

The Pertinence of Applying Qualitative Investigation Strategies in the Design and Evaluation of HIV Prevention Policies

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1. Introduction

"We think that there still exists a vast sector of science in which we are no further than in taylorian stages of intellectual work rationalization and which can do nothing but contribute to scientific rigor. Rigor when reasoning is more important than rigor when calculating. Questions is more important than rigor than questionnaires."
 Edgar Morin ¹

In the last decade, the incidence of HIV has globally diminished by 19% (Joint United Nations Programme on HIV/Aids, [Unaids], 2010). Likewise, new cases of children infected by HIV have diminished due to the spread of vertical mother-child prevention among pregnant women. The percentage of people who received anti-retroviral treatment increased by 30% due to improvements in the accessibility of therapeutic treatment. Also, the annual percentage of death caused by Aids has decreased (Unaids, 2010). Nevertheless, in spite of this progress, HIV/Aids pandemic continues to be one of the main threats to global health.

On a world scale, pandemic epidemiological data shows alarming numbers: there are more than 33 million people around the world living with HIV. Approximately, 7,000 new cases of infection arise every day. Every year, an average of 1,800,000 people die as a consequence of Aids. It is estimated that 12 million children have been orphaned (Unaids, 2010).

However, such numbers are distributed in unequal proportions throughout the world. Thus, since not every country presents the same level of prevalence, big differences can be found. Currently, most of the countries suffering from HIV pandemic are developing countries. Also, these countries show low or medium levels of human development. The Table 1 shows the relation between Human Development Index in some countries with a higher pandemic level.

As seen on table 1, the distribution of the pandemic tendency throughout these countries reveals a clear correlation: The less socio-economically developed a country is, the higher the HIV prevalence is. This being so, it is hardly surprising that sub-Saharan African or Asian countries present widespread epidemic HIV levels. On a world scale, these countries hold the highest Multidimensional Poverty Index (United Nations Development Programme, [Unpd], 2010). For instance, the worst Human Development Index in the world belongs to

¹ Morin, Eder. (2006). *The method* (ed. Cátedra).

Countries	2009 HIV estimates in Adults and children	HDI 2010
Nigeria	3,300,000	0.432
India	2,400,000	0.59
United Republic Of Tanzania	140,000	0.398
Zimbabwe	120,000	0.140
Uganda	120,000	0.422
Malawi	920,000	0.385
Zambia	98,000	0.395

Table 1. Relation between HIV and HDI prevalence

Self-made

belongs to Zimbabwe (0.291) and, at the same time, the highest levels of HIV prevalence can be found there - around 20% and 25%-, (UNPD, 2010). With the one before, in countries like Sweden, where the Human Development Index is very high, (0.773) such prevalence varies between 1% and 5% (UNPD, 2010).

Therefore, the highest number of cases are to be found in lesser developed countries, bearing almost 90% of the whole HIV prevalence worldwide. In these countries, the HIV epidemic is one of the largest National Health problems faced by their Governments. As a consequence, strategic plans of prevention, together with the provision of welfare coverage in the treatment of HIV, are given top priority by the National policies. Nonetheless, HIV epidemic does not only mean a challenge at political level, it also entails a menace to entails a menace to democracy and governability in these countries' political systems. Regarding this last statement, the South African Institute for Democracy has published a report highlighting the negative effect of HIV/Aids in the electoral processes of these countries.

HIV epidemic in these countries does not only mean a medical and sanitary problem, it also constitutes one of the main obstacles for their socio-economic development. Given the huge percentage of adults who die as a consequence of Aids, these countries lose their young people, those who could help with their economic development to a higher degree. In addition, economic productivity also decreases due to the fact that the number of people infected by Aids or those who take care of them must quit their jobs. Besides, their educational systems are affected due to the percentage of teachers who die as a consequence of Aids. This situation brings about an important loss of highly educated inhabitants. Likewise, medical expenses generated out of the provision of health services to people who live with HIV (PLHIV) and Aids, involve budgetary restrictions in the investment of public expenses in other sectors, with the aim of promoting the economic and social development of these countries. In connection with this, the UNPD estimates that in Bostwana the State Revenue dropped by 20% in 2010 as a direct result of HIV/Aids (PNUD, 2010).

