UNGASS COUNTRY PROGRESS REPORT

NEW ZEALAND

Reporting Period: January 2008 – December 2009

Submission Date 15 March 2010

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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 draft answered Annexes were then sent to stakeholders for final comment. 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 people infected through male homosexual and heterosexual contact. Since 2005, the annual number of diagnoses has remained well above the pre-2000 level.
- 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.
- Of all the people diagnosed with HIV in New Zealand from 1985 to 2009, 2.1 percent (N=61) 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 2009, 10.3 percent (N= 292) 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. 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[1] 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[2] 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, Absolutely Positive Positive) 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 promotes awareness of HIV and AIDS in the community through educational programmes with a focus on prevention and de-stigmatisation. INA organised an HIV positive Māori, Indigenous and Pasifika Conference, held from 28 January to 01 Feb 2009 where participants were encouraged to discuss the impact of HIV and AIDS on Māori, Indigenous and Pasifika people. Despite presently not receiving any financial assistance from Government, these organisations are involved in HIV awareness, self esteem development, and challenging stigma and discrimination at a number of levels
- Needle Exchange New Zealand administers the Needle and Syringe Exchange Programme along with regional programmes 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

[1] 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

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

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 acts as 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 Care Organisations which are a first 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 21 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 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 UNGASS 2008/09 Indicator Data

NATIONAL INDICATORS

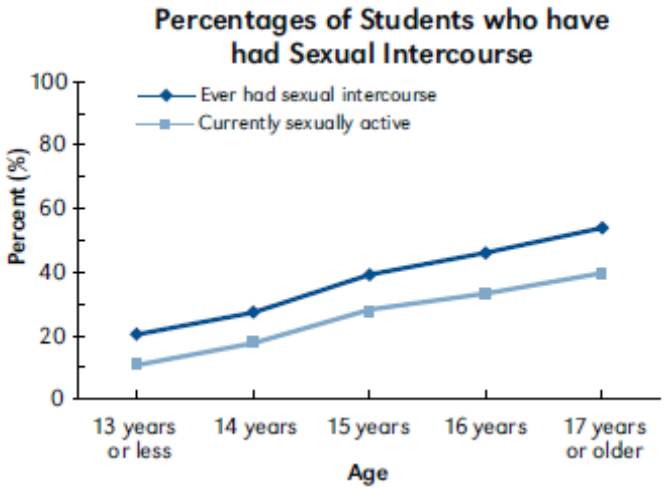
National Commitment and Action

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$29.5 million respectively for 2 year period. Total international bilateral/regional and multilateral contributions for 2008/09 was NZ$70.73 million.
Percentage of donated blood units screened for HIV in a quality assured manner.	100 percent of units tested for HIV.
Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy.	NZ citizens and permanent residents, and people holding work permits which allow two or more years in NZ are offered treatment. Those who are not entitled to receive publicly funded health care (e.g. international students, temporary visitor) do not receive subsidised antiretroviral treatment.
Percentage of HIV-infected pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission.	Of women identified as being infected with HIV, 100 percent of the mothers of babies delivered in 2008 received antiretrovirals. Complete data is not yet available for 2009. 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.
Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV.	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.
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.
Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results.	Subject matter relevant, however, no recent data is available. In a 2006 survey of MSM, 38.8% of respondents reported that they had last had an HIV test in the previous 12 months.
Percentage of most-at-risk populations 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).
Percentage of orphaned and vulnerable children aged 0-7 whose households received free basic external support in caring for the child	Subject matter not relevant.

Percentage of schools that provided life skills-based HIV education in the last academic year.	Sexuality education (includes delaying sexual intercourse and a focus on safer sexual practices) is a component of *Health and Physical Education in the New Zealand Curriculum*. The curriculum is compulsory up to and including Year 10 (14 years of age). Note: see page 15 "majority of programmes did not meet students' needs effectively".

*** *Note***: *Present contracts by the Ministry of Health for prevention and health promotion services span from July 2008 to June 2011. The domestic expenditure is therefore an approximation for 2008/09.*

Knowledge and Behaviour

Current school attendance among orphans and non-orphans aged 10-14	Subject matter relevant, however, indicator not relevant to our country.
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.
Percentage of most-at-risk populations who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission.	Indicator relevant to our country, however, no new data available. In 2006, 95% of surveyed men who have sex with men (1228 sample size) knew unprotected anal intercourse was high risk for HIV transmission. 79.3% knew that HIV virus cannot pass through an undamaged latex condom.
Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.	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 
Percentage of women and men 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.

