

IMMEDIATE START TO TREATMENT

Survey Report

Acknowledgements

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Positive Life NSW would like to acknowledge and thank the HIV positive and HIV negative community for their valuable support and time taken in completing the survey. The information will be used to inform policy development, service delivery and care at the time of an HIV diagnosis. The information has also provided valuable information to service providers and community organisations on the communities' views on the benefits and concerns as they relate to the commencement of antiretroviral treatment at the time of an HIV diagnosis.

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They do not imply any particular HIV status, sexuality, attitudes or behaviours.*

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Introduction

Significant advances in the evidence to support the prescribing of antiretroviral therapy (ART) at the time of an HIV diagnosis (ARTatD) has come from the *Strategic Timing of Antiretroviral Therapy* (START) study (Lodi et al., 2015) and from clinical programs like the RAPID Program at San Francisco General Hospital (Pilcher et al., 2017). Subsequent publications from the START study show that improved cardiovascular outcomes (Soliman et al., 2015), lower risk of chronic kidney disease (CKD) (Achhra et al., 2015) and the commencement of ART at the time of diagnosis may be beneficial in lowering viral reservoirs within the central nervous system at the time of infection (Burbelo et al., 2018).

In a randomised control trial of ART-naïve participants with CD4 cells/ μ above 500 expressed a moderate improvement in a self-assessed quality of life (QoL) when treatment was initiated immediately, compared to those who were deferred (Lifson et al., 2017). The World Health Organisation (WHO) published *Guidelines for Managing Advanced HIV Disease and Rapid Initiation of Antiretroviral Therapy* that made the general recommendation for the commencement of ART at the time of diagnosis irrespective of CD4 count (World Health Organisation, 2017).

The WHO initiated an online survey through March 2017, 'Advanced HIV Disease & Same day start of ART - make your voice heard!' (www.surveymonkey.com/r/CNJTB5) to explore the international opinion on these recommendations for starting ART on the day of an HIV diagnosis as outlined in the guidelines for people living with HIV (PLHIV). With similar interest, Positive Life NSW (PLNSW) undertook a survey of the Australian community both HIV positive and negative people, with a specific focus on NSW as these are the constituents represented by the organisation. The aim was to explore the 'communities' attitudes and views to the recommendations of ARTatD.

Method

PLNSW approached the WHO by email on 22 March 2017, for permission to adapt their survey to reflect the local demographic and jurisdictional differences. PLNSW went live with the modified survey from 16 June to 18 July 2017 using the Survey Monkey platform.

The survey consisted of 18 questions starting with HIV status then covering participant demographics for age, sex, gender, ethnicity, country of birth, language spoken at home, source of income, current place of residence in NSW stratified by Sydney Metro, Sydney outer metro, Regional or rural NSW or Not NSW.

Questions regarding immediate start to ART asked respondents if they would support immediate commencement of ART if it was recommended, what their concerns would be if this was a recommendation, what would influence their decision, and what problems would they envisage.

Questions were formatted as one answer, multiple choice or Likert scale with the opportunity to provide qualitative feedback at two points within the questionnaire after “If starting HIV treatment on the same day as you were diagnosed was available, would you support the practice” and at the end of the survey asking “Please let us know if you have any other thoughts or comments on ‘same-day’ start of HIV treatments.”

Responses were analysed using Statistical Package for the Social Sciences (SPSS), Survey Monkey basic analytics and Excel. Given the depth of responses from outside NSW, the survey results have been combined to reflect the national responses and opinions of the community.



The aim of the survey was to explore the communities attitudes and views to the recommendations of ARTatD

Results

A total of n=884 responses were recorded from within NSW and Australia combined for analysis.

