

The Role of Nurses in the Treatment and Care of HIV/AIDS patients - based on the dimensions of health care.

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Abstract

There is a lack of nursing studies that are specifically focused on assessing and caring for people living with HIV / AIDS to improve their quality of life. Little is known about the current situation regarding the care of persons living with HIV / AIDS. This cross-sectional, descriptive and analytical study will try to identify the assessment of nursing care in order to promote a better understanding of nursing care. A structured self-administered questionnaire administered from April 30 to June 15, 2014, was used for data collection. The participants were 55 patients, whose average age was 33.3 ± 7.98 years, ranging from 20 to 55 years of age, out of which 24 (43.6%) of patients were female, while 31 (56.4% of them were males). They had different socioeconomic and educational levels. Regarding the biological dimension of nursing care, despite a positive trend in patient care estimation, differences between individual patient groups are observed based on the educational level. So patients with secondary and higher education are more likely to positively assess nursing care by the biological dimension versus 8-year-old patients. While with the psychological dimension and with other dimensions such as spiritual, social, stigmatization and discrimination there is no statistically significant relation between the socio-demographic characteristics of patients. Among the 5 dimensions, it is noticed that patients have evaluated less positively stigma, discrimination, compared to other dimensions. So patients are noticed a dissatisfaction with the fact that they are treated by nurses at the time of health care. The Nursing School to increase the development and implementation of quality research should identify the feelings, experiences, experiences and meanings of HIV/AIDS patients on nursing care. HIV / AIDS is a growing risk of modern times, requiring long-lasting research and research.

Key words: HIV / AIDS, nursing care, healthcare dimensions.

1. Introduction

Human Immunodeficiency Syndrome (AIDS) is a disease that is showing an alarm worldwide as one of the most life-threatening diseases, a problem that transcends all societies. It has caused the infection of many people, from newborns, to adult individuals, and today is one of the biggest social problems due to the different forms of infection¹. According to the United Nations (UNAIDS) and the World Health

Organization (WHO) on the occasion of the World AIDS Day, in December 2001, AIDS was the most devastating disease humanity has ever faced. Since the epidemic began, more than 60 million people are infected with HIV and AIDS all over the world, 25 million people have died from the virus and is the fourth leading cause of mortality. About one third of people currently living with HIV / AIDS are between 15 and 24 years old². The person with HIV / AIDS is biologically, psychologically, socially and spiritually affected when faced with an incurable disease and has the tendency to be stigmatized by the general population. Infected people are immersed in emotions such as anxiety and guilt; face the loss of economic security, sexual function, self-respect, intimacy, fear, anger, hostility, stress, interpersonal relationships damaged to bring their beliefs and values into play. For effective participation of nursing care in HIV / AIDS patients, it is implied assistance in meeting emotional and spiritual needs, which should provide the essential requirements to maintain anxiety and emotional distress in a person with HIV. According to De Sousa et al, health professionals working with HIV in the state of the hospital environment have many obstacles in the care process⁵. During hospitalization, the HIV / AIDS patient may rarely take full care of his / her own needs so that it can be observed in various health institutions during the hospital stay by the nurses the aid is minimal or because of the fear of infection, or for any other cause related to the disease, which leads to an attitude of indifference, discrimination, marginalization to the patient who experiences the feelings of isolation and loneliness. The nursing care offered is fast, without further contact with the patient and in other cases the waiting is long for treatment. Following the questions the patient has, it is noticed that responses from nurses are very sharp and often unanswered. These facts are apparent through evidence collected by infectious disease patients and other rooms of the QSUT hospital during the professional practices performed during the treatment, which increases the patient's difficulty in accepting his illness, becoming an obstacle to boosting patient healing and stability, which is evidenced by the feeling of helplessness and frustration reflected several times as aggressive and rebellious behavior. This attitude of the nurse to the HIV patient must change for a culture of acceptability and professional responsibility, performing a full care in all its dimensions.

