# COUNTRY PROGRESS REPORT

# NEW ZEALAND

**Reporting Period: January 2012 – December 2013**

**Submission Date**

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# 1. Status at a Glance

### *Inclusiveness of the Stakeholders in the Report Writing Process*

The Ministry of Health acknowledges the support and assistance of the HIV and AIDS sector stakeholders in preparing this report.

### *Status of the Epidemic*

- In New Zealand, the early epidemic of HIV infection and AIDS was highly concentrated among men who had sex with men (MSM). The number of MSM diagnosed with HIV is still higher than the number diagnosed with heterosexually acquired HIV.

- In the late 1990s a low and stable number of MSM were diagnosed annually with HIV. This number rose between 2001 and 2005, mainly due to a steady increase in the number infected in New Zealand.

- Between the early 2000's and 2006 the number of people diagnosed with heterosexually-acquired HIV rose mainly due to an increase in people infected overseas. Since the peak in 2006, the annual number of heterosexually acquired infections has dropped, due to fewer people being infected overseas. The number of people diagnosed with HIV that was heterosexually acquired in New Zealand remains low but has risen gradually since the mid-1990s and in 2013 was only slightly lower than the number infected overseas.

- Of those diagnosed with HIV in New Zealand from 1985 to 2013, 1.7 percent (N=69) were under the age of 15 years, and 9.2 percent (N= 363) were aged between15 and 24 years at the time of diagnosis.

- Among those diagnosed with HIV, for whom information on the initial CD4 count was obtained, just under half (48%) of those diagnosed between 2005-2013 presented when the CD4 count was 350 cell per cubic mm or less, the level at which treatment is recommended.

- Most of the people who are now diagnosed with AIDS in New Zealand have only recently been diagnosed with HIV and as a result have not previously been on antiretroviral treatment.

- Based on the number of people on subsidised antiretroviral therapy (ARTs) (1800 at the end of 2013), and the assumptions that (a) 80% people with HIV have been diagnosed and are under specialist care and (b) 80% of people with HIV under specialist care are on ART, there are estimated to be around 2800 people with HIV in New Zealand. This equates to a prevalence of 62 per 100,000 total population.

### *Policy and Programmatic Response*

In New Zealand, the prevalence of HIV infection in the general population is very low (estimated to be 62 per 100,000 total population). The main risk for acquiring HIV infection in New Zealand, is still sexual contact between men. The prevalence in this group in the most recent Auckland study in 2011[1] was 6.5 percent (in the previous study in 2005/2006, the prevalence in this group was 4.4 percent). Some sections of civil society consider that this low prevalence is a contributing factor to stigma and isolation felt by those living with HIV. Although protection under the Human Rights Act 1993 has reduced (but not eliminated) the stigma experienced among gay men living with HIV, among heterosexuals in New Zealand living with the virus there remains a strong sense of stigma and isolation. This was confirmed by the review of services for people with HIV in New Zealand[2] undertaken in 2010 in which stigma was repeatedly mentioned as a major issue in the context of HIV in New Zealand.

The response to the epidemic in New Zealand from most quarters has been based on a health promotion approach and specialised programmes targeted at specific communities. For example:

- the New Zealand AIDS Foundation (NZAF) delivers HIV prevention programmes that target the most at risk populations – MSM (predominately New Zealanders) and heterosexual African migrants in New Zealand. It also provides community based HIV rapid testing services, sexual health clinics for men and care and support services for anyone affected by HIV. NZAF leads on national advocacy and Pacific Region partnerships, policy advice and coordination of the National HIV and AIDS Forum[3]. Within the NZAF's HIV prevention programmes is a specific social marketing team working to build a pro-condom social movement. Community Engagement programmes that work with community volunteers include work stream teams led by gay non-Māori and gay Māori, gay and fa'afafine[4] Pacific People and African heterosexual migrants to New Zealand
- HIV peer support organisations (Body Positive Inc., INA (Māori, Indigenous & South Pacific HIV/AIDS Foundation), Positive Women Inc.) provide support and advocacy for people living with HIV and AIDS (and their families). Body Positive Inc. also provides rapid HIV testing and other clinical services such as facial lipodystrophy treatment and counselling. INA promotes culturally appropriate sexual and reproductive key messages on HIV through educational programmes. Positive Women Inc. supports women and families living with HIV and AIDS and promotes awareness of HIV and AIDS in the community through educational programmes with a focus on prevention and destigmatisation

[1] Saxton P, Dickson N, Griffiths R, Hughes A, Rowden J. Actual HIV prevalence and undiagnosed infections in a community sample of men who have sex with men in Auckland, New Zealand. *BMC Public Health* 2012: 12:92.
[2] Miller, D. 2010. *Review of Services for People with HIV in New Zealand.* Wellington: Ministry of Health
[3] The national HIV and AIDS Forum provides advice to the Ministry of Health on emerging issues and proposed strategies for prevention and care from the perspective of the national HIV/AIDS sector
[4] A Samoan word that means Samoan who is physically male but has the spirit of women.

- Needle Exchange Services administers the Needle Exchange Programme with services delivered by regional Trusts and pharmacies across the country. Sero surveys of people who inject drugs have shown a low HIV prevalence in these groups of less than 1%.
- New Zealand Prostitutes Collective provides health promotion and support services for sex workers
- Family Planning has 30 clinics across the country and provides sexual and reproductive health services for all New Zealanders. Family Planning's HIV prevention work involves health promotion, education, social marketing, resource production and clinical and professional work
- District health boards also fund Primary Health Organisations (PHOs) to support the provision of essential primary-health-care services through general practices to those people who are enrolled with the PHO. The services include being a point of contact for people with sexual health concerns and testing and treatment of common STIs
- the New Zealand Blood Service has responsibility for ensuring the safe supply of blood and blood products
- there is access to a range of sites for HIV testing. The greatest proportion of people diagnosed with HIV infection is in primary care (around 43% over time).

Publicly funded health care is funded from Vote: Health and administered by the Ministry of Health through Crown Funding Agreements with 20 district health boards. District health boards are charged with delivering health care to New Zealanders in their regions.

Testing, treatment and care are provided in a number of health settings, including general practice, sexual health centres, community based centres and community outreach sites, specialist units based in major hospitals, and hospices. Patient centred integrated care is a particular feature of HIV and AIDS services, for example, enabling patients to care for themselves at home.

Many other programmes, funded outside Vote: Health, are important in terms of HIV prevention. For example, key issues that influence the behaviour of young people include their sense of self esteem and self confidence. Youth with low self esteem and a low sense of self worth, in particular, young gay, bisexual and transgender people are more likely to place themselves at risk. Policies and programmes (for example, Rainbow Youth, Youthline, Outline and one-stop shop sexual health services) to address these issues along with programmes to support vulnerable families and children, and programmes to reduce inequalities (including programmes to improve education and increase employment) are an important part of HIV prevention.

