

HIV NURSING

CARING FOR PEOPLE AFFECTED BY HIV

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Editorial

The bigger picture

Juliet Bennett 2

Features

Why the rush to take medication? Issues affecting when clients start taking medication

Roy Brazington..... 3

The importance of HIV specialist services for African women living with HIV in Nottingham: results of a qualitative study

Eunice Ndirangu and Catrin Evans..... 8

Gender, gender inequalities and HIV: implications for nursing care

Ursula Harrisson 14

HIV and nursing in Romania

Cristina Nitu 18

Sexual health and health promotion for people living with HIV

Sinead O'Neill 19

Research round-up

Focus on women

Catrin Evans 23

NHIVNA update

Sheila Morris 24

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HIV NURSING

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Aims and Scope

HIV Nursing has been developed as a forum for those at the forefront of caring for people affected by HIV. The journal is supported by a highly respected Editorial Board drawn from a wide range of nursing specialties. This is further strengthened by an Advisory Panel who will be making regular contributions to the journal.

HIV Nursing is intended to provide a medium for communication on issues relating to HIV care, which will be run by the care professionals for those involved in the day-to-day matters affecting the lives of patients.

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The bigger picture

Juliet Bennett

Independent Nurse Advisor

Two new and potentially influential documents have been published in recent months. Admittedly these are only intended to apply in England; however, readers from Scotland, Wales and Northern Ireland are likely to find their content both interesting and relevant to practice.

The NHS Constitution [1] brings together, for the first time in one place, the principles and values that underpin the NHS in England. The Constitution aims to clearly define the commitments, rights and responsibilities of public, patients and staff.

Many, including the RCN and BMA, see the Constitution as a welcome re-statement of the principles of equality and compassion on which the health service is based. However, patients need to know what the duty requiring NHS organisations to 'take account of the Constitution', will really mean in practice. For the NHS Constitution to make a real difference, service providers will certainly need to do more than give it 'due regard'.

In order to be effective, health services of today, more than ever before, have to listen and respond to the needs of the people they serve; and service providers must work in partnership, both with one another and with patients. One of the key principles spelt out in the Constitution is the aim to further develop the NHS into a system that is patient-centred. This could help to promote new and more effective partnerships between the NHS, other providers and with patients and communities; and we would all probably acknowledge that in our own speciality, there is still considerable room for improvement in this. However, the challenging nature of these relationships must be acknowledged. How realistic is the Constitution's 'commitment', given that in recent years cross-organisation cooperation has been severely tested, particularly as many have been in direct competition with one another?

Optimistically, we can hope that such partnerships may help to put into the mainstream some aspects of HIV care, such as testing and management of cardiovascular disease risk, and through this normalisation, reduce some of the stigma and isolation frequently encountered by those living with the virus, including their experience of accessing healthcare. However, the need for much more engagement with the public and staff about the way services are delivered at a local level will still remain.

HIV nurses, as ever, will need to continue to be prepared for, and skilled in responding to, change, not just in terms of disease management, but also in

service configuration and changing patient demands. The Constitution sets out seven weighty guiding principles, but fundamentally the patient experience, and the NHS as a whole, will, as always, continue to rely on the good will, the compassion, knowledge, awareness and commitment of those in positions of power, which includes us as nurses, at the forefront of patient care.

The second important document is the new NICE guidelines for Medicines Adherence [2]; a long overdue consensus on strategies for supporting adherence to medicines. The guidelines emphasise working on building relationships with patients, communication, patient involvement and joint decision making. As nurses working in HIV care we have prioritised this approach for many years now and have also led the way in working towards a concordance approach to supporting people taking long-term drug treatment. It is good to have this verification and national recognition of the benefits of a holistic approach to this challenging and complex area of our practice.

In this issue of *HIV Nursing*, Roy Brazington's article emphasises the role of the nurse working in partnership with patients, and as an advocate where necessary, by exploring in depth the multitude of factors, as well as clinical need, which need to be considered before people are equipped to start antiretroviral therapy.

Equally relevant to our everyday practice is the need to ensure that sexual health is assessed and promoted for all people that we see in HIV services. Sinead O'Neill's study concludes that we should also be developing our skills in facilitating behaviour change. This could be invaluable in relation to so many of our roles in promoting healthy lifestyle choices, smoking cessation and safer alcohol and drug use, as well as safer sex.

Ursula Harrison looks in depth at the impact of societal constructs that contribute to gender inequalities, and which can create barriers for women in terms of being able to protect themselves from HIV, and care for themselves once infected. The article again stresses the role of nurses working in partnership with patients in assessing the individuals lived experience and facilitating access to appropriate and effective care and support.

Christina Nitu writes the first of a proposed series of reports on Nurses' experiences of providing HIV care around the world. Her reflections are humbling, and remind us again of our privileged position, working in a comparatively well resourced health service.

Eunice Ndirangu's and Catrin Evans' interesting research report reiterates the impact of stigma and other social and economic challenges on African women accessing HIV care in the UK. In this study women benefited from a multi-disciplinary service where specialised medical, social welfare and nursing support were available in one location. The need for continued investment in partnership working both with individuals and with other organisations, such as the voluntary sector, is clear.

We are introducing a new regular feature – the Research round-up – which includes recent, relevant and interesting nursing research findings,

reviewed by Catrin Evans. We would welcome your views on this feature.

Happy reading!

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Why the rush to take medication? Issues affecting when clients start medication

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Introduction

Antiretroviral drugs have been proven to be very effective at treating HIV infection and have been used in various combinations since 1996. The guidance that informs clinicians about when to start a patient on antiretroviral therapy has evolved as the clinical evidence surrounding its use has improved. The British HIV Association (BHIVA) guidance has recently been updated [1] and now suggests that treating HIV infection earlier, that is when a person's CD4 cell count is above 350 cells/mm³, may result in better health in the longer term. The background to this decision was the publication of a number of studies, including the SMART study [2], which showed that earlier intervention improved health outcomes for people living with HIV.

However, although the SMART study involved a large cohort of participants, the number of patients who were antiretroviral treatment-naïve was quite small – 249 of the 5472 people enrolled. Therefore, the finding that earlier initiation of antiretroviral drugs may improve health in the longer term may require further investigation.

Recent manufacturing changes have enabled pharmaceutical companies to create a very convenient, one-tablet, once-a-day product, which contains three antiretroviral drugs. This has further reduced the pill burden for patients and, theoretically, improves the appeal of long-term treatment. Is this a panacea for all, or are there individuals who may not be suited to starting medication earlier with this new all-in-one pill? It should be noted that there is a greater need for vigilance regarding the issue of adherence with once-daily regimens, as there may be an increased

risk of resistance associated with delayed or missed doses. Furthermore, this perceived rush to commence medication must be considered in the context that, for many clients, HIV infection is just one of a number of issues in their lives. They may have other health-related problems, immigration or housing issues, or they may be using drugs or alcohol to cope with their diagnosis.

A number of clients who have been referred to me have adjustment problems with their diagnosis and find it difficult to make decisions about their health. They have experienced pronounced recent loss surrounding their health, and they may feel stressed and unable to cope with the uncertainty and stigma of HIV infection. They may lack motivation and this, in turn, may affect their ability to perform in their working lives. Many others may also have immigration problems and fear deportation to an uncertain future in their country of origin. These factors may lead to the client using drugs or alcohol as a coping strategy and this may affect their ability to commence or maintain adherence to any antiretroviral regimen. An algorithm to determine whether a client is ready to start antiretroviral therapy has been published by the European AIDS Clinical Society (EACS; Figure 1).

The process of adjustment to HIV infection varies from person to person. It is heavily dependent on a number of different issues, such as: the client's health beliefs; their cultural background; their past coping strategies when faced with difficult circumstances; their level of social support; and the circumstances in which they discovered they were HIV-positive. For example, the person who chooses to test for HIV as part of a sexual health screen is likely to have thought about the outcomes of the

test far more than a woman who is tested as part of wider antenatal screening, and, therefore, the former may adjust more quickly to the news.

With guidance from BHIVA and the evidence from the SMART study suggesting that patients should start medication earlier, the challenge is to encourage healthcare providers to normalise HIV testing within clinical services and for services to be available to provide support to those who test positive. The challenges for the healthcare worker are the obstacles that exist to clients adjusting to their HIV diagnosis.

