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COUNTRY PROGRESS REPORT

NEW ZEALAND

Reporting Period: January 2010 – December 2011

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. The initial phase involved circulation of the specific civil society questions and a consensus process for the civil society organisations to reach an agreement based on the majority view. Accordingly, there was not always total agreement among civil society on some answers. The use of the online 'Country Viewer' level of access was used for stakeholder peer review of the draft answered online Annexes and for obtaining any final comments.The process of finalising this Country Progress report involved both internal Ministry of Health peer review and external stakeholder peer review.

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) and it remains so for infections acquired in New Zealand.
- Over the first two decades of surveillance the proportion of people diagnosed with HIV infection and AIDS who had been heterosexually infected has increased.
- Between 2000 and 2005 there was a marked rise in the annual number of people diagnosed with HIV, due to an increase both of: (a) people infected through male homosexual contact; and (b) heterosexual contact. Since 2005, the annual number of diagnoses has remained above the pre-2000 level except for 2011 when the number of diagnoses declined.
- While most MSM diagnosed with HIV were infected in New Zealand the majority of those heterosexually infected acquired their infection overseas. The latter group are mostly made up of people from parts of the world where heterosexual HIV transmission is common.
- Many of the people who are now diagnosed with AIDS had only recently been diagnosed with HIV and therefore had not previously been on antiretroviral treatment.
- Among those opting to have an HIV test, half of those diagnosed with HIV between 2005-2010 presented at a stage when the CD4 count was below the level at which treatment is recommended.
- Of all the people diagnosed with HIV in New Zealand from 1985 to 2011, 2.1 percent (N=64) were under the age of 15 years at the time of diagnosis.
- Of all the people diagnosed with HIV in New Zealand from 1985 to 2011, 10.1 percent (N= 313) were aged between15 and 24 years at the time of diagnosis.

Policy and Programmatic Response

In New Zealand the prevalence of HIV infection in the general population is very low. 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 is confirmed by the review of services for people with HIV in New Zealand[1] undertaken in 2010 which revealed that stigma was repeatedly mentioned as a major issue in the context of HIV in New Zealand. The main risk for acquiring HIV infection in New Zealand, however, is still sexual contact between men. The prevalence in this group in the most recent study[2] was 4.4 percent.

The response to the epidemic in New Zealand from most quarters has been based on a health promotion approach. The Ottawa Charter for Health Promotion operationalises the approach and ensures the responses are led by the community groups most at risk. Specialised programmes are provided by different organisations that are 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 (including an NZAF International Development Unit), policy advice and coordination of the National HIV and AIDS Forum. Within the NZAF's HIV prevention programmes is a specific social marketing team that uses new technologies and social networking sites 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[3] Pacific People and African heterosexual migrants to New Zealand
- peer support organisations (Body Positive Inc., the Māori, Indigenous & South Pacific HIV/AIDS Foundation [known as INA], 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. 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 de-stigmatisation

[1] Miller, D. 2010. *Review of Services for People with HIV in New Zealand.* Wellington: Ministry of Health

[2] Unlinked Anonymous Study of HIV Prevalence Among Attenders At Sexual Health Clinics (2005/06): Report to the Ministry of Health by AIDS Epidemiology Group 2007

[3] A Samoan word that means Samoan who is physically male but has the spirit of women.

- Needle Exchange Services administers the Needle Exchange Programme along with regional Trusts across the country
- New Zealand Prostitutes Collective provides health promotion and support services for sex workers
- Family Planning is a not-for-profit organisation which provides quality 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 reproductive rights. There are 30 clinics with 180,000 visits per annum, nationally. HIV is integrated into all areas of health promotion, education, clinical and professional development work. Family Planning 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
- 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 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 offer 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.

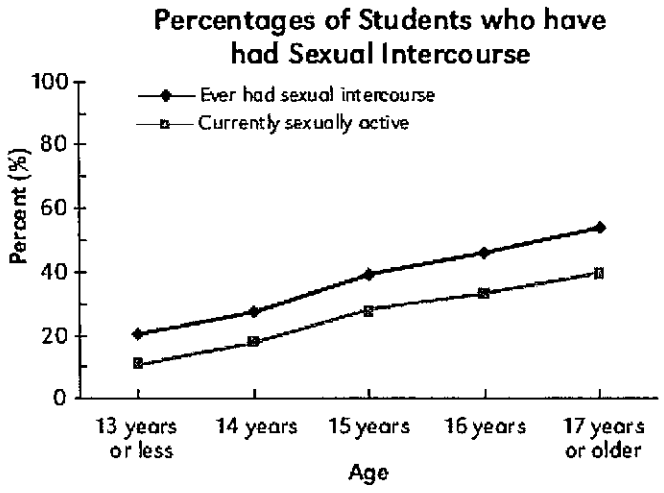
Publicly funded health care is funded from Vote: Health and administered by the Ministry of Health through Crown Funding Agreements with 20 District Health Boards charged with delivering health care to New Zealanders in their regions.

