS**

During the summer of 2009, Amnesty International announced that the local authorities in Phnom Penh evicted 32 HIV/AIDS-affected families from their homes by force (Amnesty

International, 2009). The families were moved to an area 20 kilometres from the capital, with neither access to care, nor the ability to maintenance. The houses that the families were forced to move in to is called “the AIDS-village” by the local residents. The risk is high that these families now will become more discriminated against and labelled as a group which the rest of the society should keep at a distance. This shows that there is still some work to be done to change the attitudes towards HIV/AIDS among Cambodians. People living with HIV or AIDS are already suffering from the medical consequences of their disease, discrimination would lead to further stress of their situation. The HIV/AIDS epidemic has been followed by a stigmatization against people living with the disease (Zhang et al., 2008). Previous studies have shown that stigmatizing attitudes have an impact on the quality and timing of testing, treatment, care and social support that people living with HIV/AIDS receive (Chesney & Smith, 1999; Brown, Macintyre & Trujillo, 2003). AIDS-related stigma also discourages people from practicing safe sex, seek care and get a diagnosis (Brown et al., 2003; de Bruyn, 2002). This shows that attitudes towards HIV/AIDS are an important factor to take into consideration when working preventively with the HIV/AIDS-problem.

A study made by the National Institute of Public Health in year 2005, suggest that the majority of the adult population in Cambodia is reasonably well informed about HIV/AIDS (National Institute of Public Health and National Institute of Statistics, 2006). It also points at a reasonable degree of tolerance towards afflicted persons. Still, misconceptions are common and there is a reluctance to interact with people afflicted with the disease for fear of contagion, which stresses the importance of further actions on the HIV/AIDS-topic.

### **Negative outcomes/stigmatization**

Stigmatization of the HIV/AIDS-afflicted is a very common phenomenon around the world, more and more countries are reporting discrimination against people living with HIV (de Bruyn, 2002). The social construction of AIDS-related stigma derives from components such as social fear, ignorance, anxiety, lack of knowledge, denial, shame, taboo, racism, xenophobia and moral judgements (Malcom et al., 1998). Stigma associated with HIV/AIDS as a sexually transmitted disease is more related to women than men (Liamputtong, Haritavorn & Kiatying-Angsulee, 2009). Devine, Plant & Harrison (1999) discuss the fact that the AIDS stigma is both a personal phenomenon, reflecting a potential threat to the physical well-being, and a social phenomenon, reflecting a threat to the core social values involving

sexual behavior, morality and religion. Stigmatizing reactions against people with HIV/AIDS are thought to be based upon at least two types of attitudes: the first attitude derives mainly from the fear that AIDS is a contagious disease, the second attitude derives from moral disapproval of the behaviours of the risk groups (for example homosexuals, drug users and people practising commercial sex) and their deviant behaviours (Herek & Capitano, 1998; Ogden & Nyblade, 2005). A study on community reaction to AIDS-caregivers and their families shows that most negative reactions towards people with HIV/AIDS derive from misplaced fear of contagion through casual contact (Knodel, Williams, Kim, Puch, & Saengtienchai, 2009). Negative reactions were for example reported as spreading gossip and avoidance. Research has shown that stigma against people living with HIV/AIDS (PLWHA) can lead to stress, depression and lower perceived quality of life for these people (Simbayi et al., 2007).

### **Positive outcomes**

Most of the research that has been made regarding attitudes towards PLWHAs has focused on negative reactions. To usefully provide a theoretical frame for local interventions, it is important to investigate positive outcomes as well, such as friendship and sympathy, that may arise (Knodel et al., 2009). If ignoring the local communities ability to provide supporting environments there is the risk of overlooking the potential of community-based assistance. A study made on AIDS-caregivers and their families showed that positive reactions towards PLWHAs were expressed by showing feelings of sympathy, visits from neighbours and neighbours bringing food and medicine to the families (Knodel et al., 2009). Another study that investigated how HIV could function as a key turning point in peoples lives has identified not only negative but also positive experiences (Kremer, Ironson, Kaplan, 2009). Positive outcomes associated with HIV included having a near-death experience from HIV, increased spirituality after HIV diagnosis and feeling chosen by a higher power to have HIV. People who reported getting HIV as a positive turning point in their lives felt that it changed their attitudes, behaviours, self-view and spiritual beliefs in a positive way.