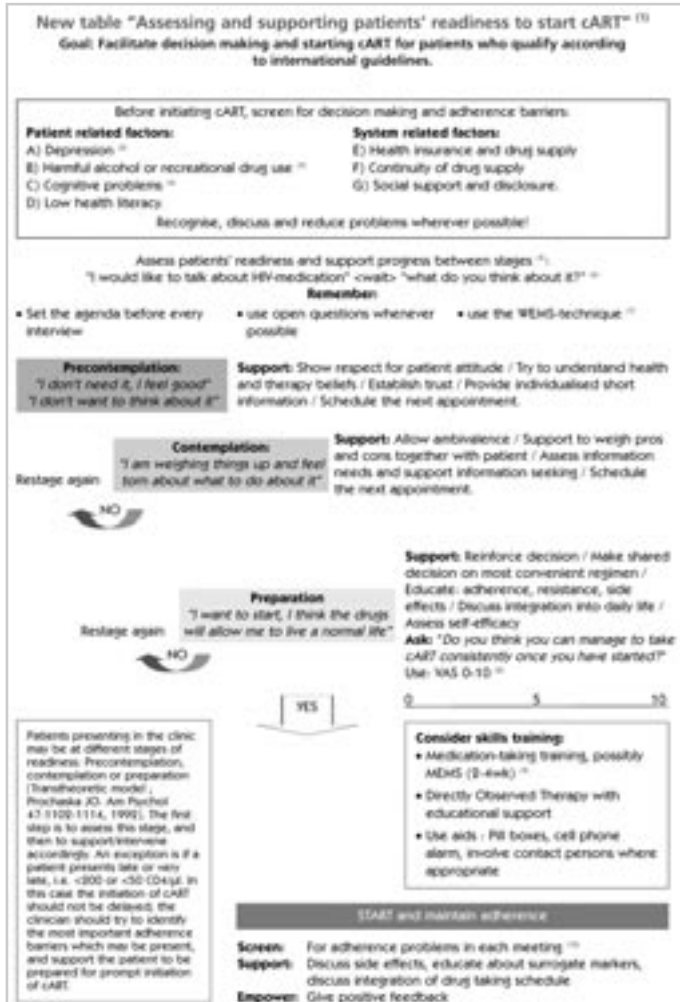
In this article, I aim to discuss some of the issues influencing commencement of antiretroviral therapy, and to illustrate how nurses can play a crucial role in smoothing this process and promoting adherence.

Factors affecting attitudes towards HIV and starting medication

Health beliefs

Health beliefs influence our choices and are affected by our family, friends, personality and the culture we grew up in. These can form

Figure 1. European AIDS Clinical Society guidelines for the clinical management and treatment of HIV-infected adults.



stereotypical norms such as men not attending the GP, or a preference for alternative medicine to help deal with health-related matters. These beliefs can also prevent people seeking medical help. This may explain why some people from areas with a high HIV prevalence do not seek help; they may have experienced HIV first-hand in their country of origin and feel it is a death sentence. It may take the person some time to realise that HIV is treatable here in the UK. Some may have suspicions about available medications and their ability to reduce the presence of virus; whereas, others may believe that HIV is a punishment from God for a sin they feel they have committed; this may have a negative effect on that person's self image, resulting in them avoiding contact with healthcare services.

Lifestyle issues

A number of clients use drugs and alcohol to enable them to cope with the stress caused by their diagnosis. It is difficult for them to adjust over the background of their continued use, and it is preferable that they reduce or stop using them. However, this may be difficult if the client has invested heavily in the positive effects of these substances. Clients may have problems with adherence if they commence a regimen while still reliant on drugs or alcohol because of the personal chaos associated with these substances.

Immigration

In the client's world, HIV and the ability to stay in the country are both very important. They may live with the constant fear of being deported or of changes in government legislation making access to treatment more difficult. They may not understand the cumbersome and bureaucratic nature of the NHS and supportive agencies such as Social Services or NASS (National Asylum Support Service). As a result, it is not really surprising that their status in the country dominates their lives.

The client may be receiving payments from their local authority or NASS that are dependent upon them having a case lodged with the Home Office and attendance at fixed appointments. They may have to reside in accommodation that may not be suitable for their needs, with facilities such as a shared kitchen or bathroom.

The recent decision surrounding case N will have consequences for all clients not originally from the UK seeking to remain, or hoping to renew applications, to stay in the country. N is a Ugandan national who was seeking to remain in the UK based on her continued need for antiretroviral therapy to maintain her health. Her appeal was rejected by the House of Lords in 2005, and was presented recently at the European Court of Human Rights in Strasbourg, which ruled that asylum seekers could

no longer remain in the UK based upon their poor health status or need for access to medication.

With all of these problems in the background, adherence to antiretroviral drugs may not be as much of a priority for immigrants as it is for healthcare professionals.

Mental health problems

Mental health problems such as depression, anxiety and, sometimes, psychosis may interfere with the patient's ability to engage with the healthcare worker to make a collaborative decision to start treatment or maintain treatment if it has already started.

The involvement of specialist services may help to engage with the person's negative thoughts surrounding HIV. It is often better to treat the mental health problem before thinking about commencing antiretroviral medication.

An avoidance of certain medications directly implicated in contributing to atypical mental health problems such as suicide or depression would also be helpful, even if this medication is seen as the gold standard in terms of its action on the virus.

Housing problems

The client may be living in poor housing, which may be affecting their health generally. More specifically, it may be difficult to share facilities with others and avoid disclosing their status, particularly if they are experiencing marked side effects or need to store medication in the fridge.

It is becoming more difficult for local authorities to provide social housing, and the quality of some of the housing offered to clients can be poor. If a client has housing problems, is it likely that adherence to antiretroviral therapy really figures in their list of immediate priorities?

What can nurses do?

The ability of nurses to assess clients in a holistic way enables them to understand why medication may not be at the heart of the client's priorities. This holistic approach may also foster the development of a rewarding relationship for the client, and result in an improved assessment by the nurse that clearly illustrates the client's current problems.

Immigration issues

The area of immigration has become problematic more recently following the European Court of Human Rights decision on the case of N. This effectively sees the end of asylum seekers using access to treatment as their basis to remain in the UK. It remains to be seen how the Home Office will implement this outcome on the ground with people seeking to remain here. However, advocacy will remain an important part of the nurse's role when dealing with vulnerable patients. Nursing staff can provide supportive letters and onward referral to

organisations that may be able to deal with specific problems these clients may have, such as lack of finance or childcare.

Is the client really ready to start?

Nurses are best placed to determine whether a client is ready to commence treatment, as long as nurses are enabled to take part in the clinical decision-making process. Nurses are in a unique position, often spending more time with the patient than any other healthcare professional and often being told things that are not shared with a doctor. Therefore, during the process of closer multidisciplinary team working, nurses are able to influence the choice of regimen and to determine whether it will really fit with the patient's lifestyle.

Motivational interviewing

Nurses can also help clients think about the process of health-related change through the use of

Case study

Trudy is a 36-year-old, single, HIV-positive woman from Uganda with a 7-year-old daughter. Trudy has an application for asylum lodged with the Home Office based on her political activities and, having been diagnosed as HIV-positive, she fears that she would not receive medication if she returned to her country of origin. Trudy attends Immigration Services every 2 weeks to sign on, enabling the Home Office to maintain contact with her and detain her if they wish. Trudy is very concerned that she will be returned home.

Trudy's perception of the nursing staff may be that they are in a unique position because they are seen as both health professionals and helpful advocates who are able to effect changes to her difficult life. This often results in a deepening of the levels of rapport between staff and clients, and may facilitate a more open relationship that may prove helpful once Trudy needs to commence medication.

However, through a thorough assessment of Trudy's needs, the nurse may establish that her priority is the requirement for information to be forwarded to the Home Office. In this case, the nursing staff could assist as part of the wider multidisciplinary team with the preparation of reports or letters, as required. Trudy could be offered information and help regarding commencing antiretroviral therapy both here in the UK and also back in Uganda. The nurses could facilitate onward referral to peer support agencies that could assist in advocacy, the provision of information regarding the availability of treatments in Uganda, and up-to-date immigration legislation from the Home Office.

Panel 1.

Pre-contemplation	This is a state where the client may not even be aware of what needs to change in their life
Contemplation	They have awareness of what needs to change but are not actively doing anything about it
Preparation	The change is being actively contemplated and plans of how this is going to happen are examined
Action	The change has begun
Maintenance	Strategies are required to maintain the change
Relapse	A return to an earlier stage

motivational interviewing. According to Bundy [3], it has been assumed that the diagnosis of a health problem is sufficiently motivating to produce an associated change in behaviour; however, this is often not the case.

The aim of motivational interviewing is to enable clients to make healthier choices and explore with the client the motivators for their current behaviours. The outcome is that the client is enabled to explore the positive and negative aspects of their current behaviours and the healthier choices they could make. However, it is important to think about why people change: it may be related to the fact that the benefits outweigh the costs; the change may be important to them; they have confidence to change; or they have the ability and support from those around them to make and sustain changes.

