

Editorial

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Welcome to the autumn issue of *HIV Nursing*. As I write this editorial, the NHIVNA annual conference seems a distant memory. It is always inspirational to come across like-minded nurses in the same field sharing their expertise and knowledge, and innovative ideas. Unfortunately we are all under growing pressure to increase productivity with decreased manpower, yet endeavour to maintain high standards of care. As a result we tend to allocate less time to evaluate and audit our work, unless it is performance-related, in which case it becomes a necessity simply to justify funding. However, we all entered nursing, first and foremost, to care for patients, and we must continue to participate in research, even on a small scale, to guide quality improvement. At conference, there was a noticeable decrease in the number of abstracts submitted, and there is no doubt that this is due to the increased pressures that nurses are under, finding little or no time to write about any audits, new policies and guidelines, or research in which they have been involved. I would like to take this opportunity to urge you all to share your innovations and developments, as it will ultimately benefit people living with HIV around the country.

The theme of this issue is *Hard-to-reach at-risk groups and vulnerable populations*. As a nation, we are working hard to increase HIV testing to reduce the transmission rate; however, we continue to see a rise in HIV diagnoses, particularly amongst MSM and heterosexuals. In 2013, some 81,510 people in the UK were known to be living with HIV. Unfortunately, another 26,100 (24% of the estimated total) are unaware that they are also living with the virus [1].

Despite everyone involved in HIV care promoting the benefits of early diagnosis, which leads to increased life expectancy, improved clinical outcomes and reduced onward transmission, there is still an obvious gap in diagnosing patients in the first instance. An audit by BHIVA in 2012 [2] indicated that there were missed opportunities for an earlier HIV diagnosis in nearly a quarter of newly diagnosed individuals.

There were 6,000 new diagnoses in 2013, and the largest number of positive tests was among MSM. Despite an increase in services for MSM, 54% of new diagnoses were among MSM [1]. The article by Vaughan Statham and Katherine Bethell describes the evaluation of ROAM, an outreach service for MSM in Edinburgh, looking at novel ways to promote testing and increase service provision. They believe that many MSM diagnosed with HIV have not previously engaged with sexual health

services, and the staff at ROAM are using their skills and expertise to support those men who identify as being gay or bisexual but who prefer to engage with generic services.

Of the 1,522 black Africans newly diagnosed in 2013, 66% of men and 61% of women were diagnosed at a late stage [1]. This cohort has remained one of the hardest to reach, not only in terms of encouraging them to test for HIV, but also retaining them in care. Many HIV-positive Africans have been shunned by their community due to the stigma associated with this disease.

Martha Baillie, Deputy Executive Director for Waverley Care, a charity organisation in Scotland, describes how Waverley Care has developed services that are relevant to, and inclusive of, Africans living with and affected by HIV in Scotland. In her thought-provoking article she highlights the importance of working with communities, and handing over ownership of HIV to these communities to provide the necessary services and to break down stigma.

We must be mindful of ensuring that we provide accessible supportive services to vulnerable populations once they have been diagnosed with HIV, as well as increasing the capacity to test them in the first instance. The article by Jennifer New highlights significant issues and barriers that lesbian, gay, bisexual, trans and intersex asylum seekers and refugees can experience when seeking asylum in the UK and, in particular, when accessing relevant support services in Liverpool. It is vital that everyone involved in HIV services, including health professionals, service providers and those involved in commissioning, work together in partnership to improve the availability and accessibility of support services for any vulnerable and isolated cohort.

There are many initiatives in the UK addressing HIV prevention work, and Sara Davis' article describes an excellent service set up in a specific community to address another health problem, namely hepatitis B, which was then adapted to include HIV testing and health promotion. It is also an excellent example of how working in partnership with other agencies in hard-to-reach communities can help services become more user-friendly, therefore improving attendance figures and reducing health inequality.

Linda Sanderson *et al.* share their experiences of a trip to Zambia. Their group, comprising a child nursing lecturer and child nursing students from the University of Central Lancashire, aimed to promote

sexual health and to provide specific knowledge and skills around HIV and sexual health promotion to community peer leaders, which they could then deliver within their own communities. Their reflective piece acknowledges the difficulties of addressing issues such as sexual health in communities with different cultural views, which is something of which we should all be mindful as we continue to deliver health messages to reduce the risk of HIV transmission. It is important in our culturally diverse society that we work with hard-to-reach populations in a respectful manner, developing partnerships with voluntary organisations within specific communities to gain their trust and confidence, ensuring that every person who could be at risk from HIV, or who has contracted HIV, gets the same access to proper treatment and care.

Another hard-to-reach group that has not been covered in any of our articles is that of injecting drug users. I have written a short report highlighting how this remains a very small cohort due to the

harm-reduction measures that have been in place in the UK for the last 30 years. However, I think it is important to be aware that many people continue to inject drugs and share drug paraphernalia, and we must ensure that as services are commissioned, drug services adapt to accommodate those people who inject drugs but do not consider themselves to have a particular drug problem.

I hope you enjoy this issue.

References

1. Yin Z, Brown AE, Hughes G, Nardone A, Gill ON, Delpech VC & contributors. *HIV in the United Kingdom 2014 Report: data to end 2013*, 2014. Public Health England, London. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/401662/2014_PHE_HIV_annual_report_draft_Final_07-01-2015.pdf (accessed August 2015).
2. Ellis S, Curtis H, Ong EL. HIV diagnoses and missed opportunities. Results of the British HIV Association (BHIVA) National Audit 2010. *Clin Med*, 2012, **12**, 430–434

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HIV Nursing 2016

Now is the time to plan ahead and decide what you will contribute in 2016!

Themes suggested for next year's issues:

1. **New developments or initiatives in care / peer support**
2. **Self-management and empowerment**
3. **HIV and key populations (sex workers, MSM, drug users)**
4. **Socio-economic influences**
5. **Distinguishing features of HIV/AIDS in the context of long-term conditions**
6. **Adherence and antiretrovirals**
7. **An issue given over to student nurse issues and observations**
8. **Research**
9. **Caring for the carers**
10. **International**

Please let us know your thoughts: editorial@mediscript.ltd.uk

- > Have you conducted research or instigated practice that has improved care for your patients?
- > You may have recently completed a dissertation or degree and would like to present your findings.
- > Or perhaps you would like to comment on a specific issue or review a book you have found valuable.

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We welcome all articles, letters, case reports and other contributions of interest to healthcare professionals working in the field of HIV – and would very much like to hear from NHIVNA members. The usual word count is around 2000 but shorter pieces are also acceptable, and non-themed contributions are welcomed.

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Guidance is available from Editorial Board members, who will be pleased to offer suggestions and answer any questions you may have. More information is available on the NHIVNA website.

If you are interested in having your work published, or would like to know more, in the first instance please contact:
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