Table 1: Sexual identity and HIV status

Sexual Identity	HIV positive	HIV negative /unknown	Sexual identity total
Gay male or homosexual	382 (87.4%)	291 (75.6%)	673 (81.9%)
Lesbian	-	- (0.3%)	- (0.1%)
Heterosexual or straight	27 (6.2%)	69 (17.9%)	96 (11.7%)
Queer	18 (4.1%)	11 (2.9%)	29 (3.5%)
Bisexual	10 (2.3%)	13 (3.4%)	23 (2.8%)
Total	437 (100.0%)	385 (100.0%)	822 (100%)

Participants were asked to identify their HIV statuses being positive, negative or unknown and how they identified their sexuality (table 1). Just over half of respondents, 437 (53.2%) indicated that they were HIV positive with 385 (46.8%) reported their sero status as HIV negative or unknown. Of the 437 who identified as HIV positive, 382 (87.4%) said they were 'Gay male or homosexual', 27 (6.2%) identified themselves as 'Heterosexual or straight', 18 (4.1%) indicated 'Queer' and 10 (2.3%) said they were Bisexual.

Of the 385 (46%) who indicated they were 'HIV negative or unknown', 291 (75.6%) identified as 'Gay male or homosexual', (0.3%) as Lesbian with the actual number too low to make further comment, 69 (17.9%) as 'Heterosexual or straight', 11 (2.9%) as 'Queer' and 13 (3.4%) as 'Bisexual'.

Table 2: HIV status, Current Gender Identity and Age

Age	HIV status	Current gender identity				Total in age group
		Male	Female	Non-binary	Different identity	
18-24	HIV positive	14 (93.3%)	- (6.7%)	-	-	15 (100.0%)
	HIV negative/unknown	74 (96.1%)	-	- (3.9%)	-	77 (100.0%)
	Total	88 (95.7%)	- (1.1%)	- (3.3%)	-	92 (100.0%)
25-34	HIV positive	99 (96.1%)	(1.9%)	(1.0%)	(1.0%)	103 (100.0%)
	HIV negative/unknown	109 (98.2%)	-	(0.9%)	(0.9%)	111 (100.0%)
	Total	208 (97.2%)	(0.9%)	(0.9%)	(0.9%)	214 (100.0%)
35-44	HIV positive	110 (99.1%)	1 (0.9%)	-	-	111 (100.0%)
	HIV negative/unknown	90 (94.7%)	(2.1%)	(2.1%)	(1.1%)	95 (100.0%)
	Total	200 (97.1%)	(1.5%)	(1.0%)	(0.5%)	206 (100.0%)
45-54	HIV positive	134 (95.7%)	5 (3.6%)	(0.7%)	-	140 (100.0%)
	HIV negative/unknown	69 (95.8%)	(4.2%)	-	-	72 (100.0%)
	Total	203 (95.8%)	8 (3.8%)	(0.5%)	-	212 (100.0%)
55 and over	HIV positive	72 (93.5%)	(3.9%)	(2.6%)	-	77 (100.0%)
	HIV negative/unknown	40 (93.0%)	(4.7%)	(2.3%)	-	43 (100.0%)
	Total	112 (93.3%)	5 (4.2%)	(2.5%)	-	120 (100.0%)
Total	HIV positive	429 (96.2%)	12 (2.7%)	(0.9%)	(0.2%)	446 (100.0%)
	HIV negative/unknown	382 (96.0%)	7 (1.8%)	7 (1.8%)	(0.5%)	398 (100.0%)
	Total	811 (96.1%)	19 (2.3%)	11 (1.3%)	(0.4%)	844 (100.0%)

HIV status cross tabulated by age and layered by current gender identity (table 2). On questions of age, current gender identity and HIV status combined, of the 884 respondents for age, the largest group, 214 (25.4%), indicated they were 25–34 years of age, followed by 45–54 years of age at 212 (25.1%) respondents, with 206 (24.4%) respondents at 35–44 years of age and 120 (10.9%) indicated they were 55 years and over.

Of these, 429 males identified they were HIV positive and of these the highest representation was from 134 (31.2%) in the 45–54 age group, followed by 110 (25.6%) in the 35–44 age grouping, then 99 (23.1%) from the 25–34 age group, followed by 72 (16.8%) who were 55 years and over. The lowest representation of HIV positive males were from the 18–24, 14 (3.3%) age group.