Regarding families, the consequences of this epidemic in the domestic economy of these countries are also devastating. When they lose the "head of the family" -the one who has to meet the economic needs of the family- they lose their income, their nutrition worsens, agricultural production falls, medical expenses increase, savings turn into debts, funeral expenses multiply, children leave schools, people's health deteriorates, and so on. In fact, a survey carried out in Zambia shows that two thirds of urban homes which have lost the head of the family as a consequence of Aids have seen their income drop by 80%. The same

survey revealed that 61% of these families moved to cheaper places to live, 39% lost their access to drinking water and also 21% of girls and 17% of boys gave up their school studies (PUND, 2001).

Finally, the spread of the epidemic in these countries is increasing, deepening existing poverty and social inequality, and reversing the trend towards their level of human development. Hence, HIV/Aids epidemic has become one of the main key aspects in national policies of Poverty Reduction Strategies (PRS) (PNUD, 2002) Such strategies are becoming the main national planning instrument in many countries. That is why HIV/Aids plays a central role in the processes of national development planning and in the budgetary allocation of these States. This contributes to the creation of adequate policies and providing the necessary resources, in order to give a wide multisectorial response to the HIV problem.

Generally, a higher prevalence of the pandemic in countries with low human development index increases social injustice and emphasizes the north-south divide. So that the fight against HIV/Aids together with the fight poverty has become two parts of the same parts of the same battle. Therefore, regarding poverty in certain countries, there will be no possibility to achieve the Millenium Development Goals (MDGs) unless HIV/Aids is efficiently treated. That is why the fight against HIV/Aids has been chosen as the sixth MDG (United Nations, [Nu], 2000).

2. The importance of prevention in the response to the epidemic

After three decades fighting against the epidemic, in the field of public health there is no doubt that the intervention from prevention policies is the most efficient weapon in order to eliminate and combat the epidemic (World Health Organization, [Who], 2010). In this sense, competent international organizations struggle more and more to make governments and other institutions aware of the importance of implementing efficient actions in order to prevent HIV. So, the last UNAIDS world report has included measurement indexes for different aspects of prevention processes carried out in different countries as evaluative indicators of the current state of the epidemic (Unaids, 2010).

All over the world, the high number of new cases of HIV in 2010 corroborate the pressing need for intervention in order to stop the development of the epidemic. There again, a higher incidence of HIV cases in developing countries has established prevention as a priority in the national policies of these countries. In connection with this, it is worth knowing that 97% of the new infections produced every day are to be found in people who live in countries with medium or low human development index (Unaids, 2010). Specifically, it is in the African context where the cases of incidence occur more frequently.

As for the development of HIV prevention policies, experience reveals that there are no universal formulae for success that might be applied to all countries. Therefore, certain strategies of prevention proved to be successful in a given country may not constitute any guarantee in another, due to the multiple factors that interfere in the development of the different policies. For instance, each context presents a set of specific needs which must be taken into account for the design and implementation of such policies. Among other things, exclusive qualities of the social and cultural elements also play a part when defining the context in which the intervention is going to take place. That is why it is advised to take into account all of these aspects and adapt the design of HIV prevention policies to the context in which they will be implemented.

Currently, there is a big concern about how to adapt prevention policies to African countries. On the one hand, it is due to the urgent need to change the development of the epidemic considering its magnitude and, on the other hand, to the ineffectiveness shown by prevention policies to date, considering the high rates of incidence. As a consequence, the epidemic stabilization has not yet been reached in some countries.

2.1 Prevention policies in the African context

HIV prevention actions developed in Africa are key to slow down the great development of this disease. Besides, prevention actions have an added value since either they must be linked to or they must incorporate values, such as justice, fairness and the promotion of dignity. At the same time, it constitutes basic principles which help to improve the African context.

Now, some of the international recommendations on public health as well as some of the existing evidence on HIV prevention in the African context to date are described.