Percentage of women and men 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.
Percentage of female and male 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
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. In 2006, 34.1% of surveyed men who have sex with men reported always using condom for anal sex with regular partner. 65.1% reported always using condom for anal sex with casual partner.
Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse.	Subject matter relevant, however, no new data is available. In 2004, 26% of survey respondents reported using a condom the last time they had sex. A report on the 2008 survey findings to the Ministry of Health is pending.
Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected.	Subject matter relevant, however, no new data is available. In 2004, 50% of survey respondents reported using a new needle & syringe each time they injected drugs and a further 40% reported doing so most of the time. A report on the 2008 survey findings to the Ministry of Health is pending.

Impact

Percentage of young people aged 15-24 who are HIV infected.	Of all the people diagnosed with HIV in New Zealand from 1985 to 2009, 10.3 percent (N= 292) were aged between15 and 24 years at the time of diagnosis.
Percentage of most-at-risk populations who are HIV-infected.	MSM - Indicator relevant to our country, however, no recent data available. 2005/06 Sexual Health Clinic survey showed overall prevalence of HIV in MSM as 44.1/1000 and a prevalence of previously undiagnosed HIV in MSM of 20.1/1000. 2005/06 sex workers no HIV positive cases out of 343 tested. 2004 IDU HIV seroprevalence <1%.
Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.	>95 percent known to be on treatment 12 months after initiation of antiretroviral therapy. Death from HIV is uncommon these days in New Zealand.
Percentage of infants born to HIV-infected mothers who are infected	For 2008/09, no children born to women with HIV infection diagnosed before they gave birth have been infected.

GLOBAL INDICATORS

Amount of bilateral and multilateral financial flows (commitments and disbursements) for the benefit of low- and middle-income countries.	Total bilateral and multilateral contributions for 2008/09 were NZ$19.13 million and NZ$51.6 million respectively.

Amount of public funds for research and development of preventive HIV vaccines and microbicides.	Nil. As a low prevalence country, there are very few clinical research programmes on HIV/AIDS.
Percentage of transnational companies that are present in developing countries and that have workplace HIV policies and programmes.	Subject matter not relevant
Percentage of international organisations that have workplace HIV policies and programmes.	Subject matter not relevant

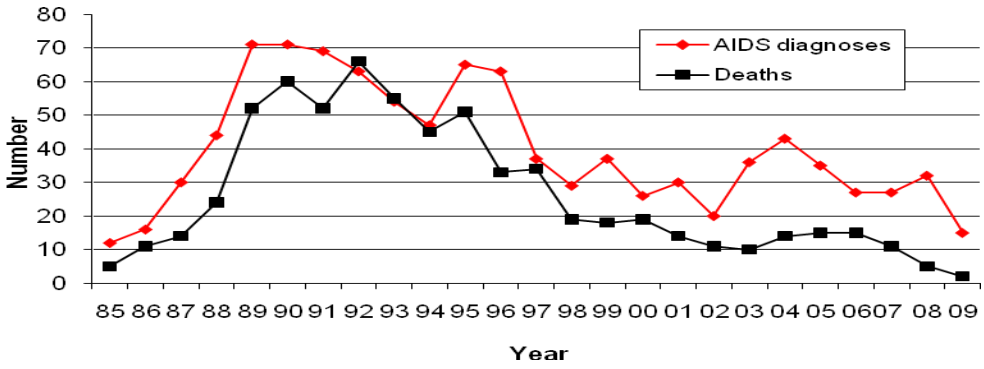
2. Overview of the HIV and AIDS Epidemic

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 (27% in 2006). 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.

