



**NHIVNA Annual Conference**  
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**Book of abstracts**

## Oral Abstracts

001

### Growing Up with HIV: Transition in Children's and Adult Services - A Chiva/NHIVNA National Audit 2025–26

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#### Abstract

Transition care is complex, and service delivery varies across the UK. This national clinical audit explores transition from paediatric to adult HIV services, benchmarking practice against Chiva Standards of care (Chiva, 2025), BHIVA Standards of Care (BHIVA, 2018), Chiva Transition Guidance (Foster, 2021) and recommendations from the BHIVA transition audit (BHIVA, 2009).

Children and Adult HIV services across the UK were contacted between June – December 2025. Initial contact was via NHIVNA and Chiva membership, national conferences and mailouts followed by targeted email contact. The audit included service evaluation and case note review developed using a Microsoft Forms platform and piloted in a large paediatric, adult and young adult clinic before national distribution. Data were benchmarked against Chiva (2025) and BHIVA (2018) national standards of care.

Audit responses included 17 paediatric (1 duplicate omitted) and 24 adult services reviews and 34 children and 52 adult case note reviews. Responses were from a variety of transition models and clinic provision. Measurable and auditable outcomes have illustrated:

- Transition summary document recorded in 70.9% (n=61) of case reviews, versus service standard of 90%.
- Named transition lead in 75% (n=12) of paediatric service responses and 75% (n=18) of adult service responses.
- 45% (n=18) of services have a dedicated transition MDT.
- Paediatric team involvement for at least 12 months following transition in 53.5% (n=46) case note reviews.
- 37.5% (n=9) of adult services reported young people disengaged with care post-transition.
- 62.5% (n=25) of services routinely screen for mental health concerns.

Areas for improvement and resourcing should focus on developing transition MDTs that include lead professionals, to ensure young people are safely transitioned to adult services thus creating robust systems to routinely monitor young people's engagement with HIV care.

Responses suggests that transition care would benefit from new resources, such as digital transition frameworks and ongoing engagement strategies, regardless of the transition model.

Findings highlight the complexity of care and variation in service delivery. The audit has identified examples of good practice, and addresses gaps in care, informing future service development through findings and amplifying the unique needs of young people growing up with HIV.

002

## Missed chances, lasting impact: learning from late hiv diagnoses to improve testing in primary care.

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### Abstract

In (anonymised city) around half of all new HIV diagnosis were late higher than the England average of 40-46%. Locally we were seeing this trend particularly amongst heterosexual men and women aged over 50 and this was reflecting in our local late diagnosis audit. The key themes from the audit pointed to a lack of HIV testing in primary care and a lack of knowledge surrounding presentation of key indicator conditions. Funding was provided from our local public health commissioner and sexual health service to explore how to improve primary care uptake and also explore the impact of late HIV diagnosis to individuals living with HIV.

16 patients living with HIV were identified as having a CD4 <200 and experienced key indicator conditions prior to diagnosis. These patients were interviewed with a set question format to discuss their experiences prior to being diagnosed with HIV.

#### Key themes identified:

- Long histories of persistent attendance to primary care spanning 3-6 years prior to diagnosis
- Lack of primary care knowledge surrounding key indicator conditions and risk factors for HIV.
- The long lasting psychological, social and economical impact of HIV late diagnosis to patients living with HIV and the impact on engagement in care.
- Patients who are late diagnosed are highly health care professional experienced and have experienced distrust, shame and being unheard.
- Stigma
- Lack of understanding from patients surrounding testing
- Lack of targeted health promotion material aimed at patient's over 50.
- increasing late HIV diagnosis in heterosexual older age groups.

#### Conclusion:

Despite ED opt out testing, HIV late diagnosis remains a concern. Early HIV testing improves patient outcomes, life expectancy and onward transmission. Increasing primary care knowledge and awareness of HIV testing Will aid in preventing HIV late diagnosis by early testing, reducing stigma, early referral to HIV services and ongoing shared care. For the patients who participated in the interview they felt that the experience was cathartic it had allowed for them to be heard, their story to matter and for them to make a change for others.

Implications for practice:

-Produce a video voiced by actors of said interviews highlighting the personal cost of HIV late diagnosis and missed opportunities for testing. The video will be shown alongside time to learn meetings and training.

-Collaborate with sexual health service to improve health promotion material targeting over 50's about HIV testing.

-Working with primary care to identify primary care HIV champions.

003

## Mind the gap: the role of the community CNS in managing complex caseloads of patients across acute and community settings

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### Abstract

Introduction:

Our HIV Clinical Nurse Specialist (CNS) team provides essential clinical support for community patients within some of the highest-prevalence areas in the United Kingdom. Our team operates across geographical boundaries, supporting patients who reside in our boroughs, regardless of whether they attend local clinics or treatment centres outside of our boroughs. Our service engages with patients who have complex care needs, encouraging adherence to medication regimens, maintaining patient engagement and retention in care, reducing hospital admissions and providing care for those that do not attend acute services.

We recognise as a team, we often provide services for our clients, to bridge the gap where services are difficult or impossible for our clients to access.

Methodology and Analysis:

In this presentation, we will audit our caseload to identify the 'gaps in care' that as a CNS we regularly are required to bridge.

We will review 10% of our cohort, specifically those with three or more complexities.

At present approximately 90% of our patient cohort are over 50 years old and face multiple co-morbidities.

For this presentation we will focus on the following four categories.

Categories	Examples of Complexities
<b>Physical Health</b>	Co-morbidities Non-adherence to treatment Palliative or end-of-life care needs Cognitive impairment Polypharmacy Advanced or late-stage HIV referrals Housebound
<b>Social Health</b>	Housing instability Financial difficulties Immigration-related challenges Children and family responsibilities Domestic violence Safeguarding concerns
<b>Emotional/Mental Health</b>	Denial of HIV diagnosis Stigma and discrimination Trust issues with healthcare services Substance use (drug and alcohol)
<b>Liaison/ Care Coordination</b>	Case management challenges Multidisciplinary team (MDT) coordination Gaps in care transitions Engagement and retention in care

Using the data collected from our audit, we will present a case study to highlight the ‘gaps in care’ which a client can fall through, if not supported.

We aim to show that the CNS acts as the primary contact, coordinating multidisciplinary team (MDT) interventions and case management to bridge the divide between acute care and community stability.

**In Conclusion:**

To prevent patients from falling through the gaps in care, the community CNS serves as a consistent bridge between acute and primary sectors. This role is vital for ensuring equitable, high-quality HIV care as outlined in the "Fit for the Future: 10-year Health Plan for England 2025" and the "HIV Action Plan for England 2025/30."

## Experiences of participants and personal nurse reflection in implementing HIV clinical protocol that includes pausing antiretroviral therapy: the RIO trial

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### Abstract

#### Background:

Antiretroviral treatment (ART) for HIV has transformed survival and prevents viral transmission to partners but cannot cure HIV and therefore must be taken lifelong. Trials testing new immune-based therapies with broadly neutralising antibody (bNAb) can confer lasting viral control without ART. To test efficacy, participants must temporarily stop ART, with frequent HIV viral load testing. We report the participant and nursing experiences participating in the RIO trial in the United Kingdom.

#### Methods:

Between January – May 2025, we conducted a qualitative study involving semi-structured interviews with 20 participants living with HIV enrolled in the RIO phase 2 double-blind randomised placebo-controlled trial of HIV-specific broadly neutralising antibodies. We transcribed, coded and analysed interviews using thematic analysis.

