Send Orders for Reprints to reprints@benthamscience.ae

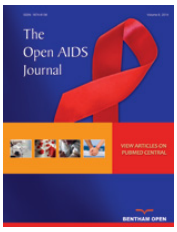
BENTHAM OPEN

CrossMark

The Open AIDS Journal

Content list available at: www.benthamopen.com/TOAIDJ/

DOI: 10.2174/1874613601812010150, 2018, *12*, 150-161



RESEARCH ARTICLE

HIV Positive Patients' Experience of Receiving Health Care Services: A Phenomenology Study in Iran

Heshmatollah Asadi[1], Mohammad-Hasan Imani-Nasab[2], Ali Garavand[3], Mojtaba Hasoumi[4], Abdollah Almasian Kia[5], Behzad Haghi[1] and Fatemeh Setoodehzadeh[6,*]

[1]*School of Health and Nutrition, Lorestan University of Medical Sciences, Khorramabad, Iran*
[2]*Social Determinants of Health Research Center, Lorestan University of Medical Sciences, Khorramabad, Iran*
[3]*Department of Health Information Management and Technology, Shahid Beheshti University of Medical Sciences, Tehran, Iran*
[4]*Health Management and Economics Research Center, Iran University of Medical Sciences, Tehran, Iran*
[5]*School of Health Management & Information Sciences, Shiraz University of Medical Sciences, Shiraz, Iran*
[6]*Health Promotion Research Center, Zahedan University of medical Sciences, Zahedan, Iran*

Received: March 23, 2018 Revised: September 12, 2018 Accepted: September 30, 2018

Abstract:

Introduction:

Most of the studies on HIV/AIDS health care status are usually conducted in big cities while small towns and rural areas are faced with specific challenges. This study aimed to identify the barriers and problems encountered by HIV-positive patients when receiving health services in the small cities and rural areas of Iran.

Methodology:

This is a qualitative study that was conducted using an interpretive phenomenology method in 2016. This study was conducted through a semi-structured interview for which a purposeful sampling method was used. In the present study, data saturation was observed after 15 interviews, but more than 17 interviews were conducted to ensure the reliability of the interview. Data were analyzed by Colaizzi's method using MAXQDA10 software.

Findings:

Barriers and problems encountered by patients when receiving health care services consisted of 10 categories, 32 main themes and 67 sub-themes. The categories were as follows: fear of revealing the disease, fear of confronting providers, seeking support, not visiting health care providers, inappropriate behavior of health care staff, concealing the disease, hardship endurance, financial concerns, psychological stress and pressure, and disclosure of patient information.

Conclusion:

Recognizing the problems of HIV-positive patients in using health care services and resolving them can help to reassure the patients about the health system. Introduction of supporting policies and regulations, appropriate public education, training health sector personnel, and provision of medical equipment and facilities would positively affect the process of solving the problems of HIV-Patients (treating HIV patients).

Keywords: HIV positive, patients' problems, Health care services, phenomenology, Iran, Colaizzi's methods.

* Address correspondence to this author at the Health Promotion Research Center, Zahedan University of medical Sciences, Zahedan, Iran; E-mail: fsetudezade@gmail.com

1. INTRODUCTION

HIV/AIDS is still a major public health challenge worldwide, especially in low- and middle-income countries [1]. Nearly 36.7 million people in the world are infected by HIV [2].

The World Health Organization (WHO) reports indicate that the rate of HIV infection is declining worldwide in line with the Millennium Development Goals. New HIV infection cases in 2015 (2.1 million cases) in the world were 35% lower than in 2000 (3.2 million) [3].

Unfortunately, WHO statistics not only did not show the downward trend of HIV infection in Iran, but the estimations by WHO indicate that during 2000 to 2015, the number of People living with HIV/AIDS (PLWHA) in Iran increased from 24,000 to 73,000 [4]. According to WHO annual report in 2017, HIV prevalence rate in Iran among people aged 15-49 was about 0.1 (<0.1-0.2). An estimation of 0.09 (0.0 – 0.322) incidence rate per 1000 persons aged 15-49 was also reported by WHO. These statistics show that the number of adults and children newly infected with HIV is about 4700 (4700 - 11000) people [5].

HIV patients face numerous problems, including; Stigma [6] and discrimination [7], lack of access to services [8], and lack of observation of their rights [9]. Stigma has devastating effects (such as depression, low self-esteem, low quality of life, and poor health outcomes) on the HIV patient [10]. In countries where HIV-infected patients are stigmatized, they are physically and verbally humiliated. It has been reported that 12-88% of HIV patients do not have access to health services [11]. Although knowledgeable, trained and motivated health care staff can play a critical role in meeting the health care needs of HIV patients, they may also play a major role in limiting the services provided to the patients [12].

The results of a study in Vietnam showed that discrimination against HIV-positive patients was common in the community and in the health sector, which hindered the use of health services by the patients. The results also showed that this attitude towards the patients would cause them to lose their jobs or get isolated [13]. Another study conducted in Iran reported that 49% of nurses had a negative attitude toward HIV/AIDS patients [14]. The findings of a study by Holtzman *et al*. (2015), in which Andersen's Behavioral Model (ABM) was used for identifying barriers to providing care for HIV patients, showed that external environment factors were among recognized affecting factors of providing care [15].