### **Attitude change**

Interventions that have been made to reduce HIV/AIDS-related stigma have shown mixed results with both successful strategies which increased tolerance towards HIV/AIDS-afflicted,

and short term effects and ineffective strategies (Brown et al., 2003). One study in a South African high school even showed that an educational program intended to reduce negative attitudes towards HIV lead to rumors about the schools students and teachers having AIDS (Kuhn, Steinberg & Mathews, 1994). These results show that interventions can both reduce and enhance stigma and indicate that new theories and research to help us understand the complexity of stigma is essential (Ernesto, Abadía-Barrero & Castro, 2005).

Attitudes can be changed directly, but also indirectly by changing the behaviour first. To attain the best result, Devine et al. (1999) propose a combination of these approaches. To directly change attitudes, a message-based persuasion can be used. In this method communications are constructed to convey positive information about PLWHAs. The expectation is then that the information creates positive attitudes, which in turn will lead to a positive behavior towards PLWHAs. Another core of AIDS stigma could be the perception that PLWHAs are seen as members of an out-group by the uninfected. This perception is related to the need of uninfected persons to protect their social identity as members of a nondeviant in-group. The most important factor to reduce the AIDS stigma could therefore be to challenge the uninfected person's perception that AIDS is a disease of "the others" by eradicating ingroup-outgroup boundaries. To create the impression of one group, and break down the conceptions of "we" versus "them", public information campaigns could be used as a method. The most important thing would be that these campaigns address risk behaviours without attributing these behaviours to a specific group. Attitudes associated with AIDS stigma are very difficult to change. AIDS stigma will therefore not be eradicated by simple informational campaigns alone, there is a need for more elaborate communications to explicitly target the various threats that uninfected people feel toward PLWHAs. In order to indirectly change attitudes by changing behaviours first, a behavioural-based persuasion can be used. One of the most effective ways to implement behavioural change is for powerful organizations to legislate and campaign for changes (Salmon, 1989). Most people already hold a positive attitude towards obeying the law, therefore it is likely that behavioural-consistent attitudes will follow.

### **Statement of the problem**

The number of people living with HIV/AIDS is increasing in Cambodia (Gisslén, 2007). These people are suffering not only from their disease but also from the discriminating and

stigmatizing attitudes from people around them (Zhang et al., 2008). Knowledge about both negative and positive attitudes towards people with HIV/AIDS is of importance when developing preventive actions against the disease.

### **Aim**

The aim of the study is to identify self-perceived attitudes experienced by people living with HIV/AIDS in Lvea Em, Cambodia.

### **Partial aim**

A partial aim of the study is to provide a basis for suggestions from the results found from this survey, as how attitude changes towards HIV/AIDS can be achieved.

### **Research question**

What attitudes are people living with HIV / AIDS in Lvea Em facing from people around them?

### **Significance of the study**

Since our partial aim of the study is to provide a basis for suggestions to how changes in attitudes towards HIV/AIDS can be achieved, we hope that this thesis can serve as an inspiration for nongovernmental organizations in their work with the HIV/AIDS-problem.

### **Method**

In the method the design, sample, data collection, procedure, data analysis and validity and reliability of the study will be described. Finally the ethical aspects that have been taken under consideration in this study will be presented.

## **Study design**

A descriptive study design with qualitative research interviews was used as a method for the data collection.

## **Sample**

A convenience sample was used, since our Cambodian contacts Asian Outreach Cambodia (AOC), provided us with informants to interview. AOC is a Christian relief organization working with various projects to meet spiritual, physical and social needs of the Cambodian people (Asian Outreach Cambodia, 2009). The HIV/AIDS problem is one of their main target areas. Contact with the AOC was made through Läkarmissionen in Sweden. The study group consisted of ten HIV- and AIDS-afflicted persons from different villages in the district of Lvea Em in Cambodia. The number of interviews was due to AOC:s time and resources. The ten informants consisted of three men and seven women, all between 25 – 48 years old. The only criterion for being included in the study was to be living with HIV/AIDS. The study did not contain any drop-outs, however, one of the original informants was unable to attend, which led to the recruitment of a new informant.

