Chapter 6
Qualitative Studies in Health-Related Quality of Life: The Case of Young People Living With HIV/AIDS

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6.1 Health-Related Quality of Life

Traditionally, health has been approached from a medical point of view and its discussion has been mainly limited to the detection and treatment of disease, pain relief and healing. As medical science has been developing, that approach has proved to be inadequate and it has been necessary to extend the concept of health to the entire life of the subject, not restricted only to the biological manifestations.

The term Quality of Life is difficult to define since it is a global and multidisciplinary term which must be considered from a cultural point of view, the historical moment and the society in which it operates (Ardila 2003).

In 1945 the World Health Organization (WHO) defined the term health as a *state of complete physical, mental and social well-being and not only the absence of disease*. This concept was pioneering at that moment but at the same time only an expression of desire but a reality and that eventually went away from that meaning and taking other dimensions the concept of health.

However, years later, the Quality of life Group at WHO took up that idea and defined health as the individual's perception of their position in life in the context of culture and value system that the subject lives in relation to their targets, expectations, patterns and concerns (WHO QoL Group 1995).

After nearly 20 years, there is still a lack of consensus on the exact meaning and evaluation of QoL. Consequently, many authors developed the concept, especially in terms of personal satisfaction in different areas, ranging from physical and financial aspects to politicians and others, relating to the physical, social and emotional well-being.

So, Ardila (2003) himself proposes a more inclusive and modern definition of quality of life as a general state of satisfaction derived from the realization of the

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individual potential. It is a subjective feeling of psychological and social well-being that includes physical and subjective aspects of emotional expression intimacy security perceived personal productivity and objective health. Thus it could be argued that quality of life includes both objective and subjective aspects as the study refers to the physical environment (social well-being) and the psychosocial environment (psychological well-being) based on experience and global vision of life or life satisfaction.

The latter concept has been analyzed from different perspectives and two main approaches that can be recognized on this regard. First, it comprises the affective or emotional approach, from which the quality of life is understood as a balance between positive and negative affect (Bradburn 1969). Second, the cognitive approach focuses on how individuals evaluate their own life in general or some aspects of it such as family, health, work and leisure (Diener 1984).

The cognitive component of well-being would be life satisfaction, globally or for specific areas and the affective component refers to the presence of positive feelings, called happiness by some authors (Arita 2005) In a different direction, some authors define happiness as a greater concept, including welfare and satisfaction (Cuadra and Florenzano 2003).

Some authors suggest that quality of life includes well-being as the subjective component of the concept (Liberalesso 2002; García-Viniegras and González 2000) which would consist of cognitive and affective aspects (Diener 1994; Diener et al. 1999).

In short, it can be said that the QoL refers to the global evaluation each subject does of his own life in general. To some extent, this satisfaction is the result of a combination between the perception of the subject itself and its environment at a micro and macro level so some variables like self-esteem and some personal characteristics are the basis of life satisfaction (Diener et al. 1999).

Regarding the importance of the components of quality of life, health is one of the leading and influencing directly and indirectly in that way. Directly, since the daily activities of the human being depend on the health status and indirectly because it affects other aspects present in the quality of life of people such as social relationships, leisure, autonomy and others (Moreno Jiménez and Kern 2005).

Currently, the area that arouses more interest and that more research is being devoted to is health. Thus, it is important to distinguish between quality of life and HRQOL.

The concept of HRQOL was included in the Index Medicus in 1966 and although some authors identify it as part of the quality of life, others report interchangeable meanings. Despite these discrepancies, the concepts must be differentiated in practice.

Patrick and Erickson (1988) specified it as a value given to life expectation and its modification by impairment, functional status, perception and social opportunities influenced by disease, injury, treatment or policies.

Shumaker and Naughtozn (1995) define it as the subjective evaluation of the influence of the current health status, health care and health promotion activities, the ability to achieve and maintain a level of general functioning allowing valued life goals and that this is reflected in their general well-being.

Other authors such as Fernández et al. (2001) state that HRQOL should comprise at least the perception that the person has of the impact that caused the disease or its treatment on his sense of well-being and ability to act (functionalism) These basic dimensions should be analyzed in the physical, emotional and social aspects.

Finally, Schwartzman (2003), from a subjective point of view, states that HRQOL is the evaluation done by an individual, according to his own criteria of physical, emotional and social state at a certain moment and reflects the level of satisfaction with a personal situation at a physiological, emotional and social level.

As it can be seen in the definitions of the above authors, they first share the idea of HRQOL as a perception, experience or subjective evaluation. Second, it is influenced by health status and, finally, that perception affects the functionality or performance of relevant activities or goals in life of a subject.

Based on the above considerations, it is important to emphasize the differences between HRQOL and quality of life. First, HRQOL is expressed based on the impact of the disease, evaluating the possibility of the presence of satisfaction of the person in a subjective way, while the quality of life emphasizes the analysis of psychosocial aspects and subjective well-being including both objective and subjective aspects (Vinaccia et al. 2007).

Throughout the statements that have been made, although there is no conceptual model of HRQOL unanimously accepted by the scientific community and there is no consensus on a quality of life meaning as well, the HRQOL could be defined as a subjective, multidimensional concept that the individual perceives about their level of physical, emotional and social well-being to understand the influence of the health condition in their life closely related to the context and the time determined where the subject is found.

There are some dimensions of HRQOL studied and related to each other in varying degrees that measure different aspects of life and autonomy of the subject. Some of the most relevant are:

Physical Functioning This dimension limited aspects of health and fitness and the impact of clinical symptoms on health or specific treatment, the personal care, performance of physical activities and autonomy. It also examines the discomfort which produces symptoms in daily life:

Psychological Factors This dimension reflects the impact of cognitive functioning and emotional state. The first refers to the ability to evoke memories at a short and long-term and the ability to think clearly. It also collects the energy and vitality or perceived competence to deal with problems arising from the illness or treatment. The emotional state includes analysis of depression, anxiety, and what concerns to the patient.

Social Aspects It analyses the impact of health status on the usual performance of social relationships, social isolation due to physical disability and altered performance of social roles in work and family life, as well as the activities and interactions of the patient with friends, family, co-workers or others.

Other particular areas of HRQOL explored by some researchers are pain, sexual function, satisfaction with life, the impact on labor productivity and activities of daily living. The number of visits to the physician for illnesses or medical problems and the need to use drugs has also been frequently used as indicators of HRQOL.