#### Results:

Twenty cisgender men participating in the RIO trial enrolled. We identified 5 main themes. First, changes in attitudes to ART early during the ATI, participants initially identified challenges with disrupting daily pill-taking routines, but over time became accustomed and expressed liberation with the absence of fear, stigma, and the need to disclose their HIV status when traveling. Second, the practicality and emotional response to viral load monitoring: once weekly testing provide reassurance about safety. Clinician-led support around viral rebound, along with options for counselling, was welcomed to manage anxiety. Third, impact of the ATI on relationships: during viral rebound, participants experienced heightened vigilance, which led to avoidance of dating, reduced intimacy, and sexual gratification.

Fourth, experiences of ART re-adherence: returning to pill adherence proved challenging for many participants. Fifth, unanticipated lengthy ATIs were met with enthusiasm but caution due to an uncertain future.

Personal reflection on supporting individuals highlighted the importance of frequent, clear and supportive communication, (weekly) rapid sharing of viral load results, non-judgemental, open discussion about sex, intimacy, relationships, sexually transmitted infection risk (STI) and recreational drug use, with rapid referral to psychological support as needed.

**Conclusion:**

When ATI trials are managed within a multi-disciplinary team which includes frequent monitoring, they are feasible, acceptable and foster trust and engagement among the community of people living with HIV.

## ‘Herstory’ rewriting the narratives of women living with HIV.

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### Abstract

**Background:** In the UK, women living with HIV remain underrepresented in research, decision-making, and service design, despite accounting for one-third of people living with HIV (Sophia Forum & Terence Higgins Trust, 2018). Women experience poorer HIV-related outcomes and face complex gender-specific challenges, including stigma, violence, mental health issues, immigration stressors, and poverty (Aghaizu et al., 2022; Flint et al., 2022). Their voices are often absent from the HIV narrative due to limited visibility and involvement in policymaking.

**Aim:** This project sought to amplify women’s voices and promote well-being through writing-for-well-being interventions, enabling participants to share their experiences in a safe, trauma-informed environment. Writing was used as a therapeutic tool to foster resilience, social connection, and empowerment.

**Methods:** Over six months, 38 women engaged in self-paced writing prompts, creative writing exercises, and workshops, supported by one-to-one coaching. Trauma-informed techniques were employed to help participants manage overwhelming emotions. Sessions emphasized safety, with guidelines such as Pennebaker and Evans’ “flip-out rule” (2014) to avoid distressing topics.

**Results:** Three overarching themes emerged:

1. Improving access to care and promoting engagement in care delivery
2. Enhancing outcomes and quality of life
3. Improving care in non-specialist settings

Participants reported mixed feelings about ageing with HIV. While some expressed confidence and gratitude for longevity, others feared stigma, co-morbidities, financial insecurity, and inadequate future care. Concerns included loss of independence, ageism, and HIV stigma in elder care. Wishes for future care emphasised HIV-friendly environments, holistic approaches, and inclusion in research and service design. Based on the feedback from the women short videos were created alongside a document entitled ‘Herstories what women living with HIV tell us must change.’

**Conclusion:** Writing-for-well-being provided a powerful platform for women living with HIV to share their stories, challenge stigma, and influence care practices. These narratives highlight the urgent need for gender-sensitive, stigma-free, and inclusive HIV services as women age with HIV.

## Facilitating HIV Confident GP practices: assessing engagement, knowledge, and attitudes in primary care

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### Abstract

**Background:** Since the start of the human immunodeficiency (HIV) epidemic in the 1980s people living with HIV have faced persistent stigma, despite the introduction of effective treatment. HIV-associated stigma has been linked with a decrease in engagement with healthcare services and poorer health outcomes in those living with HIV. As the first point of contact in general practice, staff play a vital role in the management of the condition, yet 45% of individuals living with HIV felt that their general practitioner (GP) did not know enough about their condition according to the Positive Voices 2022 survey. The HIV Confident programme aims to support healthcare, and other, organisations to address HIV-related stigma and improve staff knowledge and attitudes.

### Aims:

1. To facilitate engagement of GP practices with the HIV Confident programme within the region
2. To understand the attitudes and knowledge of healthcare professionals towards people living with HIV in primary care settings

**Methods:** A quality improvement project was conducted using baseline validated primary survey data from the HIV Confident programme. GP practices across the region were invited to participate and were contacted twice by email, with a further email and phone call to the practices within the city. Upon successful completion of the registration paperwork, practice programme leads were asked to circulate an initial survey to assess attitudes and knowledge surrounding HIV to all clinical and non-clinical staff members. Recruitment, engagement and survey responses were analysed using descriptive statistics.

**Results:** Recruitment for the first wave ran from September to November 2025. 155 practices were contacted: 7 completed the registration form, 2 registered for the second training wave in April 2026, 2 expressed interest but did not return completed forms, 1 declined to take part due to other commitments and the remaining 143 did not respond (a response rate of 7.74%). 120 responses were analysed at the time of writing. While most staff reported additional precautions when caring for patients with HIV were unnecessary, uncertainty regarding the routes of HIV acquisition remained.

**Conclusion:** These initial results highlight the need for ongoing training of all staff and quality improvement to support the care of people living with HIV in primary healthcare settings. Ensuring that primary care teams are confident in their knowledge surrounding HIV is essential to reducing stigma and improving patient outcomes.

## Reach & Engage: the role of peer support in re-engagement pathways for people living with HIV

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### Abstract

#### Background:

Disengagement from HIV care reflects structural, psychosocial, sensory, and neurodivergence-related determinants rather than a lack of motivation. This study explored how people living with HIV disengage from and return to care and brings this into dialogue with insights from HIV clinicians and support staff to inform the design of inclusive, low-threshold re-engagement pathways.

#### Methods:

We used deductive Template Analysis to examine a focus group with people living with HIV (n=6), an in-depth interview (n=1), and one focus group with HIV clinicians and support staff (n=7). A shared coding template, aligned to predefined themes (access barriers, treatment decisions, experiences while disengaged, re-engagement enablers, peer support, digital approaches, and service priorities), was applied across transcripts. A parallel template was used for the clinician and support staff data.

#### Results:

People living with HIV described disengagement as a protective response to stigma, judgement, logistical constraints, sensory overwhelm and treatment fatigue. One participant spoke of “the fear of judgements... that’s what makes people not to go to these centres.” Another described a “crash and burn” effect when attempting to enter clinical spaces due to autism-related sensory overload. Disengagement was also linked to avoidance, internalised anxiety and identity-related distress, with one participant describing the clinic and medication becoming a “huge bogeyman.”

Clinicians and support staff foregrounded poverty, homelessness, immigration anxiety, severe mental health difficulties, and the loss of walk-in access as major drivers of disengagement. They noted that basic needs often supersede HIV care, including the inability to afford transport or food required for medication. Some questioned whether “people really want to be chased so much,” highlighting the need for proportionate and respectful outreach.

Across both groups, re-engagement was supported by flexible, relational and sensory-aware approaches. These included home visits, neutral spaces, holistic support for urgent needs, early peer-support involvement and hybrid digital pathways. Peer support was consistently described as the first safe point of contact. Digital communication offered privacy and “safe passage,” though clinicians noted that online-only models may not reach the most marginalised.

#### Conclusion:

Re-engagement requires trauma-informed, structurally responsive, and neurodivergence-aware approaches that integrate peer support, holistic assistance, and hybrid digital pathways to reduce psychological and environmental barriers.

