Original Article

Aspects Influencing Access to HIV/AIDS Services among Afghan Immigrants in Iran: A Qualitative Study

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Received: 22 July 2021 **Revised:** 23 October 2021 **Accepted:** 25 October 2021

Abstract

Background: A successful response to the risk of human immunodefficiency virus (HIV) infection among immigrants requires improved access to HIV prevention, diagnosis, and treatment services. However, most immigrants face significant challenges in accessing HIV/AIDS services. The aim of this study was to explore the aspects influencing access to HIV/AIDS services among Afghan immigrants in Iran.

Methods: This was a qualitative study using conventional content analysis that was conducted from June 2018 to April 2020 in Tehran, Iran. Purposeful sampling method was performed. We conducted 25 semi-structured interviews with three groups of stakeholders including Afghan immigrants infected with or at risk of HIV (n=8), service providers (n=8), and policymakers/managers/experts (n=9). Inductive qualitative content analysis was applied according to the Granheim and Lundman method. Data were analyzed using Open Code software version 4.03.

Results: Aspects influencing access to HIV/AIDS health services were categorized into 3 themes (that were extracted from 9 categories): 1. Cultural aspects (cultural similarities and differences, values and beliefs); 2. Psychosocial aspects (social support, stigma and discrimination); and 3. Service delivery related aspects (awareness, health services coverage and integrity, health services financing, accessibility, and continuity of care).

Conclusion: The findings suggest that efforts to improve Afghan immigrants' access to HIV/AIDS health services in Iran need to consider the cultural aspects, increasing HIV awareness, providing support, reducing stigma and discrimination, and improving health services coverage, integrity, financing, and continuity of accessible services.

Keywords: Accessibility, Acquired immunodeficiency syndrome, Health services, Human immunodefficiency Virus, immigrants

Please cite this article as: Ghasemi E, Rajabi F, Majdzadeh R, Vedadhir AA, Negarandeh R. Aspects Influencing Access to HIV/AIDS Services among Afghan Immigrants in Iran: A Qualitative Study. IJCBNM. 2022;10(3):172-183. doi: 10.30476/IJCBNM.2021.91724.1805.

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Introduction

Despite international efforts for human immunodefficiency virus (HIV) prevention and treatment, many people at risk or those who are suffering from the disease do not have access to such services; thus, HIV remains a major public health issue around the world.[1, 2] According to the Joint United Nations Programme on HIV/AIDS (UNAIDS) statistics, in 2020, there were 37.7 million people globally living with HIV, 1.5 million new HIV cases have been identified, and 680000 people have died from the illnesses related to acquired immune deficiency syndrome (AIDS).[3] Immigrants are known as one of the groups vulnerable to HIV.[4, 5] Several studies have reported higher rates of HIV among immigrants, especially those coming from high epidemic origins, compared to the general population of the host countries.[6-8]

According to the evidence, the risk of HIV infection among immigrants can be related to various determinants at different levels of policymaking, socio-cultural context, physical and mental health, and their sexual behaviors.[5, 9] A systematic review reported high rates of HIV risk behaviors, such as unprotected sex, alcohol and drug use among immigrant and ethnic minority populations.[10] The results of a study on high-risk sex and displacement among refugees and surrounding populations in 10 countries showed that multiple sexual partnerships varied from 2.7% to 32.5%. Moreover, condom use in the last sex was low in most of the communities (<5%).[11] Regarding drug use, a previous study among Afghan refugees in Pakistan reported that 23% had ever used drugs, and 7% had ever injected drugs.[12]

A successful response to the risk of HIV infection among immigrants requires improved access to HIV prevention, diagnosis, and treatment services. Early diagnosis and then treatment can improve the quality of life and health outcomes in such patients[13, 14] and reduce the risk of HIV transmission.[6] However, most immigrants face significant challenges in accessing HIV/AIDS care and treatment services. A variety of individual, social, and economic as well as migration and structural aspects were identified as barriers to HIV services utilization and treatment challenges.[14, 15]