## **Gathering of data**

The data was collected through qualitative research interviews. A qualitative interview aims at understanding the informant's thoughts and feelings, what experiences she has and how her conception of the world looks like (Trost, 2005). During the interview-occasions, a questionnaire with semi-structured questions was used (see appendix 1). A semi-structured interview, which was recorded and transcribed, gave an opportunity to make changes in issues of form and sequence if necessary, to follow up the responses and stories from the informants (Kvale, 1997). The questionnaire concerned areas such as life situation, the diagnosis, reactions and attitudes and thoughts from the informant. In each area a number of questions were asked. The interviews were conducted face to face with one person at a time, using an interpreter, to counteract that the informants would be influenced by each other's answers.

## **Procedure**

Before departure, a pilot study was conducted in Sweden at the HIV-organization Noaks Ark in Gävle, to see that the questionnaire was suitable for the purposes of our study. The questions were tested on members of the organization who are living with HIV/AIDS. The pilot study did not generate any changes of the questionnaire. In Cambodia the researchers accompanied the contacts, the staff from AOC, to the district of Lvea Em. This was made on four occasions, in order to conduct ten interviews with persons suffering from HIV/AIDS. One of the contacts also worked as interpreter during the interviews. When using an interpreter during an interview, consideration must be taken to the qualities of the interpreter (Dalen, 2007). It is an advantage, as in this case, if the interpreter is familiar with the subject that the interview is regarding. The ten informants were recruited by the staff from AOC and at the same time informed of the aim of the study. They also received a letter of consent (see appendix 2) which described the conditions of participation in the study. The questionnaire was shown to members of the AOC to make sure no questions were inappropriate or offensive to the informants. Due to the limited time for each interview some of the questions in the original questionnaire were excluded. These were questions concerning aspects of background information about the informant.

The staff from AOC contacted the researchers by email to set a date for the accomplishment of the interviews. The timeframe for the use of AOC as contact organization was set to four days, during these days a lot of time was spent travelling from Phnom Penh to the district of Lvea Em and between the villages in the district. Therefore only a few interviews could be conducted each day. During the first three days three interviews were made per day. The last day consisted of a visit to one of AOC:s HIV-awareness-training program (HART-program) along with one interview. Nine of the interviews took place at the informant's homes and one at the AOC residence which is situated in one of the villages in Lvea Em. Every interview lasted on average of 25 to 45 minutes, depending on the completeness of the answers from the informants and the number of follow-up questions. One of the researchers asked the questions during the interview-occasions. The interviews were recorded and both researchers also took notes during all ten interviews.

## **Data analysis**

A content analysis was used to evaluate the results from the study. At first the ten interviews were transcribed verbatim, according to the researcher's questions and the responses from the interpreters. Pauses, silences and interruptions were also included. The transcriptions were printed and read separately by both authors who then made a brief summary of each interview. These were compared and categories/themes relevant for the aim of the study began to emerge. There were no disagreements between the researchers in terms of creating the categories. The essence of the transcriptions were cut out and assorted according to appropriate category to make sure that all relevant data had been included. Quotations were selected to strengthen the categories.

## **Validity and credibility**

According to Denscombe (2004) credibility implies that the result of a study is not allowed to vary between different measurement occasions. The result should also be the same regardless of who carries out the research. To achieve high credibility, the situation in which the study takes place, should be standardized. A high degree of standardization means that all interviews are conducted in the same manner and that the questions and the order in which they are asked are determined from the beginning (Hartman, 2004). This study used a semi-structured interview which gives a high degree of standardization, but a lower degree of structure since the questions did not have any ready-made answers.

High validity means that a study is measuring what it intends to measure (Thurén, 2007). To avoid subjectivity in the study and thereby increase the validity, it is important to identify and reflect on the researchers own influence in the study throughout the whole research process (Hallberg, 2002). It is important to check the validity and credibility already when creating the study design since the errors that affect them can be difficult to repair afterwards (Page & Henderson, 2008).

## **Ethical consideration**

Since HIV/AIDS can be a sensitive topic, particular consideration was given to ethical considerations. The informants were informed of the aim of the study both verbally and

through a consent letter (Vetenskapsrådet, 2001). They were informed that the participation was voluntary and that they could terminate the interview at any time without giving any reason. Participants were informed that all material was confidential and would be used only for the purpose of this study. This also included information concerning the organization Asian Outreach Cambodia, if they wished. The participants were informed of the purpose of the study verbally by the contacts from AOC and in writing by a consent letter. The participants' personal data were handled with care to make sure that no unauthorized person could get access to it. Since none of the informants names are used in this essay, their identity will not be revealed. All research material was destroyed after the completion of the study.