## Research, monitoring and evaluation

The evidence base for policy and clinical service development in New Zealand comprises clinical and operational research conducted by clinicians and by university deparments. The Ministry of Health funds most of the epidemiological and behavioural surveillance on HIV/AIDS in New Zealand (this research is discussed elsewhere in this report).

Improving public health surveillance is critical to ensure that reliable HIV and STI data exists to inform policy and programme planning. Recent improvements to the surveillance of STIs in New Zealand have been made to allow robust monitoring of STI rates by ethnicity.

### *Overview of indicators for Global AIDS Response Progress Reporting 2012/2013*

**Target 1: Reduce sexual transmission of HIV by 50% by 2015**

| | Indicators | Comment |
|---|---|---|
| 1.1 | Young people: Knowledge about HIV prevention | Indicator relevant to our country, however, no data available. |
| 1.2 | Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15. | Indicator relevant to our country, however, no new data available.<br><br>The New Zealand National Health Survey will include a module on sexual health over the 2014-15 period. |
| 1.3 | Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months. | Subject matter relevant, however, no data available. |
| 1.4 | Percentage of adults aged 15-49 who had more than one partner in the past 12 months reporting the use of a condom during their last sexual intercourse. | Subject matter relevant, however, no data available. |
| 1.5 | Percentage of women and men aged 15-19 who received an HIV test in the last 12 months and who know their results. | Subject matter relevant, however, indicator not relevant to our country. |
| 1.6 | Percentage of young people aged 15-24 who are HIV infected. | Of all the people diagnosed with HIV in New Zealand from 1985 to 2013, 9.2 percent (N=363) were aged between15 and 24 years at the time of diagnosis (AIDS Epidemiology Group). |
| 1.7 | Percentage of sex workers reached with HIV prevention programmes | Subject matter relevant, however, no data available. |
| 1.8 | Percentage of sex workers reporting the use of a condom with their most recent client. | Subject matter relevant, however, no recent data available.<br><br>New Zealand legislation requires operators of prostitution businesses to promote safer sex practices. |
| 1.9 | Percentage of sex workers who have received an HIV test in the last 12 months and who know their results. | Subject matter relevant, however, indicator not relevant to our country.<br>For interest, a recent New Zealand study has been published looking at sex workers' utilisation of health services in a |

| | | |
|---|---|---|
| | | decriminalised environment. This study found that most sex workers have regular sexual health check-ups. Sexual health needs are accessed through general practitioner (GP) by 41.3%, local sexual health centre by 25%, New Zealand Prostitutes Collective sexual health clinic by 15% of respondents.<br>This study also noted that even in the decriminalised environment, many sex workers do not report their occupation to the GP because of on-going perceptions of stigmatisation[5]. |
| 1.10 | Percentage of sex workers who are living with HIV | Subject matter relevant, however, no recent data available. |
| 1.11 | Percentage of men who have sex with men reached with HIV prevention programmes | GAPSS/GOSS[6] HIV behavioural surveillance from 2011 indicates that 80% recalled the *Get it On!* campaign and correctly identified its safe sex message.<br><br>Significant programmes are focused on both the 'most at risk' populations (MSM and the migrant African communities). |
| 1.12 | Percentage of men reporting the use of a condom the last time they had anal sex with a male partner. | HIV behavioural surveillance from 2011 found 82% of men recruited offline and 70% of men recruited online used a condom the last time they had anal intercourse with a casual partner. Condom use at last sex with a "boyfriend/partner" was 34% and 38% among men recruited offline and online respectively. |
| 1.13 | Percentage of men who have sex with men that have received an HIV test in the last 12 months and who know their results. | HIV behavioural surveillance from 2011 found 50% of non-diagnosed HIV positive MSM recruited offline, and 46% of those recruited online, tested for HIV in the previous 12 months. |
| 1.14 | Percentage of men who have sex with men who are living with HIV | A 2011 prevalence survey in gay community settings in Auckland showed overall HIV prevalence in MSM as 6.5% and a prevalence of undiagnosed HIV as 1.3%. HIV prevalence was lower among MSM usually resident outside Auckland (4.8%) and higher among MSM living outside NZ (13.7%). |

**Target 2: Reduce transmission of HIV among people who inject drugs by 50% by 2015**

| | Indicators | Comment |
|---|---|---|
| 2.1 | Number of syringes distributed per person who injects drugs per year by needle and syringe programmes | It is estimated that there are around 10,000 Needle Exchange attendees (using United Nations methodology of distribution estimation) with an annual distribution of 3 million needles. |
| 2.2 | Percentage of people who inject drugs who report the use of a condom at last sexual intercourse. | In the 2009 survey of people who inject drugs 62% of respondents (n=480) had had sex in the previous month, although only a third of these (34%) reported using a condom the last time they had sex. Approximately two-thirds of the respondents did not use condoms at all with new sexual partners, or with casual sexual partners, and just over half did not use condoms at all with their regular sex partners.<br>Results of a new survey are expected to be available later in 2014. |
| 2.3 | Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected. | In the 2009 survey of people who inject drugs almost 70% of the respondents reported using a new needle and syringe every time they injected drugs and another 25% reported doing so most of the time. |
| 2.4 | Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results | In the 2009 survey of people who inject drugs over 80% of respondents reported having previously been tested for HIV. Of those, 1.5% (n=6) reported having HIV and another 2% (n=8) were unsure of their HIV status. |

[5]Abel G. NZMJ 7 March 2014, Vol 127 No 1390 *Sex workers' utilisation of health services in a decriminalised environment* http://journal.nzma.org.nz/journal/127-1390/6012/

[6] GAPPS – Gay Auckland Periodic Sex Survey. GOSS – Gay online Sex survey.

| | | |
|---|---|---|
| 2.5 | Percentage of people who inject drugs who are living with HIV | The 2009 survey of people who inject drugs found the seroprevalence of HIV to be 0.4% (N=480). |

**Target 3: Eliminate mother-to-child transmission of HIV by 2015**

| | Indicators | Comment |
|---|---|---|
| 3.1 | Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission. | Of the 16 women identified as being infected with HIV in pregnancy in 2012-13, 94% received antiretroviral treatment. Even if the mother is non-resident, i.e., not entitled to receive publicly funded health care, she will receive funded antiretroviral treatment in pregnancy as part of preventive measures to limit risk of mother-to-child HIV transmission. |
| 3.2 | Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of births | 100%. |
| 3.3 | Mother-to-child transmission of HIV (modelled) | Indicator not relevant. |

**Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015**

| | Indicators | Comment |
|---|---|---|
| 4.1 | Percentage of eligible adults and children currently receiving antiretroviral therapy. | 100% |
| 4.2 | Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy | 99.1%. |

**Target 5: reduce tuberculosis deaths in people living with HIV by 50 percent by 2015**

| | Indicators | Comment |
|---|---|---|
| 5.1 | Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV. | 100%. All cases of co-infection are offered treatment for both infections. HIV is an insignificant contributor to TB in New Zealand, unlike in some other countries, and there is no evidence that its contribution is increasing. |