Notice that HRQOL dimensions should not be confused with other measures reported by the patient and used in Health Outcomes Research, such as satisfaction with medical treatment and medication, the preference for treatment, adherence and treatment compliance or expectations regarding treatment, although some of these concepts share dimensions with HRQOL.

From the above mentioned it can be deduced that the HRQOL directly involves the definition of health. However, among the definitions of health, HRQOL and quality of life, a variety of related terms can be found in the literature. These concepts are health, functional status and personal well-being. While those were used as synonyms and sometimes they are still used this way, their definitions are indeed different and have different meanings.

The *health status* is a definition derived directly from the concept of health, it was defined by Bergner (1989) according to five dimensions corresponding to: (I) genetic or hereditary characteristics (basic structure that supports the others); (II) biochemical, anatomical and physiological of a patient (associated with disease, the deterioration, disability and handicap or disadvantage); (III) functional status (activities of daily living); (IV) mental status (perception of health and mood); (V) potential of individual health (longevity and prognosis of the diseases and disabilities). The term was defined in a more direct and consolidated way by others authors who consider health as a component of the quality of life.

Meanwhile, the *functional status* refers to the evaluation of abilities and disabilities and got impulse enough to establish criteria for inclusion in clinical trials. Their evaluation instruments are described as brief, specific (for each disease) and subjective (performed by the physician)

Finally, the state of *personal well-being* refers to the general perception of the patient on their health or disease without discriminating the different aspects that determine it.

According to the arguments that have been made in all such conceptions it is important to distinguish these definitions and when to apply them in research although there will always be disagreements.

6.1.1 Psychosocial Aspects

Above mentioned dimensions of HRQOL, there are several variables that can affect the perception that a subject on its HRQOL has been assessed. Some of them are sex (among other things, by the different pain tolerance), the age (by the deterioration of the body and the loss of mobility and autonomy), marital status (for his relationship with aspects of social and sentimental support), education (by differences in the scales of social valuation and its relationship with the socio-economic level), the socio-economic level (by the health access capacity) rural or urban habitat (by the environmental influence of the stress, noise and pollution) and the cognitive disorders (for the decline to assess reality).

In the HRQOL of people living with HIV/AIDS (PLWA) are some factors socio-demographic and psychosocial that can distress it. The first include advanced age, female sex, unemployment and low income, which would affect it negative way. Nevertheless, are the psychological problems which occur more frequently in PLWA such as anxiety, depression, and behavioural disorders.

At the time of diagnosis the subjects not only experience a feeling of uncertainty relating to the hope and expectation of life in general, if not also uncertainty as to the quality and length of life, the effects of treatment and the reaction of the society of the condition. The vital events, such as the diagnosis of HIV, are relevant and crucial facts in the life of the person, affecting the evolutionary process and the valuation which the person engages in the event. These events are related to its capacity to meet it, depending on the personality, level of self-esteem and social support.

Fierro (1997, cited by Arjona and Guerrero 2004), defines the *coping* as a skill of the subject in the acquisition of some control or mastery of a given stressful situation. It also includes efforts cognitive and behaviour to mastering, tolerating or reducing internal and external demands. Consequently, it is a personal and psychological characteristic of each individual variable. Thus, Lazarus (1988, cited by Font 1990), postulated coping as intrapsychics (cognitive and affective) action-oriented efforts, in order to manage demands internal and environmental that they test or exceed the personal resources. That it to say, coping is a skill that takes on the subject of some control or domain of a given situation stressful through cognitive efforts and behaviour.

Effective coping in the PLWHA consists of generating greater adaptive in situations of stress responses as it is the diagnosis of HIV/AIDS; i.e., to the extent that there is an effective coping with stressful situations and a greater repertoire behavioural oriented to meet the demands of the middle, slowing the evolution of HIV/AIDS infection. At the same time, coping, according to the theory *coping effectiveness training*, it centres on the one hand, in strategies of the person to change the negative aspects perceived a situation and, on the other hand, in the management of the emotional responses to a stressful situation (Chesney 2003).

Similarly, there is a lack of social support from family, friends, or co-workers in the diagnosis of sickness impact, also in HRQOL. According to Brannon and Feist (2001), *social support* refers to the feeling of acceptance, affection or appraisal by others people. It is a practice of care that occurs in the exchange of relations among people and is characterized by expressions of affection, support of different behaviours, symbolic or material assistance to another person. In fact, social support is expressed as an interpersonal transaction that includes three aspects: the expression of affection from one person to another *(emotional support*), the adoption of behaviour, thoughts, or points of view of the other person (*confidential support*) and the provision of material assistance (*instrumental support*).

With regard to the functions of social support are recognized that there are four types: the emotional providing the individual feelings of esteem, affection, trust and security; the assessment, which represents the sensations experienced by the individual which can count on someone, and feel accompanied socially; the informational, also known as advice or cognitive guidance, which helps to define and address the problematic events using advice from the network and finally the instruments constitute tangible aid and material in the solution to a problem.

Likewise, the stigma and discrimination affects in transcendental form HRQOL in PLWHA. Rejection, abandonment and alteration of functionality family are associated.

Stigma is a condition, attribute, trait or behaviour that makes the individual to be included in a social category whose members is generated a negative response and are seen as culturally unacceptable or lower. Indeed, it is an attribute that "discredits deeply", society applies it and they bear it or they have stigmatized people and groups. It can be linked to specific actions, such as adultery, sexual preferences, psychoactive substance abuse or delinquent behaviour; with innate, as the sex or colour of skin, or features almost innate, such as religion or nationality and in certain infectious diseases such as HIV/AIDS, tuberculosis and leprosy. Now the stigma also is a means of social control, which defines social norms and punishes those who deviate from these. The reasoning of the stigma is the fear of the stigmatized to threaten society.

The basis of that fear is often ignorance as in the case of HIV is stigmatized where about the way of life of vulnerable groups or the realities of the sexual behaviour of people.

Additionally, stigma has been linked in the history of mankind with diseases that cause intense emotional reactions by his relationship with physical deterioration, death and sexuality as in the case of HIV, where these three components are associated with a single virus.

Although the concept is pejorative, the stigma can have positive consequences and manages to create a sense of community among the stigmatized, motivating them to rest and change to improve their lives.

Another aspect psychosocial undoubtedly affecting the HRQOL in PLWHA is *discrimination*. It can be spoken that the original "discriminate" meaning was to observe the differences. However, with the passage of time, the word has acquired the meaning of taking active or passive attitudes that adversely affect persons belonging to, or believed that they belong to a particular group, in particular to a stigmatized group.