Prevention actions must be aware of the main HIV routes of transmission in the continent. In Africa, the HIV epidemic spreads mainly through sexual intercourse. The percentage of people who became infected by this disease through routes other than the sexual intercourse is low. Nevertheless, mother-to-child transmission and hemoderivatives transfusion are the other two relevant aspects when assessing prevention measures in countries where, like in the African context, the investment in public health is not enough.

It is advisable to develop HIV prevention policies that interact with the different levels of prevention. According to the World Organization of Family Doctors (Wonca), there are four grades of prevention. Primary prevention is the one that involves action before the disease appears and, among these actions are the ones in charge of promoting health, those focused on environmental hygiene or those like vaccination or chemical prophylaxis. Secondary prevention deals with actions aimed at identifying ill patients within the population, implementing strategies of population sifting, enabling the early detection of diseases. Through implemented actions, tertiary prevention involves easing or avoiding the effects of the disease once it has been contracted. Finally, in 1986 Marc Jamouille defined quaternary prevention as *“those actions designed to restrict unnecessary damage produced as a consequence of health-care activity”*.

Within the current priority of international recommendations on health-HIV, five guidelines for intervention have been developed. These guidelines are especially relevant in countries with higher prevalence, as in most of the African countries (Who, 2009). They mainly include preventive actions in the three first levels:

1. Strengthening actions in primary prevention of the disease from the health sector.
2. Making it possible for the population to know its serological status.
3. Accelerating the spread of the treatment as well as the HIV/Aids care.
4. Strengthening health systems capacities.
5. Increasing knowledge in order to improve response.

In general, as a maxim of intervention in public health, the development of HIV-related actions, including all actions and not only preventive ones, should be adapted to each and every context in three determining factors. Firstly, they should adapt to the specific characteristics of the epidemic in question, like the particular context of each country as well as that of its community. Secondly, they should pay attention to the cultural context and, thirdly, to the level of provision of services and resources set aside for health. Related to this last aspect and in order to strengthen the adaptation of international frameworks at local level, actions developed to prevent HIV are considered to be complex interventions as

regards their evaluation processes (Campbell et al., 2000). In order to do so, it is advisable to take into account the adaptation of the process to the local circumstances before being implemented once it has been completely standardized. Therefore, for an optimal implementation, it is currently considered as necessary to have the adequate knowledge to orientate this process of adaptability of the standard theoretical framework.

In the African context, a low specific applicability of these criteria can be found. That is why a low level of key targets for prevention has been achieved. It is worth mentioning that only 32% of the African population knows their serological status. Likewise, only 45% of pregnant women receive proper care in order to prevent their children from contracting the disease. (Who, 2010).

As regards the type of epidemic, actions carried out in the African context must have plenty of characteristics unique to the generalized epidemic. This is the most common epidemiological situation in most countries of the continent. The fact of presenting generalized epidemic levels determines the monitoring of intervention priorities within the prevention area:

- Using strategies that would cover all risk behaviour of contracting the disease. Besides, these strategies must be as accessible as possible to the population in need of help.
- Decentralizing the provision of services by incorporating primary care actions as well as community actions.
- Integrating prevention services together with treatment and care services into primary care services.
- Giving priority to actions aimed at tertiary prevention making it possible to interrupt the epidemiological chain of the disease, diminishing the appearance of new cases.
- Recommending the diagnostic sifting of every person who makes use of health care services and to all pregnant women or those in a lactation period.

The existence of a whole multiplicity of cultural components characteristic of every area and unique to every social group is something that, for the time being, has not been sufficiently reflected in the adaptation of the general frameworks to each context. The recommendation that second generation epidemiological vigilance (Grulich & Kaldor, 2002) (Who, 2000) should be integrated into the tracking and monitoring processes of the disease makes it possible to count on a broader knowledge of people's attitudes and practices. Moreover, adaptation to strategies has improved. The use of qualitative methodologies in order to generate this knowledge is still very recent and, in some contexts, almost nonexistent. This is shown as a tool that supplies key elements, having a deeper impact on health when adapting actions to contexts.