1.1 Formulation of the problem

The HIV / AIDS epidemic has caused a number of reactions, and the stigma is one of them. These reactions come from individuals, communities, and even nations, and during this time it is passed from sympathy to caring for silence, denial, fear, anger, and even violence. [37] People living with HIV / AIDS and those affected by epidemics often find it impossible to live an equal, dignified and free life, as their rights are often violated based on their status as HIV-infected. This includes the right to privacy, confidentiality, access to comprehensive medical and sexual and reproductive health services, employment, education, freedom of movement, and the right to travel. Learning HIV status through laboratory diagnosis is always for the individual concerned a traumatic and life-changing experience. [38] Difficulties are related to discrimination and stigmatization, complicating the coping process and related to the need to apply holistic care models that address the psychological, spiritual, and physical dimensions of people living with HIV infection. [39] Together, these stigma-related experiences can contribute to the stress and adaptability of people living with HIV. [40, 41, 42] People with HIV infection have high rates of stressful life events.

In particular, HIV sees individuals in the face of multiple challenges that could damage their coping resources and impede their psychological adaptation to the ongoing demands of chronic and stigmatizing disease management. [43] There is a strong link between experiencing the stigma associated with HIV and reporting poor access to medical care. Studies show that people who experience high levels of stigma are more likely to disregard the regime of HIV medication. [44] In addition, research has shown that rapid progression of the disease is associated with low levels of social support. [45] Stigmatization can make PJHA(persons that live with HIV/AIDS) to renounce the right to healthcare services, may reduce their desire to go HIV-tested, affecting early prevention and treatment efforts. [46] Barriers to care relate to the social stigma surrounding HIV / AIDS in Albania or the lack of information on both patients and service providers. [47] Lack of access to medicines affects health deterioration, moreover reducing the ability to earn income and lowering self-esteem. [48] The need to travel long distances to benefit from health services is another major challenge facing the PJHA. [49] Although AIDS has already been considered a chronic and manageable disease for many, [50] PJHA still experiencing side effects due to medication. Physical symptoms and physical physical alterations experienced by WHO significantly affect career, daily roles, and quality of life. [51] The United Nations Commission on Human Rights explicitly acknowledges that "access to medicines in the context of epidemics such as HIV / AIDS is one of the key elements for achieving progressively and full compliance with the law every man to the enjoyment of the highest achievable standard of mental and physical health "(UN, 2001). Antiretrovirals have been designated as major medicines (OBSH, 2007). Data also show that antiretroviral therapy significantly improves the quality of life of people living with HIV if they start treatment early. [52] Studies in many countries of the world and especially in developed countries underline the pain relief and symptom management, psychological support, spiritual support, food and financial support as the main needs for palliative care. [53,54,55] Where the needs for palliative care are met, it is mainly due to the support that families and relatives offer. [55, 56, 57] HIV / AIDS can lead people to poverty, due to reduced work skills and increased medical costs. There is a growing need to address concerns about the work of people living with HIV because they are living longer and healthier as a result of drug treatment. [58, 59] Because of the constraints that result from the health status, as well as stigma and discrimination, PJHA face many barriers when they try to find or keep their jobs. [60, 61] The stigma that accompanies HIV has caused many people living with this disease to lack adequate care and social support and to experience a low level of emotional well-being compared to the general population. [62] Stigma plays an important role in people's decision to detect their HIV status in family, friends, and often has a negative effect on the quality of their relationship. The way of detection, residence and the fact that it belongs to minority communities are additional factors that affect the non-detection of HIV and the isolation of these persons. [63] Reducing social exclusion, along with social and emotional support, can lead to greater social cohesion and improve health. [64] Social support plays a critical role in helping people overcome epidemic structural inequalities and serve as barriers to treatment, testing and other essential services. Social support is particularly appropriate for HIV, as it can address issues of gender inequality, stigma and discrimination that exacerbate the situation of marginalized groups. Social support helps ensure that income is regular, helps to ensure living and expands the source of income (UNAIDS, 2010). PJHA need constant care that focuses on the rights and problems