In other words, discrimination may be the end result of a process of stigmatization which refers to unfair and different treatment that is given to a person on the basis of their membership, or alleged membership, a group in particular. It can be legislative (sanctioned by laws or policies) or community, action or lack of action in less formal contexts, such as workplaces or social settings, such as markets, sports, commercial centres or bars, among others. It consists of three components: discriminatory attitudes (also known as prejudices), discriminatory behaviour and discrimination. The first two apply to persons who are within the social norm; on the other hand, the latter refers to the relationship between those who are within the social norm and the stigmatized. So, when it talks about HIV discrimination, it is referring to different deal, usually harmful, who a person receives (Foreman et al. 2003).

Unmistakeably, stigma and discrimination are intimately related and generated an incremental and interactive circle among the subjects. Thus, stigma facilitates or promotes discriminatory attitudes and these attitudes are often reflected in the behaviour giving rise to acts of discrimination and these in turn accentuate or favour the stigma.

Finally, it is important to mention that social representations that have the HIV-infection, is a determining factor in all the above-mentioned aspects of HRQOL in these subjects.

The social representation is referring to a set of concepts, perceptions and meanings that shares a particular human group in relation to its members and to the surrounding environment, i.e. buildings that structure the information that a cognitive process organized by categories and classifications, providing a communications code sharing and involving everyday knowledge that exist in the minds of the people. They are socially produced and shared expertise that form from the experiences, information, knowledge and models of thought received and transmitted through tradition, education and social communication.

From these it is understand and interprets reality, is thought, organizes and apprehends everyday life; it unifies and integrates the individual and the collective, symbolic and social, thought and action. Serves as guide on social responses generated by this disease as a phenomenon the social representation permit recognition of modes and processes of Constitution of social thought, approaching people world view and understanding of social behaviour.

By all perspectives above mentioned HIV/AIDS can be seen not only as a condition from the biological, but also as a purely psychosocial phenomenon which is characterized by different behaviours, attitudes, beliefs and feelings influenced largely by the environment socio-historical-political in that develops.

6.1.2 Physical Aspects

As a final point, in assessing the physical dimension of the HRQOL in PLWHA, include aspects related to the perception of the physical condition that causes the infection itself in the subject and effects of new therapies antiretroviral (HAART) that produce changes in body morphology.

With regard to the first aspect, it can express that HIV causes in some stages of the disease, if it is not diagnosed in time or not carried out specific treatment, referred to as wasting syndrome. It is usually one of the first symptoms of AIDS, and may also occur during the period of latency or asymptomatic phase with diffuse clinical signs.

Wasting syndrome is a process associated with symptomatic infection by HIV and is characterized by intense fatigue and mental depression deep caused by depletion of the neurotransmitters sympathomimetic. It is defined as the involuntary loss of more than 10% of body weight, along with more than 30 days of diarrhoea, weakness and fever. A portion of the weight lost during wear is fat but most importantly the loss of muscle mass. This is also called “lean body mass” or “mass of cells in the body.”

On the other hand, although the treatments have caused a noticeable improvement in survival in patients affected by this condition, is known to cause toxicity in the long-term in a variable time between 12 and 24 months. This has allowed to observing changes in the appearance of the subjects developed an abnormal distribution of body fat, sometimes associated with syndrome of resistance to insulin, possible development of diabetes, and increases in the levels of cholesterol and triglycerides. This is called lipodystrophy syndrome and it has been studied in multiple investigations since the beginning of the HAART, in the 1990s (Lertora and Foster 2008).

Two components of the syndrome are described: the lipohipertrofia and the lipoatrophy. In the first, the distribution of fat has various ways to manifest itself in subjects: increase in deposits of fat in the abdomen, especially around the organ meats such as liver, kidneys and intestines, producing a very globular abdomen; breast growth by fat in men (in women without enlargement of the mammary gland); fat deposit in the cervical spine, which can be very important and it is called "Buffalo Hump" and finally, increased fat of the parotid glands.

In the lipoatrophy component fat loss occurs in areas of the body where it is normal to have it or where the fat has a protective role, specifically causes a loss of subcutaneous fat in the face, buttocks, arms and legs, simulating in these recent increases in the size of the veins of the members. Both problems are closely related and have to see activity of HIV itself on cell mitochondria and the distortion produced by the metabolism of adipose cells, with both the effect of antiretroviral drugs.

Although the direct mechanisms that trigger both are not well known, the various studies carried out so far is not conclusive.

The data accumulated after more than one decade of experience indicate that approximately half of the people who are under HAART could suffer at some time and in varying degrees of severity, both lipodystrophy as lipoatrophy. It has been observed that, in some patients, replacing those antiretroviral with greatest potential for mitochondrial toxicity, progression of lipoatrophy can be minimized and, in some cases, observed even a small recovery.

In summary, both wasting and the lipodystrophy syndrome can cause changes in the appearance of the subject. The first relates to the loss of weight, fever, chronic diarrhoea and loss of muscle mass; and the second to the loss of fat in different areas of the body, according to the predominant component.

For all the above, it is clear that HRQOL in people living with HIV/AIDS affect various dimensions, especially the factors psychosocial (social representations, coping, social support, stigma and discrimination) and alterations in the physical aspects caused by the own condition or specific treatment.

6.2 The Human Immunodeficiency Virus (HIV)

Since the discovery of the HIV that causes the Acquired Immunodeficiency Syndrome (AIDS) at the beginning of the 1980s, worldwide, the pandemic is not only a serious public health problem, but also a complex social, political, economic and cultural problem. HIV is a virus that affects the system of the body, called the immune system's defenses. The function of this system is to protect human infectious and tumoral diseases in general. All viruses are microorganisms that can only multiply to get into the cells, using the mechanisms of the same cell to reproduce and infect it.

Each virus has the ability to invade certain types of cells. Unlike other viruses, HIV has the particularity of invading the defences of the organism cells (so-called lymphocytes T CD4) destroying them progressively. For this reason, HIV can lead to AIDS, an infectious disease that means acquired (it is not hereditary, but caused by a virus) immunodeficiency (which attacks the immune system) syndrome (a set of symptoms). It is considered that HIV infection reaches the stage called AIDS when defences are weakened and cannot protect the body properly. Because of this so-called "opportunistic" diseases and tumours like Kaposi's Sarcoma could take place. The transmission route is mainly caused by unprotected heterosexual intercourse.