Testing, treatment and care are provided in a number of health settings, including general practice, sexual health centres, community based centres, 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, 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.

Overview of Core Indicators for Global AIDS Response Progress Reporting 2011/2012

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

	Indicators	Comment
1.1	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing sexual transmission of HIV and who reject misconceptions about HIV transmission.	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. The New Zealand National Health Survey will include a module on sexual health over the 2014-15 period. Findings from the Youth 2007 survey show that of school attending youth aged 13 or less 20.2% had had sexual intercourse, by the age of 14, 27.1% had had intercourse, by the age of 15, 39.2% had and by the age of 16, 46.1% had. Of school aged youth 17 years or over 53.7% had engaged in sexual intercourse 
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 2011, 10.1 percent (N=313) were aged between15 and 24 years at the time of diagnosis.

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. 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.	Topic relevant, however, indicator not relevant to our country.
1.10	Percentage of sex workers who are living with HIV	The 2005/06 Sexual Health Clinic survey – sex workers no HIV positive cases out of 343 tested.
1.11	Percentage of men who have sex with men reached with HIV prevention programmes	Subject matter relevant, however, no data is available. 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.	Indicator relevant to our country, however, no new data available. Analysis of 2011 data has not yet commenced. The analysis will result in a report on condom use looking at a range of variables that will allow monitoring of what is happening in relation to various sub-groups and locations, and in relation to attitudes to condoms and safe sex.
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.	Subject matter relevant, however, no recent data is available. Analysis of 2011 data has not yet commenced. The analysis will result in a report on HIV testing behaviour and attitudes of which can be used to inform monitoring of success in achieving the goal of increasing HIV testing and strategies for advancing this among men who have sex with men.
1.14	Percentage of men who have sex with men who are living with HIV	Indicator relevant to our country, however, no recent data available. 2005/06 Sexual Health Clinic survey showed overall prevalence of HIV in men who have sex with men as 44.1/1000 and a prevalence of previously undiagnosed HIV in men who have sex with men of 20.1/1000.

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	An estimate of around 8,000 to 10,000 Needle Exchange attendees going on the UN method of averaging out the use of needles / syringes at 270-280 injections units per year per IDU. At an annual distribution of 2.7million from the approx 200 outlets are the background figures.
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.
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	In the 2009 survey of people who inject drugs over 80% of respondents reported having previously been tested

	past 12 months and know their results	for HIV. Of those, less than 2% (n=6) reported having an HIV infection and another 2% (n=8) were unsure of their HIV status. 93% of those who indicated they had been tested for HIV reported negative test results. A small proportion of respondents (6.5%) had been tested but did not know their test result. Two respondents reported that they had HIV, only one of whom was HIV-1 positive test on serological testing.
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.	All women identified as being infected with HIV in pregnancy in 2010-11 received antretrovirals. Even if the mother is non resident, i.e., not entitled to receive publicly funded health care, she will receive antiretrovirals 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)	Topic 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	98%.

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$31.30 million respectively for 2 year period. Total international bilateral/regional and multilateral contributions for 2010/11 was NZ$19.2 million.

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)	
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. Chapter 6 explores confrontational crimes, one of the largest and most serious forms of crime covered by the survey. See page 16 of this report for online reference for the New Zealand Crime and Safety Survey 2009.
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. New Zealand has a comprehensive social assistance framework, which is universal and accessible to all irrespective of gender, age, and ethnicity.