they face in everyday life. Comprehensive care and treatment includes more than antiretrovirals, specifically involves the treatment of opportunistic infections, appropriate nutrition, psycho-social care and other essential health and social services. HIV and AIDS related intimidation and discrimination are widely known as barriers to provide appropriate health care, appropriate social and psychological support, and appropriate medical treatment. [65] Stigma affects the life experiences of an individual infected with HIV and his family. Often stigmatization is more severe for people living with HIV / AIDS than the disease itself. Stigma and discrimination leads to a crisis of identity, isolation, loneliness, low self-esteem and lack of interest in treating AIDS. [66] At the community level, fear of stigma and discrimination can cause pregnant women to avoid voluntary counseling and testing, which in the early stages helps to reduce the possibility of transmitting the HIV virus from mother to child. [67] Even family members of the infected individual also suffer from stigma and discrimination. [68] The United Nations, human rights activists and many organizations emphasize these issues in order to reduce the heavy burden of stigmatization and discrimination against PJHA. [69] For HIV-infected women, psychosocial issues such as HIV positive status detection, stigma, HIV testing, care, poverty, and gender roles are unique challenges and stressors. [70, 71] These stressors escalate when an HIV-infected individual is a woman who is simultaneously infected with HIV and cares for young children. [70] HIV / AIDS affects the productive and reproductive roles of women who are increasingly intertwined with the global market. Because of the gender roles embedded in many traditional societies, widows face a loss of support to live in the cases when their husbands die and leave them without income or property rights. [72] HIV / AIDS is related to sexual and reproductive rights. The social and cultural dimension of sexual and reproductive activity protects and violates gender inequalities and increases the vulnerability to HIV infection on both sides, both men and women. HIV / AIDS is related to sexual and reproductive rights. The social and cultural dimension of sexual and reproductive activity protects and violates gender inequalities and increases the vulnerability to HIV infection on both sides, both men and women. There have been documented incidents of women living with AIDS, who have asked for termination of pregnancy and who have been forced to sterilize. [73] Frequently, women living with HIV / AIDS are not given adequate information on pregnancy and breastfeeding. [74] Women often face a tough decision about breastfeeding as a preferred cultural option. A decision not to breastfeed children can lead to a forced discovery of the HIV positive status of women. [75] Women also reported courtly and hostile attitudes by service providers, including testing without obtaining consent and denial of service. [76] Another important issue is the discovery of HIV status. This is especially difficult in PJHA cases due to the very high stigma associated with this disease. The stigma on HIV / AIDS has been very pervasive, affecting all parts of the world. For example, studies in the United States have reported cases of rape and abuse of PJHA or persons believed to have had the disease. [77, 78,79] Some studies reported cases of WHO that were abandoned by the family, separated from their partners (especially women), killed, isolated, expelled from their communities at the time they discovered their HIV status positive. [80, 81, 82, 83] Increasing attention to status discovery and partner's announcement in HIV control programs is also supported by empirical evidence that it is an effective strategy for preventing HIV transmission to sexual partner at risk and for the promotion of early diagnosis, and which promotes treatment in those who are infected. [84, 85] Possible motivation to report to a sexual

partner is also influenced by the ethical responsibility of patients and concern for partner health, the desire for social support, the severity of the disease, various cultural factors [86] and the very important role of counselor [87]. However, it is worrying that only a small number of HIV-positive persons currently inform their sex partners about their status [88, 89] The low rate of detection of HIV positive status eventually leads to the possibility of cardiac arrest as long as such patients would prefer not to be discovered in the community. [88] It also leads to the loss of opportunities for preventing new infections at risk partners and the inability to have access to HIV services both for patients and partners. Respecting the confidentiality of patients is one of the main principles in medical ethics and also a legal duty that service providers owe their patients. However, respect for absolute confidentiality has been a subject of debate [87]. With the emergence of the HIV / AIDS epidemic this debate is about whether confidentiality should be compromised when HIV positive patients refuse to volunteer those who may be at risk of infection, especially sexual partners. [90, 91] In Albania there are no studies focusing on the rights of persons living with HIV / AIDS. During these years there has been greater attention in preventing this disease and in assessing the populations (groups of the population) with dangerous behaviors. Consequently, it is important to learn more about the experiences, experiences and attitudes that PJHA has developed as a result of new social, economic and health needs.

1.2. Determination of research / study

As mentioned, there is a shortage of nursing studies in Albania that are particularly concerned with assessing and caring for people living with HIV / AIDS to improve their quality of life. Our study is the first in this area. It reflects the importance of patient health care in the context of the HIV / AIDS epidemic, based on their experiences and experiences, assessing the perceptions of people living with HIV / AIDS.