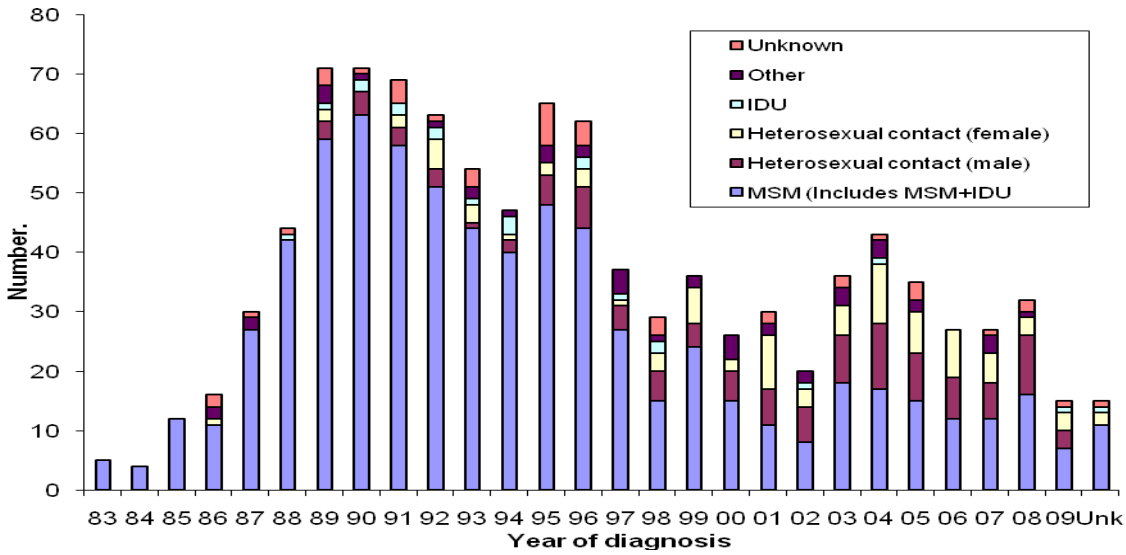
Figure 1: Number of people with AIDS and deaths of people notified with AIDS by year of diagnosis or death



(Note - The number of people diagnosed and the number of deaths in 2009 (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 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



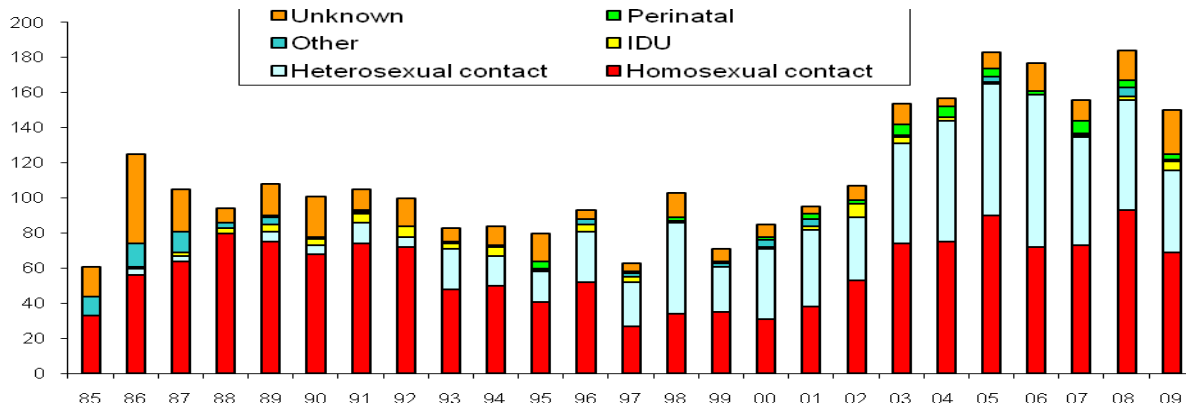
"Unk" in last bar denotes mode of infection is unknown
(Note - The number of people diagnosed in 2009 (and possibly earlier) will increase due to delayed notification)

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 the number of people diagnosed with HIV acquired heterosexually in New Zealand increased.

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

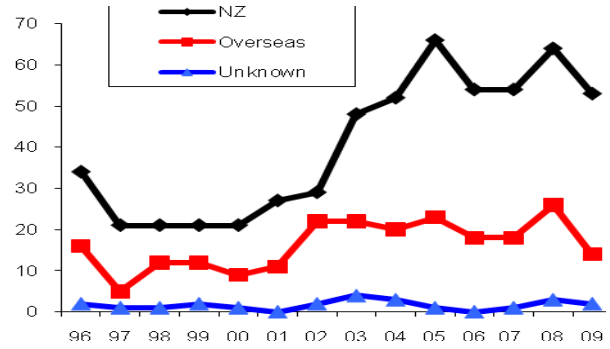
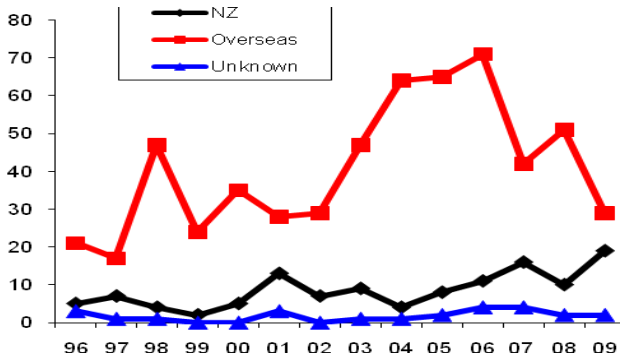


Figure 4(b): Number of people heterosexually newly diagnosed with HIV by year and place of infection



Comment

In the ten year period 1999-2008, of those diagnosed with HIV that had been acquired in New Zealand, 436 were MSM and 85 people (52 women and 33 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"[3]. 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 2006/07 Report.