There are approximately 33.3 million PLWHA in the world. There are more than 7000 new infections per day according to data from the Joint United Nations Programme on HIV/AIDS (UNAIDS 2009). Of these, 97 % are in developing countries and about 1000 are younger than 15 years and 6000 are adults over the age of 15 years, in whom 51 % are women and 41 % are young people between 15 and 24 years of age. Nevertheless, the epidemiological situation in the world is very heterogeneous, as there are large differences between the various regions, especially in developed and underdeveloped countries. Thus, *prevalence* (Refers to the number of existing cases of HIV/AIDS over a period of time and place, which is usually expressed in percentage form) rates in people among 15–49 years old in Eastern Europe and central Asia range from 0.7 to 0.9 %, and that of Western Europe is at 0.1 %. However, there are regions that have higher rates, like sub-Saharan Africa, with a prevalence of between 4.7 and 5.2 %, followed by the Caribbean, Eastern Europe and Central Asia (UNAIDS 2009).

In Latin America the epidemic is moderate and low level of HIV transmission and it is stable since 2003 with an overall prevalence of 0.5 %. Brazil, Mexico, Argentina and Colombia are Latin American countries with the largest populations and, as a consequence, with the largest number of PLWHA.

In Argentina, as well as globally, unprotected sexual intercourse continues to be the main route of transmission. The prevalence in the general population is less than 1 % (0.4–0.5 %), but in so-called vulnerable group is greater, such as 12 % among men who have sex with other men, 7 % among injecting drug users, 6 % in sex workers/s and 34 % among transgender people. In that country, in 2009, the figures rise to 130,000 people and 20 % of which are under 24 years old. In turn, it was observed that 89 % of women and 86 % of the males became infected during unprotected sexual intercourse. In the case of males, 48 % contracted HIV sexually with a woman and 38 % with another male (National Programme of Fight against Human Retrovirus, AIDS and STDs 2011).

In summary, the epidemiological evidence of the situation in Argentina indicates that HIV affects increasingly the heterosexual population, women, urban and even rural areas and young people with the common denominator of the low socioeconomic level, although with different levels of vulnerability to HIV infection.

Ayres et al. (2006, p 380) in the context of HIV/AIDS, defined vulnerability according to:

> the different degrees and natures of the susceptibility of individuals and communities to become infected, sick or dying from HIV/AIDS, which depend on your situation against the integrated set of cultural, social, political and economic aspects that located them in relation to the problem and the resources to deal with.

In this way, this author suggests that it can be identified in two dimensions: an individual dimension and a collective dimension, which in turn, is divided into two: the social and the programmatic.

The individual dimension is defined by three assumptions: to) all people are vulnerable to HIV and its consequences; (b) in infected people, the potential for vulnerability is in inverse function to social support and assistance in health which has; and (c) the cognitive, behavioural and social affect individual vulnerability of everyone.

The social dimension is determined by the economic, political, cultural, moral and institutional situations that define greater or lesser protection of society against the epidemic. This dimension includes: social norms, relations of gender and generational, concerning cultural beliefs and religious regulations, stigma and discrimination, social well-being, employment, income, social support; access to health care, education, culture, leisure, sport and media in this context also refers to freedom of thought, of expression, political participation, citizenship rights, accountability of public and private sector, and, finally, access to the public system.

The programmatic dimension is determined by the strengths or weaknesses of the programs at systems and health services for the prevention, control and care to HIV/AIDS regardless if they come from the field of Government, non-governmental, or private; or if you belong to the territorial level (national, regional, or municipal).It should be noted that these actions are closely related to the social dimension and determine the individual dimension.

On the basis of the above considerations, it can currently recognize that HIV/AIDS is a controllable disease thanks to HAART that emerged in the 1990s, which attenuate the natural evolution of the infection. This makes that the prevalence rates remain relatively stable in places where there is access to treatment have a greater survival, although there are more new cases of disease.

In this way, with a powerful therapy, there has been a marked decline in hospitalization rates, morbi-mortality (Term used in public health that encompasses the concepts of morbidity and mortality). Morbidity describes the amount of individuals who are considered to be sick in a place and time certain, while mortality refers to the number of people who die in a place and in a certain period in relation to the total population

Turning to infection by HIV/AIDS, a serious, fatal acute illness to a chronic disease, i.e., long and slow, controllable progression long-term disease. As such a condition, it produces a progressive loss of functional capacity and autonomy of the individual, with a gradual deterioration of physical, psychological and social nature that determines a decrease in the feeling of well-being.

Taking into account then the TARGA has extended the life of these subjects, an important aspect that arises is the consideration of quality of life and especially the HRQOL in this population, since HIV/AIDS is a complex constellation of disease, stigma and discrimination that affect the family, work and social life of those affected.

6.3 Methodological Tradition in HIV Research

In recent years, different HRQOL in HIV research have been performed and published, especially with quantitative methods, but very few studies using qualitative approaches. Among the first, are registered strong and consistent associations between levels of social support, psychological disorders, clinical indicators and socio-demographic variables in levels of HRQOL.

In regard to studies using qualitative methods in HRQOL in people living with HIV are less and some of them found similar results, despite using different methodologies. Most evaluated dimensions mainly focus on the psychosocial aspects of HIV/AIDS infection.

In this ways, Jones et al. (2004) used the grounded theory based on the daily life of 20 people living with HIV, Hepatitis C Chronic (HC) and who are coinfected with HIV and HC, residing in the Metropolitan Area of the city of Buenos Aires. They used the interview in depth where evaluated six categories: knowledge of diagnosis, first reactions when they are diagnosed, predictability of infection, impact of the diagnosis in the life and immediate steps after the diagnosis.

When performing the analysis, draw attention that none of the subject take knowledge of his infection in an analysis of routine or have suspicions of your probable infection. The first reactions of the diagnosis, was different for both infections, HIV was the idea of death and in the HC a misunderstanding of what causes the disease. In the analysis of predictability, patients with HIV related more drug addiction as a way of transmission, the heterosexual sexual relations without protection. HC had no clear transmission ratio. The diagnosis of both pathologies caused an imbalance in their lives difficult to overcome, but to some it meant a continuity of life style, and to others it did not.