Within female respondents, a total of 10 identified as HIV positive with 5 (50%) from the 45–54 age group making up the highest representation. Actual numbers were low in the remaining age groups not allowing for any further comment.

Respondents were asked to identify their origin by country of birth (Figure 1). Australian born respondents represented 597 (69.4%), while 263 (30.6%) respondents indicated they were born overseas. Of over the quarter of respondents who were born overseas, 89 (10.1%) were from Asia, 74 (8.4%) from the European Union, 29 (3.3%) from Oceania, 27 (3.1%) from Africa, 24 (2.7%) from the Caribbean, Central and South America, 12 (1.4%) from North America, 5 (0.6%) from the Middle East and 3 (0.3%) from Europe.

Figure 1: Country of origin (n=860)

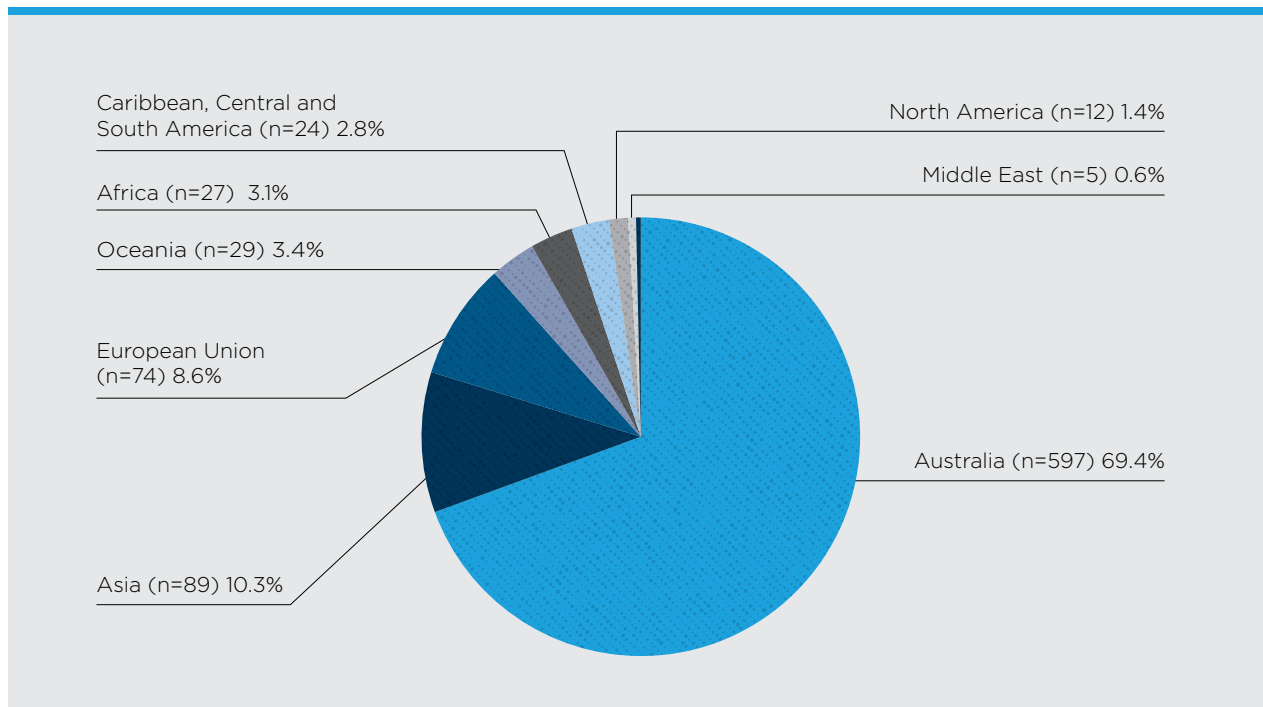


Table 3

Aboriginal or Torres Strait Islander	Number	%
Aboriginal	16	1.9
Torres Strait Islander	-	-
Both Aboriginal or Torres Strait Islander	6	0.7
Neither Aboriginal or Torres Strait Islander	817	97.4
Total	839	100.0

Respondents were asked if they were of Aboriginal, Torres Strait Islander or both or neither (table 3). Within this survey there were 16 (1.9%) Aboriginal people, respondents who indicated they were Torres Strait Islander were too low in actual numbers for any analysis and were included within both 5 (0.6%) respondents identified as both. 817 (97.4%) respondents indicated they were neither of Aboriginal or Torres Strait Islander origin.

