

COUNTRY PROGRESS REPORT

NEW ZEALAND

Reporting Period: January 2014 – December 2014

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Table of Contents

Status at a Glance	2
Inclusiveness of the Stakeholders in the Report Writing Process	2
Status of the Epidemic	2
Policy and Programmatic Response	3
Research, monitoring and evaluation	6
Overview of Core Indicators for Global AIDS Response Progress Reporting 2012/2013	4
Overview of the HIV/AIDS Epidemic	7
Case Reports of AIDS	7
Case Reports of HIV Infection	8
HIV diagnoses among Gay, Bisexual and other MSM	9
HIV diagnoses among heterosexually infected men and women	10
HIV diagnoses among people who inject drugs	12
Children infected with HIV through mother to child transmission	12
Total number of people with HIV in New Zealand	13
National Response to the HIV and AIDS Epidemic	13
Prevention	14
Approval of female condom in New Zealand	15
Community-based HIV Rapid Testing Service	15
Care, Treatment and Support	16
Global Commitment and Action	17
Major Challenges and Remedial Actions	17
Health Protection Amendment Bill	17
Monitoring and Evaluation Environment	18

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 Ministry has not been able to consult with HIV medical specialists in completing this report given time constraints.

Status of the Epidemic in 2014

- There are estimated to be around 2,900 people with HIV in New Zealand, equating to a prevalence of 64 per 100,000 total population. This estimate is based on the number of people on subsidised antiretroviral therapy (ARTs), (estimated to be 1,960 at the end of 2014), and the assumptions that (a) 85% of people with HIV have been diagnosed and are under specialist care and (b) 80% of people with HIV under specialist care are on ART.
- Of those diagnosed with HIV in New Zealand from 1985 to 2014, 1.9 percent (n=70) were under the age of 15 years, and 10.5 percent (n= 384) were aged between 15 and 24 years at the time of diagnosis.
- Among those diagnosed with HIV between 2005-2014, for whom information on the initial CD4 count was obtained, just under half (47%) presented when the CD4 count was 350 cell per cubic mm or less, the level at which treatment is recommended.

Policy and Programmatic Response

The prevalence of HIV infection in the general population in New Zealand is very low. The main risk for acquiring HIV infection in New Zealand remains sexual contact between men. The prevalence in this group in the most recent Auckland study in 2011¹ was 6.5 percent (in the previous study in 2005/2006, the prevalence in this group was 4.4 percent).

The most recent review² of services for people with HIV shows that stigma continues to be an issue in the context of HIV in New Zealand. A research study conducted from August 2012 to February 2013 looked at HIV stigma and discrimination in healthcare settings, 47% of the respondents in this study described experiencing discrimination.

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

¹ Saxton P, Dickson N, Griffiths R, Hughes A, Rowden J. Actual HIV prevalence and undiagnosed infections in a community sample of men who have sex with men in Auckland, New Zealand. *BMC Public Health* 2012: 12:92.

² Miller, D. 2010. *Review of Services for People with HIV in New Zealand*. Wellington: Ministry of Health.

- 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.
- HIV peer support organisations (Body Positive Inc., INA (Māori, Indigenous & South Pacific HIV/AIDS Foundation), Positive Women Inc. provide support and advocacy for people living with HIV and AIDS (and their families).
- Needle Exchange Services administers the Needle Exchange Programme with services delivered by regional trusts and pharmacies across the country.
- New Zealand Prostitutes Collective provides health promotion and support services for sex workers.
- Family Planning clinics provide sexual and reproductive health services for all New Zealanders. Family Planning's HIV prevention work involves health promotion, education, social marketing, resource production and clinical and professional work.
- District health boards also fund Primary Health Organisations (PHOs) to support the provision of essential primary-health-care services through general practices to those people who are enrolled with the PHO. The services include being a point of contact for people with sexual health concerns and testing and treatment of common sexually transmitted infections (STIs).
- The New Zealand Blood Service has responsibility for ensuring the safe supply of blood and blood products.

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

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

Policies and programmes are also in place in New Zealand to address issues of low self esteem and self-confidence in youths, to support vulnerable families and children, and programmes to reduce inequalities (including programmes to improve education and increase employment). Such programmes all form an important part of HIV prevention.

Research, monitoring and evaluation

The evidence base for policy and clinical service development in New Zealand comprises clinical and operational research conducted by clinicians

and by university departments. The Ministry of Health funds most of the epidemiological and behavioural surveillance on HIV/AIDS in New Zealand.

Sexually transmitted infection (STI) surveillance is also in place in New Zealand to ensure that reliable HIV and STI data is available to inform policy and programme planning.