**Target 6: Reach a significant level of annual global expenditure in low-and middle income countries**

| | Indicators | Comment |
|---|---|---|
| 6.1 | Domestic and international AIDS spending by categories and financing sources | Domestic spending on prevention and antiretrovirals was in the order of NZ$12-14 million and NZ$38.80 million respectively for 2 year period. Total international bilateral/regional and multilateral contributions is discussed under the section global commitment and action. |

**Target 7: Critical enablers and synergies with development sectors**

| | Indicators | Comment |
|---|---|---|
| 7.1 | National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation) | Civil society noted the absence of a research and moniroting and evaluation strategy |
| 7.2 | Proportion of ever married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months | The most recent survey of partner violence was the New Zealand Crime and Safety Survey 2009.<br>Following on from this survey, The Ministry of Women's Affairs have published reports on primary prevention and preventing sexual revictimisation (see Intimate Partner Violence Section) |
| 7.3 | Current school attendance among orphans and non-orphans aged 10-14 | Topic not relevant. |
| 7.4 | Proportion of the poorest households who received external economic support in the last 3 months | Topic not relevant.<br><br>New Zealand has a comprehensive social assistance framework, which is universal and accessible to all irrespective of gender, age, and ethnicity. |

# 2. Overview of the HIV and AIDS Epidemic[7]

### *Case Reports of AIDS*

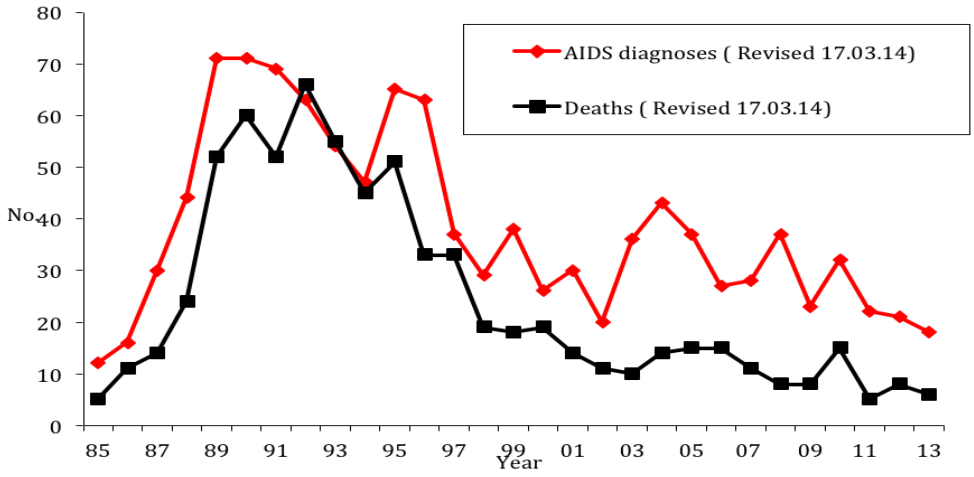
In New Zealand the number of people developing AIDS declined in the mid 1990s as it did in many developed countries as a result of improved treatments for people with HIV infection (see Figure 1).

The number of people notified with AIDS, and the number who have been reported to have died is also shown in Figure 1. The annual number of AIDS deaths is now consistently less than the number notified with AIDS. This is in contrast to the early years of the epidemic when the numbers dying were similar to the number notified a year or so earlier. This change is a reflection of the longer survival of people who are diagnosed with AIDS.

While in 1996 most (72%) of those diagnosed with AIDS had been diagnosed with HIV more than 3 months before, in recent years this is true for a minority (33% in 2013). Hence, most people currently meeting AIDS criteria are 'late testers'.

[7] Data supplied by the AIDS Epidemiology Group, University of Otago under contract to the Ministry of Health to provide AIDS epidemiological research services.

**Figure 1: Number of people with AIDS and deaths of people notified with AIDS by year of diagnosis or death**




(Note - The number of people diagnosed and the number of deaths in 2013 {and possibly earlier} will increase due to delayed notification)

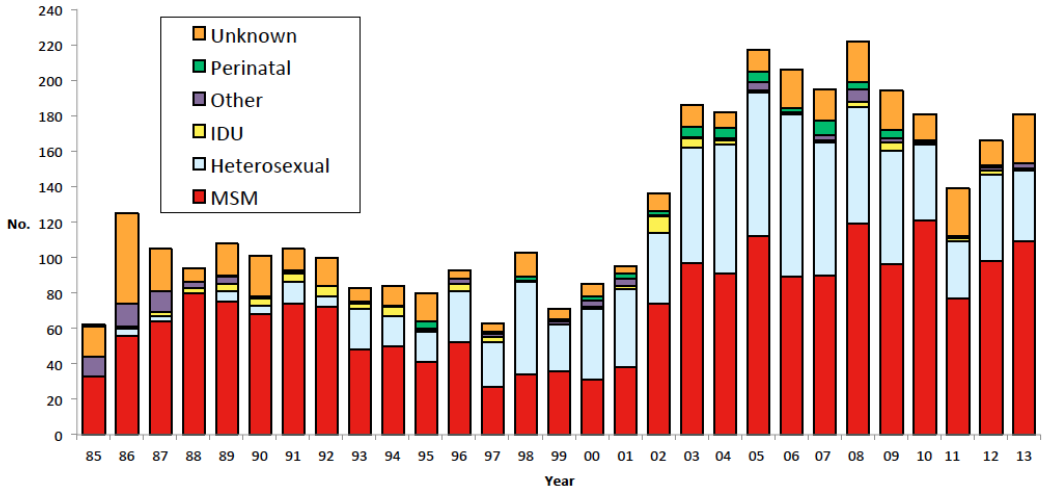
In the early years of the epidemic in New Zealand the vast majority of people with AIDS were MSM. While this has remained the major affected group, the proportion of people with AIDS who were heterosexually infected has increased. As will be discussed under case reports of HIV infection, the majority of people with AIDS who were heterosexually infected acquired HIV outside New Zealand.

### *Case Reports of HIV Infection*

As for AIDS, early in the epidemic most diagnoses were among MSM, and over time the proportion of non-MSM diagnosed has increased. While most of the MSM were infected in New Zealand and the ethnic profile of this group is very similar to that of adult men in New Zealand, the majority of the heterosexually infected people were infected overseas, and are predominately of African or Asian ethnicity.

The number of people diagnosed with HIV each year and by means of infection is shown in Figure 2.