**O08**

## **HIV Stigma and Awareness of 2030 Elimination Targets Survey in a UK District Hospital**

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### **Abstract**

#### Background

HIV-related stigma continues to affect testing uptake, confidentiality, and quality of life for people living with HIV (PLWH), despite major advances in treatment. Addressing stigma is central to the fourth 90 target and the objectives of the Fast-Track Cities initiative. In our Trust, we have signed the HIV Confident Charter to tackle HIV stigma and discrimination in workplaces. On World AIDS Day 2025, we conducted a survey to explore HIV-related stigma and awareness of HIV elimination targets within a healthcare-associated population in a UK district hospital.

#### Methods

An anonymous, opt-out survey was conducted using a structured questionnaire available in paper and electronic formats. Data were collected during World AIDS Day 2025 activities from a healthcare-associated population. Responses were collated and analysed using Microsoft Excel.

#### Results

A total of 218 responses were analysed. Most respondents were aged 25–45 years (54%), 66% were female, 40% were nursing staff, and 18% were medical staff. Over half (57%) had worked in healthcare for more than 10 years.

Evidence of ongoing stigma was identified: 18.4% reported concern about contracting HIV while providing care, 14.7% felt uncomfortable caring for PLWH, and 4.6% did not agree that PLWH should be treated equally. 18.9% believed HIV status could be disclosed to colleagues without patient consent, and 8.9% had witnessed refusal of care due to HIV status. Only 52.6% felt adequately trained to provide stigma-free HIV care, and 4.2% were unaware of Trust policies protecting PLWH from discrimination.

Awareness of HIV elimination targets was limited: 40.2% were aware of the goal to eliminate new HIV transmissions by 2030, 53.7% believed this target was achievable, and 49% felt that the Trust was actively contributing to this goal. The majority (85.8%) identified a need for additional training and resources.

#### Conclusion

HIV-related stigma and gaps in knowledge persist within a healthcare-associated population, alongside limited awareness of HIV elimination targets. Strengthening staff education, reinforcing confidentiality

policies, and expanding stigma-reduction training are essential to support equitable HIV care and progress towards eliminating HIV transmission by 2030.

009

## Development of health promotion and prevention in an individuals lived experience - case study

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### Abstract

Health promotion enables the individual to increase control over and to improve their health. Whilst this is every health professional's duty, it is easy to focus on immediate priorities only. NHVNA's person centred model of nursing recognises the importance of health promotion and prevention in HIV care. This case study will focus on Darren's experience of living with HIV. At the age of 18, just after coming out as gay, he was hospitalised. The health professionals wore "hazmat suits" which affected his belief in healthcare. Darren is now 60 years old and has been living with HIV since the age of 19. His immediate family are still unaware of his status and therefore his support has come from healthcare. Due to lack of knowledge and information, Darren also found his friends fearful and stigmatizing, therefore unsupportive. In the early years of his diagnosis, Darren's knowledge of his health grew alongside those providing care to him.

Darren's rejection by family and friends due to his diagnosis had a profound effect on his mental health. He formed a relationship but unfortunately his partners violent reaction to Darren's status causes a further spiralling downwards. With the support of his HIV team, he sought assistance from mental health therapists to regain his confidence in the world. On completion of his therapy, Darren recognised that others needed support and guidance too.

The introduction of anti-retroviral therapies was important for Darren. He developed trust in his HIV team but managed his own health choices with a strong internal locus of control. As health professionals, it is essential that our role empowers, enables and develops skills and abilities in our clients. Over time, Darren has used these abilities to provide health promotion and prevention for others with HIV. He is now the co-ordinator within a local HIV support service. Here, he collaborates with NHS, social and housing services as well as local councils, to provide opportunities that empower other individuals with HIV and their families. Under Darren's leadership, the support group embodies health promotion and prevention. It recognises that everything is not due to HIV and care requires effective links with other voluntary and non-voluntary organisations.

## O10

### Beyond the clinic walls: Long-Acting ART as a solution for early HIV engagement in a highly vulnerable patient

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#### Abstract

##### Background:

Engaging people newly diagnosed with HIV in timely, effective treatment is central to improving long-term health outcomes and preventing onward transmission. However, individuals experiencing multiple vulnerabilities, including substance use, unstable housing, and social marginalisation, often face significant barriers to attending clinic appointments and adhering to oral antiretroviral therapy (ART). Within this framework, long-acting injectable ART (LAI ART) presents an alternative approach that may overcome some of these challenges. This case study builds on evidence supporting community-based nursing models by exploring the use of LAI ART in the home of a newly diagnosed patient with complex needs.

##### Aim:

The aim of this case study is to examine whether LAI ART administered in a community setting can support engagement with HIV care, promote adherence, and achieve early viral suppression in a patient facing significant barriers to traditional clinic-based treatment. This study addresses a gap in understanding how injectable regimens may be adapted for individuals who struggle to access services.

##### Methods:

This case describes the care of a 44-year-old White British cis-female with a history of sex work, previous injecting drug use, and ongoing crack cocaine and cannabis use. She received methadone weekly and lived in sheltered accommodation at diagnosis. Following a positive postal HIV test, confirmed in clinic, she was initiated on oral ART but was unable to tolerate. Her relocation away from the clinic affected attendance and engagement. The case was reviewed at our multidisciplinary meeting, where the use of LAI ART despite the patient being treatment-naïve and viraemic, was deemed appropriate. Administration was arranged via home visits under a patient–provider agreement.

##### Results:

Viral load was used as the primary outcome measure. At baseline, her viral load was 47,000 copies/ml. Following her first injection of LAI ART, viral suppression was achieved, with an undetectable viral load recorded after two months.

##### Conclusion:

This case demonstrates that patients with high levels of vulnerability can achieve rapid virological suppression with flexible, community-based treatment options such as home-delivered injectable ART. The findings support the role of long-acting injectables in overcoming adherence barriers associated with oral regimens and highlight the importance of personalised, outreach-focused models of HIV care. Further evaluation of such approaches may strengthen service delivery for hard-to-reach populations.

## Poster abstracts

### A001

#### Inconsistencies in Hepatitis B monitoring – Using clinical audit findings to support development of a focussed MDT & clinical proforma

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#### Abstract

##### Introduction

Hepatitis B virus (HBV) is more prevalent among people living with HIV, with UK data suggesting a co-infection rate of 5–10%. Within our local HIV cohort of ~2,400, 38 individuals have confirmed chronic HBV co-infection (1.6%).

The aim this project was to:

1. Assess clinician understanding and confidence in HIV/HBV co-infection management
2. Audit current clinical practice against NICE HBV monitoring guidelines
3. Develop a focused HIV/HBV co-infection multidisciplinary team (MDT) & clinical proforma based on the audit findings and staff survey.

##### Methods

A survey was distributed to clinical staff (39 doctors and 13 nurses). Respondents were asked: (1) “How confident are you in requesting the correct routine HBV monitoring?” (Likert scale 0–5); (2) “Which blood tests are required?” (multiple choice); and (3) “Is there anything that would increase your confidence in selecting the correct tests?” (free-text). Quantitative data were analysed using descriptive statistics in Excel, and free-text responses were thematically grouped.

Concurrently, clinical records for all patients with HIV/HBV co-infections were reviewed against HBV monitoring guidelines (NICE). Data collected over the preceding 12 months included HBV monitoring serology (inc. HBV DNA, HBsAg, HBeAg & HBeAb, AFP) imaging requests (USS and FibroScan) and HIV/HBV treatment status.

##### Results

Survey responses were received from 9/39 doctors (23%) and 7/13 nurses (54%). Median self-reported confidence in selecting the correct HBV monitoring serology was 5 for doctors and 4 for nurses. However, only 2 of 16 respondents (1 doctor and 1 nurse) selected the correct monitoring serology in a multiple-choice survey.