## **Results**

In this section the answers from the informants will be reported. The results will be presented according to categories without any particular order. Quotes will be used to best reflect the informants' answers and to clarify the categories.

### **Fear of transmission**

Four of the informants mentioned the fear of contagion that other people in the community have. One of the informants said that some of the villagers will not be around her because of their fear and another one said that other people are very careful and watch their actions around her and her family.

*They are so scared of getting it just by watching me or facing my presence*

One of the informants said that other people around her who know she is living with HIV tell other people about her disease. This was not with the purpose not to protect her but to protect themselves and other people, so that they will not get HIV from her by accident.

The result showed that fear is also spread to the children in the community. Two of the informants said that they are not allowed to play or interact with other peoples children in any kind of way. One of them gave an example about her relationship with her five year old nephew. After she got HIV he came up to her and said that from now on he could not treat her

as normal, not touch her or eat anything she gives him. The fear also affects the informants own children in such a way that they are not allowed to play with other children, this was mentioned by four of the informants. It did not matter whether the informants' children were infected with HIV themselves or not, the villagers still had the fear that their own children will get HIV.

*They do not allow my children to play around even they know that they are all [HIV] negative, but they do not trust that is true*

### **Lack of acceptance**

When three of the informants told their families, relatives and friends that they were infected with HIV they felt a lack of acceptance from them. Five of the informants felt that even though they had had HIV for a longer time people around them still could not accept them as they did before. One of the informants gave an example of this when saying that among 50 persons, maybe five or ten would accept her.

*They can not accept those who have HIV.*

### **Ignorance and hatred**

One of the behaviours that people living with HIV in Lvea Em face was ignorance, which became apparent by people walking away from them, refusing to talk to them, keeping their distance or only giving them a short look. One of the informants said that people even ignore her when she is really sick. The informants also felt ignored because of the lack of help from other people. Five of the informants felt that they do not get any help with emotional and financial support from their families, relatives, friends or the community. Even though they have nothing, no one will help them.

*[They] show no compassion, no care*

One of the informants gave an example of this, related to his work situation. He felt like he is not allowed or offered the work he used to do before he got HIV. Two of the informants said that people around them do not like them and four even feel hatred from other people.

*80 percent of people around me they hate me*

The hatred was also evident in different kinds of behaviour like people talking badly behind the informants' backs. One of the informants mentioned that other people in the community spits at him when they see him.

### **Discrimination and exclusion**

Four of the informants used the word discrimination when they described the attitudes they face from other people in the community. The discrimination was most evident when it comes to be involved in the community. Nine of the informants mentioned that they are not allowed to join in social activities when people in the village get together in groups. An example of this is when they eat together. During those occasions, the informants are not allowed to participate, instead they have to take their food with them to eat at home by themselves. If they sometimes are included, the other villagers refuse to share cup or plate with them.

*In a big group like while they are eating, when they see me they walk away*

One of the informants also mentioned that when eating at the workplace he can not join the others and has to have his separate meal and eat by himself. Another informant said that she is not even allowed to have any kind of contact with anyone of the villagers.

*They even not allow me to sit next to them or just be around with me*

Another type of discrimination was shown in how other people in the community value the informants as individuals. Four of the informants have had villagers saying to them that they are valued only as a person who can not live as long as normal and is going to die very soon. One of the informants believed that the way HIV-positive people are treated is the same way all over Cambodia.

*Everyone say I will die soon because of HIV*

### **Change in relationships**

Eight of the informants claimed that the relationship that they used to have with other people have changed since they got HIV. This mostly concerned friends and other people in the community, but one of the informants also mentioned that the relationship with her family and relatives had changed. The informants felt as if people around them do not treat them the same way as before, they act differently and try to change their behaviour towards the informants. The former relationship is reduced and denied from people around them, and they can not live their lives in the same way that they used to do.

*It will always be a distance in our relationship no matter what I do*

It is not always the informant herself who tells about her disease. Two of the two of the informants mentioned that other people spread the word that they have HIV to the rest of the community. One of these two said that people at his workplace who do know he has HIV will tell other people who do not know, and that pushes him to be open about his disease.

### **Increased knowledge and attitude changes**

Two of the informants felt that increased knowledge from a training and awareness program that AOC provides in the villages did not result in any attitude changes from the people in the villages. Even though they did get HIV-training their behaviour towards the informants did not change. One of the informants claimed that she does not think that people in the village believe in the knowledge that they get from the training program, and that is why their behaviour does not change.