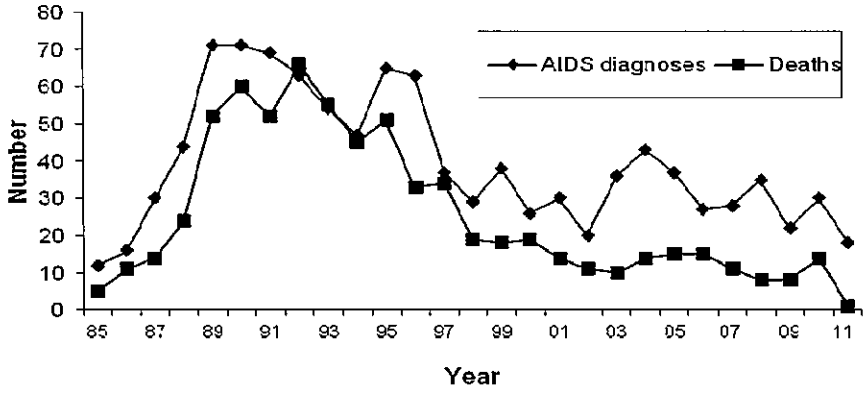
2. Overview of the HIV and AIDS Epidemic[4]

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). 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 (28% in 2011). Hence, the majority of people currently meeting AIDS criteria are 'late testers'.

The number of people reported with AIDS who are known to have died is also shown in Figure 1. The annual number 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.

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

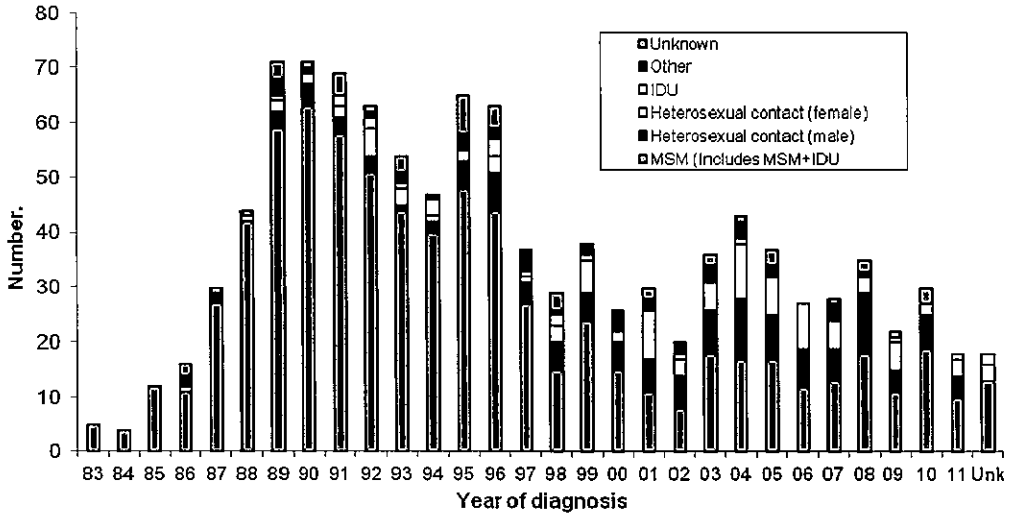


(Note - The number of people diagnosed and the number of deaths in 2011 (and possibly earlier) will increase due to delayed notification)

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

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 overall has increased (see Figure 2). 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.

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



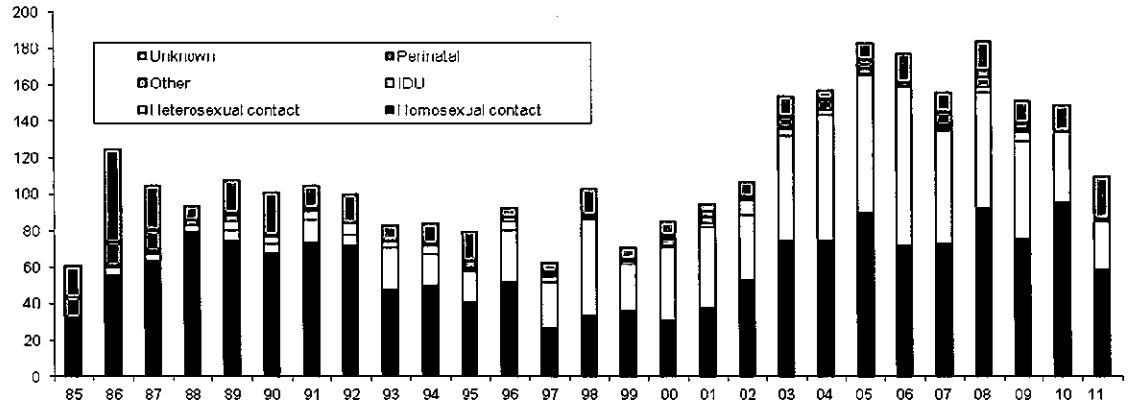
"Unk" in last bar denotes mode of infection is unknown
(Note - The number of people diagnosed in 2011 (and possibly earlier) will increase due to delayed notification)

Case Reports of HIV Infection

The overall 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 has been a striking change with a steady rise in the number of diagnoses between 2000 and 2005.