Most studies focus on the care of HIV/AIDS patients in big cities, while results from different studies show that these patients in small cities and rural areas face their own challenges [16], such as more stigma [17] and more barriers to access care services [18]. It has also been proven that HIV patients living in far-away areas have less medication adherence [17].

Therefore, we decided to investigate the barriers and problems encountered by HIV-positive patients when receiving health care services in small cities and rural areas of Iran.

2. METHODS

The present study was conducted in Iran where the Ministry of Health and Medical Education is the head of the health system and is responsible for policy making and supervising service provision in different levels of the health system. Executive tasks of the Ministry of Health have been delegated to Medical Sciences Universities of each province. In each city, there is a district health network which constitutes the smallest independent health service organization in Iran's health system. All hospitals and health care centers (in cities and rural areas) provide health services under the supervision of districts health networks [19]. In cities, there is a Behavioral Disorders Counseling Center [20] which is responsible for providing services for patients suffering from HIV, HBV, HCV and addiction. In rural areas, health care centers are responsible for these tasks. This study was conducted in Lorestan and cities with less than 100,000 populations were chosen for the study.

The present study is a qualitative one which was carried out using the hermeneutic phenomenology method in 2016. Hermeneutic phenomenology examines the meanings and the relationship between knowledge and its context, and is basically the interpretation of written phenomena. The value of knowledge in health-related fields largely depends on its relevance and importance in understanding human experiences, and hermeneutics provides a way for a deeper understanding of humans and human experiences such as health and disease [21].

The inclusion criteria were: being infected with HIV, ≥ 10 years old, knowing their HIV positive status for at least 3 months and providing informed consent for participation in the study. For those under 18 years old, consent form is signed by their parents/guardians. To select the participants, purposeful sampling was applied.

In purposeful sampling, samples are chosen based on aims [22] of the study and required information. So participants that have been interviewed together with their information will affect the next samples that will be chosen [21]. In the present study, Semi-structured interview and interview guide were used for collecting required data.

Before conducting the interviews, the research objectives and the characteristics of the research team were explained to the interviewees and their informed consent was obtained. The interviews were in-depth and semi-structured (face to face). All interviews were conducted from April to August, 2016.

To conduct the interviews, coordination with the participants was done and they were interviewed at the particular time they had offered. Interviews were conducted by two of the researchers (H.A. and A.G.). An interview guide had already been prepared using the views of the experts and the research team and based on the study objective.

Interview questions were semi-open. In semi-structured interviews with semi-open questions, the interviewer and interviewee are free to discuss more on the subject. This method allows the interviewer to ask further, differentiated questions, in addition to the questions identified in the interview guide, in order to obtain more detailed information on a specific subject. The interviewer can also ask questions in relation to the topic under discussion, about the issues raised during the interview [23].

The duration of each interview was 25 to 75 minutes. Each interview was conducted by one of the researchers in the absence of any other participant apart from the desired participant. The participants' words were recorded using a Sony icd-px33 sound recorder. During the interviews, note taking was also used to record the information.

Upon completion of an interview, it was listened to several times and then typed word-by-word so that the access to saturation level would be reached through the similarity and appropriateness of the individuals' responses. In the present study, data saturation was observed doing 15 interviews but due to the discussions between the research team members and for more certainty, 17 interviews were conducted. A total of three people who did not meet the inclusion criteria were excluded from the study. To comply with the principle of data immersion, interviews were repeatedly listened to and then typed by three members of the researchers (H.A., A.G. and M.H).

The data analysis was performed using MAXQDA10 software, and the data were analyzed using Colaizzi's method. The research team conducted peer check to agree on the codes and review the interview texts, and also reviewed the findings with the interviewees through member check. This study was reviewed and approved by the Ethics Committee of Lorestan University of Medical Sciences, Iran (No. IR.LUMS.REC.1394.131) before commencement.

3. RESULTS

In this study, a total of 17 people were interviewed, of whom 14 were male and three were female. Other specifications are presented in Table **1**.

Table 1. Characteristics of the participants in the study.

Variables		N
Gender	Male	14
–	Female	3
Marital status	Single	10
–	Married	6
–	Divorced	1
Age		32-55
time since HIV diagnosis		8 month to 7 year

Analyzing the participants' experiences revealed that the problems encountered by the patients, in terms of receiving health care services, included 10 categories, 32 themes and 67 subthemes (Tables **2**, **3** and **4**).