Political, economic, security and war conditions in Afghanistan have led to a significant movement of immigrants to neighboring countries such as Iran.[16] Despite fluctuations in the number of Afghan immigrants in Iran in recent years, approximately 1.5 million documented and one million undocumented immigrants reside in Iran.[17] Various studies have identified poor economic, social, cultural, and political conditions among Afghan immigrants that could expose them to behaviors that adversely affect their health.[16, 18, 19] A global systematic review reported that traumatic experiences and mental health problems resulting from migration challenges may put displaced populations, including Afghan refugees, at risk of substance use.[20] On the other hand, low socioeconomic status has been reported among Afghan immigrants in Iran,[16, 18] and it is important because economic vulnerability could make migrants more likely to engage in high-risk activities, such as sex work and other forms of transactional sex.[5]

In Iran, in order to respond to the HIV/AIDS epidemic, the AIDS Supreme Council was established one year after the first case of AIDS; then, harm reduction programs were implemented, and drop-in centers and triangular clinics were established.[21] Currently, HIV/AIDS prevention and treatment services such as free counseling, testing, condoms, and antiretroviral therapy (ART) are provided in Behavioral disorders Consulting Centers.[22] Given the significant number of Afghan immigrants, and the vulnerability of this group,[19] primary health services are also offered to Afghan immigrants regardless of their immigration status.[16] According to the evidence, there are a few studies on HIV and access to healthcare services among this population.[16, 18] Exploring the contextual aspects affecting access to healthcare services

plays an important role in planning and implementing the interventions. Qualitative research enables the researchers to have a deeper understanding of the phenomenon.[23] Inductive content analysis is used to describe the phenomenon in studies where there is not enough knowledge, or when it is fragmented. One of the advantages of this method is the direct collection of data from individuals.[24] Therefore, the present qualitative study was conducted to explore the aspects influencing the Afghan immigrants' access to HIV/AIDS services in Iran.

Materials and Methods

This qualitative study is a conventional content analysis that was carried out between June 2018 and April 2020 in Tehran, Iran. The inclusion criteria were: 1) Afghan immigrants living with HIV, or those who are at risk of the disease because of HIV risk behaviors in themselves or their sexual partner including injection drug use or having multiple sexual partners; 2) Those who provide services regarding HIV/AIDS prevention and treatment to immigrants in governmental and non-governmental organizations; and 3) Policymakers, managers, or experts who are directly or indirectly involved in making decisions related to HIV/AIDS prevention and treatment services. The only exclusion criterion was lack of willingness to continue the study. Purposeful sampling was performed considering the maximum variation, especially for immigrants (age, sex, education, marriage, migration status, and during of residence in Iran). The target immigrants and service providers were selected in different areas covered by primary health care centers in Tehran. In these centers, the first author examined the immigrants' health records and identified the immigrants who had HIV risk behaviors, as well as immigrants with HIV/AIDS diagnosis. To access the immigrants who did not refer to the centers, the snowball sampling method was applied. Eligible service providers and policymakers/managers/experts who met the study inclusion criteria were also selected to participate in the present study. The sampling procedure continued until data saturation was reached. Based on the inclusion and exclusion criteria, a total of 25 participants including Afghan immigrants infected with HIV (n=3) or at risk of HIV (n=5), service providers (n=8), and policymakers/managers/experts (n=9) were enrolled in the study.

The data were collected through 25 in-depth and semi-structured interviews by the first author as a PhD student. Prior to each interview, the researcher tried to build trust in immigrants through appropriate communication. In addition, a male researcher trained for qualitative interview assisted in conducting interviews with male immigrants. Each interview lasted 50-120 minutes and was completed in one session. The researcher recorded the interviews using a voice recorder. The interview questions were checked according to an interview guide. Some sample questions included (Immigrants' questions): "Please talk about living with HIV/AIDS? What did you do when you found out you were infected? What problems did you have when applying for services?" In cases they had high-risk behaviors, they were asked questions such as: "Talk about your addiction experience? In your opinion, what diseases might you get in case of drug injection or out-of-marriage relationships? What measures should be taken to prevent these diseases?" The service provider/policymaker' questions were: "Would you talk about your experience of decision making/providing HIV prevention and treatment services to immigrants? What do you think of the barriers or facilitators to access these services?"