**Figure 2: Annual number of people newly diagnosed with HIV and means of infection**

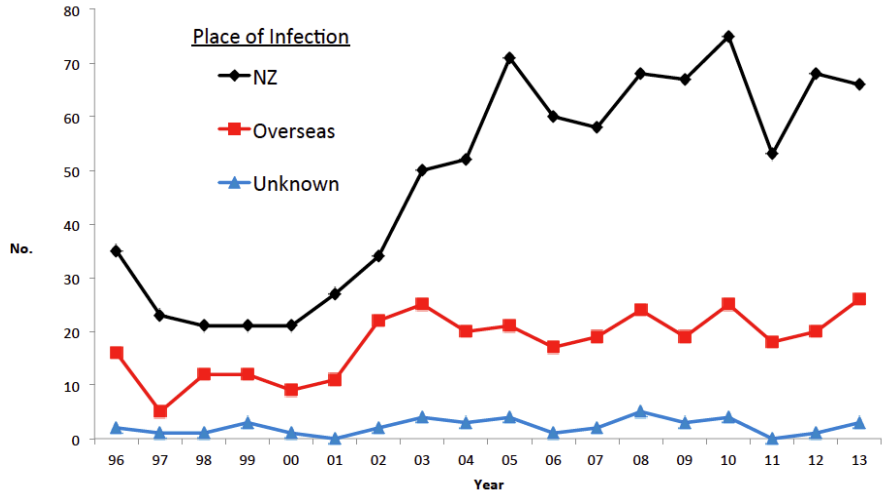



The annual number of people diagnosed with HIV in New Zealand was relatively stable for the first decade after HIV testing became available, and dropped slightly in the late 1990s. Subsequently there was a striking change with a steady rise in the number of diagnoses between 2000 and 2005. Since 2005, this number has fluctuated with an overall slight downward trend driven by a drop in the number of people heterosexually infected being diagnosed.

***HIV diagnoses among Gay, Bisexual and other men who have sex with men (MSM)***

Figure 3 shows the place of infection of MSM first diagnosed with HIV in New Zealand since 1996.

**Figure 3. Number of MSM newly diagnosed with HIV by year and place of infection**



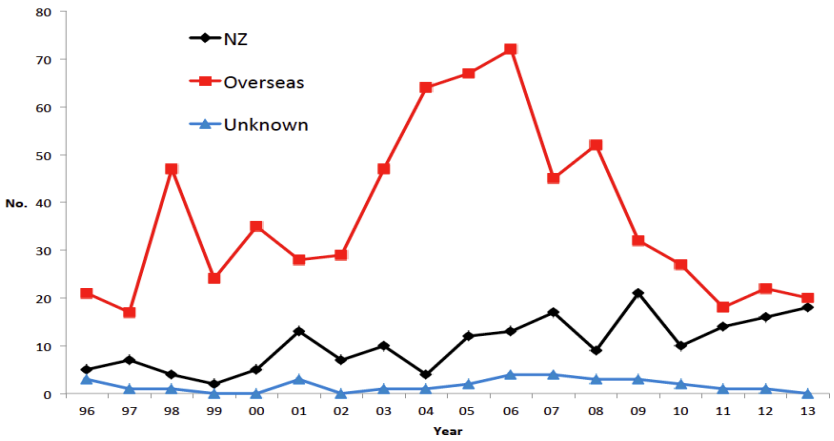
In the late 1990s a low and stable number of MSM were diagnosed with HIV annually in New Zealand. This number rose between 2001 and 2005, mainly due to a steady increase in the number infected in New Zealand. A similar rise was noted in many high income countries at this time. Since then there has been no clear trend up or down, although there have been some moderate annual fluctuations.

Over a short period the number diagnosed with HIV will differ from those infected, as diagnosis may not occur until some time after infection. However over a longer period diagnosis will give an indication of the shape of the epidemic. Clearly the rate of new infections among MSM in New Zealand is higher than in the mid-1990s.

### *HIV diagnoses among hetreosexually infected men and women*

Figure 4 shows the place of infection of men and women heterosexually infected and first diagnosed with HIV in New Zealand since 1996.

**Figure 4: Number of heterosexually infected people newly diagnosed with HIV by year and place of infection**




As with MSM, the number with heterosexually-acquired HIV rose in the early 2000s, however in this group it was mainly due to an increase in people infected overseas, which has always been higher than those infected in New Zealand.

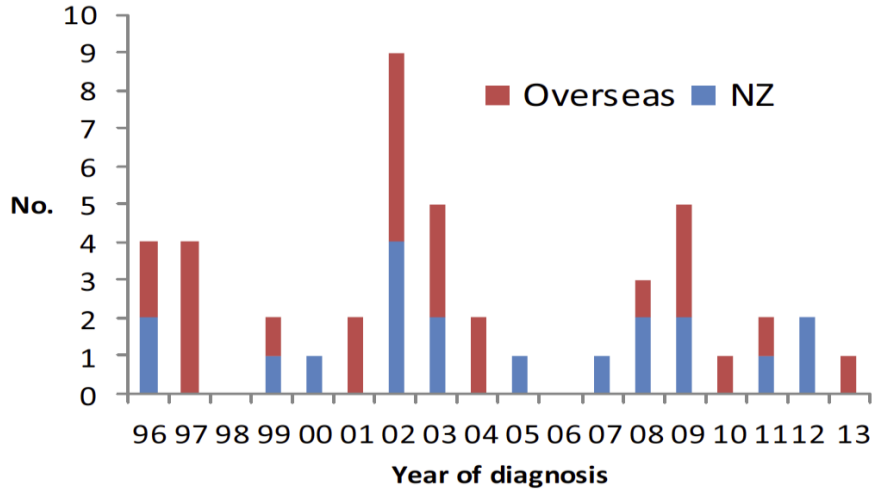
Since the peak in 2006, the annual number of infections has dropped due to fewer people infected overseas. The annual number infected in New Zeland has risen gradually since the mid-1990s, and in 2013 was only just below the number infected overseas. The annual number of infections has remained very much lower than the number of MSM.

In 2013, a similar number of men and women were diagnosed with HIV acquired in New Zealand; these people were from New Zealand European, Maori, Pacific, Asian and African ethnic groups.

### *HIV diagnoses among people who inject drugs*

New Zealand continues to have a small annual number of cases of HIV diagnosed among people who inject drugs and that have no other reported risk factors (Figure 5).

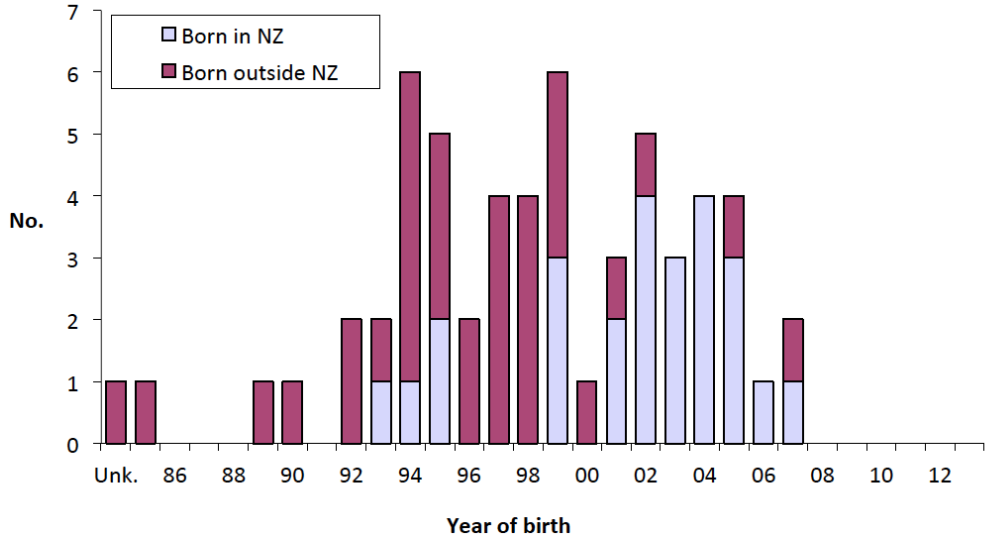
**Figure 5 The number of people diagnosed with HIV among among people who inject drugs with no other reported risk by place and year of birth**