For his part, Cardona-Arias (2010), also based on the same theory, conducted an investigation with the aim of understanding the SR on people living with HIV in Medellin, Colombia, during 2009, through semi-structured interviews, field and both participant observation as a non-participating journals. Interviews were conducted at each of the patients three corresponding with open, axial and selective coding. The RS were addressed from the procedural approach, which focuses on the symbolic production of language, from hermeneutics. The RS of the HRQOL is understood based on biological, like the importance of HAART and the provision of health services, psychological, such as the acceptance of the diagnosis and the relevance of information on health, and determinants social, such as the stigma and social support.

In addition, described some strategies used by participants to improve their HRQOL. In total 19 people aged between 29 and 67 years old, average 48, 52% of men, 58% unmarried, 73% unemployed and 57% with primary studies were interviewed. A number of participants considered the therapy as a determinant of HRQOL in the AIDS phase, but not in the asymptomatic subjects. Changes to the project of life linked to the need to redefine priorities in the life of the subject and ways of taking the new reality of infected is referred in the psychological domain.

In the initial moments, diagnosis generated feelings of hopelessness and disappointment by what the priorities of the life project focused on ideas about death and the fear of the future. Socially, the RS interview revolved around the support of family and friends, and not to the stigma. For many infected one of the best strategies to protect their HRQOL is hide the diagnosis, support in love and perform activities that occupy the free time.

On the other hand, Cantú Guzman et al. (2012) search profile psychosocial variables such as emotions, social support and coping as well as the RS who have HIV in Monterrey, Mexico in 2003. They conducted semi-structured interviews with open-ended questions in eight subjects receiving medical treatment. He was a content analysis and their respective frequencies to determine which excelled. The emotional impact at the time of diagnosis was negative, characterized by sadness and fear, as well as thoughts related to the death. It could detect various actions by the subjects, as for example with anyone let alone the situation, talking only with some relatives because with other family members you suggesting rejection, this associated with social support.

In this study, the current individuals coping was oriented more towards positive behaviours and instrumental type, based on the search for professional care and adherence to treatments. Also among the factors that have helped the subjects beyond the instrumental aspects, is maintaining hope, which denotes the importance of psychological interventions covering the social environment of individuals.

Finally, Pecheny et al. (2012) in a quantitative-qualitative descriptive study of characterization of women recently diagnosed with HIV in Argentina, during May–July 2009, evaluated women's vulnerability to infection, the contexts in which know their diagnosis, the route of transmission of HIV, when and how access to the testing and initial news impact.

Surveys and additional interviews semi-structured women and also men, couples of the same, residents in the city of Buenos Aires, were districts in urbanized areas and main cities of the country. Following interview guides, explored the secret handling, the experiences of stigma and discrimination, the impact of the diagnosis and disease, recovering the words of men and women themselves. The sample was intentional, not probabilistic and was comprised of a total of 465 women surveyed over 15 years old with a diagnosis of HIV in January 2009 or later. The age range of those interviewed ranged from 17 to 70 years and the average age was 34 years old.

They were interviewed 31 women between 20 and 62 years old; most live in urbanized areas (city of Buenos Aires and suburbs), and the rest resides in other cities of the several provinces as Buenos Aires, Córdoba, Salta and Tucumán.

All patients were heterosexual, with different marital situations: single women, married or stable union, separated with boyfriend, and widows. The employment situation of these women was in general precarious: only half works and, just a few had a job in white. Less than half received any subsidy or social plan; the Universal allocation per child is majority.

Twelve males were also interviewed. Only one of those interviewed (in quality of partner of a woman newly diagnosed with) not living with HIV. The ages ranged between 18 and 50 years old, and live in different towns of the country. All were already partner with women today living with HIV at the time of diagnosis of the same. It is stable and lasting relationships (between 3 and 9 years of relationship, at the time of the interview).

In the most of cases, wives couples have received the diagnosis at the time of childbirth or during pregnancy. This leads to that, sooner rather than later, males also performed the testing and receive a positive diagnosis as well. In two other cases, the women have done the testing for other reasons.

Only in one case was the man who first received the diagnosis, at the time of plunging by different symptoms. Two men claimed to know their serological status in advance. In both cases, they had not communicated it to their partners. Some concerned have transmitted them the virus to their partners, while in other cases they claim other reasons (such as a transfusion), believe that they have been partners of women who have transmitted to them or directly do not know or do not want to talk about the issue. At the time of questioning how to believe they have contracted the virus, the responses also vary: in addition to those who are considered to have contracted the virus with its stable couples, some believe that they did this in the context of casual relationships, with women or men.

In accordance with the found data and the analysis of this research show that vulnerability to HIV is a complex phenomenon and that it involves individual, social and programmatic dimensions. The practices of each of the people, their social relations along in life and in the present, and the impact by action or omission of the State, all this is reflected in stories over time and focuses on vulnerable to infection by HIV, as well as other conditions and damage to health and social as other diseases use of substances psychoactive, social, sexual violence and gender.

With reference to studies using qualitative methods above mentioned, can be noted that they are mostly exploratory or descriptive studies, where evaluated primarily subjective aspects such as dimensions psychosocial and some socio-demographic. Biological or physical indicators of the disease were not valued.

How you can highlight, obviously there are a greater number of quantitative studies in the literature that dealt with HRQOL in subjects with HIV/AIDS, to qualitative research. Possibly this is due to different reasons, for example to the methodological difficulty of qualitative designs, the experience of the researcher in this field of research, the time of completion of the field work and sometimes costs that involve the qualitative studies, among other factors.

In addition, sometimes working with hospitalized people or with people in deteriorated health conditions requires the brevity of the study and low complexity of the application of research in subjects with HIV/AIDS.

6.4 A Qualitative Study in Young People With HIV

6.4.1 Methodological Design

A descriptive study using qualitative method was conducted. The objective of this work was to analyse the characteristics of the HRQOL of young people with HIV/AIDS identifying the psycho-social aspects. Qualitative research in HRQOL of young people with HIV/AIDS describes the qualities of a phenomenon, in this case the condition by HIV, with the intent to obtain an understanding and interpreting deep meanings and definitions of the situation as they face these subjects, rather than the mere production of a precise quantitative measurement of characteristics or behaviour. Qualitative research is presented as a flexible, interactive design, predominantly subjective and inductive.

In one way or another, attempted to find answers about what young people think and feel about HIV, treating the researcher go towards subjects or living among them, with emphasis on everyday social practices.