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 2008 to June 2011.

The NZAF in collaboration with the University of Otago conducts behavioural surveillance of gay and bisexual men every two years (the Gay Auckland Periodic Sex Survey (GAPSS) and Gay Online Sex Survey (GOSS). International research has established that condoms and lubricant are the most effective prevention measure against sexual transmission of HIV.

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

GAPSS and GOSS research in 2002, 2004 and 2006 showed that condom use is not reducing among gay and bisexual men 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.

The NZAF has undergone a comprehensive review of its HIV prevention response during 2009 and has 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[4], 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. A 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.

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 2008/09 period have included: (a) offering HIV testing as part of general screening for sexually transmitted infections in clinics; (b) condom distribution and promotion; (c) school-based education programmes on sexually transmitted infections, including HIV; and (d) involvement with initial pilot implementation project on antenatal HIV screening.

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

[4] Whānau is the Māori word for "extended family".

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. The 2007/08 Report stated that only one District Health Board had fully implemented the Programme. Today, as of 1 December 2009, eighteen of the twenty-one District Health Boards have implemented the Programme. Another has commenced planning for implementation and the final two are yet to commence.

There has generally been a willingness from midwives and general medical practitioners to incorporate the HIV test into their antenatal care. Support for the offer of antenatal HIV screening by professional organisations combined with the regional education provided as the Programme is implemented, has led to a progressive increase in testing throughout the country as practitioners become aware of the very significant advantages for the women diagnosed with HIV in pregnancy and their unborn babies.

To support the regional training a national on-line education module for health practitioners for this programme has been developed and is now available online (www.LearnOnline.health.nz). This will enable practitioners who have not yet received education about screening to access this in their own time and from home. Planning work aimed at informing the public more widely about the Programme through consumer websites and magazines is currently being undertaken. This is intended to improve acceptance of the HIV screening offer as a routine part of antenatal care in pregnancy.

Women are increasingly starting to accept HIV screening as part of their routine first antenatal blood screen. Uptake has varied throughout the country from rates around 50 percent up to 100 percent. In regions where uptake is lower there now appears to be a progressive upward trend occurring. Those regions are working to ensure that all practitioners are educated and confident about offering the test and are targeting education at practitioners or groups of practitioners with lower screening rates.

Practitioner guidelines and a summary sheet to advise practitioners of expected best practice have been developed. Consumer pamphlets on antenatal HIV screening have been developed and are available in English

and in eight other languages. A resource for HIV, pregnancy and health designed to support women diagnosed through the 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 they can make an informed choice about participation in the Programme.

So far there have been four women diagnosed with HIV infection since implementing the Programme in New Zealand. Recent work on improvements in data management and improved access to data from all implementing District Health Boards should improve the quality of data available for national monitoring in the coming year.

Sexual Health Social Marketing Campaign

The 2006/07 Country Progress Report reported that in 2007 the Government approved NZ$18.2 million over six years for sexual health education and reducing sexually transmissible infections. Proposed initiatives included a sexual health social marketing campaign to reduce sexually transmissible infections in 15-24 year olds, and unintended teenage pregnancy in 15-19 year olds.

In 2008/09 consideration was given to the likely success of the social marketing campaign and it was concluded that a number of factors, including access to services for target groups, would first need to be addressed. Funding for the social marketing campaign was therefore re-prioritised and the campaign has not proceeded.

In February 2008, Positive Women Inc launched its national destigmatisation campaign as part of its work on raising awareness of HIV and AIDS in the community. Stigma remains ones of the greatest barriers for people living with HIV and AIDS. In September 2009, the NZAF launched a new condom promotion campaign, "*Get it On!*", with the aim of bringing its message of the importance of gay and bisexual men using condoms into the "mainstream".

Sexuality Education

Sexuality education is one of seven key areas of learning in *Health and Physical Education in the New Zealand Curriculum*. Sexuality education programmes are important sources of information and learning for young New Zealanders about sexuality and sexual health.