### *Chlldren infected with HIV through mother to child transmission*

There have been no children with HIV acquired through mother to child transmission born in New Zealand since 2007 (Figure 6). However there might be children living with undiagnosed HIV born since then, or earlier, as the last child diagnosed was over 10 years old at the time of diagnosis.

**Figure 6 The number of children diagnosed with HIV acquired throuigh mother to child transmission (MTCT) by place and year of birth**



There were just under 76,000 births and terminations in New Zealand in 2012. While most pregnant women are now tested for HIV, the number being diagnosed each year is low; only four pregnant women were diagnosed in the three-year period 2011-2013, indicating a very low prevalence among pregnant women.

***Total number of people with HIV in New Zealand.***

From 1985 to the end of 2013, a total of 3952 people in New Zealand had been found to be infected with HIV. By this time 1133 had been notified with AIDS, of whom 709 were known to have died. The number of those diagnosed with HIV who have gone overseas, or died without meeting the criteria for AIDS (and therefore being notified), is not known.

The New Zealand drug-purchasing agency PHARMAC reported in June 2013 there were 1,737 people receiving subsidised ARTs, compared with 1,616 for 2012; therefore the estimated number at the end of 2013 is approximately 1800. Assuming that 80% of people in care are on subsidised ART this suggests there are 2250 people under care for their HIV at the end of 2013. If 20% of infected people are undiagnosed or diagnosed but not in care, the total number of people in New Zealand is approximately 2800. This suggests a low total prevalence of around 62 per 100,000 total population.

## 3. National Response to the HIV/AIDS Epidemic

New Zealand's response to the HIV/AIDS epidemic continues to place primary prevention at its centre. New Zealand continues, however, to be challenged to adapt existing interventions to meet the changes in sexual practices, and attitudes towards HIV and safer sex behaviour amongst MSM. It is now clear, at least in a subset of New Zealand MSM, that new patterns of sexual partnering facilitated by the internet and other electronic media have links with HIV risk behaviour. The control of other sexually transmitted infections (STIs) in people with and without HIV infection also has a role in containing HIV spread.

New Zealand recognises that the quality and type of evidence is crucial for policy and programme planning and as such has put in place enhanced STI surveillance to ensure that reliable HIV and STI data exists. This enhanced surveillance includes routinely collecting ethnicity data to allow for rates for different ethnic groups to be reported.

The Ministry of Health is continuing to work with HIV stakeholders in the sector on our ongoing national response to HIV and AIDS.

***Prevention***

The Ministry of Health continues to contract for a range of effective HIV and AIDS-related services including health promotion and promotion of safer sexual behaviour to minimise the incidence of HIV and AIDS, prevention and

awareness activities, surveillance services, programmes for refugees and new immigrants, and independent HIV confirmatory testing services.

Behavioural surveys of gay and bisexual men in New Zealand between 2002 and 2011 have shown that condom use is being sustained among these groups in New Zealand. While this is reassuring, it is now clear that the rates of consistent condom use that were effective in reducing the HIV infections in the period up to 2001 must now be raised to higher levels to counteract the impact of a larger population of people living with HIV in New Zealand[8].

The majority of respondents to the 2011 GAPSS and GOSS surveys reported favourable attitudes towards condoms and safe sex. There was almost universal personal acceptance of condoms as a way to avoid HIV transmission, and most respondents also believed that other gay and bisexual men supported condom use. Thus there is strong evidence of a cultural norm to have safe sex among New Zealand MSM. While this is encouraging some men nevertheless report difficulties using condoms or negotiating condom use in practice. This is indicated by 2 out of every 5 respondents reporting that a condom reduces sensitivity, that almost 1 in 3 report sometimes feeling under pressure not to use a condom, and around 1 in 10 stating that the sex they have is not always as safe as they want it to be[9].

Behavioural surveys have also shown an increase in HIV testing rates. For example, the percentage of people testing at an interval of less than 12 months has risen from 35% in 2002 to 50% in 2011 among those surveyed in Auckland community settings[10].

The behavioural surveys which are conducted with MSM in a range of community settings offline (fair day, gay bars, sex-on-site venues) and online (internet dating sites and apps) show that gay and bisexual men are diverse and targeted interventions should respond to these needs. MSM recruited online have lower condom use, test for HIV less often, have more complex partnering patterns, worse attitudes to HIV and safe sex, and are younger and more bisexually identified compared to those recruited offline[11]. Of the MSM recruited offline, those surveyed in sex-on-site venues have much higher rates of sexual partner change, and are older and less gay community affiliated [12].

The NZAF underwent a comprehensive review of its HIV prevention response during 2009 and the resulting HIV Prevention Plan (2009-2014) developed a

[8] Saxton P, Dickson N, Ludlam A, Hughes A. Condom use among gay and bisexual men in New Zealand: Findings from the GAPSS and GOSS surveys 2002-2011. Research brief to the Ministry of Health. Dunedin: AIDS Epidemiology Group, University of Otago, 2012.
[9] Ludlam A, Saxton P, Dickson N, Hughes A. Attitudes towards safe sex among men who have sex with men in New Zealand: Findings from the GAPSS and GOSS surveys 2002-2011. Research brief to the Ministry of Health. Dunedin: AIDS Epidemiology Group, University of Otago, 2012.
[10] Saxton P, Dickson N, Hughes A. Condom use stable and more HIV testing: location-based HIV behavioural surveillance among MSM in Auckland, New Zealand 2002-2011. *Sexually Transmitted Infections* 2013. Online First doi:10.1136/sextrans-2013-051160.
[11] Saxton P, Dickson N, Hughes A. Who is omitted from repeated offline HIV behavioural surveillance among MSM?: Implications for interpreting trends. *AIDS & Behavior* 2013. 17: 3133-3144.
[12] Saxton P, Dickson N, Ludlam A, Hughes A. Characteristics of men who have sex with men surveyed in sex-on-site venues: Findings from the GAPSS and GOSS surveys 2002-2011. Research brief to the Ministry of Health. Dunedin: AIDS Epidemiology Group, University of Otago, 2012.

new approach based on the most up to date evidence and knowledge available. This new approach has integrated health promotion models with behaviour change strategies, and focuses on four behaviour change goals that will have the greatest impact on the HIV epidemic in New Zealand. The four behaviour change goals focus on:

- increasing the rates of condom use for anal sex for gay and bisexual men
- increasing the rates of HIV testing for gay and bisexual men
- increasing the rates of condom use for first anal sex for gay and bisexual men
- increasing the rates of condom use within New Zealand-based African communities.