The study population was consisted of young people between 15 and 24 years-old, who attended the external office of Sexual Transmission Infections (STI) during June–October 2013 at Lord's Miracle Hospital of Salta city, Argentina. This hospice has a level of complexity III, i.e. only accomplishes non-surgical and clinical treatment. It depends on the Ministry of Public Health of the Salta province. The institution assists, carries out treatment, retrieves and rehabilitates acute and chronic diseases with particular emphasis on infectious and contagious, such as tuberculosis and HIV/AIDS diseases and other emerging and re-emerging diseases from the province.

Intentional non-probability sampling was performed, i.e., young participants randomly were selected based on the ability to provide important and substantial information of their HIV status. The final sample was consisted of ten subjects of both sexes. The most important consideration in qualitative sampling is the wealth or the value of the data. The validity and significance of the knowledge generated by qualitative inquiry have more to do with the wealth of information of the selected cases and the ability of observation and analysis of the researcher to the size of the sample. It is important to remember that the logic of the intentional sampling is different from the logic of sampling probability (Patton 1990), because that will be based on the purpose rather than the statistical probability of selection.

Young people between 15 and 24 years-old diagnosed with HIV/AIDS through Western Blott laboratory technique, in the last 5 years who are receiving or not treatment HAART were included. Pregnant woman, exposed perinatal (i.e., subjects infected by HIV since birth through pregnancy transmission mother to child), subjects with disabling physical conditions, and severe psychiatric pathologies associated or not with the HIV status, inmate people and individuals with refusal to participate in the study were excluded.

6.4.2 The Field Work

Semi-structured interviews during the field work for the study of HRQOL in young people with HIV/AIDS were used as data collection technique.

Taylor and Bodgan (2000) define the interview as a situation of direct interaction where a person (interviewer) explores the views or experiences of others (interviewed) from the perspective of the latter. It is considered as an interpersonal communication in order to "verbal" answers which is characterized by the flexibility to adapt to the different personalities of each subject. In addition, it works with the words of the interviewee and their ways of feeling, not being a technique that leads simply to collect data about a person, but that he tries to speak to this subject, to understand it from the inside.

Tonon (2009) says that the interview as a meeting between two people, where personal feelings, beliefs, desires, problems, experiences and behaviour reveal. In the semi-structured interview, also known as interview based on a script, the investigative work can be organised as thematic axes of reflection or based guiding questions. An interactive, circular, and incremental process is generated in this way.

In the present investigation of HRQOL in young people with HIV/AIDS have been investigated with the aim of assessing the ideas, beliefs, opinions or perceptions, the following topics with the subsequent guiding questions:

Coping with the illness:

- How have you carried your illness from the diagnostic?
- What have you done to be able to coping with?
- Have you taken any particular behaviour?
- Do you avoid, accept or forget that do you suffer from the disease?

Social support from family, friends or co-workers:

- Apart from professional staff, have you discussed your sickness with someone else?
- Whom with?
- Have you got support from a family member, friend or co-worker? Whereof way?

Life Satisfaction:

- Nowadays, how do you feel emotionally in relation to your disease?

- Do you feel that the illness has changed anything in your life?
- In a negative or positive way?

In the first instance was asked young people about identification data in order to know social-demographic profile of the sample, such as age, gender, marital status, level of instruction, occupation, date of diagnosis of HIV/AIDS and use of treatment HAART. Subsequently, subjects authorized the completion of the interview giving informed consent in writing (according to the regulations of ethics in health research) and voluntary participation. It was explain the potential risks and benefits of the research, guarantees of confidentiality, purpose of the study, how were chosen to participate and the procedure of collection of data was used.

The semi-structured interviews lasted 30 min and were conducted in external office of the Lord's Miracle Hospital of Salta city where usually carry out diagnostic and counselling on HIV/AIDS and sexually transmitted infections. We used a digital recorder and the interviews were audio-recorded, changing the names of the informants to ensure their anonymity. During the interviews each young man was encouraged to freely describe the experience of living with HIV/AIDS, and depending on the circumstances some questions were carry out. We used a field notebook as he interviewed the subjects to take additional notes describing non-verbal communication as emotions or attitudes that were shaped not structured during the interview.

Research design was approved for implementation by the Committee of Ethics, the Teaching and Research and the General management of the institution.

6.4.3 Data Analysis

Once those interviews were transcribed completely without deleting them in electronic format, it was proceeded to make the qualitative analysis of the data.

By talking about qualitative analysis, it means, not to the quantification of data, but not mathematical interpretation process, carried out with the purpose of discovering concepts and relationships of the data and then organize them into a theoretical explanatory scheme.

According to Tonon (2012) the process of data analysis requires both theoretical knowledge, and certain attitudes and skills. In this study we used the strategy of analysis within the framework of social phenomenology called thematic analysis to identify the essence of the phenomenon of study and transform the subjective experience of young people living with HIV/AIDS in their world or everyday life.

Braun and Clarke (2006) propose the use of thematic analysis as a method to identify, analyse and report issues and structures, and can thus reveal both the experiences, such as meanings and realities of the subjects, as well as to examine the ways in which events, realities, meanings and experiences are the effects of the speech of a society. Firstly, to carry out thematic analysis, was a reading detailed and repeated the information transcribed looking for structures and meanings. At the same time, also underwent a repeated reading of the notes made in field notebooks.

Then, the initial theoretical coding were performed using words or textual phrases of the participants, which were grouped according to similar meanings related to the established themes. Subsequently, were conducted the search for topics using pictures by setting definite hierarchies of topics and subtopics worked.

Ten young people with HIV/AIDS, eight of them men and two women, with an average age of 21 years old participated in this study. Seven of the subjects were reported as unemployed, while the other three mentioned engage as administrative in a company's phones, voluntary promoter in a society for the protection of animals and sex worker respectively.

Eight of the participants obtained a level of complete primary and secondary education. The remaining two participants had an incomplete tertiary level. Two young people were studying, one nurse and another social worker. All young men said to be singles, and seven of them referred to have homosexual practices. The two women were heterosexual and single mothers. They had one or two children, correspondingly. The average date of diagnosis was two years, while the rest was 4 months old. Only a single subject was specific in treatment with HAART, while the rest had not begun treatment yet.