Table 4

Language spoken at home	Number	%
English	791	91.4
Asian Based	31	3.6
Spanish	16	1.8
Portuguese	9	1.0
Central Asian Based	7	0.8
Middle Eastern Based	6	0.7
European Based	5	0.6
Total	865	100.0

Table 4 shows language spoken at home. The majority, 791 (91.4%), said they speak English at home, followed by 31 (3.6%) who speak an Asian based language at home, then 16 (1.8%) identified they spoke Spanish, 9 (1.0%) said they spoke Portuguese, followed by 7 (0.8%) who spoke a Central Asian language, 6 (0.7%) spoke a Middle Eastern dialect and 5 (0.6%) indicated European based languages.

Table 5

Employment and source of income	Number	%
Employed	656	74.4
Disability or Aged Pension	65	7.4
Student Benefit	56	6.3
Unemployment Benefit	52	5.9
Self Employed	19	2.2
Supported by Family, Partner, Spouse or Friend	18	2.0
Superannuation	16	1.8
Total	882	100.0

Table 5 shows the employment and source of income for 882 respondents. The majority of respondents, 656 (74.4%), said they were in full time employment, followed by 65 (7.4%) on a Disability or Aged Care Pension, 56 (6.3%) said they were on student benefits, 17 (2%) said they were supported by a spouse or partner. Of the remainder, 19 (2.2%) respondents said they were self-employed, 18 (2.0%) stated they were supported by a family member, partner, spouse or friend and 16 (1.8%) relied on superannuation funds.

Table 6

Area of residence	Number
Sydney Metro	200 (23.2%)
Sydney Outer Metro	49 (5.7%)
Regional/Rural NSW	94 (10.9%)
Not NSW	520 (60.3%)
Total	863 (100.0%)

Participants were asked if they were residing inside or outside NSW (table 6 and figure 2). The majority of respondents, 520 (60.3%), said they were not from NSW, 200 (23.2%) respondents indicated they were from the Sydney Metropolitan area, followed by 94 (10.9%) from Regional or Rural NSW with the remaining 49 (5.7%) from the Sydney outer metropolitan area.