The range of health outcomes that will contribute to these goals include activities and projects that recognise the effective influences of whānau[13], peers, community and social support for safe sex practices, and make significant use of online technologies to build virtual safe sex cultures and increase rates of condom use. The core component of social marketing of condom use by MSM was independently evaluated in 2012/13. The programme was found to be highly successful with excellent reach and recognition of the messages and string indications of increased condom use by MSM[14].

Another critical aspect of the NZAF HIV prevention response is community-based rapid testing. All NZAF HIV and sexually transmitted infections screening services include therapeutic interventions from professionally qualified staff, to improve an individual's safe sex practices.

Positive Women Inc. is a support organisation for Women and families living with HIV and AIDS. They are also involved in HIV advocacy, awareness and destigmatisation. Positive Women Inc. offers a community drop-in centre in Auckland, free information, advice, referral and support services, and education programmes which aim to eliminate the stigma and isolation of living with HIV and AIDS. Following initial first-time funding to Positive Women Inc. in 2011 the Ministry of Health entered into an ongoing relational contract for a three year period from 2012 to 2015.

Positive Women Inc. sees the official funding as an "an acknowledgment of the contribution and significance that 'people living with HIV' organisations make both to the lives of those living with HIV and to the HIV response as a whole".

INA (Māori, Indigneous & South Pacific) HIV & AIDS Foundation has funding from the Ministry of Health for the period 2012-2015. This has enabled INA to work in Māori communities, schools and early education centres, in HIV prevention and reducing stigma and discrimination. INA also has two years of funding for Whānau Ora (Ministry of Māori Affairs – Te Puni Kōkiri), working

[13] Whānau is the Māori word for 'extended family'.
[14] Dr Jeff Adams and Dr Stephen Neville "An Evaluation of Get it On" Massey University School of Public Health 2013

with whānau living and affected by HIV, further educating whānau on HIV, how to live with HIV, how to prevent the transmission and reducing cases of stigma and discrimination. INA has establised a drop in centre making INA services accessible to those living in the rural Central North Island region and nationally.

Family Planning is a not-for-profit organisation which provides sexual and reproductive health services for all New Zealanders. Family Planning seeks to expand access and reduce the barriers to achieving improved sexual and reproductive health and rights. There are 30 clinics across the country with 165,440 visits per annum in total (2013 calendar year). Family Planning is the largest provider of sexual and reproductive health services in New Zealand. It is a strong advocate and lobby group for the empowerment of women and girls, particularly in respect to sexual and reproductive health issues such as HIV. Family Planning's HIV prevention work is fully integrated into health promotion, education, social marketing, resource production, and clinical and professional work. Activities over the 2013 calendar year period have included: (a) offering HIV testing as part of general screening for sexually transmitted infections in clinics; (b) condom distribution and promotion; and (c) school-based education programmes on sexually transmitted infections, including HIV.

Other programmes and clinical services are delivered via district health boards, in sexual health clinics and sexual health promotion services. The services offer free, confidential, specialist sexual health care services including diagnosis and treatment of sexually transmitted infections, telephone information and advice, testing and treatment of HIV/AIDS, sexual health counselling and free condoms. District health boards also fund PHOs to support the provision of essential primary-health-care services through general practices to those people who are enrolled with the PHO. The services include being a point of contact for people with sexual health concerns and testing and treatment of common STIs.

***Approval of female condom in New Zealand***

Female condoms will be available in New Zealand from May 2014 following an amendment to the Contraception, Sterilisation and Abortion Act 1977 to allow their sale in New Zealand.

This approval is widely supported by civil society.

***Community-based HIV Rapid Testing Service***

There are both individual and public health benefits of early diagnosis of HIV infection. Infected individuals can benefit from combination antiretroviral therapy and prophylaxis against opportunistic infections. The appropriate use of combination antiretroviral therapy has had a dramatic effect in reducing morbidity and mortality from HIV, although for some it can have significant side effects.

The NZAF and Body Positive Inc provide a free community-based HIV rapid testing service. This service has increased access to testing services across a range of ethnic groups with many individuals seeking HIV testing for the first time. Services have been extended to include sexual health clinics in the community that ensure a health promotion focus and awareness of the increased risk of HIV transmission if other STIs are present.

***Antenatal HIV Screening***

Since August 2010, it has been national policy that HIV screening be recommended and offered to all pregnant women, along with the other screening blood tests, as an integral part of antenatal care.

Regular monitoring reports for the screening programme are now being produced by the Ministry of Health, which report antenatal HIV screening uptake at the national level and regionally by district health board. These reports enable trends to be monitored over time and highlight areas that may require attention. At the national level, screening uptake is approximately 86 percent of pregnant women. Screening uptake rates do vary across the country, from around 70% to 100%. Regional variations indicate that ongoing practitioner education, along with raising community awareness of screening, remain priority areas for action.

Practitioner guidelines and consumer pamphlets on antenatal HIV screening have been developed, and consumer resources are available in English and eight other languages. A resource for HIV, pregnancy and health designed to support women diagnosed through the AHIV Screening Programme has also been developed by Positive Women Inc. A combined first antenatal blood test resource has been developed which gives information about each of the six antenatal blood tests routinely included in the first antenatal blood screen. These resources are intended to support practitioners to make the offer to women in a nationally consistent and appropriate way so that women can make an informed choice about participation in the Screening Programme.

Overall there have been 35 women diagnosed with HIV infection through antenatal testing since the beginning of 2006. For the 2012 year there were two pregnant women diagnosed through the Antenatal HIV Screening Programme and for 2013 there was one pregnant woman diagnosed. Over 80,000 women are tested each year.

***Love your Condom Social Marketing Campaign***

*Love Your Condom* is a comprehensive social marketing programme run by the NZAF HIV Social Marketing and Community Engagement team designed to increase rates of condom use for anal sex between men. It operates in multiple channels to deliver condom use behaviour change messages. The primary audiences that the *Love your condom* campaign engages with are young MSM (declining rates of condom use) and highly sexualised MSM (the group most at risk).

Research shows that MSM in New Zealand are aware of why condom use is important, and specifically, the risk of contracting HIV as a result of not using condoms and lube. Also, we know that approximately 60 percent of MSM use condoms all or almost all of the time, 20 percent some of the time and 20 percent infrequently or never. The *Love Your Condom* campaign concentrates on those who are most amenable to changing their behaviour (the 20 percent who use condoms and lube some of the time), while reinforcing the behaviour of those who use them all or almost all of the time. This also then reduces the pool of men that the group who are less likely to use condoms can have unprotected anal sex with.