The data were analyzed using qualitative content analysis, as proposed by Graneheim and Lundman.[25] The analysis process was conducted by the first and last authors. First, the recorded interviews were transcribed verbatim, the contents were reviewed several times, and meaning units were identified. The meaning units were then coded after several reviews by two authors. The codes were compared in terms of similarities and

differences. These were then reviewed, compared, and grouped to determine the categories. Similar categories were merged, and themes were extracted. Open Code software version 4.03 was used to apply the coding process. Given the addition of the interviews, the data analysis was constantly repeated, and the categories were modified accordingly.

Lincoln and Goba (1985) described credibility, dependability, confirmability, and transferability as the criteria to ensure the trustworthiness of the qualitative data.[26] Accordingly, different strategies were used in the present study to increase the credibility of the data including allocation of sufficient time for data collection, triangulation of data sources (interviews with the three groups of stakeholders including immigrants, service providers, and policymakers/managers/experts), frequent peer checking on the data, and member checking. A rich description of the participants and study context may increase the data transferability. Besides, the research team provided a rich description of the study methods to assure dependability. Confirmability was guaranteed by a weekly investigators' meetings and audit trials.

This study was reviewed and approved by the Ethics Committee of Tehran University of Medical Sciences, Iran (IR.TUMS.VCR.REC.1396.4171). Before conducting the interview, the study' objectives and necessary explanations were provided in a private room. The participants were informed that anonymity would be guaranteed, attendance was voluntary, and they could withdraw from the study whenever they wished. Moreover, oral and written consent was taken for participation and recording the interviews.

Results

The mean age of the immigrants was 39.87 (range: 23-78 years). Only one of the immigrants was covered by health insurance (P1). All the immigrants belonged to the Hazara ethnicity, and their average length of stay in Iran was 30.5 years (range: 23-36). Three migrants (P1-P3) were infected with HIV, and their duration of infection was 5, 4, and 3 years, respectively. The service providers' mean age was 38.37 years (range: 28–51), with an average working experience of 13.5 years (range: 6–30). Policymakers/managers/experts' mean age was 51.55 years (range: 39-74) with an average working experience of 20.44 years (range: 8-40). Other demographic information is presented in Tables 1 and 2.

Based on the results of the content analysis, the aspects involved in Afghan immigrants' access to HIV/AIDS prevention services (education, counseling, HIV test, and condom) and treatment services (ART, visits, counseling

Table 1: The Afghan immigrants' demographic information (n=8)

Participants	Age (year)	Sex	Education	Occupation	Marital status	Migration status	Residence in Iran (year)	Job experience (year)
P1*	37	Female	Primary school	Housewife	Married	Undocumented	36	-
P2*	32	Female	Secondary school	Labor	Married	Undocumented	32	2
P3*	32	Female	Illiterate	Labor	Married	Documented	32	3
P4□	36	Male	Primary school	Unemployed	Married	Undocumented	30	-
P5□	53	Male	Primary school	Labor	Married	Documented	27	30
P6□	23	Male	Secondary school	Labor	Single	Undocumented	23	8
P7□	78	Male	Illiterate	Unemployed	Single	Undocumented	36	-
P8□	28	Male	Illiterate	Unemployed	Single	Undocumented	28	-

*Immigrants living with HIV; □Immigrants who were at risk of HIV

Table 2: The service providers and policymakers/managers/experts' demographic information (n=17)

Participants		Age (year)	Sex	Field of Study	Job experience (year)
Service providers (n=8)	P9	31	Male	MS[a] in Clinical Psychology	8
	P10	51	Male	MD[b]	30
	P11	45	Male	MD	20
	P12	31	Male	BS[c] in Public Health	7
	P13	28	Female	MS in Social Work	6
	P14	42	Male	MD	15
	P15	32	Male	MS in Clinical Psychology	6
	P16	47	Female	MD	22
Policymakers/managers/experts (n=9)	P17	49	Male	MD	23
	P18	52	Male	MD, MPH[d]	23
	P19	48	Female	MD	19
	P20	62	Female	MD, MPH, Community and Preventive Medicine Specialist	21
	P21	50	Female	PhD in Communication Sciences	20
	P22	43	Male	PhD in Demography	15
	P23	74	Female	MD,MPH, Infectious Disease Specialist	40
	P24	47	Male	MD,MPH, Community and Preventive Medicine Specialist	15
	P25	39	Female	PhD in Nursing	8

a. Masters of Science; b. Doctor of Medicine; c. Bachelor of Science; d. Master of Public Health