Table 2. Patients' experiences before receiving services

Categories	Themes	Subtheme
fear of revealing the disease	Fear of other people's awareness of a person's illness	Fear of neighbors awareness of a person's illness Fear of provider awareness of a person's illness Fear of Family members and relatives of a person's illness
	Fear of being seen	Fear of being seen by neighbors Fear of being seen by physician Fear of being seen by Family members and relatives
Fear of confronting providers	Fear of inappropriate behavior	Fear of inappropriate verbal contact Fear of inappropriate physical contact
	Fear of being denied by health care personnel	Fear of non-acceptance Fear of not providing outpatient services Fear of rejection
	Fear of being judged by health care personnel	Fear of being judged as a convict Fear of being judged guilty
seeking support	Expectations from health care workers at peripheral levels	Expecting proper treatment of health care workers Expect to receive high quality of care Expect to receive the service in a reasonable time Expecting observance of the safety principles by health care workers Expecting spiritual support Expect health care providers to be good confidant.
	Patients support provided by high level authorities of Ministry of Health	Equipping behavioral disease counseling centers Attempts by authorities to change the public's view about HIV positive patients Observance of HIV positive patients' rights Introducing specific centers for HIV positive patients
Not visiting health care providers/Not going to health centers	Self-Medication	Purchasing medicines without prescription Self-injection of medicines
	Going to traditional healers	For tooth extraction Going to bonesetters Buying medication from traditional healers

Table 3. Patients' experiences during receiving services.

Categories	Themes	Subtheme
Inappropriate behavior of health care staff	Discrimination	Providing service to other patients and not providing to HIV patients Inappropriate way of looking at HIV patients Changes in personnel behavior towards HIV patients
	Humiliation	Verbal humiliation Humiliating HIV patients in the presence of other patients
	Rejection	Being rejected by health care personnel Being rejected by other patients
concealing the disease	Due to fear of inappropriate behaviors	Due to fear of changes in personnel behavior Due to fear of being rejected
	Due to fear of impose more cost	
	Due to the Fear of being judged	
	due to the fear of disease enclosure	for patient companions
Hardship endurance	Feeling shame and embarrassment	Shame of the service provider Shame of other patients
	denying patients right	People prevention of providing services to HIV-positive patients taking test samples without the patients' permission personnel curiosity about the patients disease
	imposing additional costs to the patients	Ambulance costs for transferring patients to other cities Cost of traveling to other cities in order to receive better services
	long waiting times for receiving services	
Financial concerns	financial inability of the patients	due to unemployment due to being poor due to lack of health insurance
	high costs of medicines and tests	costs of medicines costs of medical tests

Table 4. Patients' experiences after receiving services.

Categories	Themes	Subtheme
Psychosocial stresses and pressure	Being hopeless/ disappointed	Of receiving services Of health care authorities responsiveness Of personal life situation
	anger	with health care personnel at society with friends and companions
	Regret disclosing their HIV status	regret disclosing to health providers
	guilty conscious	Because of the concealment of the Disease Because of the possibility of infecting other people
	Decide to commit suicide	
Disclosure of patient information and its impact on patient personal life	Disclosure of patients information by health care providers	by physician by nurses BEHVARS*
	Disclosure of patient information by other people	by patient's friends by patient's companions by other patients
	Being fired from work	
	Distrust of health care Organizations	Fear of not receiving services in future visits Distrust of health care personnel

*health care personnel at health houses at rural area

3.1. Patients' Experiences Before Referral

The patients who participated in the study had experienced some problems before referring to health care centers. Their experiences had led to the lack of referral, low referral, and decreased motivation to refer to the health care centers.

3.1.1. Fear of disclosure of the Disease and Scandal

According to the participants in this study, one of their most important fears was the fear of disease disclosure. The fear of being known as HIV-infected patients by neighbors and other people, being seen by relatives, and being recognized as HIV patients by the health care personnel, were some of the experiences pointed out. Some of the quotes are as follows:

- "I'm trying not to go to a dentist at all, because I'm afraid somebody will notice my disease" (P. 11).

- "Some of our neighbors have told my dad why I go to the consulting center. So, now I have a problem with coming to this behavioral disease consulting center and I sometimes stay around for 4 hours to make sure that nobody sees me, and then I come in" (P. 6).

- "My mother had suspected why I came to the consulting center; so I told them I was taking methadone from here to quit my drug addiction. Otherwise, I promise they'll abandon me. I told them I only came here to get methadone, and if they know I am HIV-infected, I'm sure they'll stay away from me and won't approach me anymore" (P. 16).

- "Particularly if any acquaintance accompanies me, I won't say I have the disease because I don't want them to know about my diseases" (P. 7).

3.1.2. Fear of Confronting Providers

One of the experiences of the participants was the fear of the inappropriate manner exhibited by the health care personnel. (This fear leads to the lack of referral of patients, self-medication, or referral of the patients to traditional therapists or concealing their disease at the time of referral). Some related experiences of the patients were the fear of patient refusal, the fear that the personnel might change their behavior, and the fear of being rejected by the health care staff. In this regard, some of the experiences of the patients were as follows:

- ... "there is also the fear of changing their behavior. Believe me, I had a bad toothache but I took pills and didn't go to the dentist" (P. 11).

- "When I'm about leaving home I just think within myself: Oh, God! How can I go? Should I go there or not? I'm always afraid I might be maltreated" (P. 9).