So why don't people change? It seems that human behaviour often results in the person making wrong choices, as currently demonstrated by the problem of an increasingly obese population in the UK. Motivation can be described as a readiness to change. However, which aspects of a person's life may be influenced to change can vary from one time to another.

The work of Prochaska and DiClemente has demonstrated that the process of change is cyclical [4]. They originally developed their ideas from their work around smoking cessation, and it would appear that it can be applied to health-related change. They suggested that clients pass through a number of phases during the process of change, and that, often, the process would begin but then stall, returning the client back to an earlier phase. The phases are shown in Panel 1.

An algorithm incorporating the initial phases of change has been created, and forms the basis of European guidelines on how to assess whether a client is ready to start antiretroviral treatment (Figure 1). The algorithm provides detailed

information on how to assess whether a client has moved from one stage to the next, and includes useful hints on how to direct your consultation.

The important core skills required by nurses within motivational interviewing include a need to understand the client's frame of reference using reflective listening. It is important to express acceptance and affirm what the client tells you and their freedom of choice and self direction in their future decisions. The abilities to reinforce the client's own motivational statements and monitor their readiness for change are central to this approach.

During the process of working with clients, it is important not to jump ahead of where the client perceives themselves to be, or resistance may be encountered. 'Resistance' refers to when the client does not feel safe or understood by the healthcare worker, and can manifest as denial, blaming, disagreeing, arguing and hostility. The best way to help deal with resistance is to emphasise personal control and choice to the client and reinforce that it is the client who decides how they act. However, often ambivalence, where someone has conflicting feelings about something, appears to be the problem. This often tends to be expressed during the 'Contemplation' phase and working through this is the central goal of motivational interviewing.

One of the tools that can be used to help with this is the 'Typical Day Strategy' which, as one would expect, involves the client describing their typical day. This can be a useful technique to enable a client-led conversation, is useful in developing rapport, and gives an indication of the client's readiness to change. It has the advantage that it contextualises the behaviour in the person's life.

Another tool is a Decisional Balance Sheet that is, in effect, a list that enables the client to explore the

Case study

Simon was diagnosed as HIV-positive 2 years ago. Simon uses street drugs and alcohol, particularly at weekends. Simon states that he uses these as a means to forget his problems. However, the chaos in his life has resulted in missed doses of his antiretroviral medications. Simon's long-term relationship recently broke down and he is experiencing social isolation. Simon's current CD4 cell count is 234 cells/mm³ and his viral load is 400 copies/ml. During a routine appointment, Simon discloses significant levels of ambivalence related to his status and his medication regimen. Over several subsequent visits, Simon is able to articulate why he began to drink alcohol and use street drugs. He is able to discuss other coping strategies that he could use, promoting his adherence to antiretroviral therapy and reducing his use of alcohol and drugs.

pros and cons of continuing the current behaviour and the pros and cons of changing the behaviour.

Conclusions

In this article, I have attempted to suggest that although once-daily regimens of antiretrovirals and early intervention with them may be clinically indicated, this is often complicated by the patient's life outside the consulting room. I would suggest that nurses, through their working partnerships with clients, need to feel able to act as an advocate on the client's behalf regarding when they begin medication and what the regimen is. The role of the nurse is changing in terms of secondary prescribing and this may impact upon the issues of adherence and tolerability. It may also impact upon our relationships with other prescribing colleagues, enabling us to help patients make better long-term choices regarding when to start medication and what this regimen should be.

Acknowledgements

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Recommended reading

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The importance of HIV specialist services for African women living with HIV in Nottingham: results of a qualitative study

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Introduction

This article reports the results of a qualitative study of the experiences of African women living with HIV in Nottingham, UK.

Globally, sub-Saharan Africa is the region most severely affected by the HIV pandemic [1]. This pattern is also reflected in the UK where African migrants make up 27% of those diagnosed with HIV despite the fact that they constitute less than 1% of the population [2–4]. Healthcare staff play a central role in meeting the prevention and care needs of people living with HIV/AIDS [5]. In contexts of increasing migration, health workers are called upon to recognise the diverse cultural, social, economic and political histories of their patients, and to understand how these interface with their current living situation, including their HIV-related health and treatment needs [6].

Relatively little research has been conducted to investigate the health experiences of migrant populations living with HIV in the UK, or on their patterns of access to, and utilisation of, HIV treatment and care [7]. Findings from the available, but limited, studies indicate that African migrants tend to present later than other population groups for HIV testing and treatment [8]. This is attributed to a number of obstacles to seeking or accessing care, including individual/community characteristics (such as AIDS-associated stigma, lack of perceived risk and denial), and factors associated with service and welfare provision in the host country – such as perceived discrimination, language and cultural differences, financial constraints and uncertain legal/immigration status [8–10].

Migrant African communities in the UK have traditionally congregated in London, where a large range of HIV specialist medical and community-based services are available, and where material and social resources can be accessed through existing social networks. It is estimated that 81% of HIV-infected Africans live in London [4]. This situation is slowly changing however, attributed in part to the Government's policy of 'dispersal' whereby, since 1999, asylum seekers have been 'dispersed' to locations across the country. Questions have been raised as to whether HIV services outside the capital are able to provide specialist care that is appropriate and accessible for African migrant groups. Very little research has been done,

however, to explore the experiences of HIV-positive Africans living outside London [10–12].

African women and HIV

In the UK, women accounted for 65% of new HIV diagnoses made in 2003, of which more than 70% were African [2]. (A breakdown of more recent figures that combines gender and nationality is not available in the latest Health Protection Agency (2008) report). Most of the research on HIV and migrant African communities in the UK however has focused upon men, or has utilised mixed-gender samples [10,13]. Only one study has explicitly focused on African women and it drew its sample exclusively from London [14,15]. This study showed that, although not a homogeneous group, African women's experiences of living with HIV were shaped heavily by their socio-economic circumstances, by the responsibilities of motherhood and by their immigration status. In situations where women were living in relative poverty and where their immigration status was insecure, health concerns were overshadowed by more immediate survival concerns. In addition, given the limited treatment availability in African countries, for many women, staying in the UK represented their only opportunity of access to HIV treatment. Thus, some women appeared trapped in a catch-22 – even when life in the UK was difficult, going back home was no longer an option. This study [15] also highlighted the fact that HIV/AIDS remains a heavily stigmatised disease, and that fear of HIV-related stigma affected women's ability to access social support, both from family and friends or from the voluntary sector.

In order to ensure equity of access to healthcare based on gender and on locality, there is a need for more research to examine the experience of African women living with HIV in the UK and, in particular, to consider the nature of this experience for those living in areas that are less well served with specialist HIV statutory and voluntary services. Our study aimed to investigate these issues in the central English city of Nottingham. The study aimed to explore: (i) African women's experiences of coping with HIV; and (ii) their views on the city's HIV services. This paper focuses primarily on the latter issue – women's views of service provision. A fuller account of the research can be found in Ndirangu and Evans [16].

Research setting

Nottingham is the economic and cultural capital of the East Midlands area of the UK and has a population of approximately 625,000 people of whom 81.1% are classified as white-British and 15.1% are from other ethnic groups. There has been a 494% increase in new HIV diagnoses in the East Midlands region in the last decade [3]. According to the latest available cumulative figures, 412 people in Nottingham City PCT have been diagnosed with HIV, of whom 49% are African. Forty-five percent of the people living with HIV/AIDS are female, of whom 71% (n=89) are African [3,17]. HIV services in Nottingham are delivered through two different hospital clinics based in an Infectious Diseases Unit and a Genitourinary Medicine Unit. These services are supported by a multidisciplinary, community-based 'Positive Care team' (comprising a specialist nurse, a social worker, a dietitian, a community care officer and a befriending service coordinator). Although the team now also includes a Terrence Higgins Trust Centre, this was not available at the time of the research. The Positive Care team runs a weekly 'drop-in centre' where people living with HIV/AIDS can come to socialise and access professional help on an informal basis. The voluntary sector in Nottingham is small, comprising two refugee support groups and one HIV-related support group that is run by non-Africans. There are no African-focused HIV-related community organisations.

Methods

The research adopted a qualitative approach, using semi-structured interviews to ask migrant African women in Nottingham about their experiences of coming to the UK, the impact of HIV/AIDS, sources of support, coping with everyday life and views on health services [18]. Data was collected in 2005. The sample comprised eight African women from three different countries; Congo (n=1), Malawi (n=2) and Zimbabwe (n=5). They represented approximately 10% of Nottingham's female African HIV-positive population. English-speaking women aged 18–50 were recruited opportunistically via the hospital or drop-in centre with the help of the Positive Care team. Some interviews took place in women's homes, and some were held in the hospital. Ethical approval was obtained from the local National Health Service Research and Ethics Committee. Great care was taken to ensure that participants understood the nature of the study. They were assured that their participation was entirely voluntary, that it would not affect their care in any way, and that their views would remain strictly anonymous. Arrangements were made for psychological care in case anyone became distressed; however, recourse to this provision was not required.