1.2.1 The importance of research / study

Personal significance. This study is of personal importance as the professional skills gained during the course of the study, thanks to the ideas and criticisms of the scientific leader for respecting the criteria of the methodology.

Social significance. The study has social significance since HIV / AIDS has been named by many as the most devastating crisis in human health history. In recent years, this phenomenon has also affected Eastern European countries, including Albania, countries that, although still low in numbers, have the fastest rates of disease spreading

Scientific significance. HIV / AIDS is a growing risk of modern times, requiring long-lasting research and research.

2. Research Methodology

This is a cross sectional, descriptive and analytic study conducted in 55 patients diagnosed with HIV at QSUT between April 30 and June 15, 2014. They had different socioeconomic and educational levels. Informed consent was obtained at the time of data collection, and confidentiality and anonymity were assured.

Inclusion Criteria: Included in the study of patients diagnosed with HIV

Exclusion Criteria: Patients not diagnosed with HIV

2.1. The process of data collection

a. *Review of literature.* All elements of the research were reviewed to evaluate only the data with scientific or legal evidence (10 January - 15 September).

b. *Classification of information.* Classification of information was made from general concepts to specific ones and from international and national data. Each paragraph reduced, you set a specific number in the bibliography.

c. *Choice of instrument.* Some studies on nursing and nursing care were seen on HIV patients and one of them was selected from which two self-administered questionnaires were adapted. From April 30 to June 15, questionnaires were delivered to infectious services, pediatricians at QSUT and SRV.

d. *Pretest.* Two questionnaires were prepared as an applied instrument, a questionnaire for the identification of nursing care for HIV patients, which was tested in three Infective Service and Pediatric Nurses who were not included in the study to see if the questionnaires whether or not they contained incomprehensible or biased meaning. It was observed that questionnaires were not problematic in terms of questions. Also, the second questionnaire was compiled to identify perceptions of HIV patients on nursing care.

e. *Testing.* From 15 May to 15 June, questionnaires were delivered to the infectious services, and the Pediatricians of QSUT and SRV. Testing was done directly and the nurses had the time to answer the questions.

f. *Grouping and counting.* Questionnaires were grouped according to the respective services. The counting was done with the SPSS 17.0 and Excel statistical program, obtaining information presented in tables and graphs.

g. *Coding.* Data entry into the computer and editing. In each question with respective categories, they are placed by a number.

2.2. Material and procedure

Some studies on nursing and nursing care were seen on HIV patients and one of them was selected from which two self-administered questionnaires were adapted. The questionnaire was divided into several sections: it included the overall demographic characteristics of the patients involved in the study and the assessment of nursing care based on the dimensions of health care.

2.3. Statistical analysis

Statistical data analysis was performed in SPSS (Statistical Package for Social Sciences, version 18.0). For continuous variables - sizes were presented as arithmetic, median and fashion averages as well as dispersion sizes - Standard deviation variance (SD). For categorical variables, absolute and relative frequencies were presented.

2.3.1. Statistical Tests Used

Used:

Hi-square test (χ^2): for comparing the percentage of categorical variables,

Logistic regression - Chance probability OR with confidence interval 95% CI

- Evaluating the health care accompaniment in the different dimensions addressed.

Mann Whitney U test, for comparing the age of the patients by sex.

3. Results

3.1. Demographic characteristics

The sample consisted of were 55 patients, whose average age was 33.3 ± 7.98 years, ranging from 20 to 55 years old.

Table1 Summary table on the demographic characteristics of patients

Variables	Patients (n=55)		P
	N	%	
Gender			
Females	24	43,6	p=0.7
Males	31	56,4	
Age (average , SD)	33,3 (7,98)		
Birthplace			
City	45	81.8	p≤0.001
Village	10	18.2	
Educational level			
Secondary	9	16.3	p≤0.001
University	34	61.8	
Master	12	21.8	
Marital status			
Single	21	38.2	p≤0.001
Married	10	18.2	
Widowed	12	21.8	
Divorced	1	1.8	
Coexistence	11	20.0	
Profession			
Student	10	18.2	p=0.6
Domestic	2	3.6	
Employee dependent	22	40.0	
Independent worker	8	14.5	
Unemployed	13	23.6	
Student	10	18.2	

24 (43.6%) of patients were women, while 31 (56.4%) were males.