Since 2005, this number has fluctuated with a possible downward trend. The pattern of an overall increase in the number of MSM diagnosed with HIV in New Zealand over the last ten years is similar to that found in many developed countries. The number of people diagnosed with HIV each year and by means of infection is shown in Figure 3 below.

Figure 3: Number of people newly diagnosed with HIV each year by means of infection



As for AIDS, early in the epidemic most diagnoses were among MSM, and over time the proportion of non-MSM diagnosed has increased. There are, however, clear differences between these two groups as outlined below.

a) While the ethnic profile of MSM is very similar to that of adult men in New Zealand, people heterosexually infected are predominately of African or Asian ethnicity.

b) While the majority of the MSM were reported as being infected in New Zealand, this was true for only a minority of the heterosexually infected men and women. In addition, as shown in Figures 4(a) and 4(b) the overall rise among MSM, since 1999, has predominantly been due to MSM who were infected in New Zealand. In contrast, the rise in diagnoses among men and women heterosexually infected between 2002 and 2006 was related to people who were infected overseas. In 2009, however, the number of people diagnosed with HIV heterosexually acquired overseas was lower than in previous years and has continued to decline. The number of people diagnosed with HIV acquired heterosexually in New Zealand increased in 2009 and declined again since then.

Figure 4(a): Number of MSM newly diagnosed with HIV by year and place of infection

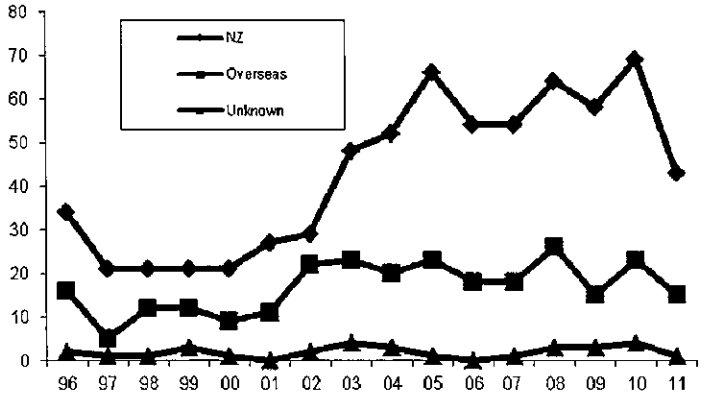
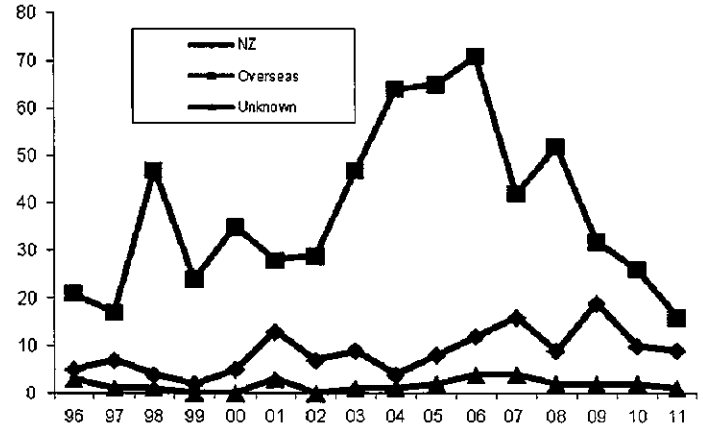


Figure 4(b): Number of people heterosexually newly diagnosed with HIV by year and place of infection



Comment

In the ten year period from 1 January 2002 to 31 December 2011, of those diagnosed with HIV that had been acquired in New Zealand, 537 were MSM and 103 people (59 women and 44 men) had been heterosexually infected. Among these MSM the distribution of ethnicities was similar to the New Zealand adult male population. Among the men and women who were heterosexually infected most were of European ethnicity. However, when account was taken of the relative population sizes, for both men and women, those of 'other' ethnicity (mainly African) were at highest risk, and for women, those of Māori, Pacific and Asian ethnicity were at higher risk than women of European ethnicity.