The interviews were conducted by the first author (a Kenyan nurse who was at that time studying for an

MSc). The interviews were audio-taped and transcribed. Data was analysed thematically using framework analysis [18–20]. Three themes are considered here: (i) living with HIV as a migrant; (ii) HIV stigma and social support; and (iii) the role of health services.

The sample

Two participants were students, four were asylum seekers and two had 'indefinite leave to remain' in the UK. All were aged between 30 and 50 years. Five participants had studied to secondary school level. The students were in part-time employment and one participant was in full-time work. The asylum seekers were barred from working and had to rely on state benefits, which (as will be described below) were judged insufficient. Women gave a variety of reasons for migration, including fleeing from war (1), political insecurities (2), pursuit of work (1), visiting relatives (2) and education (2). All participants had been in the UK for a relatively short period of time (between 1 and 5 years) and were still trying to adjust to the new environment. The majority of the participants had initially come to the UK alone, although a few of the women were later joined by some or all of their children or a husband. None the less, they found themselves without the close social and family networks that are characteristic of the African setting.

The majority of women (7) had children, four of whom had children living in the UK. The children of the other three women were still in Africa living with relatives, but were depending upon the participants for financial help. The majority of the women were the main providers and care-givers for their children, both in the UK and back home. Half of the women had been divorced prior to coming to the UK, two participants were single and had never been married, while one was widowed. Thus, most of the women were single parents with no informal psychosocial support from a partner.

The majority of the group had been HIV-positive for a period of 1–4 years.

Results

Living with HIV as a migrant

The impact of migration on the participants' health was varied and depended upon their migration status, reasons for coming to the UK and the kind of life they had back home. For the asylum seekers, lack of legal status meant that they had to live with the uncertainty of being sent back home and that they might lose access to life-saving treatment:

My head is not well, I am not thinking properly because of problems of immigration. (P5)

If I had a choice, I wouldn't be here – I can't go back home because where will I get my medication from if I go back home? What will happen to my daughter? (P6)

The view of the life in the UK depended on their previous life back home and on their current circumstances in the UK. For participants who had left difficult circumstances back home, they were grateful for the basic facilities and security that they now had:

Oh! The good day is that when I found accommodation here. I live well, everything was there, I wash my body, you are free, I had food, I sleep well with blankets, the clothes was there, everything was there. The support was there, so everything is good for me. (P2)

On the other hand, asylum seekers were struggling financially as they tried to use their meagre state welfare benefits to support themselves and their kin both in the UK and in Africa. In their view, work would help them improve their economic situation while at the same time give them a sense of normalcy and general well-being:

I was refused you know because asylum seekers are not allowed to work. You have to sit just like I am sitting, may be that is why... sometimes I think that is why I got this venous thrombosis. You know back home we work, we were working very hard. (P3)

Some of the participants had past traumatic experiences in their countries of origin that clearly affected their emotional well-being:

When they killed my mother, my father and my two brothers went to [name of home town] and I have not received any news about them. I worry if they are alive or they have already died. This is what makes me have a headache. (P5)

HIV stigma and social support

Many women in the study described how HIV-related stigma hindered them from accessing social and psychological support. A number of women kept their diagnosis a secret, particularly from others in their own countries/communities. In their view, they felt that people associated HIV with immorality and would thus view them as being immoral and undeserving of any help:

They think that maybe you used to go around with many men – you see, they will think that and won't think anything else – they will think you are a prostitute. (P5)

No, I didn't tell anyone. Because who can I tell? I will tell my friend and then she will tell another... then all the people from your country will know that you are sick. Then they will start to talk and you will feel bad. That is why I do not tell anyone. (P4)

Some of the asylum seekers in particular seemed lonely and socially isolated, and their situation was exacerbated by being housed in poor

accommodation in 'rough' parts of the city. In these difficult circumstances, some women noted that their childcare responsibilities and love for their children were the key factors that kept them going:

Everything is for the children, the children you know. I haven't got time for myself really, when they told me. Since then, I do not feel well – sometimes I think to myself to drink all the medicine and die, but when I look at my children there, I know it's worth it. (P5)

As noted in other studies (e.g. [21]), all the participants attended church and found great comfort in their faith.

Role of the HIV services

Significantly, health and social care services were the most common source of support for the participants – as reported in other studies from the UK [15]. Many participants depended on the Positive Care team for support with issues such as getting a solicitor for their immigration problems, housing and obtaining benefits. Healthcare providers were said to be the most preferred source of support because they already knew about HIV and could offer tailored support:

Ooh! The first days I am crying when I get illness. Oh! My Lord.....my children... but [the social worker] said to me 'No, no you will get better'. (P2)

All the participants seemed to be extremely satisfied with the care they received and two participants contrasted their specialist care with previous more negative experiences of GP care.

I used to go to the GP but then her actions were not pleasing enough. So when I explained to the doctor at [name of hospital] they said if am unwell I should just rush to the hospital for treatment – At the GPs, they will say come tomorrow or maybe this medication... you will not find this medication in the pharmacy and so on. Such words are not encouraging to a patient. (P7)

Women's expressed satisfaction with their healthcare appeared to be reinforced by the obvious contrast in health services between their country of origin and the UK. Some participants reported coming from situations where there is a lack of resources and where they have experienced stigma and discrimination, especially from healthcare workers. For example, one participant described the care her boyfriend had received in Africa:

In Africa there is no medication and they are not too good in hospitals. They won't treat you very well. Here doctors are very careful, yes they I don't know what to say, each time you go for check up. But back home check up is on your first day, that's it until you die. (P1)

Participants cited the drop-in clinic as being a particularly useful source of support. Although the drop-in is not specifically for African women living with HIV/AIDS, it offered the participants a chance to meet other HIV-positive people and to share and learn more from them. Participants using the drop-in clinic seemed to cope better with being HIV-positive than the participants who did not use this service.

Here at the drop in – most helpful – because they [drop-in] teach me how to practice safe sex and how to look after my body. (P1)

The drop-in, it brings people together to talk about what is worrying them. There are specialists to provide help especially for those recently diagnosed it is a source of motivation from success stories. (P8)

But as it is now.... You know when I went there [drop-in] the people I was seeing there are the people I was seeing when I go to [name of hospital]. So my mind says 'oh this people maybe they are like me'. (P3)

However, probably due to fears about confidentiality and stigma, the participants were universally adamant that they did not want a support group specifically for African women. This seems to contradict findings from other studies which indicate that African community organisations can play a major role in supporting African people living with HIV in the UK [11,22].

Discussion

This brief research report reiterates the challenges that HIV-positive African women in the UK may face in disclosing their status and accessing support due to stigma, uncertain legal status and difficult social/economic circumstances [2,5,15]. The need for secrecy can lead to physical and emotional isolation as women struggle to keep their HIV status a secret. The loss of social networks and/or not wanting to establish new ones means that African women may rely heavily on health/social care workers for support. Significantly, in this small study, the health service was represented as the only safe social space in which women could access non-judgemental care and support. Women appeared to be extremely satisfied with the care they received and did not report any significant barriers to accessing care. This is undoubtedly partly due to the multidisciplinary nature of service provision in which specialised medical, social welfare and nursing support was available in one location. The dedication of those in the Positive Care team and drop-in facility was also recognised.

A key implication from this study is that in geographical areas such as Nottingham where the voluntary sector contribution to HIV care is limited, it is important that statutory HIV services recognise the potentially critical role they play in supporting

this patient group, and ensure that adequate staff time and resources are made available to continue this effort.

Conclusion

In conclusion, HIV services in the UK appear to play a central role in meeting the needs of African women living with HIV/AIDS [11,14]. Coming from a context where HIV/AIDS is still heavily stigmatised, African migrant women appear to highly value care that is non-judgemental, personalised and kind. However, as with all nursing care, it is important to recognise that African immigrant women are not a homogeneous group but rather have unique and varied needs, different experiences and expectations from healthcare services. Assessment of each individual remains crucial [9].

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Gender, gender inequalities and HIV: implications for nursing care

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More than half of the 40 million people infected with HIV worldwide are women. The HIV epidemic is increasing faster amongst women than men and nowhere is this trend more apparent than in sub-Saharan Africa [1]. In the UK, one in 440 pregnant women is HIV-positive and 2007 statistics have shown an increase in the number of women acquiring HIV within the UK [2]. What makes women susceptible to HIV? How can nurses take gender into consideration in their approach to improving services and assessing the needs of HIV-positive women in their care?