A 2006 review of sexual health education in schools conducted by New Zealand's Education Review Office (ERO) found a majority of programmes did not meet students' needs effectively. Some peer support organisations consider that there is a lack of effective HIV education, prevention and destigmatisation programmes focused at youth in schools and more generally a lack of HIV information material for the general population.

The Ministries of Health and Education have followed up on the ERO report's recommendations, however, progress towards improving sexual health education in schools remains slow. A service improvement project to address this has been planned by the Ministry of.

Recommendations for HIV Testing of Adults in Healthcare Settings

The 2006/07 Country Progress Report reported updated recommendations for HIV testing of adults in healthcare settings had been developed and were pending release. The aim of the updated recommendations is to promote more frequent HIV testing and to "normalise" the protocols around HIV testing where such testing is being performed in a medical context. The recommendations are not intended to modify current recommendations concerning HIV testing and counselling of persons at high risk of HIV who are being tested in the non-clinical setting, for example, community based testing at the New Zealand AIDS Foundation or drug treatment clinics.

The updated recommendations were released in January 2008. The table below sets out the number of laboratory test payment claims types covering the period 2005 to 2009.

Year	2005	2006	2007	2008	2009
HIV Screen Test	58,635	68,246	68,271	80,604	Data not yet available.
Antenatal HIV Screen Test		2,679	8,534	8,621	Data not yet available.

Gender Based Violence

The Taskforce for Action on Sexual Violence (TASV) was established by Cabinet in July 2007 to provide leadership and co-ordination in the area of sexual violence across government and non-government sectors. The TASV's work programme is based on the following priority areas: prevention strategies, early intervention and crisis response, recovery and support services relating to sexual violence, treatment and management of offenders, the effectiveness of the criminal justice system responses to sexual offending, and the responsiveness of the justice system to victims of sexual violence and improving their outcomes.

The TASV has identified the need for a Sexual Violence Prevention Plan. The Ministry of Health has led the development of a cross-agency work programme. The draft work programme focuses on primary prevention activity defined as 'stopping the problem of sexual violence before it ever occurs' and recommends future actions to be taken by government and the community. The draft work programme is expected to be considered by Cabinet early in 2010.

The Ministry of Women's Affairs (MWA) has undertaken a number of projects in the area of violence against women. In September/October 2009, MWA

published the results of its two-year sexual violence research project, 'Strong and safe communities – Effective interventions for adult victims/survivors of sexual violence'. Since then, MWA has held presentations and workshops with government agencies, non-government organisations and members of the criminal justice system across New Zealand.

MWA, with the Office of Ethnic Affairs (OEA) is working on a project on intimate partner violence in Ethnic communities. Since September 2009 MWA and OEA have met with a number of Ethnic and mainstream organisations and support services in order to explore the prevalence and issues relating to intimate partner violence in Ethnic communities in New Zealand The consultation meetings identified a number of barriers to seeking support and services, including a lack of information about New Zealand law, rights and responsibilities, as well as a lack of knowledge on where to go for help. MWA and OEA are addressing this by producing some information on New Zealand law and a directory of services aimed at Ethnic community leaders. MWA is also carrying out a literature review on culturally appropriate interventions to prevent and respond to intimate partner violence in Ethnic communities.

MWA was successful in receiving one-year's funding (2009/10) from the Cross Department Research Pool (CDRP) involving a number of partner agencies, including the Ministry of Health as second lead agency. The project is entitled: 'Staying safe, bouncing back – promoting respectful relating and resilience in young people, and preventing sexual violence'. This research project is considering matters around resilience, and sexual violence and coercion, within a Māori (indigenous) world view. The project is exploring the literature, and developing a methodology for working with Māori youth on these issues. This research project is intended to be a platform for future research in this area. The project is due to finish by 30 June 2010.

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 16 different antiretrovirals for treating HIV infection.

At the time of writing this report PHARMAC was assessing new HIV funding proposals. These are: (a) antiretrovirals for non-workplace related HIV post exposure prophylaxis; and (b) funding of darunavir (Prezista) for multi-drug resistant patients. Consideration is also being given to an application to increase the number of antiretrovirals funded for patients with multi-drug resistant HIV infection.

Trends in patient numbers and expenditure (New Zealand dollars) over the last 5 years (PHARMAC financial year runs 1 July – 30 June) are shown in the table below:

FYE Year ending	2005	2006	2007	2008	2009
Patients receiving funded antiretroviral therapy	**771**	**904**	**952**	**1062**	**1145**
Expenditure (million)*	**$8.9**	**$10.4**	**$11.8**	**$14.0**	**$15.8**

* Note that the figures differ from those provided in 2007 as these are PHARMAC financial year figures rather than calendar years which were provided previously.