3. National Response to the HIV/AIDS Epidemic

The development of the HIV/AIDS Action Plan in 2003 comprised the second phase of the 2001 Sexual and Reproductive Health Strategy. 'New Zealand's approach continues to put primary prevention at its centre. We must maintain and strengthen our efforts to reduce the risk, vulnerability and impact of the epidemic on the communities most at risk of HIV infection'[5]. 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 clearly demonstrable, at least in a subset of New Zealand MSM, that new patterns of sexual partnering facilitated by social technologies such as the internet and other electronic media have links with HIV risk behaviour. Also, HIV is seen in the wider context of sexually transmitted infections and the control of other sexually transmitted infections in people with and without HIV infection has a role in containing HIV spread.

The Ministry of Health is continuing to work with HIV stakeholders in the sector on our ongoing national response to HIV and AIDS. The following sections reflect the changes made in New Zealand's national commitment since writing the 2008/09 Report.

[5] Reference: *HIV/AIDS Action Plan 2003,* Foreword by the then Minister of Health, Hon Annette King.

Prevention

The Ministry of Health continues to contract for a range of 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. The contract period is generally for a three-year term and the principal contracts presently span from July 2011 to June 2014.

Behavioural surveys of gay and bisexual men in New Zealand between 2002 and 2008 have shown that condom use is not reducing 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.

Analysis of 2011 data has not yet commenced. The analysis will result in a report on condom use looking at a range of variables that will allow monitoring of what is happening in relation to various sub-groups and locations, and in relation to attitudes to condoms and safe sex. The report analysis will be core for monitoring impacts of promoting condom use for men who have sex with men and in targeting specific sub-groups in the development of condom related programmes.

The NZAF underwent a comprehensive review of its HIV prevention response during 2009 and the resulting HIV Prevention Plan (2009-2014) developed a 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 sexually transmitted infections and HIV testing rates 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 will include activities and projects that recognise the effective influences of whānau[6], peers, community and social support for safe sex practices, and will make significant use of online technologies to build virtual safe sex cultures and increase rates of condom use. Various aspects of the current prevention plan are currently under evaluation but no data is ready for dissemination.

[6] Whānau is the Māori word for 'extended family'.

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.

During 2011 Positive Women Inc. expanded its services after receiving funding from the Ministry of Health. Following initial first-time funding to Positive Women Inc. the Ministry of Health has now entered into an ongoing relational contract for a further three year period from 2012 to 2015. As a result the organisation now has much more security. It has been able to employ extra staff, in particular, a qualified social worker and has been able to establish a Community House for women and families living with HIV. Positive Women Inc. also uses the House as a base for its offices. Positive Women Inc. sees the official funding as 'a huge shift on the part the government whom are now acknowledging 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'.

Family Planning provides ongoing sexual and reproductive health services for all New Zealanders. Family Planning's HIV prevention work is fully integrated into health promotion, social marketing, resource production and clinical work. Activities over the 2010/11 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.

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 on morbidity and mortality from HIV, although for some it can have significant side effects.

Since December 2006 the NZAF has been providing a highly successful free community-based HIV rapid testing service. This service has proved successful in terms of increasing 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 sexually transmitted infections are present.

Antenatal HIV Screening

Progressive implementation of the Universal Routine Offer Antenatal HIV Screening Programme (the Programme) commenced in March 2006 and was completed in August 2010. From this time on, 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.

There has generally been a willingness from midwives and general medical practitioners to incorporate the HIV screening into their antenatal care. Support for the offer of antenatal HIV screening by professional organisations, combined with targeted education provided as the Screening Programme was implemented, has led to a progressive increase in screening throughout the country.

Regular monitoring reports for the 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 88 percent of pregnant women. Screening uptake rates do vary across the country, from around 65 percent to 100 percent. 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 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.

There have been 18 women diagnosed with HIV infection through ante-natal testing since the beginning of 2006. In 2010, three pregnant women were diagnosed with HIV infection through ante-natal testing.

Get it On! Social Marketing Campaign

Get it On! is a comprehensive social marketing programme run by the NZAF HIV Prevention team (Social Marketing and Community Engagement) designed to increase rates of condom use for anal sex between men (goals 1 and 3 of the HIV Prevention Plan). It operates in multiple channels to deliver condom use behaviour change messages. The primary audience segments that the *Get it On!* 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 *Get it On!* programme 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 the group who are less likely to use condoms can have unprotected anal sex with.