This article will analyse the concept of gender and how this can affect women's health with respect to HIV/AIDS. It will define and outline key issues that perpetuate women's vulnerabilities to HIV such as biological differences, gender roles, and gender-based violence. It will also illustrate how nurses could mainstream gender within HIV services in order to improve their assessment of their patients and the services offered to those patients.

Definition of gender and gender inequalities

Gender is a social construct that differentiates the power, obligations, roles and responsibilities of the feminine and the masculine in society. In its broadest sense it defines an individual's opportunities, roles, responsibilities and relationships in relation to this [4,5]. Gender inequalities are gender constructs that discriminate against women in particular, by preventing them from having an equal role with men within their household, communities and civil society. The World Health Organization [1] argues that certain gender inequalities have contributed to the HIV/AIDS epidemic.

Biological vulnerability and prevention

Heterosexual sex is the most common route of transmission of HIV for women and accounts for 90% of transmissions [6,7]. Sexual physiological differences between men and women do determine vulnerability to infection. Women have a higher probability of acquiring HIV from their male partners, due to their physiological differences and this is precipitated by untreated STIs, and immaturity of the female genital tract, particularly in younger women [8].

Preventative measures such as the condom, that help to prevent HIV, STIs and pregnancy are essentially seen as a male form of contraception and therefore require men's co-operation at the time of intercourse; in a way which other modern contraceptives such as the pill and intrauterine device do not [9]. Fundamentally, when using condoms women lose complete control of contraception and the power shifts back to men. Beliefs around pregnancy and fertility also make it difficult for women to negotiate condom use in marriage [10]. Therefore there is an urgent need to increase funding in areas of prevention that are controlled by women themselves, such as preventative antiretroviral drugs, microbicides and vaccines [11].

Gender norms and roles

Gender norms are the set of perceived behaviours and roles that women and men are expected to conform to within a society [1]. Socially constructed differences between women and men are typically related to their reproductive function. Therefore the reproductive roles of women such as childbirth and maintenance of the family have been used to justify their subordination to male heads of family and the denial of equal opportunities globally [12]. Roles specifically attributed to women in society are commonly associated with female monogamy, marriage, motherhood, care-giving and power over decision-making.

Gender roles that contribute to social vulnerabilities to HIV are related to unequal power relations because women are often dependent on men for their survival, emotionally and economically [13]. As a result of this lack of power within relationships, women can find it difficult to negotiate condom use or gain access to prevention and reproductive services [14]. The notions around female monogamy and marriage have led to a double standard where women's sexual expression is often judged more rigorously than men's [14]. This double standard also denies the active role men play in transmitting HIV/AIDS through their sexual behaviour. In many societies, it is a gender norm for men to have many partners even when they are in a long-term sexual relationship [4,15].

Women's ability to be mothers and care-givers, means that they have specific differences in their duties, responsibilities, rewards and entitlements compared with men [16]. The altruistic model of motherhood is usually exacerbated when women

are living with HIV as women have to balance the concept of motherhood with the potentiality of bearing a child infected with HIV and caring for this child in the future. In a UK study [17] it was found that HIV-positive women tended to be the primary care-givers of both infected and uninfected children, there were high levels of single parenthood because women had lost extended family support due to migration, and many fathers were absent due to abandonment and death.

Equally, a woman's ability to make decisions within the household can be a more direct measure in terms of her being able to make crucial health choices. Decision-making abilities can indicate the power dynamic women face in terms of other family members in their own effort to secure their own welfare but also those of their children. It has been found that women who have strong decision-making powers have better outcomes in terms of maternal health. Similarly, women who headed households and single mothers were also more likely to have a final say in decisions and were substantially more likely to use health services and deliver babies in a hospital [18]. Although this study looked primarily at women accessing maternity care, there may be a similar influence of decision-making abilities in women's ability to access HIV/AIDS care, particularly when starting treatment and monitoring adherence.

Gender-based violence

The World Health Organization [19] argues that gender-based violence is well recognised as a major human rights violation, a public health problem and is seen as an epidemic which overlaps that of the HIV epidemic. Figure 1 shows that violence can occur at any phase of a woman's life; it can be present from the cradle to the grave, and can be perpetuated by society, individuals and the family. Violence is not always physical but can include emotional, verbal, sexual and economic abuse of the individual [20].

Gender-based violence can prevent women from accessing HIV prevention and reproductive services. Violence can also escalate when women demand condom use, or at diagnosis. The quote bring 'AIDS in the Household' is all too real for women in the world today. Women who are victims of intimate partner violence are less likely to test, to have safe sex or to access care. A Human Rights Watch study in Uganda [22] found that women suffering from domestic violence were less likely to ask for money or permission from partners in order to attend HIV/AIDS facilities or seek information, and in some cases were forbidden from taking a test.

This is supported by studies related to maternal health which illustrate that women experiencing intimate partner violence are less likely to access antenatal care; they present late and have a 37% risk of obstetric complications requiring admission to

hospital before delivery [18]. The Confidential Enquiry into Maternal Death [23] recommended that, as part of antenatal care packages, midwives screen all pregnant women for domestic violence and obtain training in order to do so. Another study in the UK found that many of the women reported having experienced stigmatisation and violence as a result of HIV; such as rejection from partners, eviction from home and being refused contact with their children. It also found that both poverty and violence affected HIV-positive women's ability to adjust to diagnosis [17].

It is essential that nurses have an understanding of how gender-based violence can affect women's ability to adjust to diagnosis, how it can prevent partner notification and women's ability to access health/reproductive services. Nurses need to be able to identify how to refer women to refuges, social services and organisations that can assist women to escape violence. Nurses need to be aware of the harmful effects of intimate partner violence on children and also how to refer children to child protection services when necessary. Escaping violence is one way in which nurses can improve health outcomes of women and children in their care. The question is, as HIV services open doors to more and more women, should nurses within clinics screen all women for violence as part of their first and yearly assessments? This article, as outlined above, argues that nurses should.

Mainstreaming gender and gender inequalities in nursing assessment

Gender mainstreaming as a process can be a model by which to improve services at clinic level and enable better assessment of women affected by HIV/AIDS from a national and international perspective.

The concept behind gender mainstreaming is to develop health services that are gender-sensitive and address the needs of both women and men equally, with the end result that services are valuable to all male and female clients. As illustrated, because of harmful gender constructs, women in general have borne the brunt of the HIV epidemic and HIV services are a long way from addressing women's needs.

One way that services could be improved would be to incorporate social and physiological gender differences in nursing assessments and to improve access to reproductive services for HIV-positive women. This would include integrating services such as yearly cervical cytology, sexual health screening, family planning, emergency contraception, female condoms, pre-conceptual counselling, fertility awareness and domestic violence screening within HIV nursing clinics.

The NHIVNA core competency 'Assessment of health and well-being' [24] is a tool that can be