Table 3: Subcategories, categories, and themes of the study

Subcategories	Categories	Themes
Religious and linguistic similarities Different accent	Cultural similarities and differences	Cultural aspects
Male-dominated culture Collectivism Compliance with healthcare	Values and beliefs	
Supportive role of family, friends and community Addiction as a barrier to receiving support	Social support	Psychosocial aspects
Stigma manifestations HIV concealment Lack of anti-discrimination laws and programs	Stigma and discrimination	
Poor HIV educational policies Limited exposure to HIV information	Awareness	Service delivery related aspects
Service availability Fragmentation of healthcare	Health services coverage and integrity	
International funding opportunities Affordability	Health services financing	
Time Distance	Accessibility	
Turnover of service providers Displacement of immigrants	Continuity of care	

and training, laboratory test, and vaccines) were categorized into 3 themes: Cultural, Psychosocial, and Service delivery related aspects. According to Table 3, these themes were extracted from 9 categories and 20 subcategories.

1. Cultural Aspects

This theme describes the impact of the immigrants' cultural characteristics on their access to HIV prevention and treatment.

Categories that comprise this theme were "cultural similarities and differences" and "values and beliefs"

1.a. Cultural Similarities and Differences

Given that Afghan immigrants belong to the Hazara ethnicity and because of religious and linguistic similarities with Iranian culture, their access to HIV prevention and treatment services are facilitated. However, the Afghan immigrants' accent has sometimes prevented effective communications and made it difficult to receive HIV prevention and treatment services. One of the participants stated: *"Many Afghans have difficulty speaking the formal language; that is, they cannot properly raise their issues. Even those with good command of Persian may have an accent and many of them usually convey their words through a mediating person which can interfere with their communications" (P14).*

1.b. Values and Beliefs

Some values in Afghanistan, such as the male-dominated culture, have imposed restrictions on the use of HIV services. Regarding the use of medical services, women usually tend to hide their problems and ignore talking about the manifestations of probable sexual diseases due to the fear of losing their spouses. Not only did men resist using HIV services, but also, as the family decision-makers, they sometimes even prevented women from seeking such services. One of the service providers asserted: *"Some Afghan women have to prevent the condom use because their husbands do not like to use one" (P13).*

Collectivism and belonging to the community of friends or relatives has been identified as an important factor in using preventative services such as Drop-In Center services in addicted Afghans. One of the managers believed that in addition to facilitating receiving group support, collectivism has prepared the ground to use HIV prevention training services among peers through social learning opportunities (P22). In terms of receiving treatment services in hospitals, a healthcare provider said: *"Afghans usually have support groups among themselves. There is a leader in each group of friends or coworkers who takes charge of the others, especially if one of them gets sick." (P11).* Furthermore, compliance with healthcare interventions facilitated the use of preventive and treatment services. One of the physicians said: *"During the years I worked with Afghans, I saw that they were very persistent in their treatment, and when they went to a doctor, they took their treatment very seriously". (P10)*

2. Psychosocial Aspects

The psychosocial aspects were identified as another theme related to HIV prevention and treatment utilization. Categories that comprised this theme were "social support" and "stigma and discrimination".

2.a. Social Support

The supportive role of family and community resources (such as friends, peers, service providers, and non-governmental organizations (NGOs)) was identified as a facilitator for access to HIV/AIDS services. *"Family support is very important. One of my patients is always accompanied by his brother and they show up on time. However, if the patient does not have any support, he should withstand much pressure which, therefore, affects the continuity of the treatment..." (P9).* On the other hand, addiction was considered as one of the important barriers to receiving financial and emotional support from family, friends, or community. Failure to receive such support was identified as another barrier to HIV service utilization.