Weakness in health systems which implement actions and policies is a very common factor all around Africa. Such weakness does not always derive from the low budget allocated to its development. In the last years, poor systems and limited resources, together with important obstacles that eliminate the possibility to improve these systems, demand the need to search for evidence-based knowledge in order to determine which actions are the most cost-effective in HIV. This knowledge would help to establish criteria that could improve the management of the intervention.

Out of all this generated knowledge, taking into account the target context of the chapter as well as efficiency criteria previously mentioned, we wanted to pay special attention to the value of implementing associated measures of secondary and tertiary prevention, like diagnosis and treatment, respectively.

The initial intervention model in the fight against HIV implemented only tertiary prevention measures, in spite of its low efficiency when trying to reduce the progression of the disease.

The target was to reduce the high rate of mortality caused by this disease at that time. Nowadays, the antiretroviral treatment has evolved and it is considered to be highly active (HAART). Cohort studies in serodiscordant couples and pregnant women living with HIV have proved that patients who receive good treatment and have an undetectable viral load are less likely to transmit the disease (Quinn et al., 2000). This ART has proved to be a very good method to reduce the transmission of this disease and that is the reason why, currently, on a global scale, all countries are advised to reach universal coverage (Granich et al, 2009) of the treatment. The reason is not only that the rate of mortality decreases but also its effect on the transmission chain.

There is a great variability when it comes to value the cost-effectiveness of HIV strategies depending, above all, on the country where the action is implemented (Andrew, 2002). Following this criteria, actions of prevention that cause a deeper impact and those enjoying a better cost-effectiveness criteria are meant to limit mother-to-child transmission of the disease. Regarding the diagnosis of the disease in the population, the HIV strategies meet the requirements defined by Frame and Carslon (Frame & Carslon, 1975) in order to be able to carry out actions of secondary prevention and, therefore, make quite an impact both on the health of the patient and on the health of the whole population. The necessary criteria for this applicability are the following:

1. The disease must be an important health problem, having a clear effect on the quality of life and life expectancy.
2. The disease must develop through an asymptomatic initial stage and its natural history must be known.
3. There must be an effective treatment accepted by the population in the case that the disease is detected in its initial state.
4. There must be a sifting test which has to be quick, safe, easy-to-do, highly sensitive, highly specific, of high positive predictive value and well accepted by doctors and patients.
5. The sifting test must keep a good cost-effectiveness balance.
6. The early detection of the disease and its treatment during the asymptomatic period must diminish morbidity as well as global or each of them separately.

In the last years, the scientific community issued an appeal for the innovation of developed prevention strategies (Piot,2008). Current recommendations in order to cause a greater impact on health in the African context suggest that actions of secondary prevention, such as diagnosis, and actions of tertiary prevention, such as ARV treatment, are joined (Dood, 2010). It is important to bear in mind that without diagnosis there is no treatment and, as seen before, preventing this disease from being transmitted becomes a limited task.

3. Application of qualitative methodologies in HIV prevention

“Aids has proved that epidemics take place at different levels: biological event, social perception, collective response and individual phenomenon, both existential and moral [...].Each disease, as social phenomenon, is a unique configuration of events and responses both in the biological sphere and in the social sphere“ (Mariano Bronfman²).

In the scientific field, HIV epidemic has traditionally been investigated by clinical epidemiology. For this reason, the predominant theoretical development has been the

² Mariano Bronfman: Social Sciences and Aids. Magazine of Public Health and Mexico 1999;Vol.41(2):83-84.

biomedical model. Concerning this subject, most of the investigations to be found on scientific literature are prevalence and/or ecological studies. In this sense and in general terms, knowledge based on data that mainly describe the way this epidemic is distributed throughout the population according to certain factors predominate (Caitlin et al., 2010).

However, the relevance and significance that HIV epidemic has gained in the social sphere nowadays constitute evidence. This fact can be clearly seen, for instance, when paying attention to the social stigma generated around HIV (Skinner & Mfecane, 2004). That is why most of the interventions being carried out in the field of HIV take into account the social dimension of the problem. In this sense, epidemic research beyond simple observation of how it is distributed throughout a given population is required.