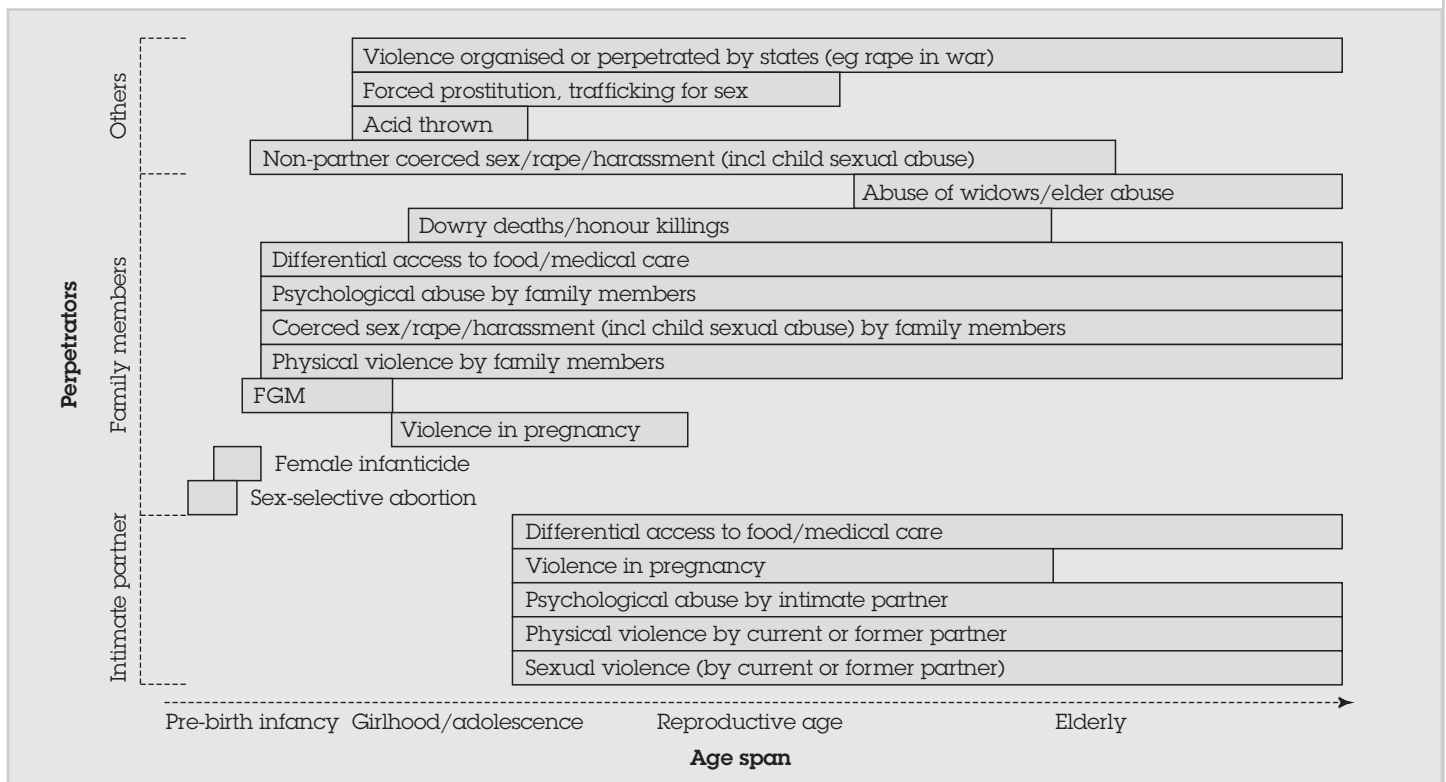


Figure 1: Violence and abuse against women over time adapted from [21].

used to address the health needs of women. As it is gender neutral, each component of the competency should be analysed through a 'gender lens'. For example, in the physical assessment module, the gender lens can be used to highlight the physical characteristics that can make women more vulnerable to HIV. Women tend to have different pathophysiology, different disease progression, different issues around the tolerability of HAART and women may have different priorities regarding their physical health as they are more likely to put the physical needs of others above their own, such as children. When assessing social well-being, as illustrated earlier, women have specific roles within their families, they may be primary carers of a disabled husband or child, they may be experiencing domestic violence, they may be a single parent on a low income, or may be experiencing poverty due to asylum. On a psychological level women may have been victims of sexual violence in their home countries, they may be reluctant to disclose their status due to fear of stigmatisation, abandonment, rejection or violence and this in turn may affect their ability to adjust to diagnosis and may create future isolation from services. It is important to stress that HIV-positive women rely heavily on health services for physical, social and psychological support as they may have limited social support networks outside the clinic setting.

As a result of understanding gender differences, nurses can be in a better position to assist in a client's well-being and create better pathways of care. Nurses can refer women to voluntary organisations focused on women's needs, involve

statutory services as appropriate, change to treatments with better tolerability, and more importantly provide reproductive services within clinics specifically focusing on prevention (STIs, cervical cytology), protection (female condoms, post-exposure prophylaxis and emergency contraception) and conception (to prevent onward and vertical transmission).

It is important for nurses giving care and developing services for women clients to be aware of societal gender constructs that contribute to gender inequalities, which in turn have created barriers for women in terms of being able to protect and care for themselves in the midst of this epidemic.

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HIV and nursing in Romania

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Editor's note: As a central European country, Romania has a relatively low HIV prevalence, with around 0.1% of the adult population infected (less than the UK, at 0.2%). However, Romania has the highest proportion of paediatric HIV cases following an outbreak during the 1990s.

In this article, the first of a series from colleagues across the European region, Cristina Nitu shares some thoughts about nursing in Romania, and developments in HIV care, treatment and support.

Romania is a former communist country in south-eastern Europe, famous as the country of vampires (especially Dracula), and the football player, Mutu. Romania is blessed with high mountains, plains with rich soil, and the Danube Delta. The language spoken by the Romanian people is Latin-based with Slavic and Turkish elements, from our Slavic neighbours and a history of many conquests.

For 50 years this beautiful country was led by communists, who, during their final 15 years, decreased the local consumption of goods in order to increase exports, and educated 'multilaterally developed' workers for industry fields, planning to increase the workforce by encouraging families to have more children. To obtain a high number of newborns, the Government decided to forbid the sale of contraception, and it was made illegal to perform sterilisation or abortion.

At that time, during the 1980s, the only way to become a nurse was to attend a nursing school following 8 years of primary and secondary education. This type of school provided general education, medical and nursing knowledge, and after 4 years of education, a 19-year-old nurse could work in any specialty as a 'general nurse'. No further training was available for intensive care, geriatrics, obstetrics or anaesthesia. Between 1985 and 1989 there was also a shortage of medical equipment and little knowledge about single-use devices. This, coupled with the lack of access to sex education and condoms, led to the sudden increase in children affected by HIV in the country during the late 1980s and early 1990s.

I finished the nursing school in September 1987 and started to work for the Emergency Hospital in Bucharest. It was a hospital with 700 beds and eight wards: surgery, internal diseases, orthopaedics, ICU and five surgery blocks. I had worked in ICU for the

first 5 months having no clear idea about parenteral communicable diseases. Nurses performed venepuncture for blood samples and intravenous infusions using glass and metal syringes. Intravenous catheters and protective gloves were not available.

In the summer of 1989, while I worked as an anaesthetic nurse, written information from the Ministry of Health was distributed, telling doctors and nurses about a new disease, AIDS. We were told that a virus caused the disease by destroying the immune system, and it was transmitted by sexual and parenteral routes. Just after this revelation, in December 1989, the communist government was removed and Romania became an open country. After this, medical supplies suddenly improved and disposable syringes, intravenous catheters, disposable surgery kits, and single-use blades became available.

In 1991 Romanians become aware about the thousands of HIV-infected children in their country. These children were kept mostly in hospitals, abandoned by their families and stigmatised by the rest of the people. AIDS was something that everyone was afraid of, but no one knew how to recognise.

In 1992 I went back to school, a nursing college, to continue my nurse education. One day, I met a few HIV-infected children. Later, after I finished the nursing college, I was hired as a junior nurse in a new ward for HIV-infected children. This ward was built as a hospital and home for 65 abandoned patients. The chief of the unit was an infectious diseases physician who had treated those children since 1989. He wanted to create a caring and loving environment, where the children would not be stigmatised, and where their suffering could be eased.

Our young patients were 4-7 years old, and had many of the diseases and symptoms associated with immune system collapse. They had chronic diarrhoea, skin disorders (*scabies*, *Tinea capitis* and *T. corporis*), tuberculosis and delayed psychological development due to neglect. What followed in the next years was proof that love and good medical care could make a difference to their lives. No antiretroviral therapy (ART) was available, and our care focused on providing proper hygiene, treating opportunistic infections, giving love and education. Dermatological treatment was given twice a day after baths, and hair was cut once a week. The majority of the children had chronic otitis media and their ears needed cleaning twice daily. At that time, it was also hard to convince those 6-year-old

children to eat – they were not used to doing this, or they didn't know how to eat with cutlery from a plate. They only knew baby-bottles.

Starting this project, and working with, and educating junior nurses had great results, with the children receiving the care and support they required. Outside the hospital walls, however, HIV stigma was still very strong. The children were denied access to schools, and so a special education unit was established in the hospital.

After antiretroviral therapy became available in 1997, our patients' health immediately changed, and some were finally accepted by their families, and were eventually able to find jobs. Antiretroviral therapy is paid from government funds, and regimens follow European guidelines. Currently, around 6500 people are taking it, 2000 of whom are aged between 14 and 20.

There is still something missing from this chain of care, however: the support system does not yet sufficiently address adherence. Hopefully, a first step has been made recently. At the unit where I work a multidisciplinary team that involves physicians, two nurses and two psychologists has been established. Our small team has already met with colleagues from Western Europe, and we hope that learning from other regions, as well as listening to feedback from our clients, will help us as we begin to focus on meeting the individual needs of people living with HIV.

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Sexual health and health promotion for people living with HIV

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In 2006, the British Association for Sexual Health and HIV (BASHH) [1] published a guideline whose scope and purpose was:

To support people with HIV to enjoy good sexual health for their own personal well-being, as well as to help clinicians to provide treatment and care for people with HIV and to prevent onward transmission of the virus and sexual infections.