Among the 38 individuals with HBV co-infection, audit findings from the previous 12 months revealed: HBV DNA 31/38 (82%), HBsAg 18/38 (47%), HBeAg 9/38 (24%), AFP 30/38 (79%), Liver USS 23/38 (61%), and FibroScan 3/38 (8%). Four patients had detectable HBV DNA. All individuals were prescribed tenofovir-based anti-retroviral therapy.

Thematic analysis of free text responses indicated a shared desire for targeted HIV/HBV education sessions, visual prompts within electronic patient record (EPR) systems, and regular multidisciplinary team (MDT) meetings to support the management of patients with HBV co-infection.

## Conclusion

The findings emphasise the need for improved standardisation in HBV monitoring for people living with HIV and HBV co-infection. In response, local changes have been implemented, including updates to the EPR interface and the introduction of a twice-yearly HIV/HBV MDT. A re-audit is planned in 12 months to evaluate the impact of these interventions.

## A002

### Uncovering the hidden workload of HIV clinic nursing

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#### Abstract

##### Background

In the current commissioning climate it is essential to capture the breadth of HIV nursing expertise and activity. Specialist HIV clinic nurses play a pivotal role in identifying people living with HIV who have nursing needs requiring support and intervention. Much of this work is invisible and unquantifiable. The utilisation of a named nurse role has been shown to address unmet needs of HIV patients and reflects a person-centred model of HIV nursing.

The aim of this audit was to capture the nursing needs of current named nurse caseloads, monitor core outcomes and review current referral criteria.

##### Method

This was an audit of Band 5 and Band 6 named nurse caseloads in a large urban HIV clinic. An audit group was convened with the team of named nurses to agree audit goals and data fields. Data were collected by individual named nurses on their own caseloads on a shared data sheet and included demographics, viral load, CD4, current ARV prescription and follow-up. Existing priority care categories of Red, Amber or Green and nursing issues defined within existing referral criteria were also collated. Further additional criteria were formulated to test if expansion of referral criteria was indicated.

##### Results

There were 163 patients allocated named nurses of which 75% were male, 23% female, 2% non-binary with a mean age of 50 years. 29/163 (18%) had a detectable viral load and 12/163 (7%) had a CD4 less than 350 cells/mm. 9% were not on ARVs. Of those on ARVs 4/163 (2.5%) did not have a current prescription. 87% of patients had follow-up appointments and 21/163 had none of which 42% were detectable.

The priority care categories were Red 24%, Amber 28% and Green 48%. Review of current referral criteria identified 398 nursing needs (See table 1)

<b>Table 1: Nursing needs under current referral criteria:</b>	
Mental Health	75 (46%)
Attendance support	64 (39%)
Substance misuse	51 (31%)
Adherence support	39 (24%)
Comorbidities	38 (23%)
New diagnosis	28 (17%)
Insecure Housing	27 (16%)
Cognitive Function	16 (10%)
Ultrasound venepuncture	15 (9%)
Coping/Adjustment	14 (8%)
Domestic Violence	12 (7%)
Under 25 years	10 (6%)
Social Care	9 (5%)
	<b>Total 398</b>

The additional criteria developed identified the following issues; poverty 6%, safeguarding 1%, immigration 3%, neurodiversity 5%, social isolation 7%.

#### Conclusion

This collaborative audit has highlighted the role of HIV clinic nurses in identifying and addressing the spectrum of nursing needs in our caseload.

## A003

### Managing menopause in women living with HIV – an online practical guide to support clinical practice

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#### Abstract

##### Background:

Women living with HIV entering their midlife should be provided with adequate information about the menopause and possible treatment options, including advice about lifestyle modification aimed at reducing menopausal symptoms and improving longer term health.

An online guide to managing menopause in women living with HIV can provide clinicians with the confidence to provide up to date, evidence based information.

##### Method:

The development of the online guide was organised and fully funded by Gilead Sciences Ltd. Clinician support was provided by a Consultant Nurse in menopause and a Consultant Physician in Sexual and Reproductive Health with patient representation from the Health Inequalities Lead, Terrence Higgins Trust and 4M Network of Mentor Mothers.

Clinician support was provided by a Consultant Nurse in menopause and a Consultant Physician with patient representation from the Health Inequalities Lead, Terrence Higgins Trust and 4M Network of Mentor Mothers.

The representatives were purposely selected to provide their knowledge and insights into how to best address the needs of women living with HIV entering perimenopause and/or experiencing menopause symptoms.

Input was gathered via semi-structured expert meetings plus a review of existing materials and the findings analysed to (1) explore areas of best practice, (2) identify potential barriers and (3) compile approaches aligned to guidance for implementation.

##### Results:

Whilst there are local areas of excellence, in general, supporting information for women living with HIV and their clinicians can be fragmented and materials don't reflect the diverse population that services see, e.g. Eatwell plates are aimed at a Western diet. Services can be stretched and there is a postcode lottery for menopause services.

The online THRIVE framework was developed to support HIV clinicians to support women through the menopause transition.

**Take note of early symptoms**

**Holistic health assessment**

**Respond with personalised management**

**Integrate care across services**

**Verify patient needs continuously**

**Elevate standards of care**

**Conclusion:**

Menopause in HIV needs to be managed in a holistic manner, with bespoke, person-centred advice. Healthcare professionals will benefit from the bringing together of resources to aide them in giving advice to women living with HIV to better support them in making sustainable changes, as well as signposting for additional support and information. The comprehensive and easy to use online guide can provide this much needed resource.

**A004**

## **Isn't this our bread and butter, so why aren't we doing it? Opt-out Blood Borne Virus (BBV ) screening pilot within Sexual Health Services (SHS)**

Mrs Carly Porter, Miss Sian Griffiths

Swansea Bay University Health Board, Swansea, United Kingdom

### **Abstract**

#### Background:

Blood Borne Virus (BBV) screening—which includes HIV, Hepatitis B, Hepatitis C, and Syphilis—is crucial in sexual health services (SHS) for preventing transmission, enabling early treatment, and improving health outcomes. Traditionally, screening has followed an opt-in approach, requiring explicit patient consent. A newer strategy, "opt-out" screening, integrates BBV testing into routine care, automatically offering tests unless declined, thereby increasing uptake by reducing barriers such as stigma and the need for patients to take the initiative. This is particularly relevant in SHS, where BBV risks are higher. Introducing opt-out screening can facilitate earlier diagnosis and streamline access to treatment. Given the absence of BBV testing in our A+E department, providing this service within SHS ensures effective management.

#### Materials and Methods:

An audit of BBV testing rates informed the pilot, it showed a 21% testing uptake. Launched in September 2024 across integrated sexual health clinics, gender, pregnancy advisory, HIV, and outreach services. BBV and Syphilis screening were included as part of routine consultations, with all patients informed and able to decline. Data were collected from electronic patient records using the all-Wales coding system, ensuring anonymity.

Results:

Period	Sept 2024–Sept 2025
Total attendees	20,874
Screened for BBVs	10,434
Opted out	2,809
Not offered / undocumented	7,631
New Syphilis diagnoses	142
New Hepatitis C diagnoses	4
New Hepatitis B diagnoses	13
New HIV diagnoses	2

Conclusion:

Integrating opt-out BBV screening into routine SHS care led to 50% of attendees being screened, enabling early diagnosis and timely treatment of BBVs. This approach reduces barriers, such as stigma, and enhances public health outcomes. Ongoing evaluation will help refine the model for wider implementation, underscoring the value of innovative strategies in improving patient care and BBV prevention, with a clearer analysis of the justification for opting out and for the absence of documentation.