3.1.3. Expectations for Support

The patients emphasized their need to be supported by the community, government, and health care systems before referring to receive services. The participants in this study had some expectations before referring for services, among which were the expectations for appropriate attitude by health care personnel, receiving high-quality health care services, receiving the services in a reasonable and proper time, observation of safety principles by the health care staff, not being rejected by the health care staff, being accepted by the health care providers, mental support, secrecy, more equipped counseling centers for behavioral diseases, correcting people's views about HIV-positive patients, observing the rights of HIV-positive patients, and introducing service centers to HIV patients.

Some of the patients' quotations regarding "expectations for support" are as follows:

- "A doctor or nurse can be very influential in my life. Even if a doctor or nurse tells me falsely: "God may heal you ", I'll get energy and strength from his/her words... There must be a center where we could report that sometimes we go and no one helps us. Or there must be a phone number for reporting these cases" (P. 4).

- "We have that disease for sure. At least our rights should be observed in the few years we're going to live. I shouldn't be excluded. Instead of taking my hand, they catch me red-handed. At least somewhere should be introduced to us by the Behavioral Disease Consulting Center so that we can go there for dentistry services" (P. 6).

- "Should I not have a place in this community? I was stupid, I didn't understand, and for whatever reason I got this disease. I have now been excluded from society, I need support now, I demand that the health care personnel help me when I need them" (P. 7).

3.2. Patients' Experiences when Receiving Services

The participants in the study had experienced some problems when they referred to the health care centers. What follows is the secondary themes and quotations from the participants in the study.

3.2.1. Inappropriate Attitude of Health Care Staff

The inappropriate attitude of health care staff included the following secondary themes: discrimination, humiliation, rejection by the staff, and patient refusal. Some patient quotations were as follows:

- "For example, when I want to give them my health insurance book, they wear gloves and take a corner of the book. It gives me a bad feeling and is really annoying. Sometimes I'm choked with tears and say to myself that I should quit taking these drugs" (P. 11).

- "One day, I went there and after they understood I was an HIV patient, they said they didn't have empty beds" (P. 1).

- "I told him I was an HIV patient. He first said they didn't have sterile gas, and then said they were out of ampoules" (P. 3).

- "As soon as I said HIV she completely changed as if her head was hit with a hammer" (P. 7).

- "I caught a cold when I was in prison. There was a doctor there whom I referred to and said that I was an HIV patient. He started to swear and told me very bad things such as "You are a parasite of this community. You are a misfortune for the community. You made yourself miserable and want to infect other people in the society" (P. 6).

3.2.2. Concealment of Disease

This theme includes the following secondary themes: concealment of disease due to the fear of patient refusal, concealment of disease due to the fear of inappropriate behaviors of others, concealment of disease due to the fear of changing behaviors, concealment of disease due to the fear of being imposed with more costs, concealment of disease due to the fear of being judged, concealment of disease due to the fear of disease enclosure from patient companions, concealment of disease due to the fear of being rejected and not receiving service. These problems cause the patients to conceal their disease when they refer to health care services and not inform their nurses, physicians, or other health care personnel about their disease. Here are some of the patients' quotations:

- "When I go there, I don't say I'm an HIV patient, because they may reject me and don't provide me with services" (P. 5).

- "For example, when I went to the dentist, I was careful not to let them know I was an HIV patient; otherwise, they might change their behavior" (P. 11).

- "When I went there, I didn't say that I was an HIV patient because I knew their behavior would change completely" (P. 8).

3.2.3. Hardship Endurance

Hardship endurance means enduring the difficulties that HIV-positive patients face when receiving health care services, including long waiting times in receiving services, prevention of people from providing services to HIV-positive patients, imposing additional costs to the patients, taking test samples without the patients' permission, and curiosity about the disease. These factors cause the patients to suffer from hardship when referring to health care centers to receive services. Some experiences of patients are as follows:

- "I had to go to one of the neighboring towns for my Caesarean section ...We waited until night, and following further coordination, we finally got admitted. I even had gone there before, but to get rid of me, they falsely said: " Go home and come back in a few weeks" (P. 5).

- "I had liver problem and my belly was swollen. I was sent to be admitted but they didn't admit me and I was in the corridors for some days. They said they didn't have an empty bed and asked me to go home and come back the next day; but I stayed there overnight, and again the next day they didn't admit me" (P. 15).

- "For example, dentistry; I swear I didn't have my teeth pulled in this city ... I had to go to a neighboring town to have my tooth pulled" (P. 4).

3.2.4. Financial Concerns

Financial concerns are the patients' experiences with regard to high drug costs, costs of medical tests, and financial inability of the patients with HIV. In this regard, the patients expressed their own experiences as follows:

- "I used to go to 13 Aban Pharmacy in Tehran to get my liver medicines. Every month, I paid 260,000 tomans (74.2 $) just for my ampoules, apart from transportation costs and fares. It goes back to years ago, but due to lack of finance I didn't continue my treatment course" (P. 9).