First, when analysed the psychological aspects of HRQOL in young people, it was observed that in all subjects at the time of the diagnosis HIV provoked an emotional impact with negative feelings such as fear, sadness, and denial of the disease. In this way, the subject usually suffers from a state of crisis that manifests itself in a social, physical and psychological imbalance i.e. goes through what is called a Vital Event. One of the young people said in this regard:

> … I'm not going to lie, when they say to you that you have HIV you get upset, there everybody was upset, there you said positive, but in my case, Yes, I was obviously disturbed. I couldn't believe it… Typica reaction, crying all day, because you never know, there is no cure, only treatment; they take it badly, if the treatment lasts 10 years and then, you still die… (male, 24 years old)
>
> And mostly I try not to remember, I try to think that it didn't happen, I don't remember, no nothing. The first days with my husband crying every day… because to us? It was a thing which we couldn't, understand that it had happened to us… And, well, the first few days I was crying all the time, the first months… and after that I didn't cry any more… (female, 19 years old)

Other young people expressed, along with previous feelings, ideas of trying to damage his life or suicide:

> …and when they found out (parents)… they felt bad, very bad… At first I wanted to kill myself. They had to take stop me… (female, 24 years old).
>
> The truth, at the beginning I was scared, I started to cry… what would I do if I had HIV. I thought of this madness, of killing myself, I don't know… (male, 24 years old)

It is important to emphasize that there is a grieving process, which in the case of HIV, certain stages shows very well in every disease. This grief represents an imbalance of the health state and well-being that perceives the subject and usually requires a period of time to get the person back to this state of balance.

According to Kubler-Ross (1969, cited in Kuczewskiahe 2004), there are five stages of grief popularly known by the acronym DABDA, including denial, anger, bargaining, depression, and adaptation of the disease.

In relation to the current coping of the suffering in young people, i.e., the ability to have people in acquiring some control in a stressful situation, included both efforts to adapt both cognitive as behaviour among the first, it was observed that subjects most well accepted disease, after having experienced some stages of mourning. They took it as part of everyday life and continued their normal life performing routine without any interference. Some young peoples expressed:

> … I decided that it was alright…I have the disease, and that I'd go on as I am now but with more stack obviously, trying to brace myself, try not to be depressed "bajonearme". Really it's useless, so… (male, 17 years old).
> If obviously accept it and try to be calm… positive and everything'll be ok, if I'm calm out there….at first, I was "bajoneada", but now I've been thinking about everything; it's alright. I'm more concerned about it and so…(female, 24 years old)
> … I accept it, I had to accept it… because I have to live with the problem, it's in me… but obviously, as I say… not… in the meaning of life… I feel like a little… I'd say… disappointed… (male, 23 years old)

However, other subjects were difficult for them admit the sickness and they are with depressive pictures, while others deny it still… At the stage of depression the people realizes her illness and suffers loss of different aspects of life and demonstrate a depressive reaction accompanied by fear, loneliness and loss of ability to fight and will to live. Only three subjects felt these emotions:

> It's hard to accept. It was very hard. Out there the other day when I got the news I couldn't bear it. The truth is that I was lost. I didn't know… Out there… I try not to remember that and going on with my normal life. No, I don't want to think about it. And the truth is I'm feeling bad, depressed, but I try not to lie down because I'm a very depressive person… the truth is that I don't know if I'm accepting it or not, if I should change for good, I know I have to but… Or is it that you like me are just spending time… (male, 24 years old)
> The truth is that I'm feeling bad (distressing look with tears in his eyes)… I can't accept it yet… (male, 24 years old)

Some young people tried to not fall into depression and staying emotionally well either with its vital as small children, or in some cases links to the parents. A young man said:

> .. I don't let myself go for my children's sake,… I have my two little children and they are the only thing that I have and I have to be strong for them, because I know if I get to cry or anything like that, it's worse for me and my defences are low (female, 19 years old)

On the other hand, very few young people use work or study as a coping resource, since most were unemployed and not studying. Other young people used strategies of reasoned action, since they meant that they were suffering the consequences of certain behaviours and unsafe sexual practices which had been carried out, a young man said in this regard:

> … I, psychologically, accept it, I'm fine. Knowing the consequences I don't care myself… What I have to do is to resign myself to the fact… (male, 24 years old).

At the same time, certain positive and negative behaviours were generated to meet them. Among the first subjects demonstrated a greater commitment to continue studying or find employment and greater capacity for reflection in family relations to avoid conflicts:

> … Before, I didn't know anything, I used to answer my mom back and now it's like that… I'm like that… I try to live a better life. I try to live well. Avoid fighting, avoid… For example I used to argue about with my mom about little things and now I try to not get angry… (female, 24 years old)

However, the most important positive aspect that young people expressed is that from the HIV diagnosis generated positive attitudes of self-care with behavioural changes in sexual practices. In addition, they also expressed wanting to care for other people to prevent secondary transmission of disease. These individual resources generated promote what is called resilience, i.e., skills that allow, even under unfavourable conditions, build and deploy behaviour favourable to oneself and to the own environment that surrounds it. Several young people said in this regard:

> …If I catch this disease, I have to accept it and move forward and now take care of myself and take care of other people…(male, 23 years old)
> …I don't know how people negatively prefer to infect everyone and don't care about anything, don't care about anything else. In my case I'm not like that. I prefer to take care of myself and take care of the person by my side, my… (male, 24 years old)
> … in a relationship, but I already know that I have to take care of myself, but I would do anything for the other person, because I wouldn't like to do to someone else what they did to me…(male, 17 year old)

In terms of negative behaviour, coping resources, young peoples, before the revelation of HIV conducted as main action hide your diagnosis, appealing to different strategies to be able to keep it secret from family, no close friends or work colleagues.

On the other hand, interviewees highlight the importance of Social support in HRQOL, i.e., if the young man has an affective network and contention that help the coping with the condition. Most of the parents of the study subjects were unaware of the diagnosis and young people received, not just emotional support, but also instrumental:

> …my family's giving me all the support I need when I feel bad. When I'm sick they're always watching out for me; and my friends, whenever I need them, they also there for me…(male, 24 years old)
> They try to give me psychological support, try to be with me telling me not to give in, controlling that I'm following the treatment, see now they were going to come with me, but they couldn't, they're calling me and so… They are supportive in this regard, to help me get well…(male, 24 years old)

In other cases, they only knew one diagnosis of parents or siblings and the other was unaware of the analysis. One of the young commented in this regard:

> …Not emotionally, because… we're different… My mom is cool (says it with disappointment) we clash… since I was a kid, with my mom; his departure, I've felt much rejection against my mom…(male, 24 years old)

Friends are a very strong and important support in nearly all teens analysed, especially confidential type. In one case a young man concerned have a friend who also lived with HIV he did have empathy and confidence to share disease:

> ..They talk about it, that is not a disease that can be spread by kissing, embracing, all that… (male, 24 year sold)…
> I feel a little better informed, a little more content, because the suffering and good done by this whole issue of social networks, and all that. He meets people….learns different, different stories about people, you know…(male, 23 year old)

In young concerned fear homosexual practices, friends with similar sexual preferences occupy the role of surrogate family in the absence of support from family, especially parents who generate behaviours of rejection by the choice of the sexuality of children. The interviewed young people, who work, noted that social support of co-workers there is no since they are unaware of the disease.