Despite the lack of behaviour change through the awareness program mentioned, five of the informants felt the opposite. They thought that through the knowledge from the program people become more familiar with HIV and thereby more acceptant of the disease. The

informants also felt that people who have participated in the program are not as scared of them as they used to be and that their relationship has improved. All of this has made the daily life easier according to the informants.

*Before they don't want to talk to me and try to ignore and neglect, but through the awareness and training team I noticed that some of them they change their attitude towards me*

### **Positive attitudes**

The result showed that seven of the informants have experienced positive attitudes from people around them. Five of the informants felt love and care from family members or other people in the community. Two of them also felt as if people around them now have more acceptance compared to when they first heard about the informants having HIV. For two of the informants, the relationship with their families became closer and they realized that family members cared for them more. This was evident in actions like giving the informants advice on how to live healthy and have good hygiene. One of the informants' mother also said that she should not worry about what other people in the village think about her.

*I realized that my mother care for me more and she gave me good advice on how to live longer to look after my children*

When it came to relationships with other people in the community and to be involved in the community activities two of the informants said that some people let them join and one said that they usually let her and her family be involved. One of the informants said that people who know and understand about the disease still maintain a normal relationship with her. Another informant simply said that now, when some time has passed since she got the disease, people in the community treat her and her family good. Positive attitudes were also shown, according to two of the informants, when families, relatives and neighbours feeling worried and concerned, like sharing their food when they had plenty of it.

People around three of the informants where very surprised when they found out about the disease, they described it as *unbelievable* and *impossible*. Two of the informants also

mentioned that people around them did not think that they deserved to have the disease and one of the informants said that people felt pity on her.

*They where very surprised when they know that we have HIV*

## **Discussion**

In this section the main results of the study will be summarized. The researchers will then discuss and construct the results of the study. The method used in the study will be evaluated. At the end suggestions for future action and research on the topic is presented.

### **Summary of result**

The result of the study showed that there are several negative attitudes connected with people living with HIV in the district of Lvea Em, Cambodia. All of these attitudes constitute the answer to the research question of the study. The main reason for negative attitudes seems to be fear of contagion which in practise for example is shown by the informants being pushed out from the social activities in the community. Increased knowledge of ways of contagion has had both negative but mostly positive effect on attitude change. The result also showed some positive attitudes that derive from having HIV, like the discovery of love and care from family members and a strengthening of the relationship to them.

### **Discussion of the results**

The villages in the district of Lvea Em might not be comparable to "The Aids-village" that was created by the local authorities in Phnom Penh in the summer of 2009 (Amnesty International, 2009). However, the result clearly showed that there are negative attitudes connected with HIV and to people living with the disease in Lvea Em. The fear of contagion seems to be a strong underlying cause for these negative attitudes. This is confirmed by Malcom et al. (1998) who says that fear is one of the social constructions that AIDS-related stigma derives from. Parker and Aggleton (2003) also agree that stigmatizing attitudes is connected with fears of contagion and lack of knowledge about how the virus is transmitted. Negative attitudes were also shown as lack of acceptance and hatred from the uninfected

persons. Talking badly about the informants behind their backs and spitting at them are obvious ways of showing hatred. Many of the informants were not receiving the same acceptance and respect from people in the community as they used to before they got HIV. Neither HIV, nor any other disease, should be the reason for non acceptance or disrespectfulness. The health problems that PLWHAs in Lvea Em have to cope with from the disease are complicated enough, therefore they should not have to go through more suffering.

Negative attitudes towards people living with HIV were shown through actions such as ignoring, neglecting and excluding these people. People could demonstrate their ignoring attitudes by walking away, refusing to talk to them, keeping their distance or only giving them a short look. These are actions which creates a distance between the afflicted and the other people in the community. According to Devine et al. (1999) the most important factor to reduce AIDS stigma is to eradicate ingroup-outgroup boundaries and break down the conceptions of “we” versus “them”. The actions of ignoring and neglecting that the PLWHAs in Lvea Em face are just the opposite. Instead of reducing the distance it increases between the two groups. The exclusion is shown by the PLWHAs not being allowed to take part in social activities in the community. Many of the informants’ examples of social activities regard eating together in a group, they are not allowed to join in these occasions. Eating together with other people is an important part of the social interaction with people around us (Andersson, 1980; Holm, 2003). Sharing a meal brings people together and is a way for people to strengthen their relationship (Holm, 2003). To not be included on these occasions gives the PLWHAs a disadvantage in their social interaction with other people in the community. This situation of not being able to participate in this kind of social activities also reinforces the distance. All of these three actions; ignoring, neglecting and excluding can be seen as discrimination of these people which make their life situation worse than it already is due to their disease. To reduce the distance it is important to create the impression of the whole community as one united group instead of two (Devine et al., 1999). This will increase the feeling that everyone in the community is of the same value, no matter what complaint you may have. Five of the informants said that they did not get any help, neither with emotional nor financial support, from either families, relatives, friends or other people in the community. If the community was more united as a group they might be more helpful.