- "Sometimes I get sick and the cost of some medical tests is very high. For example, some tests cost 1700000 tomans (485.7 $). Sometimes they introduce charity centers, but these are mostly in Tehran. Well, it is two years since I've been unemployed, and I really can't afford even the transportation costs, let alone paying for my medical tests" (P. 11).

3.3. Patient Experiences after Receiving Services

These experiences relate to after receiving services by HIV-positive patients. As the patients pointed out, the problems encountered before and at the time of referral have caused some complications and unpleasant experiences after the referral. These experiences are dealt with in the following.

3.3.1. Psychosocial Stress

How to deal with the patients and the problems arisen will cause psychological stress in the HIV-positive patients after their referral. Some of these stresses are called despair, anger, regret, suicidal thoughts, depression, and feeling of guilt. For instance, the patients participating in this study stated that:

- "In some places I go for injections, they refuse to administer the injections, leaving me disappointed; I ask myself: "what do I want this life for?" Why should I be alive?" I swear to God, I was about to commit suicide once the dentist didn't give me any services" (P. 4).

- "Then, outside the hospital, I was so angry and I felt so sorry for myself that I injected all the ampoules for myself as I noticed there was no camera there" (P. 13).

- "Honestly, once I referred for an injection, but I didn't say that I was sick. Then I feared there was a 1% possibility that they wouldn't notice the blood-contaminated syringe and wouldn't observe safety precautions, so that one of the staff who mopped the floor in the hospital might touch the syringe and the disease might be transmitted to him/her. I felt

guilty, and that feeling tormented me for hours and days. Even after a long time I didn't calm down and still felt guilty" (P. 4).

3.3.2. Disclosure of Patient Information

One of the important problems the patients reported was the disclosure of patient information and the fear of disclosing patient information by health care providers, physicians, nurses and other staff. Some patients said they had such an experience. Some patients' quotations are as follows:

- "Once the healthcare provider who worked in our village knew that I was an HIV patient, he revealed it to some of the villagers. Since then, the people in the village stayed away from me and said that my entire family was infected with HIV. So, I had all my children and my wife checked to prove the villagers that my children weren't sick (P. 17).

- "In this very behavioral disease counseling center, about five years ago the employees had informed the family of an HIV patient about his disease, and he told us the story. Since then, I didn't trust the employees for a long time and I was afraid that the health care staff might not be confident" (P. 9).

4. DISCUSSION

Iran is among the countries where the trend of getting AIDS has not only failed to decline during the past 15 years, but it has been rising continuously [4]. Various studies have been done on the problems of HIV-positive patients in Iran, but they have been mainly conducted in large cities with a high urban population, including Tehran (urban population of 7.8 million), Isfahan (urban population of 2.1 million), Kerman (urban population of 632 thousand people), and Shiraz (urban population of 1.7 million) [24 - 30]. However, small cities (urban population less than 100,000 people) and rural areas have their own problems, and the patients living in these areas should also be taken into consideration [16].

4.1. Patients' Experiences Before Referral

The findings of this study showed that one of the problems of HIV-positive patients before referring to receive health care services is their unpleasant experiences, including the fear of disease disclosure (to health care staff, neighbors, relatives and acquaintances). Results of the study by Cook *et al*., in 2015 showed that in rural and small communities in northern Florida, HIV patients have fears of issues such as confidentiality and privacy; and the fear of being recognized by friends and acquaintances working in health care centers and the fear of disease disclosure were the major causes of not patronizing health care services. Furthermore, the limited number of service providing centers was another problem for HIV patients [16]. The results of Cook *et al*., study are consistent with those of the present study. But the results of the studies conducted in large cities are not consistent with our study results and they did not report the fear of disease disclosure among HIV patients [13, 27, 28, 30, 31].

It is recommended that health system authorities and policy makers design and implement public education programs for the general public, introduce health mobile services to provide Tele-counseling to HIV patients, and provide online appointment reservation and scheduling mechanisms for health care services through telephone and Internet.

The findings of this study showed that another problem of HIV-positive patients before the referral for health services was the fear of inappropriate attitude of health care personnel. Cook's findings also showed that the fear of inappropriate behaviors in the community prevented the patients from engaging in their care process [16]. But in 2011, Kagashe *et al*., conducted a study on patient satisfaction with health care services provided in HIV clinics. The results of their study showed that 97.3% of the doctors in Amana Clinic and 93.2% of the doctors in the Muhimbili Clinic had a friendly behavior with the patients [32]. It is recommended that the authorities in Iran take into consideration the measures taken in other countries regarding the appropriate behaviors towards HIV patients and use their effective experiences.

In the process of learning from other countries' experience, the focus should be on health care providers. For this, it is suggested that training courses for health care personnel should be planned, implemented and assessed. Appropriate legislation and legal support of HIV patients against inappropriate treatment and discrimination can help to reassure them on the health system.