## A005

### Can HIV positive women breastfeed safely?

Ms Anna-Luisa Simonini, Miss Amanda Whittaker

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#### Abstract

##### Introduction

Pre 2018, the British HIV Association (BHIVA) recommended exclusive formula feeding to remove all risks of postpartum HIV transmission to infants, recently BHIVA (2025) acknowledges more women are wanting to breastfeed and have updated their guidelines accordingly. Advances in antiretroviral therapy have significantly reduced the risk of transmission, enabling healthcare professionals to support informed, individualised feeding choices.

The guidelines promote shared decision making encouraging open supportive discussion and the provision of written information about feeding. If women choose to breastfeed and are aware and accepting of the low risk of HIV transmission, then they should be supported to do so.

##### Background

Our cohort is over 2500 patients, just under half, 1,131 are female. In 2012 we had our first breastfeeding patient, there have been 322 pregnancies up to 03/2026.

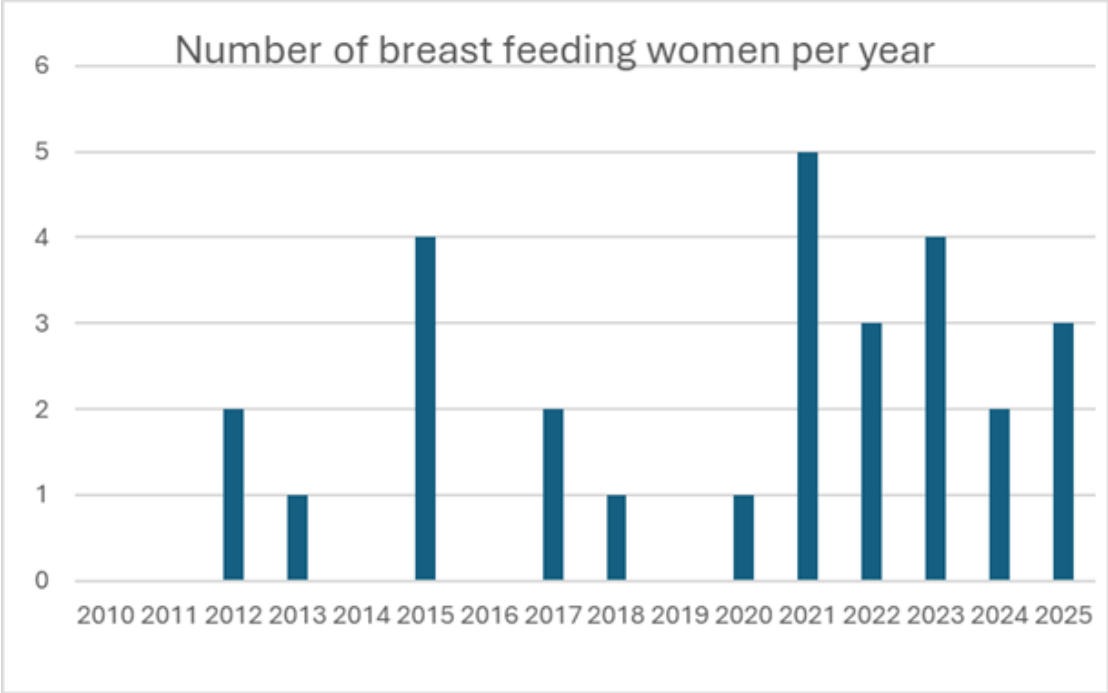
The aim of this audit was to see if the change to the BHIVA guidelines was reflected in our pregnant cohort in relation to the number of women choosing to breastfeed.

##### Method

Retrospective look back of paper and electronic notes of the 28 patients who had breastfed since 2012, one record was not available. We looked at their age, ethnicity, whether they were on treatment, mother's viral load (VL), length of breastfeeding and whether the baby's birth VL and final antibody test was negative.

##### Results

The age range was 21 – 54, with most in their 30's, 97% were Black African. 26 women took BHIVA approved ART, except one patient on Biktarvy. At delivery, (start of breastfeeding), 26/27 women had an undetectable VL. BHIVA recommends breastfeeding for <6 months, a few of our women breastfed beyond this, one up to 20 months. Despite some deviating from the recommended clinical advice, there were no transmissions of HIV to the babies, confirmed by a negative antibody test at 18 months.



**Conclusion**

Although national and local guidelines recommend formula feeding, if a woman wants to breastfeed and meets the criteria outlined by BHIVA, we will support her in this. It is known that the highest risk of transmission is in women who breastfeed without medical support and monitoring. Within our service we acknowledge that the most common reasons for wanting to breastfeed are the health benefits of breastmilk and infant bonding

Our small cohort study shows that thanks to advances in HIV treatment, women can now be supported to breastfeed safely, helping many fulfil a dream of motherhood that was once thought impossible.

## A006

### Positive Milestones for Heterosexual Men

Ms Samantha Katembere, Mr Iain Spooner, Ms Sarah Fraser

Positively UK, London, United Kingdom

#### Abstract

##### BACKGROUND/CONTEXT

In 2022, men accounted for three-quarters of all suicide deaths in the UK, with suicide remaining the leading cause of death for men under 50. (ONS 2022)

In the HIV sector, heterosexual men lacked a dedicated support group, (Positive Voices 2022). Heterosexual HIV-positive men were significantly under-engaging with services.

In 2023, 51% of heterosexual men diagnosed with HIV were diagnosed late compared to 30% of gay and bisexual men. In London, 60% of heterosexual men were diagnosed late versus 29% of gay and bisexual men. (UKHSA 2024)

Late diagnosis results from both patients and healthcare professionals perceiving heterosexual men as low risk, compounded by outdated information and stigma that HIV is a "gay disease." (BMC 2018)

##### METHODS/INTERVENTION

The monthly Straight Talk meeting was established (January 2023) to address this gap. Heterosexual men were contacted through database emails, peer workers' referrals, and posters in clinics.

The group provided a confidential space for heterosexual HIV-positive men to share stories, create friendships, and reduce isolation. It helped address self-stigma and misconceptions about HIV being a "gay disease." Participants chose a mixed-gender format. A heterosexual man co-facilitated the group, enabling crucial peer mentoring.

Monthly meetings offered hot drinks and nutritious meals. Activities included talks from medical professionals and respected HIV community members, plus an "ask it basket" for anonymous questions. Social activities included museum visits, garden walks, and picnics in Royal Parks. A 24/7 WhatsApp group maintained ongoing connection.

##### RESULTS/OUTCOME

By end of January 2023, 10 people attended Str8talk 4 men 6 women

By the end of December 2025, 134 people had attended Str8talk 56 men and 77 Women and 1 gender queer nonbinary.

The group achieved remarkable diversity: financially stable to homeless participants, British nationals and asylum seekers, migrants from Africa, Europe, and Asia, ages ranging from 20s to 70s. Members regularly expressed gratitude, with feedback naming the "delightful get-together" and "elegant ambience."

## **DISCUSSION/LESSONS LEARNED**

This project was highly successful and focus group feedback was overwhelmingly positive. However suggested improvements included greater meal variety, more outings, and additional volunteers for one-to-one support.

## **KEY MESSAGE/CONCLUSION**

Specialised peer support for heterosexual men with HIV is vital for health, empowerment and wellbeing. Straight Talk peer group shows that a tailored support group open to heterosexuals of both gender is a welcome intervention for heterosexual men with HIV who often struggle to access services.