The *Get it On!* approach is entirely focussed on the normalisation of condom use, and the costs/benefits of condoms as a part of sex. *Get it On!* does not engage in scare tactics as research shows scare 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 *Get it On!* is sexy, smart, pro-sex, urban and fun.

Various aspects of *Get it On!* are currently being evaluated and no data is available at this stage.

Intimate Partner Violence

The most recent survey of partner violence was the New Zealand Crime and Safety Survey 2009 (NZCASS), which surveyed participant's experiences of crime in 2008 and in their lifetimes. Chapter 6 explores confrontational crimes, one of the largest and most serious forms of crime covered by the survey, in more depth. It examines confrontational crimes through the lens of different offender–victim relationships, including crimes by partners and people well known to the victim.

The results in Chapter 6 are here:

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

One of the major findings from NZCASS is the prevalence of multiple victimisation[7] and repeat victimisation[8] as a result of confrontational crime by a partner, including physical violence. Multiple and repeat victimisation account for a high proportion of partner crime (see Figure 1 here: http://www.justice.govt.nz/publications/global-publications/c/NZCASS-2009/publications/global-publications/c/NZCASS-2009/documents/NZCASS%20Multiple%20victimisation.pdf).

New Zealand research indicates that there is a substantial overlap between different forms of partner violence, including physical and sexual violence (see page 48 here: http://www.mwa.govt.nz/news-and-pubs/publications/pathways-to-recovery-pdf).

[7] Multiple victimisation is when a person experiences two or more offences within a 12 month period, regardless of the type of offence.
[8] Repeat victimisation is when a person experiences the same type of offence more than once within a 12 month period.

Some findings indicate that around a third of all sexual offences against women are perpetrated by current partners (see page 53 here: (http://www.justice.govt.nz/publications/global-publications/n/nz-crime-safety-survey-2006-key-findings/publication/?searchterm=new zealand crime and safety survey).

The Ministry of Women's Affairs is working on a paper that looks at addressing repeat sexual victimisation and multiple victimisation of women and girls. The implications of the findings for policy and practice, and particularly ways of strengthening existing efforts to prevent revictimisation, will be taken up in cross-agency meetings.

The Taskforce for Action on Violence within Families (the Taskforce) is supporting evidence-based, effective approaches to addressing intimate partner violence (and other forms of family violence). The Taskforce is developing an outcomes framework that will serve as a long-term planning tool and identify indicators to enable us to track progress for various outcomes over time. The Taskforce is also monitoring outcomes of promising overseas gender-based approaches to intimate partner violence, to promote discussion about the types of gender-based approaches that would work best in the New Zealand cultural context.

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 vaccine each year.

The Pharmaceutical Management Agency (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 19 different antiretrovirals for treating HIV infection.

In 2010 approvals were granted to: (a) widen antiretroviral funding to allow access to antiretroviral therapy for post exposure prophylaxis following non-occupational exposure to HIV (nPEP) and to amend the Special Authority for percutaneous exposure; and (b) to allow funding for combination treatments of up to four antiretrovirals (excluding ritonavir used as a potentiating agent in combination with some antiretroviral agents). These approvals took effect in July and August 2010 respectively.

Also, among the list of significant new investments of publicly funded medicines during 2010/2011 by PHARMAC were the antiretroviral agents Darunavir (new listing of antiretroviral for multi-drug resistant HIV) and Etravirine (new listing of antiretroviral for multi-drug resistant HIV).

Trends in patient numbers and expenditure (New Zealand dollars) over the last 7 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
Patients receiving funded antiretroviral therapy	863	917	1,010	1,090	1,204	1,348	1,518
Antiretrovirals expenditure	$8.9 Million	$10.4 Million	$11.6 Million	$12.3 Million	$13.0 Million	$14.5 Million	$16.8 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
0 to 14	Female	11	12	13	10	9	4	4
	Male	7	7	9	20	18	19	24
15+	Female	178	178	196	213	232	257	294
	Male	666	721	793	847	945	1068	1195
	Total	863	917	1010	1090	1204	1348	1518

In December 2010 a survey of all specialists approved to prescribe antiretroviral agents in New Zealand found that just under 80 percent of their patients were on antiretroviral therapy.