The mean age of male patients in the study is 33.2 ± 8 years, while the average age of women is 33.4 ± 8 years, statistically significant difference between them (Mann Whitney U = -3.6, p = 0.8)

It is noted that 78.2% of patients or 43 patients were born in rural areas versus 21.8% of patients born in urban areas with statistically significant differences between them ($p \leq 0.05$).

Among the interviewed patients, it was noted that:

- 9 patients (16.1%) had 8 years of education,
- 34 patients (61.8%) had secondary education and
- 12 patients (21.8%) were university graduates

Thus it is noticed that there is a dominance of patients who have completed secondary education (61.8%), with statistically significant difference between them ($p \leq 0.05$)

We see the distribution of the patients involved in the study according to their civil status. Thus:

- 21 patients (38.2%) found to be single,
- 10 patients (18.2%) were married,
- 12 patients (21.8%) were found to be widows,
- only one patient (1.8%) turned out to be divorced and
- 11 patients (20%) were currently living together.

It is noted that there is a dominance of single patients followed by widows, followed by cohabitation and fewer cases of married patients and only one patient case who was divorced, with statistically significant difference between groups ($p = 0.001$)

Regarding the occupation of patients:

- 22 or 40% of them were employed dependent on one institution,
- 13 patients or 23.6% of them were unemployed,
- 10 patients or 18.2% of them were students,
- 8 patients or 14.5% of them were self-employed / self-employed
- 2 patients or 3.6% of them were housewives with statistically significant changes ($p = 0.006$)

Table 2 Shows the Assessment of nursing care based on the biological dimension

Statement	Always	Usually	Anytime	Rarely	Never
Explanation of procedures by the nurse	8 (14,5)	34 (61,8)	11 (20,0)	0 (0,0)	2 (3,6)
Concern about hygiene	3 (5,5)	15 (27,3)	26 (47,3)	10 (18,2)	1 (1,8)
Fulfillment of nutrition needs	0 (0,0)	15 (27,3)	21 (38,2)	17 (30,9)	2 (3,6)
Nursing attention to problems	2 (3,6)	4 (7,3)	26 (47,3)	22 (40,0)	1 (1,8)
Assistance to moving difficulties	3 (5,5)	16 (29,1)	25 (45,5)	10 (18,2)	1 (1,8)
Provide solutions to sleep problems	10 (18,2)	28 (50,9)	12 (21,8)	5 (9,1)	0 (0,0)
Information on oral hygiene	4 (7,3)	24 (43,6)	19 (34,5)	7 (12,7)	1 (1,8)
Care shown during administration of medications	17 (30,9)	23 (41,8)	14 (25,5)	1 (1,8)	0 (0,0)

Regarding the biological dimension of nursing care, despite a positive trend in patient care estimation, differences between individual patient groups are observed based on the educational level.

Table 3 Evaluation of nursing care based on spiritual dimension

Statement	Always		Usually		Anytime		Rarely		Never	
	N	%	N	%	N	%	N	%	N	%
The nurse offers spiritual help to cope with your illness (regarding the god)	0	0	4	7,3	20	36,4	22	40,0	9	16,4
Discovering the nurse's values of love and hope during your society as a spiritual experience	0	0	4	7,3	29	52,7	13	23,6	9	16,4
The nurse helps you discover your belief in god (or a force majeure) by respecting your beliefs	0	0	2	3,6	18	32,7	27	49,1	8	14,5
The nurse shares her spiritual experience and motivates you to approach the master	0	0	1	1,8	12	21,8	26	47,3	16	29,1
When you need the support of a priest, pastor, or others for your spiritual need, the nurse helps you with their presence	0	0	1	1,8	15	27,3	26	47,3	13	23,6

Regarding the spiritual dimension, there is no significant statistical link between the socio-demographic characteristics of patients.