Authors:

Samantha Katembere

Iain Spooner

Sarah Fraser

## A007

### Pre-Exposure Prophylaxis for HIV use among gay and bisexual men in Northern Ireland - Where are the gaps?

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<sup>1</sup>Belfast Health & Social Care Trust, Belfast, United Kingdom. <sup>2</sup>Rainbow Project, Belfast, United Kingdom

#### Abstract

##### Background

Northern Ireland became a FastTrack region April 2024. One of the targets is to get to zero new transmissions of HIV by 2030. In Northern Ireland gay and bisexual men who have sex with men (gbMSM) remain the group most impacted by new and late HIV diagnosis, 62% and 45% respectively. Pre-Exposure Prophylaxis (PrEP) is a key component in the reduction in HIV transmission and is provided in all GUM clinics across the region. The aim of this study is to access gaps in knowledge, use and barriers to equitable access to PrEP in Northern Ireland.

##### Method

A voluntary anonymous online survey was conducted July 2025 to February 2026 using Survey Monkey. It was piloted and distributed by QR code through clinical and voluntary networks.

Data collected included, demographics, sexual behaviour, Sexually Transmitted Infection (STI) history. It then divided into two parts:

- One - for those on PrEP, assessing use and accessibility.
- Two - for those not on PrEP, assessing reasons why not. It provided links for further information and how to access PrEP and PEP.

##### Results

206 responses collected, 90% Male, 83% identified as Gay or Bisexual, and 94% were White. 68% reported last HIV test in the last 6 months and 25% report an STI in past year.

20.2% reported Chemsex use, 49% group sex and 35% sex-on-premises-venue (SOPV) use.

78% have used PrEP, with most accessing this from a GUM clinic. Of these, 47% were taking Daily, 34% Event based dosing (EBD) and 5% other.

10% have accessed Post-Exposure Prophylaxis (PEP) because they hadn't taken their PrEP, 6.5% reported condomless sex but took neither PEP nor PrEP. Respondents taking EBD used a number of factors to decide when to use PrEP.

58.6% found PrEP easy or very easy to access. However 12% reported it difficult or very difficult to access, 19% had run out at least once.

**Conclusion**

Our findings suggest high acceptability of PrEP use amongst respondents, it provides insight into its use and knowledge of HIV prevention, along with perceived risk. Further work is required to reduce misconceptions, increase referrals and uptake of PrEP. Strong community involvement, targeted health promotion strategies and improvement in service delivery will all be needed to reach the target of zero new HIV diagnosis by 2030.

**A008**

## **Analytical treatment interruption studies: patients' experiences**

Mr Tom Fernandez, Mr Tom Allan, Mr Jonathan Edwards, Miss Jia Bo He, Mrs Abigail Tobin, Mr Olly Wigzell

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### **Abstract**

#### Background

Continuous antiretroviral therapy (ART) has long been the established method of controlling HIV; however, newer agents that offer the possibility for antiretroviral-free HIV suppression challenge that premise. To evaluate the efficacy of these investigational therapies, a closely monitored pause in ART, known as an Analytical Treatment Interruption (ATI), is widely used in cure strategy research. Whilst ATIs have proven invaluable in measuring virological control without ART, they have also provided a unique set of challenges to potential participants.

#### Aims

To explore the complexities of participating in ATI studies through the perspectives of patients.

#### Methods

Data from medical notes and study recruitment logs was analysed to describe trends in ATI uptake. Thematic analysis was subsequently used to understand the reasons underlying these trends.

#### Results

Between 2021 and 2025, a total of 170 patients' notes were analysed, of whom 19 entered the screening phase and only 7 enrolled onto ATI studies. The main recruitment challenges identified were strict study eligibility criteria and patient concerns about participation, which were grouped under the themes of apprehension, relationships and logistics.

Patients' apprehension included anxiety about not being on ART, fear of viral rebound, potential physical illness, consequences for future treatment options and the overall psychological impact. Relationship concerns included an altered feeling of self, the worry of onward transmission and worries about disclosure. Logistical issues most frequently cited the demanding visit schedule with weekly visits that included viral load testing.

The positive aspects of taking part included a sense of altruism, helping shape the future of HIV and having more control of their health.

## Discussion

ATI studies are a relatively new scope of research. Hence careful patient selection and attention to detail are paramount. This review highlights the importance of taking a measured and personalised approach with patients considering ATI research. Discussion about risk-benefits and awareness of language used are pivotal in gaining informed consent and management of expectations. Apprehension and fear amongst patients should be openly acknowledged and clear information, close monitoring and psychological support readily available throughout the study. Skilful scrutiny of clinical records is essential to mitigate the risks of participation. It is hoped that consideration of these issues can help with improving recruitment and retention as well as the overall patient experience of ATI research.

## A009

### Restless on the rock: a snapshot of sleep in Jersey's HIV population

Mrs Michelle Mulhall, Miss Betty O'Shea, Miss Louise O'Reagain

Jersey General Hospital, St Helier, Jersey

#### Abstract

##### Background

Sleep disturbances are a recognised and clinically relevant comorbidity among people living with HIV, with potential effects on quality of life, mental health, cognition, and engagement with antiretroviral therapy. Sleep difficulties in HIV are often multifactorial, reflecting physical conditions, psychological and social stressors, life stage transitions, and treatment related effects, including adverse effects of antiretroviral therapy.

In October 2025, European AIDS Clinical Society (EACS) updated their guidelines to recommend routine screening for sleep disorders in people living with HIV. This ongoing service evaluation aims to explore the early prevalence and demographic patterns of sleep disturbance within a randomly screened HIV clinic population in Jersey and to consider preliminary implications for multidisciplinary service provision.

##### Methods

As part of this ongoing evaluation, a random sample of 31 adults was selected from a cohort of 150 people living with HIV receiving routine care in Jersey. Screening for sleep disturbances was undertaken in line with the 2025 EACS guidance. Demographic data, including age and gender, were analysed descriptively to identify early patterns among those reporting sleep difficulties. Local referral pathways and access to diagnostic sleep studies were reviewed to assess existing service capacity and potential barriers to assessment.

##### Results

In this preliminary sample, 11 of 31 patients (35.5%) reported sleep disturbances. Sleep difficulties were more commonly reported by male patients and were observed across a wide age range from 35 to 75 years. Among female patients reporting sleep disturbance, most were aged 36 to 45 years. While numbers are small, this pattern may be consistent with the perimenopausal transition, during which hormonal changes are commonly associated with sleep disruption and may represent an additional contributing factor for some women living with HIV. Despite many patients meeting criteria for further assessment, access to specialist sleep services is limited. Although referral for sleep study is available, Jersey has no dedicated sleep medicine service or local specialist follow-up. Patients would therefore require referral to centres in the UK, leading to delays in care.

##### Conclusion

These preliminary findings indicate that sleep disturbances are common among people living with HIV in this setting, with notable variations by age and gender. Sleep difficulties in HIV are not solely explained by physical pathology; psychological factors, social context, life stage, and antiretroviral-therapy-related effects also warrant consideration, including potential review of existing regimens. Identified service

gaps underscore the need for routine screening and development of holistic, multidisciplinary care pathways.

## A010

### Long-acting ART works: What a 30 patient audit reveals about adherence, complexity, and outcomes

Mrs Samantha Worboys, Mrs Laura Cunningham-Smith

Dorset Health Care NHS, Bournemouth, United Kingdom

#### Abstract

##### Introduction

Long-acting injectable (LAI) antiretroviral therapy is an alternative to daily oral treatment for people living with HIV, and may be particularly helpful for those who find adherence difficult. This audit looked at who is receiving LAI in our service, why it was started, and how patients are doing, to help improve care.