The informants mentioned that one hard thing about living with HIV is that they can no longer live as normal, nothing can be as before and they can never be cured from the disease.

All of the negative attitudes that they face only make their life situation worse. Not even when meeting with new people it is possible to feel as a normal healthy person. This was because other people had already spread the word of the respondents having the disease, so that everyone knew about their condition. Because of this they can never forget about the fact that they have HIV. Four informants had even experienced that other people value them as persons who are going to die very soon. This also makes it hard for the PLWHAs to live a normal life and find the strength to cope with the disease. The question that derives from this is how is it that the informants, considering the poor circumstances under which they live, still manage to keep their life going?

Besides of fear, lack of knowledge is another component that generates AIDS-stigma (Malcom et al., 1998). Even though two of the informants felt that the increased knowledge, due to the training and awareness program, did not have any effect on attitudes towards them, there were several of the informants who thought the opposite. This leads to the conclusion that increased knowledge *does* have an impact on peoples' attitudes and that educational programs are important factors in the work to reduce the AIDS-stigma. A survey conducted by the National Swedish Board of Health and Welfare during 1987-2007, about the public knowledge, attitudes and behaviour to HIV/AIDS in Sweden, showed that still in the year 2007 a fairly widespread concern regarding the interaction with PLWHA:s remains (Herlitz, 2007). However, the survey from 2007 shows that the general public had a more positive attitude towards PLWHAs in comparison with the previous surveys. In addition to interaction with PLWHAs this positive development also concerns questions about the public's perception of PLWHAs ability to have sexual intercourse. This positive development is probably due to the growing public knowledge and awareness about HIV/AIDS.

Because of the existing fear of contagion it is important that people learn about the true ways of transmission and that people really believe in the information they are given, in order for educational programs to be successful. One way to increase the probability that people believe in the information they are given is to use a theoretical model for health interventions named the Social influence model. This model emphasizes the importance of role models and significant others as sender of the information (Wijk, 2003). In the preventive work in Lvea Em the village council in each village can work as role models because of their powerful position and can be used to spread the information about HIV and AIDS to the other people living in the village.

Despite all the negative attitudes that the PLWHAs in Lvea Em are facing some of them still manage to find some positive outcomes from having the disease. Five of the informants felt love and care from their families and other people in the community. Another two felt that their relationship with their families had improved since they were infected with the disease. The positive attitudes were also shown through people having more acceptance now than before and letting the PLWHAs join in social activities in the community. These positive attitudes might be one of the answers to why the informants still manage to cope with their disease and continue to live their life. The aim of this study was to identify self-perceived attitudes experienced by people living with HIV/AIDS. The positive and negative attitudes identified in the result make the purpose of the study fulfilled.

### **Discussion of the method**

In this study, qualitative interviews have been used as a method of data collection. When using interviews, it is important to consider the extent to which the researcher can influence the situation. He or she should only ask questions, to capture the informants' opinions and feelings without sharing their own other than to a very limited extent (Trost, 2005). For the interviewer it is always important to be able to feel empathy for the informant's views and to be acquainted with her situation, especially when dealing with such a sensitive and taboo subject as HIV/AIDS. In this study this was, for us as researchers, no difficulty since the interviews took place in the informants' own context; in their country, in their village and in their homes.

By using qualitative interviews as a method the informants could not get influenced by any ready-made answers, which gave them the freedom to respond with their own words, ideas and reasoning (Kvale, 1997). As the researchers did not provide any ready answers their own involvement and influence was reduced. If instead an inquiry had been used, it would have been much easier for the informants to fill in only one response, but now they had the opportunity to speak freely about the subject. Given the study's topic, an interview seemed to be the best way to get the most out of the informants' answers. Furthermore, with an inquiry there is no certainty that any of the options would have matched the attitudes that the informants in Cambodia face.