Table 4 Evaluation of nursing care based on the social-family dimension

Statement	Always	Usually	Anytime	Rarely	Never
Knowledge of family conflicts	1 (1.8)	32 (58.2)	14 (25.5)	5 (9.1)	3 (5.5)
The nurse helps the patient's family in the process of adapting to the disease	3 (5.5)	29 (52.7)	17 (30.9)	3 (5.5)	3 (5.5)
Prepare family for home care	1 (1.8)	18 (32.7)	3 (5.5)	3 (5.5)	3 (5.5)
Taking measures for integration and achieving a proper relationship with society	6 (10.9)	29 (52.7)	16 (29.1)	1 (1.8)	3 (5.5)
Emotional support of the family members by the nurse	5 (9.1)	27 (49.1)	15 (27.3)	5 (9.1)	3 (5.5)

Preparing the family to accept the patient's illness	2 (3.6)	33 (60)	15 (27.3)	2 (3.6)	3 (5.5)
The nurse speaks of the values that help you improve the current situation	2 (3.6)	16 (29.1)	21 (38.2)	8 (14.5)	8 (14.5)

* Numeric values for each of the categories are displayed in the form: n (%).

Regarding the family dimension, there is no significant statistical link between the socio-demographic characteristics of patients.

Table 5 Evaluation of nursing care by the psychological dimension based on the demographic characteristics of patients

Psychological Dimension	Positive rating N (%)	OR *	95% CI*	P**
Gender				
Females	24 (43.6)	ref		
Men	30 (54.5)	0.4	0.01-10.6	0.6
Birthplace				
City	43 (78.2)	ref		
Village	11 (20.0)	0.8	0.03- 20.7	0.9
Educational level				
8 year education	8 (14.5)	ref		
Secondary Education	33 (60.0)	1,3	0.04-35.2	0.9
University	13 (23.6)	1.6	0.02-87.8	0.8
Marital status				
Single	21 (38.2)	ref		
Married	9 (16.4)	0.14	0.00-3.9	0.2
Widowed	12 (21.8)	0.6	0.1-31.1	0.3
Divorced	1 (1.8)	0.7	0.0-4.9	0.2
Coexistence	11 (20.0)	0.6	0.2-6.4	0.4
Profession				
Student	10 (18.2)	ref		
Household	2 (3.6)	0.3	0.0-15.2	0.5
Employee dependent	21 (38.2)	0.7	0.2-18.2	0.8
Independent worker	8 (14.5)	0.8	0.1-45.2	0.9
Unemployed	13	1.2	0.0-70.3	0.9

* Chance Relationship (OR) and Lower and Upper Confidence Rate 95%

** P value (statistical significance)

A p <0.05 for the difference according to square square test statistic.

Male patients are 0.4 times more likely to evaluate positively nursing care by the psychological dimension compared to women without statistically significant change (OR = 0.4, 95% CI-0.01-10.6)

Patients from the village are 0.8 times more likely to evaluate positively the dimension of nursing care psychiatry compared to patients from the city, statistically significant (OR = 0.8, 95% CI: 0.03-20.7)

Patients with secondary education are 1.3 times more likely to assess positively nursing care versus 8 year old patients (OR = 1.3; 95% CI: 0.04-35.2); as well as university-educated patients are 1.6 times more likely compared to 8-year-old patients without statistically significant change (OR = 1.6; CI95%: 0.02-87.8)

Married patients are 0.14 times more likely to assess positively nursing care compared to single-sex patients, statistically significant (OR = 0.14, 95% CI: 0.0-3.9). Thus, widest patients have 0.6 times more unlikely to evaluate positively nursing care, statistically significant difference (OR = 0.6, 95% CI: 0.1-31.1). Divorced patients are 0.7 times more likely to assess positively nursing care compared to single-sex patients, statistically significant (OR = 0.7, 95% CI: 0.0-4.9). Patients in coexistence are 0.6 times more likely to positively evaluate nursing care without statistically significant change (OR = 0.6, 95% CI: 0.2-6.4). Dependent workers are 0.7 times more likely to assess positively nursing care in the psychological dimension compared to student patients, statistically significant (OR = 0.7, 95% CI: 0.2-18.2); Independent workers are 0.8 times more likely to be compared to student patients, with statistically significant difference (OR = 0.8, 95% CI: 0.1-45.2), while unemployed patients are 1.2 times more likely to assess positively the care nursing by the biological dimension versus the students without statistically significant changes (OR = 1.2, 95% CI: 0.0-70).