Currently, the HIV epidemic represents a social phenomenon that mainly affects the area of public health. The HIV epidemic as a social phenomenon acquires different meanings depending on the kind of society in which it is found, since cultural and social contexts play an important role in all countries. For example, although HIV is seen as a chronic disease in the collective unconscious of most developed countries, this virus is considered to be fatal and lethal in the developing countries (Conde, 1997). There again, as HIV is meddled in social constructs like life, health, death and disease, it is also steeped in specific connotations that every culture attributes to these social values.

So that HIV acquires meanings, representations, perceptions, values and related to social and cultural contexts. Such contexts give meaning and guide people's behaviour and actions to confront HIV. These distinctive values, meanings and so forth, will have an effect on preventive actions that are being taken in order to face the HIV phenomenon. As can be seen, qualitative aspects that are also important to know in order to prevent and eliminate the epidemic mark the HIV phenomenon.

By applying the methodologies which have developed the traditional approaches to HIV study, the knowledge of HIV qualitative aspects is difficult to achieve. Nowadays, with the aim of setting out a deeper and more holistic HIV knowledge, other perspectives and theoretic approaches belonging to disciplines other than health are applied. For instance, approaches to the epidemic phenomenon have been carried out by different sciences -like hermeneutics, phenomenology or ethnography- in which their theoretical frameworks from disciplines like Anthropology or Sociology (Arachu & Pau, 2003). The efforts made by UNESCO in order to develop and promote a cultural approach to the HIV epidemic are especially worthy of notice (United Nations Educational, Scientific and Cultural Organization, [Unicef], 2003).

Theoretical approaches in the field of social sciences have incorporated HIV study methodologies different from the quantitative, which is traditionally applied by clinic epidemiology. Among these methodologies, the use of qualitative methodology prevails. Therefore, qualitative methodology is no longer a method exclusively used in disciplines connected to the social sphere. In this sense, it appears more and more frequently in health related studies, whose scientific expansion displays as much on publications and seminars as on medicine and public health related conferences.

On an international level, different authors have placed particular emphasis on the necessity and in the advantages of using this methodology in the field of public health (Bryman, 1984). Also, its relevance to social epidemiology has been highlighted. For instance, it has been pointed out its importance when used in order to evaluate peoples' health care from a

more dynamic and comprehensive perspective. It has also been stated the necessity to know both the adaptation of qualitative methodology for its study and the socio-cultural background together with people's values as health determining factors.

As compared to other diseases or to other health related subjects, qualitative methodology has been widely used in the study of the HIV. However, qualitative investigations performed in this field are still few. But there are still fewer qualitative research aimed at putting into practice the necessary knowledge in order to evaluate and design HIV prevention policies.

Nevertheless, the results of the studies carried out show the adaptation and benefits of this methodology to the understanding and comprehension of the different factors that intervene in the HIV epidemic phenomenon. So that the adaptation of qualitative strategies to the study of the HIV phenomenon constitutes a potential instrument of support to design effective preventive strategies and, therefore, carry out effective and efficient policies in the intervention of this epidemic.

4. Application of a case: Equatorial Guinea

4.1 Epidemiological context

The HIV/Aids epidemic is also severely affecting Guinean people's health. On the basis of parameters established by the WHO, Equatorial Guinea suffers from generalized epidemic (Unaid, 2010 b). The HIV prevalence among people between 15 and 49 years of age is 3.2% (IC 95% 2.0 -4.4%). Likewise, Aids represents the main cause of individual mortality (Who, 2008).

In a context of generalized epidemic, competent international organizations warn of the urgent need for these countries to set appropriate measures in motion in order to reverse the epidemic curve. They also emphasize the importance of carrying out prevention policies with the aim of diminishing and eliminating the magnitude of the epidemic. At the same time, they urge the governments of these countries to establish and coordinate effective strategic plans for the prevention of the HIV. In this regard, one of the preventive measures recommended by the WHO is to spread the HIV diagnosis tests throughout the whole population, regardless whether there is clinical suspicion or not, and suggests having the test done at least once a year (Who, 2007) given the positive results that this action would carry with it in both individual level and community level. On an individual level: it initiates and holds preventive behaviour towards the HIV acquisition and transmission, immediate access to care, treatment and support of people living with HIV, major efficacy on interventions in order to prevent mother-to-child transmission, better planning to improve the future life. On community level: it diminishes denial, stigma and discrimination associated to the HIV and demands aid for an adequate answer. However, evidence suggests that, in terms of cost-effectiveness, everyone having the test done becomes profitable on the long term, regardless whether they take part in high risk behaviour or not. (Patel, 2005).