##### Methods

We carried out a retrospective audit of 30 patients on LAI. We collected data on demographics, clinical background, social factors, reasons for starting treatment, and viral load outcomes.

##### Results

Most patients were male (80%), with ages mainly between 35 and 64 years. The majority identified as men who have sex with men (63.3%) and were of White ethnicity (83.3%). Before starting LAI, most patients (86.7%) already had an undetectable viral load. The average time since HIV diagnosis was 14 years. A third had co-morbidities and over half were taking other medications. Overweight and obesity were common (63.3%).

Mental health conditions were present in 46.7% of patients, and 36.7% reported chemsex-related drug use. Over half (53.3%) were supported by outreach services, and more than a third had previously been lost to follow-up.

The most common reason for starting LAI was difficulty taking daily oral treatment (46.7%), followed by personal preference (23.3%) and side effects (13.3%).

Overall, 96.7% of patients now have an undetectable viral load. Patients supported by outreach services did particularly well, with very high rates of viral suppression despite often having more complex needs. This suggests that LAI, alongside outreach support, works especially well for patients who may otherwise struggle to stay engaged with care.

##### Conclusion

LAI is working well in our service, especially for patients with adherence challenges. The best outcomes were seen in those supported by outreach services, showing the value of combining simpler treatment with flexible, patient-focused support. Ongoing monitoring of weight, co-morbidities, and wider health needs remains important. Further work could look at patient experience and longer-term outcomes.

## A011

### A rapid scoping review of tools and approaches for medication adherence screening and assessment

Miss Nicola Galbraith<sup>1</sup>, Mr Nisal Edirisinghe<sup>2</sup>, Dr Philippa Pristera<sup>2</sup>

<sup>1</sup>Gilead Sciences Ltd, London, United Kingdom. <sup>2</sup>Cuttsy and Cuttsy, Cambridgeshire, United Kingdom

#### Abstract

**Purpose:** Research in the UK and Ireland has highlighted inconsistencies, lack of standardisation, and reliability issues in how healthcare professionals (HCPs) assess adherence in HIV care. Adoption of formal adherence screening is limited among HCPs due to perceived complexity and integration challenges.

These issues are further exacerbated by a lack of HIV clinical guidance. We conducted a rapid scoping review to:

1. Identify existing tools or methodologies for screening or assessing medication adherence that:
  1. Could be utilised for individuals living with HIV
  2. Are tailored for non-English speaking individuals or those with additional needs
2. Understand the most accurate or reliable approaches and the barriers to their broader implementation.

**Method:** Between mid-July and mid-August 2024, pre-defined channels and publications were rapidly but systematically screened, to identify relevant adherence monitoring tools, resources or approaches. Our scope was global and looked both within and beyond the field of HIV. Duplicates or items not relevant were removed and new avenues were explored until saturation. A synthesised list of approaches was reviewed to describe the design and suitability of available options.

**Results:** 23 distinct adherence-related questionnaires and scales were identified, alongside 7 models and a number of generalised measures and approaches, as outlined in the summary figure below.

<p style="text-align: center;"><b>Questionnaires</b></p> <ol style="list-style-type: none"> <li>1. Illness Perception Questionnaire (IPQ)</li> <li>2. Beliefs about Medicines Questionnaire (BMQ)</li> <li>3. Simplified Medication Adherence Questionnaire (SMAQ)</li> <li>4. Brief Medication Questionnaire (BMQ) 1 and 2</li> <li>5. The Adult AIDS Clinical Trials Group (AACTG) Adherence Instruments</li> <li>6. CPCRA Antiretroviral Medication Self-Report Questionnaire</li> <li>7. Self-Reported Adherence (SERAD) Questionnaire</li> <li>8. Adherence Starts with Knowledge (ASK-12 -20) Questionnaire</li> <li>9. WebAd-Q Questionnaire (WebAd-Q)</li> <li>10. Making Medicines Work For You (MMWFU) Screener</li> <li>11. Identification of Medication Adherence Barriers Questionnaire (IMAB-Q)</li> <li>12. SPUR™ digital tool</li> </ol>	<p style="text-align: center;"><b>Scales</b></p> <ol style="list-style-type: none"> <li>1. Morisky Medication Adherence Scale (MMAS)</li> <li>2. The Hill-Bone Scales</li> <li>3. Self-efficacy for Appropriate Medication Us</li> <li>4. Medication Adherence Self-Efficacy (MASE) Scale</li> <li>5. HIV Treatment Adherence Self-Efficacy Scale (HIV-ASES)</li> <li>6. Brief Adherence Rating Scale (BARS)</li> <li>7. Medication Adherence Report Scale (MARS)</li> <li>8. Adherence to Refills and Medication Scale (ARMS)</li> <li>9. Basel Assessment of Adherence to Immunosuppressive Medications Scale (BAASIS)</li> <li>10. General Medication Adherence Scale (GMAS)</li> <li>11. Visual Analogue Scale</li> </ol>
<p style="text-align: center;"><b>Models</b></p> <ol style="list-style-type: none"> <li>1. COM-B model</li> <li>2. Behaviour Change Wheel</li> <li>3. Information-Motivation-Behavioural (IMB) Model</li> <li>4. Health Belief Model</li> <li>5. Appointment-based Models</li> <li>6. ADPIE Nursing Process</li> <li>7. Medication Adherence Support Decision AID (MASDA)</li> </ol>	<p style="text-align: center;"><b>Objective measures</b></p> <ol style="list-style-type: none"> <li>1. Medication Possession Ratio</li> <li>2. Pill counts or Digital pill bottle/cap</li> </ol> <p style="text-align: center;"><b>Digital monitoring approaches</b></p> <ol style="list-style-type: none"> <li>1. Mobile tracking apps, e.g. Medisafe, MyMeds</li> <li>2. Digital health platforms, e.g. Wellth, PillPack</li> </ol> <p><b>Other:</b> Community outreach, Peer-mentoring, Treatment planner, Pre/post counselling</p>

Of note, despite the critical role of HIV medication adherence, limited reference to adherence tools was identified within abstracts from BHIVA, BASHH or HIV Glasgow Conferences

**Conclusion:** We identified a vast range of tools and approaches used globally to monitor or measure adherence across therapy areas. Newer tools that take a more holistic, person-centred view of adherence could be considered for adaptation into HIV care. However, the overall accessibility of the tools identified could be improved. Visuals are rarely used to clarify content and translations are not always available which may have implications from a health equity perspective

## A012

### Beyond the numbers: Understanding why patients miss HIV appointments and how services can respond

Mrs Samantha Worboys, Mrs Laura Cunningham-Smith

Dorset Health Care NHS, Bournemouth, United Kingdom

#### Abstract

##### Introduction:

An increase in demand for appointments within local HIV clinics and an emphasis on a 'need to find' patients disconnected from their care encouraged an audit of missed appointments with the aim of identifying patients for follow up in addition to generating insights around missed attendance behaviours.

##### Methods:

Using attendance data from a level 3 integrated sexual health clinic, a retrospective audit was undertaken between October 2022 and October 2023 of patients who Did Not Attend (DNA) their scheduled appointment. Information about patient's viral load, history of mental health and emotional wellbeing issues, in addition to problematic drug and alcohol use was collected for analysis.

##### Results:

75% (n=699) of HIV patients (n=931) attended their booked appointment. Out of the remaining 25% (n=232), 112 missed one appointment, 55 missed 2 appointments, 23 missed 3 appointments and 42 missed four or more. A focus on patients missing 4 appointments or more was taken to identify characteristics of serial DNA'ers.