Another problem of the patients before referral was inadequate patient support. The patients are confronted with a limited number of service-providing centers and inadequate facilities. The participating patients expected HIV service providers to be introduced to them. They also expected to be provided with more facilities such as dentistry services at

the Behavioral Disease Consulting Center. The patients expected more support from the community and the health system. The UNAIDS report on MENA countries emphasized that in areas where governmental and nongovernmental support was low, working with high-risk populations and groups was really difficult. The report also emphasized that the participation and capacity of social organizations in the countries of the region were limited and needed to be redesigned in accordance with the needs of HIV patients [33]. It is recommended that more legal supports be provided for HIV patients and the number of service providers, especially in less populated areas should be increased. Providing sufficient equipment and trained personnel is also recommended for behavioral disorders counseling centers.

4.2. Patient Experiences During Referral

The results of this study showed that one of the problems of the participating patients was the inappropriate attitude of the personnel when they referred to the health care centers. The inappropriate attitude included discrimination, humiliation of the patients, rejection of the patients by the personnel, and patient refusal. In 2012, a study was conducted by Thanh *et al*., in Vietnam. The findings of the study showed that discrimination against HIV-positive patients in the community and in the health sector was common and prevented the search for and use of HIV-related services by the patients [13]. Karamouzian *et al*., also showed in their study that HIV patients had experienced verbal and non-verbal blames by service providers [28]. The results of that study are consistent with those of the present study. Zeighami Mohammadi's study of nurses showed that there was a significant relationship between the fear of the risk of HIV/AIDS and discrimination against the care and treatment of AIDS patients [26]. Hence, one strategy was to educate health and medical personnel. Besides, providing appropriate facilities for the care of HIV patients might help correct the inappropriate behaviors exhibited by the health care personnel.

The UNAIDS report emphasized that stigma and discrimination were among the threats faced by MENA countries. Stigma and discrimination were some of the main reasons why HIV-infected people or at-risk populations did not have access to essential HIV services. Discrimination and stigma also limited the effectiveness of the response to HIV in this region [33].

The findings of this study showed that one of the patients' experiences when visiting the hospitals and health centers was their disease concealment. Disease concealment might occur for various reasons such as the fear of being rejected, the fear of not being admitted, and the fear of a change in the attitude of health care personnel. In their study, Fallahi *et al*., examined 330 patients who referred to three behavioral disease clinics in Tehran. The results of their study showed that 40% of HIV-positive patients had not informed their treatment team about their disease when using dentistry services, and the most common reason for this was their fear of not being admitted by the health staff [34]. Concealment of the disease by the patients can cause the disease to be transmitted to other people. Therefore, disease concealment has to be reduced by providing the patients with the necessary services and gaining their trust. One measure that can be taken in this area is to use HIV patients to provide services to other HIV patients.

The results of this study showed that the patients were having numerous difficulties in terms of receiving health care services. Some of these difficulties included a long waiting period for receiving the services, prevention of people from providing services to HIV-positive patients, and imposing unnecessary travels. Therefore, in some cases, HIV patients had to travel to neighboring cities to receive appropriate services. The patients' experiences of having problems in the community in terms of not being provided with services and traveling to other cities are among the issues not mentioned in other studies conducted in Iran [25, 27, 30] and other countries [16, 31].

Another problem of the patients was the financial constraints when receiving health care services. This category of experiences included high drug costs, costs of medical testing, and the patients' inability to afford the costs. In the study by Nasirian and Haghdoust [30], it was found that the high cost of medical tests was one of the reasons for not referring for treatment. In their study, Shakuri *et al*., showed that HIV had a devastating effect on the patients' financial status [25]. Limited financial resources had been one of the causes of the HIV patients' reluctance to use health services in Vietnam [35]. Therefore, in order to prevent the creation of a ring of poverty and disease, necessary measures should be taken to cover HIV patients with insurance, or increase their financial access by providing free services to them.

4.3. Patient Experiences After Receiving Services

Psychological stress has been one of the experiences of HIV patients after receiving health care services. Some of the stresses experienced by the patients participating in the study included despair, anger, regret, suicidal thoughts, depression, and feeling of guilt. The stresses experienced by the patients were due to the inappropriate attitudes and the problems encountered when receiving health care services. In the study by Rahmati the HIV patients had experienced

waiting for death, suicide attempts and feeling of hopelessness due to HIV stigma [27]. Given the fact that there is an inverse relationship between the high levels of psychological problems, especially depression, and the follow-up of the treatment process by HIV patients [36], it might be said that depression and psychosocial problems will adversely affect the attainment of the goals set for coping with HIV.

The results of this study showed that patients' information has been disclosed in some cases, and this has caused them to be expelled from work consequently leading to their distrust in the health care personnel. Disclosing the patients' information has not only led to their job abandonment but also to the lack of referring again or even concealing their disease in future referrals. Job abandonment, dismissal [27], and exclusion at the workplace (13) were among the experiences of HIV patients in other studies as well.