As for HIV preventive measures carried out by the Guinean population, there is almost no information that describes and explains this aspect due to the lack of research in this field of study. Nevertheless, there is some data extracted from a transversal study conducted by ISCIH in collaboration with MINSABS. In this study, people aged between 15 and 50 were given a questionnaire - the CAP survey³ - about different aspects concerning sexual life and

³ "Knowledge, attitudes and practices about nuptiality, sexual activity, HIV/Aids and STD"

HIV/Aids. Results related to the execution of HIV diagnosis show that almost $\frac{3}{4}$ of the people who participated in the survey had never had the tests done (Ministry of Health and Social Welfare of Malabo, 2006). The fact that an important percentage of the population is not aware of their serological status aggravates the magnitude of the epidemic due to the existing risk of exponential growth, as a consequence of HIV transmission through people unaware of their seropositive status. Likewise, this study also stresses the vulnerability of this society towards the epidemic, since evidence shows that being aware of one's serological status is the first step to be taken in order to prevent and treat the disease.

Regarding the use of male condoms among the Guinean population, the CAP survey produced alarming results. Sexual intercourse is the main HIV transmission route in Equatorial Guinea. That is why, in this country, different social agents competent in HIV prevention have made tremendous efforts to extend and promote the use of male condoms when having sex in order to control this transmission route. In spite of the efforts made, the results of the CAP survey show that the use of the male condom has not been one of the prevention methods used by a vast majority of the Guinean population. Although 73% of those polled point out that they do know how to use male condoms as an HIV preventive measure, almost seven out of ten declared that they had not used them in the last twelve months when having occasional sex with different partners. The male condom was not used by 73% of those men who had sex with prostitutes either.

Generally, CAP results reveal that the Guinean population has taken few measures regarding HIV prevention.

4.2 Justification for the study

No sociological investigation considering HIV as a social phenomenon had been previously carried out in Equatorial Guinea. That is why there was no holistic or hermeneutic knowledge about the epidemic phenomenon in the country.

Until the completion of the ESEVIGUE study, there was no qualitative data about the epidemic. In this sense, the qualitative aspects of the epidemic constitute key elements to take into account when designing HIV prevention policies. For instance, there was no information about the meaning or possible meanings that the epidemic had acquired in society. Moreover, there was no information about the elements -whatever their nature: cultural, social, political, economic...-that could be interfering with the results of the implemented prevention strategies, acting like barriers and/or facilitators. In general, explanatory information about people's practices and behaviours related to the implemented prevention strategies was non-existent.

Given the absence of these data, the possibility to carry out an investigation in order to announce this situation arises. In the last analysis, the reasons why the preventive measures developed in the country got such results will be evaluated and explained. In this context, the ESEVIGUE comes into being with the general aim of: "understanding and generating knowledge about the epidemic phenomenon in Equatorial Guinea".

This study targeted the use of generated knowledge as support in order to direct the decision taking process, regarding the different strategies and measures to be implemented in the area of HIV prevention.

This research started in Bata in August 2009 and has been led jointly by MINSABBS, in Malabo, and the National Centre for Tropical Medicine of the Carlos III Health Institute, (Referential Centre for the Control of Endemic Diseases [CRCE], 2009) in Spain. This

investigation has been carried out by a research team made up of professionals belonging to both institutions.

4.3 The basis of the methodological design

Although epidemiological methods have been traditionally regarded as the standard reference for the study of public health, these methodologies are based on a reductionist view of the world in which simple causality standards are established through statistical processes (Baum, 1997). Health and disease are the result of a complex interrelation of social, economical, political and environmental factors. Interpretative methods based on qualitative techniques are generally well prepared for the analysis of complex situations and contribute to a large extent to the study of public health (Baum, 1997).