The *Love Your Condom* approach is entirely focused on the normalisation of condom use, and the costs/benefits of condoms as a part of sex. *Love Your Condom* does not engage in scare tactics as research shows such tactics are not effective in public health initiatives, and also because they tend to negatively brand HIV positive people. The tone or 'brand personality' of *Love Your Condom* is sexy, smart, pro-sex, urban and fun.

***Intimate Partner Violence***

Following the 2009 New Zealand Crime and Safety Survey, which found that multiple and repeat victimisation account for a high proportion of partner crime in New Zealand[15], the Ministry of Women's Affairs (MWA) has published a report entitled *Lightning does strike twice: preventing sexual revictimisation*[16]*.* This report emphasises the importance of early identification of repeat surviviors and the need to break the cycle of repeat revictimisation and to provide consistent and appropriate support for survivors and there families.

The MWA has also recently published a report entitled *Current thinking on primary prevention of violence against women*[17]*,* the purpose of which was to generate discussion about primary prevention of violence against women and how these approaches can be effectively implemented in New Zealand.

[15] http://www.justice.govt.nz/publications/global-publications/c/NZCASS-2009/publications/global-publications/c/NZCASS-2009/documents/The%20New%20Zealand%20Crime%20and%20Safety%20Survey%202009%20Main%20Findings%20Rep.pdf

[16] http://mwa.govt.nz/sites/public_files/Lightning%20does%20strike%20twice_2012%20report.pdf
[17] http://mwa.govt.nz/sites/public_files/Final%20Current%20thinking%20on%20primary%20prevention.pdf

***Care, Treatment and Support***

Treatment and care for people with HIV is of a high standard with a good range of funded antiretroviral agents available. People with HIV are also eligible to receive free influenza vaccination each year.

PHARMAC is the entity responsible for managing New Zealand's Pharmaceutical Schedule, which lists the community pharmaceuticals subsidised by the Government. New Zealand currently funds 21 different antiretrovirals for treating HIV infection.

In 2012 approval was given to lower the threshold at which people living with HIV could access publically funded antiretroviral medications to 500 CD4 or less.

In 2012, two new combination treatments, Truvada (emtricitabine with tenofovir disoproxil fumarate) and Atripla (efavirenz with emtricitabine and tenofovir disoproxil fumarate) were subsidised.

Trends in patient numbers and expenditure (New Zealand dollars) over the last 9 years (PHARMAC financial year runs 1 July – 30 June) are shown in the following tables.

| | FY ending Jun 2005 | FY ending Jun 2006 | FY ending Jun 2007 | FY ending Jun 2008 | FY ending Jun 2009 | FY ending Jun 2010 | FY ending Jun 2011 | FY ending Jun 2012 | FY ending Jun 2013 |
|---|---|---|---|---|---|---|---|---|---|
| Patients receiving funded antiretroviral therapy | 863 | 917 | 1,010 | 1,090 | 1,204 | 1,348 | 1,518 | 1,616 | 1,737 |
| Antiretrovirals expenditure | $8.9 Million | $10.4 Million | $11.6 Million | $12.3 Million | $13.0 Million | $14.5 Million | $16.8 Million | $17.8 Million | $21.0 Million |

| | | FY ending Jun 2005 | FY ending Jun 2006 | FY ending Jun 2007 | FY ending Jun 2008 | FY ending Jun 2009 | FY ending Jun 2010 | FY ending Jun 2011 | FY ending Jun 2012 | FY ending Jun 2013 |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 to 14 | Female | 11 | 12 | 13 | 10 | 9 | 4 | 4 | 6 | 7 |
| | Male | 7 | 7 | 9 | 20 | 18 | 19 | 24 | 22 | 20 |
| 15+ | Female | 178 | 178 | 196 | 213 | 232 | 257 | 294 | 300 | 317 |
| | Male | 666 | 721 | 793 | 847 | 945 | 1068 | 1195 | 1288 | 1393 |
| | Total | 863 | 917 | 1010 | 1090 | 1204 | 1348 | 1518 | 1616 | 1737 |

Although access to treatment and support is widely available in New Zealand, Civil Society have noted that stigma, discrimination and geographic isolation are some of the known barriers to accessing specialist clinical services and support.

### *Global Commitment and Action*

The New Zealand Aid Programme focuses on four priority themes to stimulate sustainable development. Promoting human development is one of these themes, and within this, improved health outcomes is a high priority. Sexual and reproductive health is one of the health areas prioritised.

While the Government's aid programme provides core contributions to multilateral and regional agencies and bilateral support to developing countries in Asia, Africa, Latin America and the Caribbean, the core geographic focus is on the Pacific region.

New Zealand works with a range of multilateral partners to help address HIV/AIDS. In 2012/13 NZ$1.5 million was provided in core, unearmarked, funding to the United Nations Joint Programme on HIV/AIDS (UNAIDS). In 2012/13 core contributions were also provided to the following UN and international voluntary agencies engaged in addressing HIV: UNFPA ($6 million), UNDP ($8 million), UNICEF ($6 million), WFP ($6 million), UNHCR ($6 million), UN Women ($2.5 million) and the International Planned Parenthood Federation ($2.5 million). Funding was also provided for the World Bank's International Development Association ($19.140 million in 2012/13). In 2012/13, NZ$1.5 million was provided to other programmes focused solely on HIV AIDS including towards the implementation of the Pacific Regional Strategy on HIV/AIDS and other STIs, and for a non governmental organisation project in Kenya. On top of this, $6.6 million was provided to a range of health activities, with a partial focus on HIV AIDS, primarily in Papua New Guinea and the wider Pacific region.

New Zealand civil society groups have also been making contributions and building collaborations internationally. For example, New Zealand holds a position on the International Council of AIDS Service Organisation and the International Indigenous Working Group on HIV and AIDS.

## 4. Best Practices

### *HIV Testing and Counselling*

In 2010 the Ministry of Health commissioned a national review of HIV services in New Zealand. The report from this Review included several recommendations, one of which being the need to develop national guidelines and standards for HIV testing and counselling.

Although New Zealand has its own national protocols for HIV testing and counselling, the review found that these are not well known and as a result

significant variations were observed in the processes employed for HIV testing of individuals within and across sectors in New Zealand.

The recommendation on the need to develop national guidelines and standards for HIV testing and counselling aims to ensure standards are aligned to developments in HIV testing technology and reflects the availability of testing outside of routine clinical settings.

The Ministry of Health consulted with all key stakeholders with regards to HIV testing standards and guidelines. The recommendations from this consultation focused on work force development and establishing standards. The Ministry of Health is working with testing and counselling service providers to ensure they maintain quality standards.

### *HIV Behavioural Surveillance Survey of African Communities in New Zealand*

AfricaNZ was a research project undertaken jointly by Massey University and the University of Otago with the aim of informing HIV infection prevention and health promotion programmes by understanding the HIV risks in the African Community in New Zealand. This project involved HIV Behavioural Surveillance Surveys of African communities in New Zealand. African communities have the highest HIV prevalence rates for the heterosexual population and the second highest after European for the MSM population in New Zealand.