New Zealand has a legislative protection[5] for public health which can be applied, for example, in a circumstance where an individual is a high risk for transmitting an infectious disease like HIV to others as a result of not being able to understand and exercise restraint over their behaviour. New Zealand currently has one individual held in residential detention care under the Act.

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$19,125,620 in 2008/09.

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 and treatment as well as support for people living with HIV in the Pacific and Africa. This includes NZ$3.65 million towards the implementation of the Pacific Regional Strategy on HIV/AIDS and other sexually transmissible infections.

New Zealand's primary multilateral partner for HIV/AIDS is the United Nations Joint Programme on HIV/AIDS (UNAIDS) which received NZ$3.5 million in 2008/09, an increase of NZ$1 million over the previous year. In 2008/09 annual contributions were also provided to the following agencies engaged in addressing HIV to some degree: UNFPA ($6 million), UNDP ($8 million), UNICEF ($6 million), WFP ($6 million), UNHCR ($6 million) and the World Bank ($13.3 million), the Asian Development Bank ($6.2 million) and the International Planned Parenthood Federation ($2.5 million).

[5] The Health Act 1956 (the Act), section 79 "Isolation of persons likely to spread infectious disease"

New Zealand continues to engage in international meetings on HIV and AIDS issues including in support of Pacific Island interests. In addition, civil society was funded to attend two UNAIDS Programme Coordinating Board meetings as part of the New Zealand delegation. At the time, there was only one other country that evidenced this level of partnership with civil societies.

4. Best Practices

Statutory Review of the Prostitution Reform Act 2003

The 2006/07 Country Progress Report reported that a statutory review of the Prostitution Reform Act 2003 (PRA) would be completed by June 2008 and would help determine the extent to which the PRA is achieving its purpose. The following briefly summarises the findings of the review. The full report is available online at http://www.justice.govt.nz/prostitution-law-review-committee/index.html

The purpose of the PRA was to decriminalise prostitution (while not endorsing or morally sanctioning prostitution or its use); create a framework to safeguard the human rights of sex workers and protect them from exploitation; promote the welfare and occupational health and safety of sex workers; contribute to public health; and prohibit the use in prostitution of persons under 18 years of age. The PRA also established a certification regime for brothel operators.

The review by the Prostitution Law Review Committee (the Committee) found that during the five years post enactment of the PRA, the sex industry has not increased in size, and many of the social evils predicted by some who opposed the decriminalisation of the sex industry have not been experienced. On the whole, the PRA has been effective in achieving its purpose, and the Committee is confident that the vast majority of people involved in the sex industry are better off under the PRA than they were previously.

Progress in some areas, however, has been slower than may have been hoped. Many sex workers are still vulnerable to exploitative employment conditions, and there are still reports of sex workers being forced to take clients against their will. Nevertheless, it is encouraging to note that most sex workers contacted during the research for this review were aware of their right to say “no”, and that the behaviour of some brothel operators in this respect has improved since the enactment of the PRA.

The Committee acknowledges that there remains disapproval and dislike directed by some people at people who work in the sex industry and mistrust and suspicion directed at the authorities by some people in the sex industry. In this atmosphere, the Committee believes that a period of relationship building will be necessary before the rights and responsibilities of those in the sex industry will be fully realised. People working in the sex industry, and those working in organisations that deal with the sex industry, need to make positive efforts to work together. The recommendations in this report reflect this view.

Review of Blood Donor Behavioural Deferral Criteria

In March 2009, the New Zealand Blood Service (NZBS) introduced a new set of behaviour based donor deferral criteria. These criteria were developed in 2008 by an independent expert advisory group commissioned by NZBS. The background to the view was as follows.

The NZBS has a statutory obligation to keep up with developments and new technologies that relate to the services it provides. In doing so, the NZBS has an obligation to reassess donor exclusion criteria as developments alter the overall risk/benefit balance for those who donate blood. In addition there had been specific complaints raised about the current deferral criteria which required consideration. In particular the concerns were about the justification for different deferral periods for men who have sex with men and heterosexuals, and about the rationale for broad deferral categories based on behaviour rather than on specific risk activities.