Figure 2: Area of residence

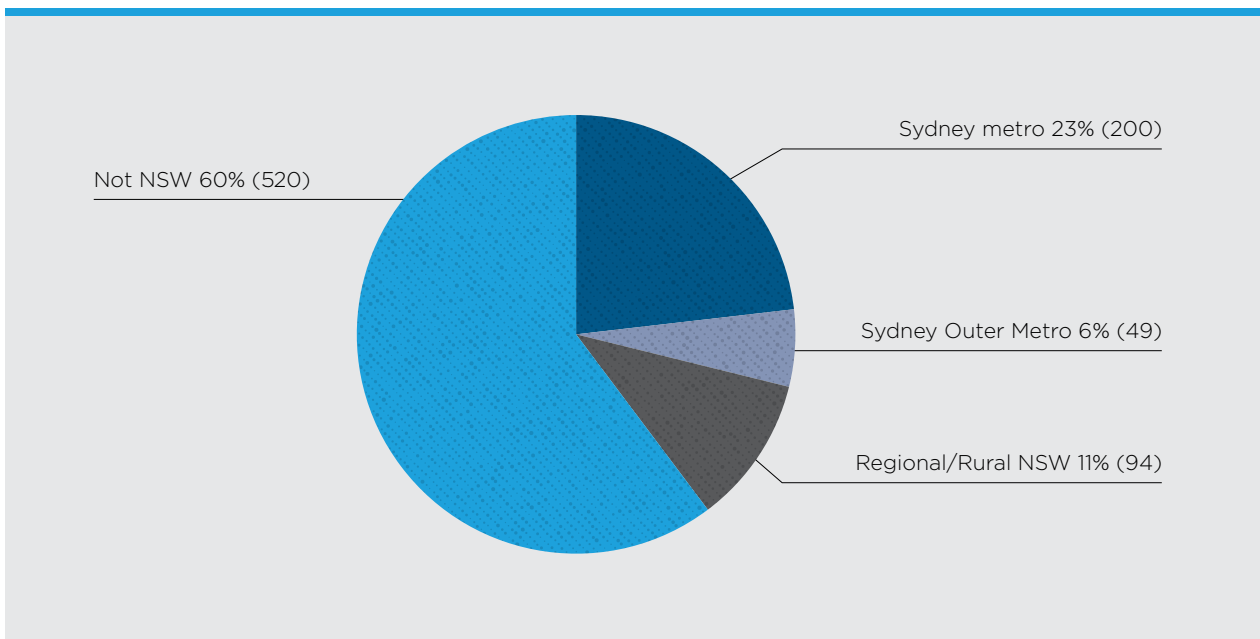


Table 7

Starting HIV treatment on the same day of diagnosis if available

	Supporting same day treatment		
	Yes	No	Unsure
HIV positive	305 (79.8%)	54 (14.1%)	23 (6.0%)
HIV Negative/Unknown	313 (90.5%)	16 (4.6%)	17 (4.9%)
Total	618 (84.9%)	70 (9.6%)	40 (5.5%)

On the question of supporting commencement of treatment on the same day of diagnosis if it was available (table 7), the respondents were stratified into two groups, HIV positive, HIV negative/unknown.

In total, 618 (84.9%) indicated they would support starting treatment at the same time as a HIV diagnosis, compared to 70 (9.6%) who indicated they would not support treatment at diagnosis and 40 (5.5%) respondents said they were unsure if they would support the practice. Of those who identified as HIV positive, 305 (79.8%) supported starting treatment same day as diagnosis. 54 (14.1%) did not support the idea and 23 (6.0%) were unsure. Those who identified as HIV negative or unknown, 313 (90.5%) supported starting treatment the same day as a HIV diagnosis, 16 (4.6%) did not support it and 17 (4.9%) were unsure. Respondents were offered a free text field response box for further comments.

“I was started the next day. I felt that something was being done immediately to help me and I was not left in limbo. I watched the viral load drop and felt immediately that I was on the road to recovery and the dreaded disease was not going to be a major issue, because it had been treated and there was an immediate response.”

Qualitative comments from 82 participants were themed to reflect the general comments by all respondents irrespective of HIV diagnosis. The most common theme was that *immediate start of antiretroviral treatment needs to be a personal choice*, followed by:

- *needing time to adjust to a diagnosis*
- *that the evidence needs to demonstrate a benefit*
- *that a decision would be based on the doctor’s recommendation*
- *consideration of time of seroconversion and time of beginning treatment was important*
- *needing to be clear that the HIV diagnosis was correct*
- *that the right medication was being prescribed*
- *that beginning of treatment within one to four weeks of a diagnosis was acceptable.*

Seven PLHIV commented in total. Six respondents stated that on reflection they would start the day of their diagnosis while one said they would not start on the same day of diagnosis. Responses from HIV negative or unknown participants focused on the need to be clear about the diagnosis that treatment was the correct choice and they would be guided by medical opinion.

Table 8

If it was standard practice to start treatment on the same day you are diagnosed with HIV, what do you think would be the benefits?	Number of responses
Starting as early as possible is beneficial for health	650 (80%)
Starting treatment as early as possible will provide a sense of control over HIV	546 (67%)
For pregnant women, starting treatment early will protect the unborn baby	269 (33%)
Starting treatment as early as possible will protect sexual partners	530 (65%)
Other	98 (12%)
Total	816 (100%)

Respondents were asked to prioritise the benefits for starting treatment on the day of diagnosis (table 8). 816 respondents responded to this question and could choose more than one option and recorded 2,093 responses.