The aim of the research was to observe the epidemic as a social phenomenon so that, considering biological investigative or medical approaches, a social perspective of the HIV study was adopted. The design of the investigation has been a qualitative one. The decision of carrying out a qualitative methodological design was backed up by the adaptation that qualitative strategies have shown in order to generate holistic, deep and comprehensive knowledge of the real situation under study. Nowadays, in the area of public health, the effective use of qualitative techniques for the understanding and comprehension of factors and processes affecting health and disease is also sufficiently verified. To be more specific, many examples of qualitative methodology applied to the study of the HIV and its context can be found in scientific literature (Medicus Mundi, 2007). In this respect, it is worth mentioning that, confronting epidemiological and quantitative HIV medical study, this type of investigations have proliferated over the last decades.

The sample used in the investigation was a structural one. As in quantitative investigations, the sample design constitutes one of the first methodological aspects to be defined. However, its theoretical basis differs from the sample design in quantitative research. Whereas sample design in quantitative research is based on the concept of statistic representation, in qualitative research it is based on the social signification criteria of the individuals (Valles, 1997). In this sense, sample validity is not given by the number of individuals that make up the sample but by the pertinence of selected individuals in connection with the aims of the study.

Regarding the object of the study, a first general criterion of sample inclusion was established: Individuals aged between 13 and 60. Defining this section of age span became relevant due to the fact that the main HIV route of transmission is sexual intercourse. Therefore, in view of prevention, getting to know the meaning of the HIV epidemic phenomenon and other related aspects within the sexually active population in Guinea was considered to be pertinent.

In the second place, the sample was segmented according to certain variables of interest: being infected by HIV or not, sex, age, education level and place of residence. This segmentation was aimed at identifying and gathering different perceptions and experiences of the HIV. For instance, the initial hypothesis was that, in general terms, there would be differences between PLWHIV and those who do not, as regards perceptions, meanings and practices. Likewise, it was also considered to be pertinent to pay attention to the thoughts of different social groups so as to know the various conceptions of HIV that there may be throughout the whole variety of social groups that form the Guinean society. The objective was to adequate prevention strategies to the specific needs of each social group. For the

purpose of this research, the sex and the gender of the individuals, their education level, etc. was taken into account.

Information gathering techniques applied in order to produce and collect information were: semi-structured individual interview and discussion group. These techniques are generically named qualitative techniques. In order to develop both techniques, the script item was outlined. The script item is a gathering information tool that contains qualitative techniques. This script item was drawn up through open questions that explored analytical dimensions related to the object of study. Now, in table 2, some of the analytical dimensions are shown:

ANALYTICAL DIMENSION	CATEGORIES AND QUESTIONS
Health meaning and value	What are the important things in your life? What does health mean to you?
Social Perception of the HIV	What do you think about the HIV? What do people say about the HIV?
Knowledge about the HIV	What is the HIV? Are the HIV and Aids the same disease? How can a person become infected by the HIV?

Table 2. Analytical Dimensions of the ESEVIGUE research

Before the fieldwork was performed, the script item was tested following preliminary interviews. The aim of testing this instrument was to check the validity of its technical design as regards the content of the questions, the format and the language.

4.3.1 The reasons why semi-structured interviews are applied

Semi-structured interviews were done to people living with the HIV. The application of this technique, in opposition to other group qualitative techniques like discussion groups, has the advantage of preserving anonymity and confidentiality about the serological status of the interviewee.

Semi-structured interview is performed on the basis of a face-to-face conversation between the interviewer and the interviewee. That involves immediate and personal norms of verbal interaction generating, therefore, a subjective knowledge of the observed reality (Alonso, 1994). The interview is a communicative tool that sets out to grasp meanings that are influenced by the constructions made by the individuals themselves according to their experience:

“Personal interview results very productive to the study of extreme or typical cases in which the attitudes of certain people embody, in every sense, the ideal model of a certain attitude much less crystallized in the average of the group of reference (Ortí, 1986)”.