Particular recommendations of the guideline are given in Panel 1.

With this guideline in mind, we undertook a retrospective audit of a clinic that had been set up specifically to provide for the sexual health needs of HIV-positive patients.

Panel 1: Recommendations

- Staff to be trained in taking a sexual history and an appropriate sexual health assessment
- A sexual assessment documented at first presentation and at 6-monthly intervals
- Local care pathways for diagnosis, treatment and partner work for STI in people with HIV
- Syphilis serology to be incorporated into the routine HIV bloods and at 3-monthly intervals
- Annual cytology for HIV-positive women and recorded in HIV medical notes

This particular clinic is a nurse-led, self-referring, open-access clinic with an appointment and walk-in service for 5 days each week. The five nurses who run the clinic are either band 7 or 8 and between them, have many extra qualifications including independent prescribing, physical assessment, family planning and motivational interviewing techniques.

Aims and objectives

The aim of the audit was to review this nurse-led, sexual health-screening clinic for HIV-positive patients within a GUM setting and the specific objectives were to:

- Identify the number of infections (STIs) and diagnoses within the clinic;
- Identify the health promotion opportunities taken and the education given within the clinic.

Methodology

The study retrospectively audited patient records for a 1-year period, 1 May 2006–30 April 2007, inclusive. All patients who attended the clinic during this time were included although patients attending only for follow up, results or treatment were omitted from the sample. The number of patient attendances in the final audited sample was 447.

Statistical Package for Social Sciences (SPSS) version 14, and Excel 2008 were used to analyse the data

Table 1: Demographic details of each audited attendance.

Average age 37 yrs		Number	Percentage of total
Ethnicity	White	354	79
	Black	47	11
	Asian	10	2
	Other	11	2
	Unknown/no record	25	6
Gender	Male	436	97.5
	Female	11	2.5
Sexual orientation	MSM	412	92
	Heterosexual	30	7
	Bisexual	5	1

entered from the audit collection tool. Ethical considerations were addressed when undertaking this study. A pilot study of the data collection tool verified the reliability and validity of the findings.

Results

Table 1 shows demographic details for each of the audited attendances. There were a number of patients who had multiple attendances within the study timeframe. Seven patients who attended were aged over 60, two of whom were diagnosed with an STI: one with rectal chlamydia and the other, a 72-year-old, with an infectious stage of syphilis. There were 18 patients under the age of 24, of whom three were women. Three patients were diagnosed with lymphogranuloma venereum (LGV), three with gonorrhoea and there were five other cases of chlamydia.

A high proportion ($n=215$) of the patients had self-referred to the clinic; however, 12 were referred by their HIV doctor, 19 from an 'other' source and there was no documentation for 201 attendances. Reasons for attendance were reviewed and 174 patients were asymptomatic, while 273 (61%) were symptomatic. Of the 65 patients who attended the clinic as a result of contact with an STI, 47 were asymptomatic.

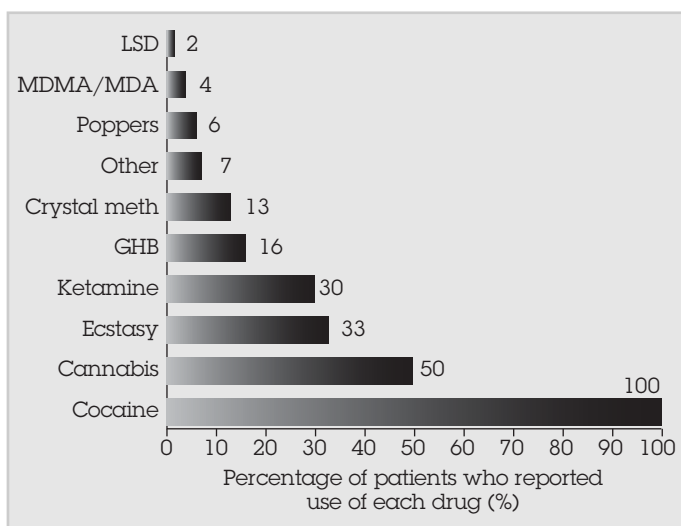


Figure 1: Recent recreational drug use was reported by approximately one-third of patients.

Patients presented with a number of symptoms, the most common of which were urinary ($n=77$) and rectal symptoms ($n=58$), and urethral discharge ($n=66$). 'Other' symptoms were reported by 70 patients and included diarrhoea, pins and needles, and itching. Sore throat was also very common and accounted for 28% of the 'other' symptoms. Two patients had pharyngeal chlamydia and one had pharyngeal gonorrhoea.

The majority ($n=308$) of attendances had between 1 and 5 partners; 55 attendances had 6–10 partners, 33 attendances had 11–20 partners, and 36 attendances had more than 20 partners within the last 3 months. The remaining 15 had no partners or no documentation.

Of the patients who attended the clinic, 293 reported having a regular partner and 36 had no regular partner. There was no documentation in relation to a regular partner for 115 and it was not applicable for three attendances. The HIV status of regular partners was also reviewed and 75 attendances were aware that their partner was HIV positive, 23 attendances stated that their partner was HIV negative, 24 attendances were not aware of their partner's HIV status and the remaining 325 attendances had no documentation of their HIV status recorded in their clinical notes.

Drug use was also reviewed and 38% of patients reported recent recreational drug use, 32% stated no drug use and 29% did not have their recreational drug use recorded. The most commonly used recreational drugs can be seen in Figure 1.

Syphilis serology was offered and tested for 305 attendances, not done for 75 and there was no documentation in relation to syphilis screening for the remaining 67. Within this study 15 patients were diagnosed with syphilis of whom six were confirmed on the initial visit by dark ground microscopy or clinically by the symptoms.

With regard to hepatitis A, B and C, screening and vaccination records were reviewed. It was found that there was no documentation for 245 patients with respect to hepatitis C (HCV) serology; however, 133 patients were tested, while 54 were not. Thirteen patients were already aware of their HCV infection. As a result of attendance at the clinic, two people were diagnosed with HCV. These patients also denied intravenous drug use.

Within the study timeframe, 30% of the patients were diagnosed with a sexually transmitted infection (STI), and the breakdown can be seen in Figure 2.

Health promotion and education

The use of condoms for a number of sexual activities was recorded. A large proportion of the patients reported that they did not use condoms for orogenital sexual contact whether they were passive ($n=62\%$) or active ($n=63\%$) and 36%

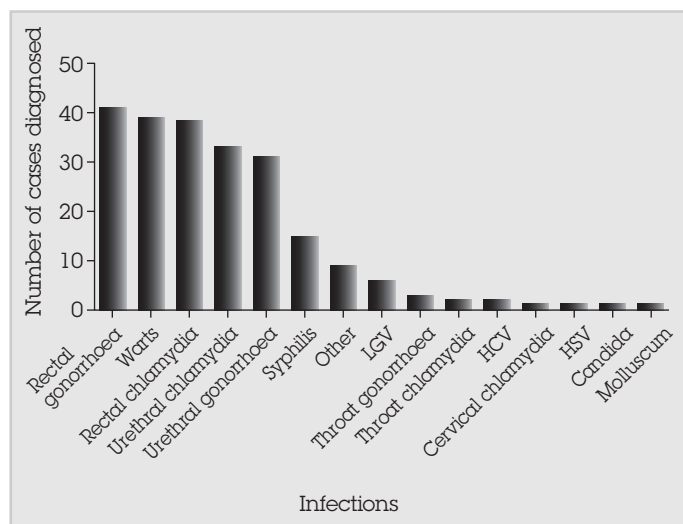


Figure 2: The number of cases of each of the infections diagnosed.

reported unprotected insertive and receptive anal sex. Furthermore, condom use during anal sex was not documented for 47% of the patients. Safer sex was discussed with 376 patients and post-exposure prophylaxis (PEP) awareness was documented for only one attendee. Discussion of the legal implications surrounding disclosure was documented for only seven patients who attended, and there was no documentation for the remaining 440 attendances.

Discussion

Detailed sexual histories

It is evident that there is a need for a detailed sexual history to ensure that the nurse includes the essential questions in order to undertake the appropriate tests. Furthermore, despite the low risk and prevalence of pharyngeal STIs it is still recommended that these tests are obtained for certain MSM (men who have sex with men) [2]. A detailed history will also allow the nurse to highlight any health education needs for the patient such as for recreational drug use and risk behaviour.

Many papers and other authors confirm the link between the increase in sexually transmitted infections (STI) and HIV risk with recreational drug use and high-risk sexual behaviour [3,4]. Therefore, there is a great need to include questions about drug use during the consultation session as well to give health advice regarding safe drug use and the risks associated with drug use.