The NZBS asked an independent expert advisory group to review the current criteria for the deferral of people from blood donation based on behaviour. This relates to sexual and drug using behaviour which may put people at risk of transfusion transmissible infections. There may be some risk to recipients of blood and blood products if these people donate blood.

The principal task of the review group was to review the ongoing appropriateness of exclusion of donors on the basis of current and/or past behaviour to ensure the safety of blood and blood products in New Zealand. Particular emphasis was put on: (a) the appropriateness of ongoing exclusion of men who have had sex with men; (b) possible approaches to the risks associated with heterosexual activity in relation to geographic areas of high prevalence; (c) sex work; and (d) advice on the development of effective communication tools.

The recommendations made by the independent expert advisory group included:

- the deferral criteria for people who have injected themselves with drugs not prescribed by a doctor should remain (lifetime deferral)

- the current ten-year deferral period for men who have had male-to-male sex should be shortened to five years. The grounds are that a change to a five-year deferral will not increase risk to the blood supply, either from incident or prevalent HIV infection or from undetected novel infections. The reduction in the period of exclusion aims to attain the least restrictive method of maintaining the safety of the blood supply.

- the deferral criteria for heterosexuals who have lived in, or who come from, specified countries should be modified. The list of countries and map should change to better reflect the areas with generalized heterosexual HIV epidemics: i.e. an estimated prevalence of HIV of >1 percent in the population. Such lists and maps are available through

- the one year deferral should remain for a woman who has had sex with a bisexual man, and for those who have had sex with a person who carries the hepatitis B or C viruses, or an injecting drug user, a sex worker, a person with haemophilia or related condition, or with a person who has lived in or comes from a country with high HIV prevalence.

- the current deferral criteria for sex workers should be amended. People who have worked as sex workers only in New Zealand should not give blood for one year. People who have worked as sex workers in any other country should not give blood for five years.

The full report by the Independent expert review of the NZBS behavioural donor criteria can be obtained at:

http://www.nzblood.co.nz/site_resources/library/News_and_Events/Behavioural_Donor_Deferral_Criteria_Review_Final_Report.pdf

Comparison of current and previous behavioural donor criteria

Previous Criteria	Current Criteria – Effective 2nd March 2009
You should NEVER give blood if: • You, or any of your current (or past) sexual partners have (has) AIDS or a positive test for HIV. • You carry the Hepatitis B or C virus. • You have ever injected yourself, even once, with drugs not prescribed by a Doctor. • You have haemophilia or a related clotting disorder and have received treatment with clotting factor concentrates at any time. • You think you need an HIV or Hepatitis test.	**You must NEVER give blood if:** • You, or any of your current (or past) sexual partners have (had) AIDS or a positive test for HIV. • You carry the Hepatitis B or C virus. • You have ever injected yourself, even once, with drugs not prescribed by a Doctor. • You have haemophilia or a related clotting disorder and have received treatment with plasma derived clotting factor concentrates at any time. • You think you need an HIV or Hepatitis test.
You should not give blood for TEN YEARS following any occasion in which: • You have had sex with another man, even 'safer sex' using a condom (if you are a male). • You have worked as a sex worker (prostitute) or accepted money or drugs in exchange for sex.	**You must not give blood for FIVE YEARS:** • Following oral or anal sex with or without a condom with another man (if you are male). • After engaging in sex work (prostitution) or accepting payment in exchange for sex in any country other than New Zealand. • After leaving a country in which you have lived and which is considered to be high risk of HIV infection (includes sub Saharan Africa and parts of Asia. Full list available at blood collection sessions and at by clicking here
You should not give blood for ONE YEAR after sex with: • A man who has had sex with another man (if you are female). • Anyone whom you know carries the Hepatitis B or C virus. • Anyone who has ever injected themselves with drugs not prescribed by a Doctor. • A sex worker (prostitute). • Anyone with haemophilia or a related clotting disorder who has received clotting factor concentrates at anytime. • Anyone who lives in or comes from a country considered to be high risk for HIV infection. (See map Appendix Seven).	**You must not give blood for ONE YEAR:** • Following sex with anyone: - whom you know carries the Hepatitis B or C virus. - who is a sex worker (prostitute). - who has ever injected themselves with drugs not prescribed by a Doctor. - who lives in or comes from a country considered high risk for HIV infection. - who has haemophilia or a related blood clotting disorder and received treatment with plasma derived clotting factor concentrates at any time. • After engaging in sex work (prostitution) or accepting payment in exchange for sex in New Zealand. If you are a woman, after engaging in sex with a man who has had oral or anal sex with another man

5. Major Challenges and Remedial Actions

A rights based approach to management of the few people with HIV who put others at risk of HIV transmission

All people in New Zealand have a legal duty[6] not to endanger the life, health or safety of others. In law, this means that HIV infected people must take "reasonable precautions" to avoid transmitting HIV. In 2005, an important precedent was established in New Zealand that using a condom and lubricant was a reasonable precaution to discharge the duty of care in a criminal nuisance prosecution under Section 145 of the Crimes Act 1961.