Global Commitment and Action

New Zealand's overseas aid programme prioritises sexual and reproductive health care and services while advocating for strengthened linkages between sexual and reproductive health and HIV and AIDS activities. The total bilateral, regional and multilateral expenditure for sexual and reproductive health, including HIV and AIDS was NZ$19.2 million in 2010/11.

While the Government's aid programme provides core contributions to multilateral and regional agencies and bilateral support to developing countries in Asia and Africa, the core geographical focus is on the Pacific region. The overseas aid programme funds health sector programmes and activities addressing HIV and AIDS prevention, treatment, care and support. This includes NZ$7 million over five years towards the implementation of the Pacific Regional Strategy on HIV/AIDS and other sexually transmissible infections.

New Zealand works with a range of multilateral partners to help address HIV/AIDS. In 2010/11 we provided NZ$3.5 million in core, unearmarked, funding to the United Nations Joint Programme on HIV/AIDS (UNAIDS). In 2010/11 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), and the International Planned Parenthood Federation ($2.5 million). We also provided $2.5 million core funding to UN Women and funding for the World Bank's International Development Association and the Asian Development Bank's Asian Development Fund.

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 was 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 has contracted services to lead a national conversation related to HIV testing standards and guidelines with all key stakeholders. Recommendations in relation to national guidelines and standards for HIV testing and counselling in New Zealand will be developed.

A report to the Ministry of Health is due by 30 June 2012.

Support for People with HIV and AIDS in New Zealand

The 2010 national review of HIV services in New Zealand identified a number of areas where service coverage for people living with HIV and AIDS (PLWHA) could be improved. One of these areas related to smaller non government organisations (NGOs) with demonstrated records of service provision and defined constituencies that were having difficulty addressing the needs of their constituents. Even though the constituencies of smaller NGOs may be well defined and relatively small, the needs are significant and growing, both in terms of practical and emotional elements.

The Review recommended that the Ministry of Health considers core funding in each case to support sustainable, outcomes-based activities so these

NGOs are not constantly distracted from their primary missions by the need to find funding for survival.

The Ministry of Health has responded to the recommendation and has entered into ongoing relational contracts with a number of smaller NGOs servicing people living with HIV and AIDS to provide social support, address stigma and discrimination, and promote safe sex.

HIV Behavioural Surveillance Survey of African Communities in New Zealand

The Ministry of Health has commissioned an HIV Behavioural Surveillance Survey 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.

This research will:

- assist the understanding of HIV epidemiology and demographic knowledge of African communities
- provide a better understanding of the sexual behaviours and attitudes in the context of cultural beliefs and practices
- provide an understanding of barriers to accessing health services and ways for overcoming these.

This research will contribute to preventing transmission of HIV, reduce the number of people living with undiagnosed HIV and improve the health outcomes of Africans living with HIV in New Zealand.

Late Presentation of HIV infection using Surveillance Data

In 2011, staff at the AIDS Epidemiology Group at the University of Otago published a paper entitled 'Late presentation of HIV infection among adults in New Zealand: 2005-2010'. Surveillance data was used to report adults with HIV who had a 'Late presentation' of HIV or 'Advanced HIV disease'.

'Late presentation' refers to entering care with a CD4 count <350 cells/ µL, or an AIDS defining event, regardless of CD4 count. 'Advanced HIV disease' was a subset having a CD4 count <200 cells/ µL and also included all who had an AIDS defining event regardless of CD4 count. The data showed that:

- overall, 50 percent of adults diagnosed with HIV from 2005-2010 were 'late presenters' and 32 percent had 'advanced HIV disease'
- compared to MSM, men and women heterosexually infected were more likely to present late
- 'Late presentation' and 'Advanced HIV disease' were significantly more common among older MSM
- Maori and Pacific MSM were more likely to present with 'Advanced HIV disease'.

The main conclusions from these results were that there may be inadequate levels of testing for HIV in New Zealand and that the Ministry of Health Guidelines for testing need to be supported and encouraged in medical settings.

The full paper can be found at:

Dickson, NP., McAllister, SM., Sharples, K., Paul, C. "Late presentation of HIV infection among adults in New Zealand: 2005-2010". *HIV Medicine* 2011. DO1:10.1111/j.1468-1293.2011.00959.x

Study into Undiagnosed HIV in MSM

In November 2011 a research article entitled 'Actual and undiagnosed HIV prevalence in a community sample of men who have sex with men in Auckland' was submitted for publication. The article was accepted and published in February 2012. This was the first estimate of actual and undiagnosed HIV infection among a community sample of gay men in New Zealand.