CONCLUSION

The problems of HIV patients were classified into three main themes: before, during, and after referral. On the whole, what HIV patients experienced from healthcare system of the rural/small cities in Iran was not good, as they faced certain barriers for using health care services. Patients who wish to participate in disease prevention programs should trust the HIV care system and use the required services easily. Appropriate and necessary services should also be provided in a supportive and stress-free environment for these patients.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

This study was reviewed and approved by the Ethics Committee of Lorestan University of Medical Sciences, Iran (No. IR.LUMS.REC.1394.131) before commencement.

HUMAN AND ANIMAL RIGHTS

All the reported experiments in accordance with the ethical standards of the committee responsible for human experimentation (institutional and national), and with the Helsinki Declaration of 1975, as revised in 2013 (http://ethics.iit.edu/ecodes/node/3931.

CONSENT FOR PUBLICATION

Written and informed consent was obtained for the study.

CONFLICT OF INTEREST

The authors declare no conflict of interest, financial or otherwise.

ACKNOWLEDGEMENTS

Hereby, the authors would like to thank the participants who spent their worthwhile time to contribute in the study. This paper was extracted from a project that is supported by Lorestan University of Medical Sciences, (grant no.A-10-1479-1; ethical code: LUMS.REC.1395.133).

REFERENCES

[1] WHO. Fact sheet 2017. Available from: http:// www.who.int/ mediacentre/ factsheets/fs360/en/ [cited 2017 May 3].

[2] WHO. 10 facts on HIV/AIDS 2017. Available from: http:// www.who.int/ features/ factfiles/ hiv/en/ [cited 2017 May 3].

[3] WHO. Global Health Observatory (GHO) data: Number of people newly infected with HIV/AIDS: WHO; 2017. Available from: http:// www.who.int/ gho/hiv/epidemic_status/ incidence/en/ [cited 2017 May 3].

[4] WHO. Global Health Observatory data repository: Number of people (all ages) living with HIV Estimates by country WHO; 2017. Available from: http:// apps.who.int/ gho/data/ node.main.620?lang=en [cited 2017 May 3].

[5] WHO. Country Factsheets; Islamic republic of iran: HIV and AIDS Estimates; 2017. Available from: http:// aidsinfo.unaids.org/ [cited 2017 Aug 8].

[6] Turan B, Hatcher AM, Weiser SD, Johnson MO, Rice WS, Turan JM. Framing mechanisms linking HIV-related stigma, adherence to treatment, and health outcomes. Am J Public Health 2017; 107(6): 863-9.
[http://dx.doi.org/10.2105/AJPH.2017.303744] [PMID: 28426316]

[7] Nöstlinger C, Rojas Castro D, Platteau T, Dias S, Le Gall J. HIV-Related discrimination in European health care settings. AIDS Patient Care STDS 2014; 28(3): 155-61.
[http://dx.doi.org/10.1089/apc.2013.0247] [PMID: 24568694]

[8] Remien RH, Bauman LJ, Mantell J, *et al.* Barriers and facilitators to engagement of vulnerable populations in HIV primary care in New York City. Journal of acquired immune deficiency syndromes 2015 May 1;69(0 1):S16.

[9] Mawar N, Saha S, Pandit A, Mahajan U. The third phase of HIV pandemic: Social consequences of HIV/AIDS stigma & discrimination & future needs. Indian J Med Res 2005; 122(6): 471-84.
[PMID: 16517997]

[10] Valencia-Garcia D, Rao D, Strick L, Simoni JM. Women's experiences with HIV-related stigma from health care providers in Lima, Peru: "I would rather die than go back for care". Health Care Women Int 2017; 38(2): 144-58.
[http://dx.doi.org/10.1080/07399332.2016.1217863] [PMID: 27485767]

[11] Global Health Sector Strategy on HIV/AIDS 2011–2015. Geneva: World Health Organization 2013.

[12] Bharat S, Mahendra VS. Meeting the sexual and reproductive health needs of people living with HIV: Challenges for health care providers. Reprod Health Matters 2007; 15(29)(Suppl.): 93-112.
[http://dx.doi.org/10.1016/S0968-8080(07)29030-5] [PMID: 17531750]

[13] Thanh DC, Moland KM, Fylkesnes K. Persisting stigma reduces the utilisation of HIV-related care and support services in Viet Nam. BMC Health Serv Res 2012; 12(1): 428-37.
[http://dx.doi.org/10.1186/1472-6963-12-428] [PMID: 23176584]

[14] Ghorbani G, Alishiri G, Joneidi N, Esfehani E, Hoseini S. Effect of education on knowledge and attitude of nurses after twenty years after epidemic of AIDS. Iran J Clin Infect Dis 2005; 11(35): 85-9.