2.b. Stigma and Discrimination

Manifestations of HIV-related stigma were described as fear, stress, blame, rejection, and social isolation. These feelings or experiences were perceived from various sources including family, relatives, friends, community, and service providers. Concealment of the disease

and unwillingness to seek the related services were identified as the outcomes of stigma. One of the immigrants who was infected with HIV, along with his husband and child, also stated that: *"No one in my family knows about my infection, at all! I think they may leave us if they know about it.* Tearful, she continued: *"Once I told a doctor about my problem and the doctor reacted so strangely and badly that I decided not to see him anymore" (P2).* Another immigrant who was at risk of infection said: *"I'm afraid to get tested for HIV. Because if I am infected, I will be ashamed and I may be rejected from my family."(P4).*

Inefficient policies and training programs for healthcare providers and the lack of anti-discrimination laws led to increased discrimination in access to HIV services. One of the policymakers, as a specialist in infectious disease, asserted that: *"I can still feel the fear of horrible social stigma. My patient saw a dentist and told him/her that she is infected with HIV. The dentist, then, had thrown away her medical file and said to her that you enjoyed your moments and now you are here to make me infected as well?" (P23).*

3. Service Delivery-related Aspects

Aspects related to service delivery were defined in four categories of "awareness", "health services coverage and integrity", "health services financing", "accessibility", and "continuity of care".

3.a. Awareness

Poor education policies about HIV/AIDS to various groups including immigrants, the community, healthcare providers, and several organizations have led to a lack of awareness, increased stigma and discrimination, and ultimately reluctance to receive such services. Not only immigrants, but also various organizations were unaware of the existing services. Besides, immigrants had very little information regarding HIV. When one of the immigrants with addiction issues was asked about HIV transmission, he said: "*Such diseases are due to lack of hygiene. For example, my friend got HIV because he collects garbage from the trash. I told him to stay away from me so that HIV would not be transmitted to me". (P5)*

3.b. Health Services Coverage and Integrity

The Iranian health system provides HIV services to documented or undocumented immigrants. This issue was identified as a facilitating factor to improve the access to such services for Afghan immigrants at the policymaking level. However, because of the lack of integration and comprehensive coverage of such services, Afghan immigrants had to be referred to other centers to receive some specialized, para-clinical, or dental services. As a result, they could refrain from receiving these services. One policymaker believed that: *"The most important reason for limited access to these services is that the coverage is poor" (P18).* One of the HIV infected immigrants also said: *"This center does not provide specialized dental care. Once I went to a dental clinic; when I said I was HIV positive, they said they would not do anything for me, and asked me to go somewhere else". (P1)*

3.c. Health Services Financing

Regarding the policy level, international funding opportunities for the allocation of health programs to immigrants have played an important role in raising policymakers' attention to Afghan immigrants in HIV control programs: *"At the moment, a variety of the United Nations agencies are helping to control HIV in Iran. Given that the issue of immigrants and refugees has become very prominent in the world, they have required that the majority of their funding supports should depend on the fact that a certain percentage of these groups should be spent in the programs designed for the immigrants and refugees" (P21).* Providing free HIV treatment for Afghan immigrants, similar to that of Iranian patients, facilitated the utilization of services. However, the costs of some services

such as some laboratory tests, specialist visit fees, pneumococcal vaccine, and hospital services would have made it difficult to access such services. In the case of HIV prevention services, at-risk immigrants did not seek these services because they were afraid of the costs. Furthermore, the use of HIV prevention and treatment services required additional costs of commuting and leaving the job. One of the immigrants said: *"When I found out I was infected with HIV, I was shocked! I thought that there were three of us (my infected spouse and child) and how could we afford to buy the costly drugs. However, it was a relief when I heard that the services were free in this public center, for instance, the drugs, visits, blood tests, and gynecological healthcare... But, if we have to go to a doctor's office or a hospital, it would be really expensive because we are poor. We don't have any insurance support. Moreover, the costs of commuting will also be added to this list" (P2).*

3.d. Accessibility

Regarding the location of the service, the time as well as the distance to receive the service impact the utilization of HIV services. Given that immigrants are among the marginalized groups and face various obstacles while referring for and using HIV services, healthcare providers and policymakers believed that it was necessary to pay attention to the accessibility of services in Afghan's colonies and providing outreach services for them. Patient participants said:

"Sometimes I have to take my daughter out to the doctor because it takes me a while to get here" (P2).