Of those found to be HIV positive and who provided information on testing behaviours, 14 men (20.9%) were undiagnosed. Most (78.6%) had previously tested for HIV and the majority (85.7%) believed themselves to be HIV negative. Lack of awareness of their HIV infection was more common among non-Europeans, and possibly also younger men.

The findings on undiagnosed HIV infection reinforce the importance of condom use as a prevention tool, as testing or disclosure-based approaches have inherent flaws.

Despite having a high HIV prevalence relative to the general population, MSM in this study exhibited a lower prevalence of infection than MSM in other large cities around the world and also a low level of undiagnosed infection, which is encouraging.

The research article can be found at:

Saxton P, Dickson N, Griffiths R, Hughes A, Rowden J. Actual and undiagnosed HIV prevalence in a community sample of men who have sex with men in Auckland, New Zealand. *BMC Public Health* 2012, **12**:92.

5. Major Challenges and Remedial Actions

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

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.

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 to use while the Government considers the Public Health Bill.

The Public Health Bill contains measures that can be taken to prevent spread of communicable conditions that pose a risk to public health.

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 until 2011 when there was a decline. The increases have been associated with factors unseen in the 1980s and 1990s. Key to understanding this increase has been recognition of the impact on the total numbers of people living with HIV on the rapidly reduced deaths by AIDS.

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, we would expect to see a higher number of new infections 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.

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 we are to limit new HIV infections.

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) and Gay Online Sex Survey (GOSS 2006, 2008 & 2011)	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.
HIV Futures	Surveys on populations of people living with HIV and AIDS in NZ (2001 and 2005). HIV Future 2 was released in 2008.
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 assist guide the Government's policies around HIV and AIDS.

Get it On! Social Marketing Campaign

The Ministry of Health funds the New Zealand AIDS Foundation to deliver a comprehensive social marketing campaign which aims to: (a) reduce HIV transmission through increased condom use; and (b) increase testing rates for HIV and STIs. The *Get it On!* social marketing campaign is aimed at increasing condom use.

The Ministry of Health has initiated an evaluation of the campaign. The evaluation aims to determine whether the campaign provides value for

money, and whether or not there has been any behavioural change in condom use.

The evaluation will run from February to late June 2012, with a final report due 30 July 2012.

Review of HIV Positive Services

In January 2010 the Ministry of Health commissioned a review of services for people in New Zealand living with HIV. The review examined existing service coverage for people living with HIV and AIDS (PLHA), including those services not funded by the. The aim of the review was to inform the Ministry of Health's investment in services for PLHA, it was not a review of service quality or a compliance audit.

Key stakeholder organisations (both government funded organisations and peer support organisations), were reviewed. The review report was delivered to the Ministry of Health in May 2010 and is available at:

http://www.health.govt.nz/publications/David%20Miller

The Review identified that services for PHLA in New Zealand are reaching and being appreciated by those for whom they are designed. Service users were unanimous and enthusiastic in their appreciation of the services provided by District Health Boards and community-based NGOs, and excellent collaboration among service providers.

However the Review also identified gaps in policy and service delivery and concerns regarding service quality. These include mental health coverage and primary care. The report notes that PLHA are using District Health Boards and NGO services as a proxy for primary health care services as a way of receiving free treatment.

The report summarised the issues identified by the Review as follows.

- "The Ministry of Health *HIV/AIDS Action Plan* (2003) is out of date and needs revision
- There is no national HIV research strategy; evaluation of quality of service delivery across sectors is absent
- Mental health coverage for PLHA – particularly longer-term mental health support – is difficult to access in most areas
- Cost is an obstacle to accessing primary care for many PLHA; DHB and NGO HIV services are a proxy for primary care services
- There are variations in T&C [testing and counselling] for HIV according to sector and service
- Stigma, particularly in minority populations, creates obstacles to HIV service engagement
- NGOs are experiencing difficulties in coping with demand".

The Ministry of Health has commenced consideration of actions to address these issues. Some responses have already been initiated and are reported on in this document (see under "Best Practices").

9. Annexes

ANNEX 1: Core Indicators for Global AIDS Progress Reporting 2012 and Universal Access in the Health Sector Reporting

ANNEX 2: National Commitments and Policy Instrument (NCPI)