Table 6 Estimation of nursing care based on the dimension associated with stigma, discrimination

Statement	Always	Usually	Anytime	Rarely	Never
Do you think that health personnel find it hard to take care of you?	6 (10,9)	13 (23,6)	5 (9,1)	4 (7,3)	27 (49,1)
Exclusive or special hospitals should be created for people with HIV / AIDS.	4 (7,3)	1 (1,8)	14 (25,5)	9 (16,4)	27 (49,1)
Perceive that nurses should avoid all contact with people with HIV / AIDS.	1 (1,8)	1 (1,8)	2 (3,6)	9 (16,4)	42 (76,4)
Conversation or random contact with a person with HIV can infect other people.	11 (20)	6 (10,9)	3 (5,5)	11 (20)	24 (43,6)
In cases of hospitalization according to nurses, people with HIV / AIDS should be isolated?	26 (47,3)	22 (40)	2 (3,6)	2 (3,6)	3 (5.5)

Does the nurse show particular care to a patient with HIV?	9 (16,4)	6 (10,9)	3 (5,5)	17 (30,9)	20 (36,4)
Do you think that the nurse is afraid of being sick of SIDA when he or she meets people with AIDS.	1 (1,8)	2 (3,6)	4 (7,3)	19 (34,5)	29 (52,7)
He perceives that the nurse is afraid of spreading the HIV virus to other people during the care.	1 (1,8)	4 (7,3)	10 (18,2)	28 (50,9)	12 (21,8)

So, we see that, according to patient statements, we have a dominance of the common case of nursing staff explaining the procedure they are going to do.

4. Discussion

Early studies have portrayed nursing staff (along with other health care workers) as frightened, ill-informed and discriminating. to contact with HIV-AIDS patients. [93] In the studies on continuing education and training of nurses related to HIV-AIDS, deficiencies have been identified in the provision of healthcare, the appropriate training for the treatment of HIV patients, especially in non-physical and biological dimensions. With the availability of antiretroviral treatments, HIV is increasingly known as a chronic disease with which people live for many years. [94] Therefore, undertaking this study and recommending continuing the study of this broader field is very important. Regarding the demographic characteristics of the patients, no statistically significant difference was observed among the age-group infirms <30 years (33.8%), 30-40 year old (24.7%), 41-50 age group nurses and those aged older than 50 years (15); while among men (15.6%) and females (84.4%) a statistically significant change was observed.

In our study, as in other studies [95], the average age of patients was 33.3 ± 7.9 years. The age ranged from 20 to 55 years. Comparing with studies such as Hinkin's, Charles H., et al., (2004) [96] where age ranged from 25-69, or Cysique, Lucette A, (2006) where ages ranged from 28-59 years; we can say that in our sample we have a younger age group. Among the patients 43.6% (24 cases) were women and 56.4% (31raste) were males. According to the IPH report (2015) so far, between 70% (613raste) men and 30% (257 cases) of women with male HIV positive male and female farms. The mean age of male patients in the study is 33.2 ± 8 years, while the average age of women is 33.4 ± 8 years, statistically significant difference between them (Mann Whitney U = -3.6, p = 0.8). Patients with secondary education are 12.1 times more likely to evaluate positively nursing care versus 8-year-old patients; as well as patients with university education are 4.4 times more likely compared to 8 year old patients with statistically significant change (OR = 4.4; CI95%: 0.1-66.9). Patients reported statistically significant differences between their education level, with the largest proportion of patients with secondary education (61.8%) followed by those with higher education (21.8%) and fewer than those with education 8 years old (16.1). It is noted that there is a dominance of single patients followed by widows, followed by cohabitation and fewer cases of married patients and only one case of divorced patient with statistically significant difference between groups (p =

0.001) .78.2% of patients or 43 patients were born in rural areas versus 21.8% of patients born in urban areas.

It should also be noted that patients who have been hospitalized for several weeks of treatment are dominated by patients compared to patients who have months of hospitalization or those who have only a few days. It is noticed that we have very few patients who have been diagnosed with HIV for a few weeks, compared to those who have been diagnosed with their disease for years and months, with a significant difference between them ($p \leq 0.05$). Among the 5 dimensions, it is noticed that patients have evaluated less positively stigma, discrimination, compared to other dimensions. So, among patients, there is a dissatisfaction with how they are treated by nurses at the time of health care.

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