So that this technique was carried out with the aim of getting to know the experiences and meanings felt by people living with the HIV. Therefore, its application in the ESEVIGUE resulted in the knowledge of the subjective aspect of suffering HIV. Also, this technique provided information about the phenomenon of the epidemic from the point of view of the people living with the HIV.

4.3.2 The reason why the discussion group is applied to the study

The discussion group was performed among the population segment of participants who did not know if they were seropositive and/or those whose blood tests results were negative. Since it is a group technique, it has the advantage of confronting and gathering discourse from the different social groups in one session. At the same time, in economical terms, this technique becomes more profitable

The different points of view of the studied reality regarding the position occupied by the individual in the social framework can be known through the application of discussion groups (ref.). This used to be a key aspect of the technical selection since it allowed the gathering of different HIV related discourses in order to produce and adapt prevention strategies to the specificities of each social group. Therefore, the application of such technique created diverse knowledge about the different social aspects regarding the HIV.

4.3.3 Fieldwork

Finally, fieldwork based on qualitative methodological strategies was done with the aim of generating knowledge about the HIV phenomenon. Prior to the phase of gathering information, the research team applied the non-participant observation technique. It was aimed at validating different aspects of the study protocol such as sample design or instruments to collect information. It was also aimed at later development of fieldwork.

Geographically, this research took place in Bata between January and April 2010 and it was carried out by a multidisciplinary working group made up of sociologists, doctors, nurses and lab assistants.

5. Conclusions

In terms of results achieved, the application of qualitative methodology has turned out to be very adequate and valid in order to generate holistic and comprehensive information of the HIV epidemic phenomenon in Equatorial Guinea. So that data has been generated in order to allow both evaluating some of the prevention strategies in the country and showing some of the key aspects to take into account in decision-making processes in the strategy to be implemented.

For instance, results show the inadequacy of massive HIV/Aids information and prevention campaigns carried out in Equatorial Guinea. The association established between the HIV, Aids and death has caused much alarm and fear among the population. Nowadays, it constitutes one of the main barriers for the population to have diagnostic tests done of their own free will. The conducted campaigns played a decisive role in the HIV social construction, which does not favour the integration of people living with Aids into society. Such social construction about people living with the HIV having abandoned the services of the HIV treatment and diagnosis, influenced the reasons given in order to explain why they decided to give up their treatment.

Results have also revealed the importance and necessity of implementing and carrying out prevention strategies considering already existing specificities and needs among different social groups. In this sense, interviewed women's and men's different ways of understanding health and facing the disease are shown. These aspects must be taken into

account when designing prevention strategies in order to achieve maximal efficiency and effectiveness in results.

Nevertheless, the development of the methodology has not been exempt from difficulties and inconveniences. The first drawback was brought about by the application of this type of methodology in a context of low involvement of the population in social movements and slender culture of social discussion forums. In spite of counting on the collaboration and participation of MINSABS, occasionally people did not want to participate in group sessions for fear of attending politically oriented meetings. Likewise, this fear was also revealed through some of the participants' concerns regarding the confidentiality of the provided information related to personal assessment and opinions about the country.

Difficulties were also revealed due to the lack of tradition in qualitative research in the country. That is why human resources educated and/or qualified in this methodology can scarcely be found. As a consequence, identifying and integrating Guinean personnel into the research team was quite difficult.

To sum up, the HIV epidemic is a complex social phenomenon in the Guinean society. In this sense, the HIV epidemic phenomenon has acquired particular connotations that require specific interventions in this field. Moreover, it also reveals that working frameworks and multidisciplinary action is required in order to prevent and treat the epidemic.

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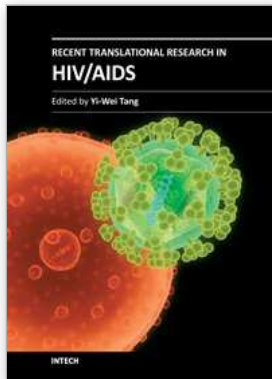
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