'Starting treatment as early as possible is beneficial for my health' was identified by the majority of respondents 650 (80%), as being the most beneficial reason for starting treatment on the day of diagnosis. *'Giving a sense of control over HIV'* was next at 546 (67%) respondents followed by 530 (65%) respondents who chose *'Protecting sexual partners'*, *'Protecting the unborn baby for pregnant women'* 269 (33%) with *'Other reasons'* on 98 (12%) responses.

"I requested it first day but was told I needed to wait 2-3 months. I could feel the state that my immune system was in, it felt like it was being put through a shredder, I wanted to stop the virus from replicating, I just wanted to feel better."

"When I was diagnosed there were two theories running around, one that treatment should be delayed until absolutely necessary and the second if caught early enough and treated with intensive antiretrovirals it could potentially reverse a positive diagnosis. I was diagnosed within six months of contracting the virus and wish I had a doctor who is willing to try that method to help prevent any physical and/or mental decline."

Table 9

If beginning treatment on the same day of diagnosis, which of the following statements would influence decision to start	n	Mean
Being prescribed the HIV treatments that work best for you	420	3.4
Having time to ask questions and talk about treatment before you start	427	3.8
Being able to make your own decision when to start treatment	403	4.1
Having support from your doctor so you can take treatment daily	394	4.2
Feeling free of pressure and coercion to start treatment	412	4.9
Being diagnosed with another health condition that needs to be dealt with, before you start HIV treatment	402	5.2
Having support from other people so you can stay on treatment	402	5.4
Wanting to make sure your mental health and/or substance use is managed before you start HIV treatment	391	5.7
Having other life concerns (housing, employment, relationships) that need to be dealt with before you start HIV treatment	427	5.9
Total	240	

Respondents were asked to rank, which statements would influence their decision to start treatment on the day of an HIV diagnosis (table 9). *'Being prescribed the HIV treatments that work best for you'* was ranked the highest, followed by *'Having time to ask questions'*, and *'Being able to make your own decision to start'* were ranked second and third respectively. *'Having support from your doctor'* was ranked fourth, then *'Feeling free of pressure and coercion'* came in fifth, and *'Being diagnosed with another health condition'* ranked sixth. *'Having the support to stay on treatment'* ranked seven and *'Wanting to make sure mental health or substance use issues were managed before starting'* ranked eighth. *'Needing other concerns to be addressed including housing, employment and relationships'* were ranked ninth.

Note these figures were generated from the national combined responses of the survey due to the complexity of the way the question was structured within the survey. The means were used to rank the responses.

"It's a huge ask for newly diagnosed. They need a few weeks to get their head around diagnosis and to really commit to ART. Yes taking ART these days is quite simple, but it is a big commitment to be adherent for the rest of your life. Gotta be ready!"

Table 10

What possible problems do you foresee with same-day start of HIV treatment	n	%
Worried about Treatment Side Effects	399	17.4
Needing More Information	318	13.8
Finding the Right Doctor	314	13.7
Not Being Ready	310	13.5
Feeling Pressured	281	12.2
Fear of Stigma and Discrimination	276	12.0
Telling Partner or Friend	193	8.4
Unable to Attend for Follow-up Appointment	131	5.7
Other	77	3.3
Total	2299	100.0

Foreseeing problems starting treatments the same day as a diagnosis (table 10), shows being 'Worried about Treatment Side Effects' ranked highest followed by 'Needing More Information' closely ranked with 'Finding the Right Doctor', and 'Not Being Ready' for treatment so soon after a diagnosis of HIV. Ranked next were 'Feeling Pressured' to start treatment, 'Fear of Stigma and Discrimination', 'Telling a Partner and Friends' about the HIV diagnosis. 'Unable to come to the clinic for follow-up appointments' ranked as the lowest of concerns.

"There would need to be time for careful consideration of the choice of medications and information to help maintain the strict adherence that is needed."

Qualitative responses to the question, “If it was standard practice to start treatment on the day you are diagnosed with HIV, what possible problems do you foresee with same-day start of HIV treatment”.