Two reports have been produced:

- AfricaNZ Count: An estimate of currently resident and HIV positive Africans in New Zealand[18].
- AfricaNZ Care: A report on knowledge, attitudes, behaviours and beliefs about HIV among Black Africans living in New Zealand[19].

These reports are available at http://africanz.massey.ac.nz

The studies found that there is a relatively high level of knowledge about HIV in older populations, but the lowest knowledge and most negative attitudes are among young men.
Respondents living with HIV reported a high level of non-HIV stigma from non-HIV health care and dental providers.

A range of recommendations were made including recommendations on education, communication, working together and the need for further research.

[18] Dickson, N., Henrickson, M. & Mhlanga, F. (2012). *AfricaNZ Count: An estimate of currently resident and HIV positive Africans in New Zealand.* Report completed for the Health Research Council of New Zealand and the Ministry of Health (Contract 11/965). (ISBN: 978-0-473-26111-5)
[19] Henrickson, M., Dickson, N., Mhlanga, F., & Ludlam, A. (2013, June). *AfricaNZ Care: A report on knowledge, attitudes, behaviours and beliefs about HIV among Black Africans living in New Zealand.* Report completed for the Health Research Council of New Zealand and the Ministry of Health (Contract 11/965). (ISBN: 978-0-473-26113-9)

## 5. Major Challenges and Remedial Actions

### *Management of People with HIV who Place others at Risk of Infection*

Currently New Zealand lacks legislation to support use of effective public health policy response mechanisms for managing people with HIV who recklessly and knowingly place others at risk of infection (as well as those with other significant communicable conditions, e.g. hepatitis C). Accordingly, difficulties have been reported by some medical officers of health[20].

However, the number of individuals at any one time for whom public health mechanisms are needed to manage the issue is small. The overwhelming majority of people with HIV in New Zealand actively take steps to ensure that transmission of HIV to others does not occur.

The Ministry of Health is exploring possible legislative amendments which could form the basis for interim public health policy response mechanisms for public health protection services.

### *New HIV Diagnoses in Men Who Have Sex With Men (MSM)*

Through the last decade New Zealand has continued to experience ongoing increases in new HIV diagnoses among MSM (in 2011 there was a decline followed by a slight rise again in 2012). The increases have been associated with factors unseen in the 1980s and 1990s.

Until 2000, the numbers of new HIV diagnoses had been decreasing. However, a few years after antiretroviral medications were introduced the number of people living with HIV began to rise. The growing pool of people with HIV infection means that if the annual rate of secondary transmission from HIV positive individuals remains stable, a higher number of new infections would be expected every year. In order to reduce the annual number of new infections, it will therefore be necessary to considerably reduce the annual transmission rate. Simply maintaining the annual transmission rate is not enough. A reduction in the annual transmission rate can be achieved by increasing condom use among the most-at-risk population groups, and by diagnosing new infections early and treating HIV to reduce infectiousness. As noted in section 3 the Ministry of Health continues to contract for a range of effective HIV and AIDS-related services to work towards this.

Research has shown that gay and bisexual men in New Zealand are maintaining their current rates of condom use. While this is a considerable achievement given the changes in the epidemic such as the impact of effective HIV treatments and internet dating, the levels of condom use must be increased if the rate of new HIV infections is to be limited.

[20] Medical officers of health are Public Health Specialists, designated under the Health Act 1956 to improve, protect and promote the health of the population in their health districts.

***Treatment as prevention***

New Zealand's primary approach to the HIV epidemic has been to promote prevention. For example, the NZAF works to reinforce the condom message. As a result, New Zealand has managed to preserve strong gay community support for condom use for HIV prevention. New Zealand also encourages HIV testing to achieve early diagnosis.

Evidence has not yet been collected and published on the population level effectiveness of treatment as prevention. At this stage, New Zealands view is that while the approach may have a part to play in HIV prevention, it should not replace primary prevention. It remains necessary that condom use and HIV testing continues to be encouraged amongst those at risk.

## 6. Support from the Country's Development Partners

Not applicable.

## 7. Monitoring and Evaluation Environment

In the absence of a Monitoring and Evaluation plan, the Ministry of Health, district health boards and their contractors (which include non government organisations and other civil society organisations) periodically report on key performance indicators stated in their Annual Plans, Strategic Plans or contract reports. Stakeholders draw upon existing documentation of HIV and AIDS in New Zealand (examples shown below) and ensure that the analyses of HIV and AIDS data are linked to key public health policies and relevant Government processes.

| DOCUMENT / PUBLICATION | DESCRIPTION |
|---|---|
| AIDS – New Zealand | Ministry of Health/NZ AIDS Epidemiology Group report gives an up-to-date view of the national situation (twice yearly). |
| Gay Auckland Periodic Sex Survey (GAPSS 2002, 2004,2006, 2008, 2011 and 2014) and Gay Online Sex Survey (GOSS 2006, 2008, 2011 and 2014) | GAPSS assesses sexual behaviour in respect to HIV risk practices amongst MSM in the Auckland area (two-yearly). GOSS is the same survey but accessible to all MSM on a specific internet dating site nationally. |
| National Service review (2010) | The Ministry of Health commissioned a national review of HIV services in New Zealand. The report from this Review included several recommendations including the need to develop national guidelines and standards for HIV testing and counselling. |
| National Needle Exchange Blood-borne Virus Seroprevalence Survey | Cross sectional surveys of risk behaviours and prevalence of blood-borne viral infections among injecting drug users (periodic: 1997, 1998, 2004, 2009). |
| Sexual Health Clinic Surveys | Unlinked anonymous prevalence surveys of HIV infection among attendees of sexual health clinics (periodic). |

New Zealand's census, blood screening, antenatal HIV screening monitoring reports, perinatal monitoring database and the New Zealand Paediatric Surveillance Unit monitoring of infants with HIV infection also provide important information used for policy and health promotion planning.

The Ministry of Health has established monitoring reports for the Universal Offer Antenatal HIV Screening Programme. These reports enable trends to be monitored over time and highlight areas that may require attention.

The Ministry of Health funds meetings of the National HIV and AIDS Forum, a defined membership of those involved in the HIV and AIDS sector that includes civil society, government, District Health Board clinical staff, tertiary based researchers and organisations representing people living with HIV and AIDS.

The Forum meetings focus on co-ordination of progress of the response to HIV as well as identifying issues, sharing knowledge, and providing input into sector responses that guide the Government's policies around HIV and AIDS.

The Forum has developed an Action Plan to Eliminate Stigma in response to the findings of the National Service Review. The plan has not been funded at this point in time but initial implementation within existing resources is planned for 2014.

## 8. Annexes

ANNEX 1: Indicators for Global AIDS Response Progress Report 2012/2013

ANNEX 2: National Commitments and Policy Instrument (NCPI)