As for the questionnaire the initial questions were used for the researchers to get a better picture of the informants' life situation. These questions provided a better pre-understanding and therefore seemed necessary to include. The interviews were expected to take longer time than they really did. Some of the informants gave very detailed answers, while others gave very brief answers, especially the male informants, this is probably why the interviews took less time than expected. If we had known this when constructing the interview guide the questions which had greater relevance for the aim of the study could have been expanded to get even richer answers. Since the men replied very briefly, more questions about the subject, from different viewpoints could have been asked in order to induce longer and more comprehensive answers from informants. However, the remaining questions in the questionnaire served as intended, except the question whether the informant considered himself to have received sufficient help to cope with the disease. This question could have been elaborated with an accompanying question about what kind of help the informants wished for in those cases when the answer was a simple "No".

During the interviews, a Cambodian interpreter was engaged since all of the informants only spoke the Cambodian language, Khmer. The use of an interpreter may affect the data collection since communication then has to pass one extra stage (Dalen, 2007). This may lead to difficulties for the interviewer to get close to the respondent, which is important for the understanding of the informants experiences of the subject covered. One thing in this study that to some extent compensated for this, was that the interpreter worked with issues related to HIV/AIDS. It was also an advantage that the interpreter recognized and was familiar with different expressions and terms related to the topic. A further way to strengthen the validity of a study is if the interpreter is part of the culture area in which the study takes place and it is ideally if the informant and the interpreter are from the same culture (Kapborg & Berterö, 2002). One of the threats to the validity of this study was that the researchers could not control the situation when the interpreter and the informant were speaking their mother tongue since the researchers neither understood nor spoke Khmer. The interpreter had also been in contact with all the informants in the different villages before and therefore they could feel secure with her being there, but on other hand this could also have contributed to the informants feeling insecure of telling her everything.

In qualitative studies the ideas of validity and credibility are slightly different from quantitative studies since these concepts (that is validity and credibility) derive from quantitative methodology (Trost, 2005). When using qualitative interviews the aim is to understand how the respondents think, feel or behave, which is different from a quantitative study where the aim is to measure something. This study was conducted by two researchers which were favourable for the study's credibility and validity. The preparatory work, like literature collection and review of previous research on the subject, has partly been made individually by each of the two researchers. Each researcher has covered different parts of the subject. This has resulted in a greater overview of the subject field than if the work had been carried out by a single researcher. The interviews were transcribed, then read and summarized separately by the two researchers. The summaries were compared, and from these categories were created. In qualitative research reliability and validity deal with how credible the found categories are, that is, how well they are in line with reality (Hallberg, 2002). To test this, a co-reviewer can serve as a controller of the validity of the category, which is a common way in order to increase quality of the study. The control and quality assurance in this study has been carried out since one of the two researchers has been able to act as co-reviewer. As the essence of the transcriptions were cut out, they could be sorted into different categories and thus make sure that all data of relevance were included. In this study, quotes from the interviews were used to strengthen and clarify the different categories. In this way, the validity of categories could be tested (Hallberg, 2002). By recording all the interviews the credibility could be further enhanced (Enmarker, 2010).

For the validity of the study it is important that the questions asked in the interviews are designed to measure what the study really intends to measure (Ciliska, Cullum & Dicenso, 1999). To check this, before implementing the study, a pilot study on PLWA:s in Sweden was made. The pilot study could not be completely applied to the real study since the conditions for PLWHAs in Sweden and Cambodia differ. Questions regarding accommodation, family and work situation were designed for the poor conditions in Cambodia and therefore they did not have the same relevance in the pilot study. The questions which were directly related to the purpose of the study, such as questions about attitudes to HIV and reactions from the people around the PLWHAs, however, are questions that all PLWHAs can relate to no matter what their living conditions look like.

Credibility constitute one of the biggest problems in qualitative studies and, therefore, qualitative interviews (Trost, 2005; Thurén, 2007). Even if the survey would have been conducted with the same researchers and the same questions asked, in the same way, to the same informants there is no guarantee that the answers necessarily would be the same. In addition, follow-up questions that arose during the interviews would be difficult to recreate at another time.