In late 2009 there was a case before the courts concerning an individual who was alleged to have transmitted, or attempted to transmit HIV with the intent to do so. This case is not a new scenario but is unusual and there have been remarkably few incidents over 25 years of the HIV/AIDS epidemic in New Zealand. The majority of people living with HIV take appropriate precautions to take care of their sexual health and their partners.

The NZAF has been chairing a working group of the National HIV and AIDS Forum in drafting a rights based guidance document for use in the rare situation of a person living with HIV being unable or unwilling to take appropriate precautions to protect others from HIV transmission.

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. These 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. This 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

[6] Charges can be brought under the Crimes Act 1961 (for example, section 145 – Criminal nuisance; section 188 – Wounding with intent; section 201 – Infecting with a disease).

effective HIV treatments and internet dating, the levels of condom use must be increased if we are to limit new HIV infections.

It is a serious concern that international research has predicted that if the incidence of HIV infection continues at current levels, the prevalence of HIV among gay and bisexual men who are currently aged twenty could be as high as 50 percent by the time they are 50 years of age (Stall, R. 2009. "Running in Place: Implications of HIV Incidence Estimates among Urban Men Who have Sex with Men in the United States and Other Industrialized Countries" in *AIDS Behaviour,* 13:615 - 629*).*

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)	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, 2008 planned).
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.

A monitoring and evaluation framework has been established for the Universal Offer Antenatal HIV Screening programme (the Programme). The AIDS Epidemiology Group at the University of Otago has been contracted to provide monitoring and evaluation of some aspects of the Programme, and to issue six-monthly reports.

The Ministry of Health funds meetings of the National HIV and AIDS Forum to monitor progress on the *HIV/AIDS Action Plan 2003*.

Survey of HIV Positive New Zealanders

The first large-scale, comprehensive examination of the health and social experiences of HIV positive New Zealanders (*HIV Futures New Zealand 1*) was reported on in 2002. For that survey, 226 HIV positive men and women (24.8 percent of the New Zealand HIV positive population) across the country were involved.

In March 2008, a second survey (*HIV Futures New Zealand 2*) involving 261 HIV positive individuals was reported. Both surveys examined health and treatments, service engagement, relationship to HIV community, sex and relationships, housing, employment, finances and discrimination. The findings represent a sharp and critical opportunity for an assessment of the New Zealand response and the ways in which it is serving or disadvantaging people living with HIV/AIDS.

HIV Futures New Zealand 2 identified that clear improvements for people living with HIV in New Zealand had taken place since the first survey despite some challenges remaining. Three key areas of important change since the first survey was undertaken are:

a) a higher proportion of respondents reported having received pre-test counselling or engaging in a pre-test discussion than in 2001
b) a smaller proportion of people living with HIV/AIDS reported having difficulties using antiretroviral treatments (2001: 79%, 2007: 44%). This was reflected in lower proportions reporting side-effects (2001: 44%, 2007: 26%) and difficulties with drug timing (2001: 44%, 2007: 24%)
c) fewer people living with HIV/AIDS reported receiving less favourable treatment in relation to accommodation (ever: 2001, 12%; 2007, 4%), at health services (ever: 2001, 31%; 2007, 22%) and in relation to obtaining insurance (ever: 2001, 36%; 2007, 26%).

Copies of the full report can be obtained by contacting the New Zealand AIDS Foundation (email: contact@nzaf.org.nz).

Review of HIV Positive Services

A review is of services delivered currently to people who are HIV positive is currently in progress. The purpose of the review is to inform decisions in regards to future investment in this area. The overall aim is to ensure that future investment contributes towards improving service coverage for people who are HIV positive and that those services are effective and cost efficient.

As part of the review key stakeholder organisations (both government funded organisations and peer support organisations), will be reviewed. The review is scheduled for completion by mid April 2010.

9. Annexes

ANNEX 1: Core Indicators for the Implementation of the Declaration of Commitment on HIV/AIDS.

ANNEX 2: UNGASS –National Composite Policy Index (NCPI) 2009