Participants were offered a free text field to list any further concerns they may foresee in starting treatments the same day of diagnosis. Cost and access to medications, and availability including logistics of returning to live in another country, being from a rural or remote setting was identified as possible barriers. Some expanded on these barriers:

“Needing more information and making informed decisions.”

“I would rather the doctor pushed me a little bit to start earlier and gave me less of an option to delay as my concerns about treatment were unfounded.”

“... I certainly would need to be well informed and ask lots of questions before I start any drug.” and “I think the sooner the better, treatment comes first, everything else can follow making the decision to commence lifelong treatments immediately after receiving the shock of diagnosis is a huge ask.”

Others expanded on what they felt the benefits might be:

“... being told you can start medicating this immediately, when properly communicated, has the potential to lessen the effect of receiving the very bad news.”

“... a good strategy is to encourage antiretroviral treatment as early as possible but still inform the patient that the choice is up to them and if they feel comfortable starting the treatment that early.”

Qualitative responses on "same-day start" of antiretroviral medication at time of an HIV diagnosis.

The final question of the survey provided participants with a free type field to add further comments on the idea of access to antiretroviral treatment within 24 hours of an HIV diagnosis. Number of responses totaled 216, of these 146 (68%) identified as HIV positive, 58 (27%) identified they knew their HIV status to be negative, 4 (2%) identified that they did not know their HIV status and 8 (4%) preferred not to disclose their HIV status.

PLHIV made more qualitative comments than HIV negative people at a ratio of 1,576 words to 268 words respectively. For this question, there was an underrepresentation of responses from females and other minority groups from gender and ethnicity based cohorts were also under represented due to a low number of responses.

The majority of comments were supportive of the idea of immediate commencement of antiretroviral treatments at time of a HIV diagnosis but wanted to ensure that people were ready to start. Some people had bad experiences at the time of diagnosis or being put on the wrong treatment stating the need to get it right. Other themes supported the need for it to be a personal choice and not to be coerced.

Themes from those living with HIV, ranged in length of time from their diagnosis from 1 to >30 years. Some described quality of life, having lived longer term wishing they had access to better medications earlier in their diagnosis, that they are living but at a cost of the damage of either having



taken these medications e.g. “AZT [zidovudine] monotherapy” or having to wait to start medication HIV has done damage to their bodies and affected their lives. Those living longer term with HIV identified the benefits of treatments that are available now and if receiving an HIV diagnosis now some would commence ART immediately. Some still cautioned the impact of a diagnosis and that it remained a personal choice while others questioned why this was not policy and why has it taken so long to come to Australia. One participant cited the RAPID program from San Francisco. Of those more recently diagnosed one expressed:

“I’m angry I wasn’t able to take control of my HIV status immediately. I had to wait for it to inflict enough damage to my immune system before I was allowed to start treatment I certainly think same-day start should be an option”.

One participant who was supported to start ART early stated:

“I believe, the start of the early treatment played a major part ... gave me a confidence to say that IT IS actually, NOT a death sentence, in relation to my health and physical being. And to see those significant number differences in main sections of my test results, prevented me NOT feel and see myself as a victim and not to listen to ... my negative emotions and thoughts...”. (respondent’s emphasis)

Additionally, better education for healthcare professionals with and linking to peer support were identified as important.

Participants who identified their HIV status as being negative or unknown, were more cautious citing concerns regarding side effects, making sure the strain of HIV being treated was the correct one, one person posed the question on why it would be beneficial to take medication at the time of diagnosis *“Please tell me WHY it is best to start treatment straight away...”*.

Other themes were that a new diagnosis would be a lot to take in, not be pressured by a false sense of urgency, fear of stigma and discrimination, needing to have all the facts and needing support.

Discussion and conclusions

There are limitations and biases in this survey, some that have been consistent with previous PLNSW surveys. There is an under-representation of women (2.4%), peoples from culturally and linguistically diverse (CALD) backgrounds, and those identifying as Aboriginal, Torres Strait Islanders or both (2.5%). The survey would have been strengthened by a broader range of gender diversity.