"This center also give counseling to our families, but they live far from here and do not come here. Thus, they do not understand how the disease is transmitted" (P3).

3.e. Continuity of Care

Given the unstable conditions of immigrants' residence and/or turnover of doctors or healthcare workers, it would be difficult to keep the continuity of care to Afghan immigrants. Furthermore, those immigrants who did not have residence permits were sometimes reluctant to pursue prevention and treatment services due to the fear of being arrested. The immigrants were particularly reluctant to receive HIV prevention services such as condoms, education, etc. which require trust and comfort with the service provider. Regarding the use of treatment services, the immigrants' displacements interfere with the regular periodic visits and receiving ART. One of the healthcare providers believed that: *"All healthcare providers who are involved in this field must constantly take part in the process because they get to know each other (service providers and the clients) and it will be easier for the Afghan immigrants to seek the services, especially for sexually transmitted diseases. However, the doctors' turnover is high in the healthcare system" (P14).*

Discussion

The findings of the present study showed that, from the perspective of the immigrants, healthcare providers, and policymakers/managers/experts, the Afghan immigrants' access to HIV prevention and treatment services is affected by cultural, psychosocial, and service delivery related aspects in the context of Iran.

The cultural similarities between Afghan immigrants and Iranians, collectivism, and compliance with healthcare services were among the cultural aspects that could facilitate the use of HIV services. Culture includes norms, values, beliefs, traditions, behaviors, and other cultural patterns that immigrants have brought from their homeland and can influence their tendency to use such services.[27] The immigrants who participated in the present study had lived in Iran for a long time (with an average of 30.5 years). Besides, some of them belonged to the second generation of immigrants in Iran which made them feel engaged and comfortable living in Iran and using such services. However, the Afghan immigrants' accent was considered as a communication barrier to access such

services. Similar to our finding, a previous study mentioned linguistic barriers in communications as the barriers to access and use of HIV tests among the immigrants.[14]

According to our findings, the male-dominated culture in Afghan society prevented women from talking about sexual issues and made them ask for permission from their husbands if they wished to use such services. The results of a qualitative study also showed that Tajik male migrant workers' wives were unable to talk about their concerns regarding sexual activities, HIV/AIDS, condom use, and HIV testing because of gender norms limitations in a male-dominated society.[28]

The free access to HIV services such as ART, visits, and periodic laboratory tests for the immigrants was the aspect facilitating their access to such services regardless of the legal status of their migration. However, the immigrants' economic and occupational conditions, lack of insurance, and lack of financial support were among the barriers that limited the use of costly services for the immigrants. Besides, other factors such as lack of knowledge regarding free services like HIV tests led the at-risk immigrants to be reluctant to use these services. Previous studies have also identified the same barriers to the use of HIV services among the immigrants.[14, 29, 30]

The findings also showed that receiving emotional and information support could play a facilitating role in the immigrants' access to and use of these services. On the contrary, deprivation of social support due to addiction prevented them from using such services. The ethnic community or networks can play a supportive role in the socialization of immigrants toward developing health-seeking behaviors and offering information to health services, helping with translation and transportation, and giving advice for taking health-related decisions.[27] A review study further highlighted the ongoing social support as one of the factors that can facilitate the refugees' access to healthcare services.[31]

Fear of the HIV-related stigma or its experience, rejection by family and community, as well as experiencing discrimination by service providers, were identified as the aspects that could lead to concealing sexual problems from the families and healthcare providers and can also lead to reluctance to use the related services. In this regard, appropriate policymaking to increase HIV knowledge in the community and also among the service providers can reduce the experience of stigma toward Afghan immigrants with HIV risk behaviors and ones living with HIV. Moreover, the implementation of anti-discrimination laws will facilitate this procedure as well. Based on abundant evidence, HIV-related stigma is associated with concealment of the disease, delayed diagnosis and treatment, and subsequently with an increase in the transmission of the disease. HIV-related stigma has also been recognized as one of the major barriers to access HIV services.[14, 15, 29, 32-34] Furthermore, previous studies have suggested raising awareness of HIV as a technique to reduce stigma and increase the use of HIV services.[32-34]