The average age of patients missing four or more appointments was 41, representing a range of 22-57. 37/42 (88%) had an undetectable viral load. 25/42 (60%) previously reported poor levels of mental health, 12 of which also experienced concurrent issues with drugs and/or alcohol. Overall, 29/42 (69%) identified as male. Patients were more likely to miss an appointment for HIV bloods (n=115) than attending to be reviewed by a clinician (n=82).

##### Discussion:

Missed appointments can impact negatively on patient engagement and experience within sexual health clinics that continue to face challenges around demand, capacity and funding. Findings suggest that whilst most patients only miss one appointment, those missing four or more have a controlled HIV infection but may benefit from additional support with mental health and substance use. These findings encourage us to consider alternative methods of engagement such as community outreach or telephone consultations.

**A013**

## **Loneliness in a crowded room? An exploration of loneliness from the perspective of women living with HIV?**

Ms Laura Makey

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### **Abstract**

Loneliness is conceptualised as a subjective feeling of being without actual or desired social and familial connections. Loneliness is now part of the UK political agenda; however, public health campaigns and social media have inadvertently created a stigma surrounding loneliness that can act as a barrier to self-reporting. This research aimed to explore the influences of living with HIV on the experience of loneliness for women. Women were met with via online interviews to explore their experiences of living with HIV and their experiences of loneliness. The analytical findings demonstrated that loneliness is not attributable to a single cause and arises from multiple, intersectional factors that impede meaningful connection with others. Women described a 'subjective loneliness' where they felt a lack of understanding from their social or family network and from the wider society. Subjective loneliness manifested at times, such as when grieving a HIV peer, the loss of social and familial identity when first being diagnosed with HIV and from a lack of support in initiating or maintaining a romantic relationship. Furthermore, the cumulative impacts of directly or indirectly experiencing HIV stigma created a range of isolating experiences. Women in this research described how, over time, they navigated feelings of loneliness with agency, which took the form of peer support within their same-identity community, support from an informed family, and a nonjudgmental approach from healthcare practitioners. Women also gained agency in advocating for themselves and other people living with HIV. This research gives important insights into how women living with HIV navigate feelings of loneliness and how loneliness can be felt when around others. The insights underscore the need to support WLHIV by empowering women through the ongoing and timely peer support and women-centred resources to empower women. Furthermore, the insights direct the development of educational packages for healthcare and voluntary sectors that aim to educate about the nuances of loneliness stigma so that people feel better equipped to have important conversations about loneliness.

## A014

### Reasons for HIV testing in a single health centre: a preliminary descriptive study

Dr Sehlule Vuma, Dr Stanley Giddings

University of The West Indies, St Augustine, Trinidad and Tobago

#### Abstract

Human immunodeficiency virus (HIV), continues to be a major health issue. It damages the immune system leaving patients prone to debilitating multi-systemic opportunistic infections (OIs), and related malignancies. It may be acquired from sexual or parenteral contact with infected body fluids, and from mothers to children in utero or at parturition. People most at risk, key populations (KPs), have the majority of new infections. They experience stigma and discrimination which hinder them from accessing health services. With the incurable nature of HIV, patients need lifelong antiretroviral therapy (ART) which controls viral replication and enhances immunity. Some people living with HIV may be asymptomatic, and may unknowingly transmit the virus, for example through unprotected sex. ART makes HIV a manageable chronic illness. Early intervention is recommended to prevent complications and morbidities, and save lives. Furthermore, with ART-reduced viral load, or increased viral suppression there is decreased viral transmission sexually. The World Health Organization recommends starting ART soon after diagnosis, regardless of CD4 counts. Using ART as a preventive measure requires that people know their HIV status, which requires early diagnosis, thus early testing. Reasons for late testing include fear of stigma and discrimination, poverty and poor access to testing sites.

Objective: To describe reasons for HIV testing at an adult outpatients HIV clinic.

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Methods: This retrospective, quantitative, descriptive study, reports reasons for HIV testing of 78 patients. Data were extracted from patients' records including gender, age, occupation and reasons for testing. Results were analyzed using SPSS-22.

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Results: 29(37.18%) had no symptomatic diagnosis, 11(14.11%) tested voluntarily, 12(15.38%) were contacts of HIV positive partners, 4(5.13%) were contacts of partners who had died. The 49(62.82%), with clinical presentations were symptomatic for various OIs including pneumocystis pneumonia 8(10.26%), candidiasis (7.69%), histoplasmosis 2(2.56%), toxoplasmosis 1(1.28%) and shingles 1(1.28%). Sexually transmitted infections accounted for 6(7.69%) and lymphadenopathy, 4(5.13%). Of the 60patients with available employment data, 14(23.33%) were unemployed, and 46(76.67%) were employed in various occupations. Correlations between age and being symptomatic as reasons for testing were weak, but significant ( $r=.324$ ), and low between employment status and symptom status ( $r=.123$ ).

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Conclusion: Th majority of patients tested because of HIV complications. Significant percentages were unemployed. Strategies to increase early, voluntary testing are important, including education about benefits of early testing and increased access to testing sites especially among KPs and the unemployed.

## A015

### “Meeting needs, not appointments”: Long-acting injectables in a nurse-led outreach model

Mrs Samantha Worboys, Mrs Laura Cunningham-Smith

Dorset Health Care NHS, Bournemouth, United Kingdom

#### Abstract

##### Background:

Continuity of HIV care can be difficult to maintain for individuals facing homelessness, substance use, migration, mental-health challenges, or unstable living conditions. Clinic-based models often fail to meet the needs of those most at risk of disengagement. In response, the CNS team designed and implemented a nurse-created, nurse-led outreach service to meet people living with HIV in their own environments. Central to this model is the use of long-acting injectable antiretroviral therapy (LA-ART), which has significantly improved outcomes among individuals unable to maintain daily oral adherence.

##### Aim:

The project aims to enhance engagement, adherence, and viral suppression among the most vulnerable people living with HIV

##### Methods:

The outreach service was developed and delivered by nurses, using a structured MDT discussion, repeated outreach attempts, unannounced visits, and flexible clinical consultations away from traditional settings. Nurses initiate ART, including LA-ART, in homes, community spaces, cafés, and workplaces. The model relies on multi-agency collaboration with housing providers, addiction services, voluntary organisations, probation, and police. Case studies (Sharon and Miguel) illustrate the practical implementation of LA-ART within a nurse-led outreach framework.

##### Results:

The introduction of LA-ART within this nurse-led outreach model has enabled significant improvements in viral suppression among individuals previously unable to maintain oral therapy. Sharon, with long-standing non-adherence and repeated non-attendance, reached undetectable viral load within one month of starting injectables at home and remains suppressed with two-monthly visits from the nursing team. Miguel, experiencing homelessness and frequently losing medication supplies, has been transitioned to injectables to stabilise adherence following successful suppression on oral therapy. Across the service, over half of all patients receiving injectables are managed through outreach, demonstrating the feasibility and success of nurse-delivered LA-ART in community settings. Outreach has also reduced the local “need to find” list from 20 individuals in 2022 to only a handful in 2026, with 70 patients actively supported by the nurse-led team.

##### Conclusion:

This nurse-created, nurse-led outreach model demonstrates that flexible, community-based HIV care can substantially improve health outcomes among the most vulnerable populations. Long-acting injectables play a pivotal role by removing daily adherence barriers and enabling sustained viral suppression. When delivered through persistent, relationship-focused nursing and strong interagency collaboration, LA-ART has the power to transform engagement, enhance safety, and ensure equitable access to HIV care.