[15] Holtzman CW, Shea JA, Glanz K, *et al.* Mapping patient-identified barriers and facilitators to retention in HIV care and antiretroviral therapy adherence to Andersen's Behavioral Model. AIDS Care 2015; 27(7): 817-28.
[http://dx.doi.org/10.1080/09540121.2015.1009362] [PMID: 25671515]

[16] Cook CL, Lutz BJ, Young M-E, Hall A, Stacciarini J-M. Perspectives of linkage to care among people diagnosed with HIV. J Assoc Nurses AIDS Care 2015; 26(2): 110-26.
[http://dx.doi.org/10.1016/j.jana.2014.11.011] [PMID: 25665884]

[17] Kalichman SC, Pellowski J, Kalichman MO, *et al.* Food insufficiency and medication adherence among people living with HIV/AIDS in urban and peri-urban settings. Prev Sci 2011; 12(3): 324-32.
[http://dx.doi.org/10.1007/s11121-011-0222-9] [PMID: 21607719]

[18] Reif S, Golin CE, Smith SR. Barriers to accessing HIV/AIDS care in North Carolina: Rural and urban differences. AIDS Care 2005; 17(5): 558-65.
[http://dx.doi.org/10.1080/09540120412331319750] [PMID: 16036242]

[19] Yaghoobi H, Ahmadiniya H, Shabani Z, Vazirinejad R, Zolfizadeh F, Rezaeian M. The epidemiological investigation of patients with HIV/AIDS in bandar abbas behavioral disorders counseling center during 2005-2015. JRUMS 2018; 16(10): 969-82. http:// journal.rums.ac.ir/ article- 1- 3815-en.html

[20] Mehrdad R. Health system in Iran. JMAJ 2009; 52(1): 69-73.

[21] Hajbagheri A, Parvizi S, Salsali M. Qualitative research methods Tehran. Boshra publishing 2009.

[22] Pickard A. Research Methods in Informaton. London: Facet Publishing 2007.

[23] Patton MQ. Designing qualitative studies. Qualitative research and evaluation methods 2002; 3: 230-46.

[24] Savabi O, Hasankhani A, Mohamadikhah Z. The attitude and practice of dentists in relation with HIV and HBV infected patients in isfahan province. Indian J Med Educ 2011; 10(5): 868-85.

[25] Shakoori A, Darkesh M. The explorative study of the Socio-Economic state of HIV affected patients in iran (The Case of Patients of the Infectious Sector in Imam Khomeini Hospital). Journal of Social Problems of Iran 2013; 4(1): 21-43.

[26] Zeighami-Mohamadi S, Zeinali E, Esmaily H, Nikbakht-Nasrabadi A. Fear of being at risk of acquiring HIV, willingness to care, and discrimination in care and treatment of AIDS patients among nurses. Scientific Journal of Iranian Blood Transfusion Organization 2011; 8(3): 217-28.

[27] Rahmati-Najarkolaei F, Niknami S, Amin-Shokravi F, Ravari A. HIV/AIDS patients' experiences about stigma: A qualitative study. Journal of Qualitative Research in Health Sciences 2012; 1(2): 71-80.

[28] Karamouzian M, Akbari M, Haghdoost A-A, Setayesh H, Zolala F. "I am dead to them": HIV-related stigma experienced by people living with HIV in Kerman, Iran. J Assoc Nurses AIDS Care 2015; 26(1): 46-56.
[http://dx.doi.org/10.1016/j.jana.2014.04.005] [PMID: 24856436]

[29] Zeighami-Mohamadi S, Zeinali E, Esmaily H, Nikbakht-Nasrabadi A. Nurse's perspective about discrimination in nursing care of patients with AIDS. Iran Journal of Nursing 2011; 24(71): 28-41.

[30] Nasirian M, Haghjou L, Mounesan L, Kamali K, Haghdoost A-A. Sexually transmitted disease surveillance status in iran from the viewpoint of involved experts and practitioners. Journal of Health & Development 2015; 4(3): 259-76.

[31] Wanyenze RK, Matovu JK, Kamya MR, Tumwesigye NM, Nannyonga M, Wagner GJ. Fertility desires and unmet need for family planning among HIV infected individuals in two HIV clinics with differing models of family planning service delivery. BMC Womens Health 2015; 15(1): 5.

[http://dx.doi.org/10.1186/s12905-014-0158-x] [PMID: 25627072]

[32] Kagashe GA, Rwebangila F. Patient satisfaction with health care services provided at HIV clinics at Amana and Muhimbili hospitals in Dar es Salaam. Afr Health Sci 2011; 11(3)(Suppl. 1): S60-6.
[PMID: 22135647]

[33] Middle East and North Africa - Regional Report on AIDS: 2011. UNAIDS 2011.

[34] Fallahi H, Fotohi A, Farzadi F, Yonesian M, Almasi F. HIV-positive individuals utilization of dental services PAYESH 2008; 7(1): 59-60. Persian.

[35] Maher L, Coupland H, Musson R. Scaling up HIV treatment, care and support for injecting drug users in Vietnam. Int J Drug Policy 2007; 18(4): 296-305.
[http://dx.doi.org/10.1016/j.drugpo.2006.12.006] [PMID: 17689378]

[36] Yoo-Jeong M, Waldrop-Valverde D, McCoy K, Ownby RL. A structural equation model of HIV-related symptoms, depressive symptoms, and medication adherence. J HIV AIDS 2016; 2(3)
[http://dx.doi.org/10.16966/2380-5536.123] [PMID: 27695710]