The awareness about HIV and available services was poor due to the weakness of HIV public education policies in Iran. Besides, the low socioeconomic status among Afghan immigrants limited the conditions for the provision of effective education and exposure to HIV prevention information. Given the culture of compliance with healthcare services among Afghan immigrants, their access to HIV prevention services can be significantly facilitated through raising awareness. In the field of treatment services, HIV-infected Afghan immigrants gained adequate knowledge and awareness of the disease after undergoing the necessary treatment and training services and willingly pursued their treatment programs as a result of the increased awareness. These findings indicate appropriate training and counseling in the field of medical services and, therefore, highlight the need to improve awareness regarding HIV prevention. The results of a systematic review indicated that the lack of information about HIV among

the immigrants acted as one of the barriers to the intention to use HIV tests; in contrast, more knowledge in this area can act as a facilitator.[14]

Providing healthcare services for the immigrants regardless of their nationality and the legal status of migration facilitated the availability of HIV services. However, not only is HIV an infectious disease, but it is also considered as a social phenomenon; therefore, providing available services to HIV control requires collaboration between the health system and political, immigration-related, economic, social, cultural as well as other areas. There is also a growing focus on the role of international institutions in filling the healthcare gaps where the governments are reluctant or unable to cover.[15] Despite some organizational cooperation in planning these programs in Iran, there are still some obstacles including the weakness of intersectoral collaboration in the implementation phase, which led to fragmentation of HIV health care. Based on the results of an overview of systematic reviews, the lack of collaboration between agencies and service providers for continuity of care, the connection between service organizations, as well as the complexities of paperwork and administrative processes were identified as some barriers to access healthcare services for refugees.[31]

The immigrants may face numerous challenges while receiving services including transportation costs, fear or experience of stigma and discrimination, instability of immigrants' settlement, and fear of arrest; hence, it is important to pay attention to different dimensions of service delivery to maintain the quality and utilization of these services for immigrants. Therefore, it is necessary to improve the continuity of care, as an important factor in this field, through allocating resources to maintain healthcare providers, which is important in building trust and seeking services among Afghan immigrants. Moreover, paying attention to the location and providing outreach services by peers at the immigrant colonies can lead to improvement of the marginalized group's access to services as well as reduction of stigma which, in turn, has a facilitating role in using such services. The results of previous studies have been consistent with the findings of the present study, highlighting that location and organization of services were reported as the challenges to access HIV testing and care in African migrants in Ireland.[35] Another study showed that providing HIV tests in more accessible areas, not just in clinics and hospitals, can be considered as a facilitator to HIV testing among Latino immigrant men.[36]

To the best of our knowledge, the present study is the first to explore the aspects involved in the Afghan immigrants' access to HIV prevention and treatment services in the Iranian context. Moreover, the experiences of the three groups of immigrants, service providers, and policymakers/managers/experts helped the examination of a wider range of aspects at different levels. Given that the majority of Afghan immigrants in Iran belong to the Hazara ethnicity, the researchers' access to other ethnic groups was limited and all the participating immigrants in the present study were Hazara. Moreover, all of the participants had lived in Iran for a long time. In other words, less diversity in the sampling of Afghan immigrants in terms of ethnicity and length of stay are among the limitations of the present study.

Conclusion

The present study showed that Afghan immigrants' access to HIV services in Iran is not solely related to economic aspects. It is also necessary to consider other issues including cultural, psychosocial, and service delivery aspects to improve the immigrants' access to such services. Overall, given the complexities of access to such service, the findings of this study can help the researchers and policymakers to make plans and conduct culturally specific interventions to improve the Afghan immigrants' access to HIV prevention and treatment services which also necessitates more accurate attention to the context and existing barriers and facilitators.

Acknowledgement

Elham Ghasemi extracted the present manuscript from the Ph.D. dissertation. Tehran University of Medical Sciences (TUMS), under Grant, supported this study [No: 96-03-62-36567]. We thank all the participants who provided their time and shared their experiences so openly. We also appreciate Dr. Vahid Jahanmiri Nejad, Shah Jahan Shayan, and Family Health Association of Iran for their support during data collection.

Conflict of Interest: None declared.

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