There is a high representation of males (97.5%) with 80% identifying as 'Gay Male or Homosexual' with a majority engaged in full time employment. This representation is consistent with the current profile of previous surveys and close to the profile of the stabilised population of those affected by HIV within NSW. The under-represented demographic is possibly due to the reach of the survey which was primarily promoted through PLNSW social media and communication platforms and through interstate partner non-government organisations (NGOs) and passive distribution networks. These populations within the survey do not comprehensively represent the emerging at risk of HIV populations. There has been a 41% decrease within NSW of new HIV diagnoses in MSM compared to the average of the previous six years while there was a 13% increase in new HIV diagnoses in MSM born overseas and in 2017 these exceeded that of locally born MSM who acquired HIV (Health, 2018). Conversely there has been a 29% increase in the average number of new infections in the heterosexual population within NSW (Health, 2018). While heterosexually acquired HIV remains small in absolute numbers at 55 respondents representing a 31% increase in those diagnosed with non-early infections, this is with a CD4 count less than 200 or AIDS defining illness in the absence of 'Early' diagnosis (Health, 2018) p.13.

The WHO recommendations for the early initiation of antiretroviral therapy irrespective of CD4 count, plus the experiences of those commenced on ART at the time of diagnosis in services like the RAPID Program in San Francisco, have demonstrated clear benefits for better longer term health outcomes for people diagnosed with HIV (Abassi, Rhein, Meya, & Boulware, 2018). However this does not translate to all HIV diagnoses as those who are diagnosed 'not early' with the risk of immune reconstitution inflammatory syndrome (IRIS) (Abassi et al., 2018; da Silva et al., 2017; Fournier et al., 2017; Meireles, Souto Moura, & França, 2017). This presents a challenge within the current demographic of those who are at risk of HIV within NSW in particular where the majority of diagnoses are being made in low HIV case load general practice services (Health, 2018) and are from a developing country where they may have been exposed to *tuberculosis* (TB), *toxoplasmosis*, *cryptococcal disease* and at risk of *multifocal leukoencephalopathy* (Abassi et al., 2018; da Silva et al., 2017; Fournier et al., 2017; Meireles et al., 2017). ARTatD for those who are presenting 'not early' are at risk of IRIS which may result in anxiety at the time of diagnosis for the person if they are aware of the recommendation to start ART at the time of diagnosis but not made fully aware of the contraindications. Low case load general practitioners giving an HIV diagnosis are supported by an experienced HIV prescribers through the HIV Support Program (HSP) (NSW Health, 2017). The program would be strengthened by ensuring those newly diagnosed are consistently linked to counselling support and also to a peer at the time of their diagnosis. The requirement remains for access to accurate information and support at the time of an HIV diagnosis.



The strength of this survey is the representation of those currently affected by HIV both recent to longer term

The strength of this survey is the representation of those currently affected by HIV both recent to longer term. This was observed within the extensive qualitative discussion fields of the survey, which described their experience and depth of insight into what it is like to receive an HIV diagnosis, the current quality of access and barriers to HIV treatments at the time of diagnosis and the majority supporting the initiation of antiretroviral treatment within 24 hours of a HIV diagnosis. A consistent and common agreement that has emerged is that the person at the time of diagnosis needs to be ready to commence ARTatD and not feel pressured or coerced. It is also clear that while viral suppression could be gleaned as a public health pressure to commence people on ARTatD there is also recognition by the community that there are benefits for the individual both physiological and psychological.

The caveats for a person for ARTatD are access to the right information that need to be delivered with confidence and constancy by healthcare providers, that the right medication be prescribed and be accessible at point of diagnosis and that psychological supports be readily available including access to peer support. A focus on information around the quality and safety of the current ARTs that are currently being prescribed, assurances by the practitioner that once viral suppression has been achieved with the statement that they will be at 'zero' risk to their sexual partners must be a mainstay of the information being given at the time of the diagnosis. Referral to peer support will achieve assurances that the possibility of a life they chose to lead is possible and achievable. It is quite clear from the qualitative responses that if a person asks for ARTatD this should be prescribed and that this decision needs to be a fully informed, be an individual choice and not denied unless contraindicated.

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