### **General discussion and suggestions of further research**

The result showed that negative attitudes towards PLWHAs in the district of Lvea Em have been identified. This shows that there still is work to be done to reduce these attitudes. According to Devine et al. (1999) AIDS stigma will not be eradicated by simple informational campaigns alone. There is a need for more elaborate communications to explicitly target the various threats that uninfected people feel toward PLWHAs. In this study some of these threats have been identified which can help the relief-organization AOC to target their efforts towards these threats in order to reduce stigma and discrimination in the Lvea Em district. This fulfills the partial aim of this study, which was to generate suggestions as how attitude changes towards HIV/AIDS can be achieved.

One of the things that AOC could strive for is to create a united group feeling in each village in the district of Lvea Em (Devine et al., 1999). This can be made by getting the PLWHAs and the non-infected people in the village to do things together, to learn more about one another and create opportunities for common experiences. In this way, the sensation of two groups will be reduced and the people in the village can be brought together.

In this study various positive attitudes towards PLWHAs have emerged. One of these is the support that families and relatives show the afflicted. This is something that the AOC should grasp and strive to develop. They could for example organize a special program exclusively for the families where they can meet other parents, relatives and friends of PLWHAs to discuss and share their feelings, thoughts and experiences. This could lead to an easier way for them to cope with the fact that someone close to them has HIV. They may also feel that they are not alone in their situation. In this way, it can become easier for family members and relatives to serve as a good support to PLWHAs. AOC could also organize special meetings

exclusively for the village council in Lvea Em, which could serve as role models for the people in the village. During these meetings AOC can educate and show people of the village council how to best act and work with questions regarding HIV/AIDS.

The research shows that there are positive attitudes among people in the villages in Lvea Em towards PLWHAs. In the future it would be interesting to investigate how these attitudes affect PLWHAs in their daily life and whether they affect the quality of life in a positive way, both in the district of Lvea Em and for PLWHAs in general. Further, it would be interesting to investigate whose attitudes that have the greatest impact on the PLWHAs. Is it for example family members, members of the village council or a personal role model in form of a celebrity?

Attitudes associated with AIDS stigma are very difficult to change (Devine et al., 1999), but it is important not to give up hope, but to continue the work to eliminate the negative attitudes and the stigma that still exist. This work would have a positive impact on the public health in Cambodia. It might be a great hope, but we wish that this study may have a small part in this future work.

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# Appendix 1: Questionnaire

**Gender:**

Man:      Woman:

**Age:**

## Life situation

- What is your life situation like?
  - Where and how do you live?
  - Do you have a family: husband/wife, children, parents? Do you live with them?
  
- Do you have a job?
  - If yes, what kind of job?
  - How many days a week do you work?
  - Is this income enough to provide food, shelter and health service for you and your family?

## The diagnosis

- Do you want to tell us how you were infected with the disease?
  
- When did you get diagnosed with HIV?
  - How come you got tested for HIV?
  - Did you experience any symptoms?
  
- How does the disease affect your: family life, work situation, social life?

## Reactions/attitudes

- Did you tell your husband/wife or other family members that you had HIV
  - If not, how did they find out?
  
- How did people around you react when they heard about your disease: family, relatives, friends?
  - What did they think of your disease?
  - How are you treated by people around you: at work, at home, among relatives, by people in the community?
  
- Have you ever felt that you are being treated differently in society because of your disease?
  - If yes, in what way?

## Thoughts from the respondent

- Do you think you are getting enough help to cope with your disease: from your family, relatives, neighbours, the community?
  
- How much do you think the community you live in know or understand about HIV?
  
- From what you already have told us, what is the most difficult thing about living with HIV/AIDS? Are there any positive outcomes from your disease?

## Appendix 2: Consent letter

Hello,

Our names are Sara Bodling and Sarah Larsson, we are studying our sixth semester on the Health Education Program at the University of Gävle. We are currently working on our thesis in Public Health.

You are hereby requested to participate in a study designed to describe attitudes towards people living with HIV/AIDS. If You choose to participate in the study, it means that You will meet us for an interview about Your experiences of attitudes towards Your illness.

We would be very grateful if You want to participate in our study. To get the analysis of the results as accurate as possible the interviews will be recorded. Your responses will be anonymous, meaning it will not be possible to trace your answers back to you. The participation is voluntary and may be discontinued at any time during the study. The material we receive will also be handled confidential so that no unauthorized person can get access to it.

Do you have any questions, please do not hesitate to contact us:

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Thank you in advance.