Finally, emphasis is placed on young people with HIV feel emotionally against the disease and if you have changed something in their life, it is either negative or positive, i.e. to what extent feel satisfaction with life despite living with HIV.

Thus, the majority of young people with HIV manifest feel good emotionally at the time of the interviews against the disease, after crossing the different stages of mourning and that change little life that were doing. Some young people were pronounced:

> …in spite of everything, I'm trying to smile, not to let myself fall because it's a normal disease, one can have a normal life, always taking care of the other person. I'm well, calm… Well, all in all. I'm trying to push on like other people…(male, 24 years old)
> Emotionally well, because I don't put up a barrier a barrier, er… as they say… when… treatment that the disease does not affect my head, I try to think it's part of my life and contro lmyself and go on with my normal life…(male, 24 years old)
> Emotionally I feel quite well, normal and, for me, normal is pretty good…(smiles nervously) I'm doing pretty well at the University, I feel livelier…(male, 17 years old)

However, despite the acceptance of the condition, they referred some positive and negative aspects of living with HIV. Few young men expressed positive aspects with respect to disease. General outlined that the disease served them as an instance of learning for life, and in turn, also help to better understand people living with HIV and have no prejudices about them.

On the negative aspects is where the subjects expressed greater concerns. Young men reported to have uneasiness at the time maintaining sexual practices with current partner or initiate new relationships with others for fear of rejection of those couples. Another aspect mentioned by them was the concern of some young people by the desire to have children. Young people pointed out in this regard:

> …for, er, if I have a couple I have to say although, er, I suppose that that couple'll still want to be with me, or breaking off the relationship, you somehow have to say…(male, 24 years).
> I said my life is over, as we say, everything… no longer the same relations, I'll be one sick person, as they say… the first thing they say, you have a disease… you're going to sick all your life, and sometimes it's ugly to feel…(male, 23 years old)
> If I believe it would be difficult for me to get a boyfriend, but not for fear of telling her I'm HIV positive, but because I'm not prepared…(male, 24 years old)

> …as it's beginning to change… that already from now on if you want to be with someone, again I am afraid to be with someone new or want to get to know someone…(male, 24 years old)

Another aspect related to the mentioned above is the concern of some young peoples is about the fatherhood. One young people said:

> Because if I can't have any children, do you understand me… say if I want to I have to be well, but… If 'm not I'm going to get something else… and that's what I don't want. That directly me I am only and it is… not… to ruin someone else's life, do you understand me… or to get someone to like me and I directly think not… because it's already happened to me…(male, 23 years old)

On the other hand, also referred to as something negative, employment problems, since they think that they may have difficulties in income when the employer applies for routine blood tests and seropositivity is revealed to HIV in the results. In this respect a young man said:

> They closed doors on me, as for example, I wanted to see if I could get into the police force and that kind of thing that you aspire sometime or you've ever wanted…because they always ask for these… ask for these health analysis… Good shops and stuff, I also know that I won't be able to…Sooner or later when they want to have my papers in order it will happen to me that, that's going to come out that… (male, 22 years old)

In turn, the generation of family conflicts are glimpsed from diagnosis. By the way a young man expressed:

> Well, at first nothing went well… my family moved away, turned away from me, most of my family, I expected another reaction from my family… and no, they walked out on me, all of them… can get or I can… they don't understand that there are methods to avoid contagion, but as they are all boys and I might infect them the door are closed…(female, 19 years old)

Among the positive aspects young people perceived of living with HIV perceived it as an instance of learning in life and have no prejudice with other subjects:

> Nowadays, I see people in a different different way, I manage to understand other people, I'm not prejudiced, but at the same time we are also biased, even with myself and if I can't do this because I have this disease, and maybe if I can do it, mostly because of prejudice and my low self-esteem… (male. 22 years old)

6.5 Conclusions

In this qualitative study interviewed young people expressed, from a psycho-social aspect of HRQOL, emotionally feel good with a positive impact in the diagnosis of HIV and a global vision in life favourably with appropriate psychological and social well-being. In regards to social support, it should be noted that participants had adequate support, both emotional and instrumental, friends and parents had minor pictures depressive, as well as a better perception of quality of life since they used effective defeats resources to cope with the condition. One must understand then, that HIV/AIDS is not only a mere disease from biological, if it is not a psycho-social phenomenon in a given socio-historical-cultural context.

This research evidence of some progress in several ways since it becomes a source of theoretical, methodological and practical knowledge of reference in research on HIV/AIDS. First, it generates an acquisition of other knowledge from the social sciences, not only personal but also professional level. This occurs by a subjective interaction between the interviewer and the vulnerable population so discriminated against and stigmatized by society. Secondly, the approach of the QoL in subjects with HIV with qualitative methods is imperative to understand and interpret the subjective aspects of the individual, and thus have a better general understanding of the experience of the subject with the condition, since it is currently a controllable chronic disease in the long run.

Finally, the results presented in this study emphasize the need for a therapeutic approach integrated between infectiologists physicians, mental health services and social assistance, as it is considered the person who lives with HIV/AIDS as a complex phenomenon, requiring a comprehensive and multidisciplinary management this will make more rational decisions to the of the subject who lives with HIV and perform in this way, interventions that can cause greater impact and effectiveness in public health programmes

While there are some limitations of the study, as the greater predominance of males with homosexual preferences and the amount of subjects interviewed, this study is only a new look of a research integrating the individual with HIV to get not only a greater survival of the subject, but a better quality of life and have hope in the future to carry an everyday normal interference-free and full of satisfaction. Without any doubt, HIV/AIDS is a complex constellation of psychosocial, stigma and discrimination alterations that affect family, working and social life of the subjects and becomes unavoidable will be current studies is directed towards qualitative research to better understand the socio-cultural determinants of the process health—care in these subjects.

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