Syphilis and hepatitis

Within this clinic, syphilis serology was undertaken when indicated owing to the recent increase in syphilis among HIV-positive MSM, which has emphasised the need for regular screening [5]. This also suggests that there is a need to include this test within patients' routine HIV bloods.

In 2004, BHIVA suggested that all HIV patients and all MSM regardless of HIV status should have

regular HCV screening [6]. Recently the Health Protection Agency has reported an increase in HCV prevalence in HIV-positive MSM [7]. The increased risk of co-infections such as hepatitis among HIV-positive MSM has been demonstrated [8,9] and it has been argued that the increase in HCV may be due to sexual practices such as fisting and multiple partners [10]. As shown earlier only two people were diagnosed with HCV and both patients denied intravenous drug use. Nevertheless, this indicates the need to continue to screen all MSM and all HIV-positive patients routinely for HCV. This again emphasises the need to record a detailed sexual history and advise patients of the risk of certain sexual practices.

In relation to these audit figures for HCV screening, the number of HCV cases found may be low as the incubation period for HCV can be up to 6 months and it may have been too early to detect. In addition, although documentation for HCV screening was lacking in these GUM notes, it was felt that HCV screening may already have been recorded in patients' HIV medical notes.

Changes in practice

Following this study, the paperwork used within this clinic has been changed to include a number of essential questions. To promote discussion, a proforma was designed with a number of health promotion 'tick boxes' that included discussion of safer sex, PEP awareness, HIV status of partners, legal issues, number of partners, drug use, and superinfection and resistant strains of HIV.

Recommendations

Overall the findings of the audit reflect national epidemiology showing an increase in STIs amongst HIV-positive MSM.

- This paper highlights the high-risk sexual behaviour and drug use. Therefore, the main recommendation from this study is the need for both nurses and doctors in contact with this cohort of patients to highlight the risk of this behaviour on their health.
- An awareness of the risks and transmission of STIs is essential and there is a need for condom, glove and safe drug use to be addressed. There is also a need to discuss antiretroviral drug-resistant strains of HIV, superinfection and the risk of co-infections and their impact on a patient's health.
- It is vital for healthcare professionals to address the legal issues and implications around disclosure and the risk of onward transmission. For further information in relation to the legal implications patients should be directed to THT (www.tht.org.uk).
- It is also suggested that health professionals working with this group of patients undertake some form of behavioural change training such as cognitive behaviour therapy or motivational

interviewing in order to help patients reduce risk-taking behaviour and to support them in their behavioural change.

- Training is required for all staff to undertake a sexual health assessment and screening to target those people not accessing this particular clinic.

Conclusion

Although this study is limited by its self-selected population and not a true reflection of the rest of the clinic, it does, however, reflect the national picture. The results strongly highlight the need to focus on health promotion, STI and secondary HIV prevention, and risk reduction in sexual behaviour/practice and drug use.

Acknowledgements

I would like to thank Colin Roberts, Lead Nurse Specialist, and Linda Greene, Clinical Director/Consultant for their support and guidance throughout this project.

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Research round-up: focus on women

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Two recent studies summarised below (albeit conducted in the USA) highlight some of the issues facing HIV-positive women, and challenge us to continually develop our practice to meet their needs.

Enriquez E, Lackey N, Witt J. Health concerns of mature women living with HIV in the midwestern United States. *J Assoc Nurses AIDS Care*, 2008, **19**, 37–46.

This research, conducted in the USA, addresses the health concerns of older women living with HIV. It notes that in the USA over 50% of people living with HIV will be aged over 50 by 2015. Relatively little research has been done to investigate how living with HIV and its treatment interfaces with the challenges of growing older. Eighteen women over 40 years (mean age was 47) took part in this qualitative interview study that was analysed thematically. Women's concerns fell into physical and emotional categories. In terms of physical issues, women noted that they would like more frequent healthcare visits and screening in order to reassure themselves that they were healthy in the face of a perceived sense of greater vulnerability and fear of cancer. In addition, women appeared at times to be unsure whether symptoms they were experiencing were HIV-related or related to the ageing process (e.g. fatigue or dry skin). Interestingly, the women noted that their healthcare providers seemed unprepared or unable to answer their questions on HIV and ageing and found themselves in an information vacuum. In terms of emotional issues, the women cited stigma as contributing to on-going isolation and inability to obtain social support for their illness. Interestingly, some women also mentioned that their healthcare providers (especially male providers) rarely asked them about their emotional state or needs: *'we need to talk to someone about this stuff that is happening with our body because your doctor won't know what to tell you – we don't discuss this stuff'* (p.42). The authors conclude that this group of older women saw themselves as 'pioneers' of a sort – amongst the first groups of women ageing with HIV infection. It was an uncertain and lonely journey.

This a small study but it has a number of implications for nursing practice:

- Nurses need to be well informed about the relationship between ageing and HIV. They should be able to describe the symptoms of the menopause and ageing.

- Nurses should proactively initiate discussions with older clients about possible symptoms and provide information about health screening interventions.

For more information see:

www.thebody.com/content/art31086.html

Bova C, Burwick T, Quinones M. Improving women's adjustment to HIV infection: results of the Positive Life Skills Workshop. *J Assoc Nurses AIDS Care*, 2008, **19**, 58–65.

This study reports a pre- and post-course evaluation of a 10-week-long positive life skills workshop for women living with HIV in Massachusetts, USA. The workshop's main aims were to reframe negative meanings (about themselves and about HIV infection), enhance social support and provide help with physical symptom management. The study reports on 187 women who participated in workshops over a 6-year period with a mean age of 39 years (range 23–62 years). Statistical tests showed that participation in the workshop significantly improved adherence to antiretroviral therapy, led to lower levels of stress, and improved mental well-being. During the workshops, the women identified further areas where they felt they needed more support. These included developing comprehensive services for women aged over 40 years, improving access to services for HIV-infected working women (e.g. evening classes), and developing programmes for children of HIV-infected parents.

The authors concluded that the study provides useful evidence for the value of theoretically informed interventions to improve women's adjustment to an HIV diagnosis. Interestingly, although the authors felt that all components of the intervention were important to its success, they noted that, in their opinion, the most critical factor was the *'consistent delivery of positive reframing messages that helped women to think differently about their future with HIV'* (p.65). Nurses should consider referring their clients to services in their areas that run life-skill interventions. In addition, even though many HIV nurses may not be directly involved in running such interventions, they can communicate positive messages to women in their everyday interactions.

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NHIVNA update

The first announcement is now available for the 11th Annual Conference. The conference will be held in Birmingham, 25–26 June 2009. The programme is very exciting, with many excellent speakers and topics. There is still time for you to plan to submit an abstract. There will also be scholarships available to help student nurses and junior nurses to attend. Further information on the conference, abstracts and the scholarship applications is available on the website (www.nhivna.org).

Thanks to everyone who has returned their members' questionnaire. The information gathered will be of great benefit to us in ensuring members continue to get what they need from our organisation.

There will be some changes to the Executive Committee this summer. Some members are due for retirement. If you have ever thought of

becoming involved, now could be the opportunity. Election details will be circulated to members in the spring. However, if the prospect of standing for election seems too daunting, you could always volunteer to help out on a specific project. We are keen to involve members in all the various projects we have on the go and look forward to hearing from you. Contact us by email at: nhivna@mediscript.ltd.uk

Boehringer Ingelheim is sponsoring 20 free memberships for new nurses to join NHIVNA. If you know of a colleague who would gain from membership, please let them know of this offer. Anyone applying for free membership should complete a membership form and submit a short supporting statement. Full information is available on the NHIVNA website (www.nhivna.org).

Sheila Morris
Chair

Call for Papers 2009

HIV Nursing welcomes all articles, editorial letters, case reports and other contributions which would be of interest to healthcare professionals working in the field of HIV.

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As professional nurses, one of the best ways to raise our profile is by demonstrating innovative work that improves the lives of patients, family, and staff within the domain of HIV care.

HIV Nursing aims to provide a forum for those at the forefront of caring for people affected by HIV and is intended to provide a medium of communication on issues relating to HIV care. Readers' contributions are highly valued.

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Wu AW, Rubin HR, Mathews WC *et al.* Functional status and well-being in a placebo-controlled trial of zidovudine in early symptomatic HIV infection. *J Acquir Immune Defic Syndr*, 1993, **6**, 452–456.

Miller D. *Living with AIDS and HIV*. Macmillan Press, London. 1987.

Corey L. HIV vaccine: update on science and policy. 14th International AIDS Conference. Barcelona, 2002, Abstr. TuOr143.

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