Overview of indicators for Global AIDS Response Progress Reporting 2014

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

	Indicators	Comment
1.1	Young people: Knowledge about HIV prevention	Indicator relevant to our country, however, no data available.
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.	Indicator relevant to our country, however, no new data available. The New Zealand National Health Survey being run in the 2014-2015 period includes a module on sexual health. Findings from this survey will be available in 2017.
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. The New Zealand National Health Survey being run in the 2014-2015 period includes a module on sexual health. Findings from this survey will be available in 2017.
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. The New Zealand National Health Survey being run in the 2014-2015 period includes a module on sexual health. Findings from this survey will be available in 2017.
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 2014, 10.5 percent (N=384) were aged between 15 and 24 years at the time of diagnosis (AIDS Epidemiology Group).
1.7	Percentage of sex workers reached with HIV prevention programmes	Subject matter relevant, however, no data available.
1.8	Percentage of sex workers reporting the use of a condom with their most recent client.	Subject matter relevant, however, no recent data available. New Zealand legislation requires operators of prostitution businesses to promote safe sex practices.
1.9	Percentage of sex workers who have received an HIV test in the last 12 months and who know their results.	Subject matter relevant, however, indicator not relevant to our country. For interest, a recent New Zealand study has been published looking at sex workers' utilisation of health services in a decriminalised environment. This study found that most sex workers have regular sexual health check-ups. Sexual health needs are accessed through general practitioner (GP) by 41.3%, local sexual health centre by 25%, New Zealand Prostitutes Collective sexual health clinic by 15% of respondents. This study also noted that even in the decriminalised

		environment, many sex workers do not report their occupation to the GP because of on-going perceptions of stigmatisation ³ .
1.10	Percentage of sex workers who are living with HIV	Subject matter relevant, however, no recent data available.
1.11	Percentage of men who have sex with men reached with HIV prevention programmes	HIV behavioural surveillance from 2014 ⁴ (GAPSS/GOSS surveys) indicates that 93% of MSM recruited offline and 85% of MSM recruited online had seen condoms promoted "very frequently", "often" or "occasionally" in the previous 12 months (remainder stated "rarely" or "never"). Significant programmes are focused on both the 'most at risk' populations (MSM and the migrant African communities).
1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.	HIV behavioural surveillance from 2014 found 81% of men recruited offline and 71% of men recruited online used a condom the last time they had anal intercourse with a casual partner. Condom use at last anal sex with a regular boyfriend or husband was 32% and 33% among men recruited offline and online respectively.
1.13	Percentage of men who have sex with men that have received an HIV test in the last 12 months and who know their results.	HIV behavioural surveillance from 2014 found 49% of non-diagnosed HIV positive MSM recruited offline, and 41% of those recruited online, had been tested for HIV in the previous 12 months.
1.14	Percentage of men who have sex with men who are living with HIV	A 2011 prevalence survey in gay community settings in Auckland showed overall HIV prevalence in MSM as 6.5% and a prevalence of undiagnosed HIV as 1.3%. HIV prevalence was lower among MSM respondents usually resident outside Auckland (4.8%) and higher among MSM living outside NZ (13.7%).

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

	Indicators	Comment
2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	It is estimated that there are around 10,000 Needle Exchange attendees (using United Nations methodology of distribution estimation) with an annual distribution of 3 million needles.
2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse.	In a 2013 survey of people who inject drugs 49.6% of the 689 respondents had had sex in the previous month, although less than a quarter (23.6%) reported using a condom the last time they had sex. Approximately one quarter (27%) of the respondents did not use condoms at all with new sexual partners.
2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected.	In the 2013 survey of people who inject drugs 66% of the respondents reported using a new needle and syringe every time they injected drugs and another 27% reported doing so most of the time.
2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	In the 2013 survey most people who inject drugs that use needle exchanges have previously been tested for HIV. However, many were not aware of the results.
2.5	Percentage of people who inject drugs who are living with HIV	The 2013 survey of people who inject drugs found the seroprevalence of HIV to be 0.2% (N=689).

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

³Abel G. New Zealand Medical Journal 7 March 2014, Vol 127 No 1390 *Sex workers' utilisation of health services in a decriminalised environment* <http://journal.nzma.org.nz/journal/127-1390/6012/>

⁴Saxton P, Dickson N, Hughes A, Ludlam A. *Gay Auckland Periodic Sex Survey (GAPSS) and Gay men's Online Sex Survey (GOSS): Basic frequency tables 2002-2014*. Auckland, New Zealand: The University of Auckland, 2014. Available at https://cdn.auckland.ac.nz/assets/fmhs/soph/sch/gmsh/docs/BFReport_34LoRes.pdf.

	Indicators	Comment
3.1	Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission.	Of the 24 women known to be infected with HIV when pregnant between 2012-14, for whom this information is available, 92% received antiretroviral treatment. Even if the mother is non-resident, i.e., not entitled to receive publicly funded health care, she will receive funded antiretroviral treatment in pregnancy as part of preventive measures to limit risk of mother-to-child HIV transmission.
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of births	100%.
3.3	Mother-to-child transmission of HIV (modelled)	Indicator not relevant.

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

	Indicators	Comment
4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy.	100%
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	98.4%

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 antiretrovirals was in the order of NZ\$26 million for the 2013/2014 financial year. Total international bilateral/regional and multilateral contributions is discussed under the section global commitment and action.

Target 7: Critical enablers and synergies with development sectors

	Indicators	Comment
7.1	National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)	Civil society noted the absence of a research and monitoring and evaluation strategy
7.2	Proportion of ever married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	The most recent survey of partner violence was the New Zealand Crime and Safety Survey 2009.
7.3	Current school attendance among orphans and non-	Topic not relevant.

	orphans aged 10-14	
7.4	Proportion of the poorest households who received external economic support in the last 3 months	<p>Topic not relevant.</p> <p>New Zealand has a comprehensive social assistance framework, which is universal and accessible to all irrespective of gender, age, and ethnicity.</p>

2. Overview of the HIV and AIDS Epidemic⁵

Case Reports of AIDS

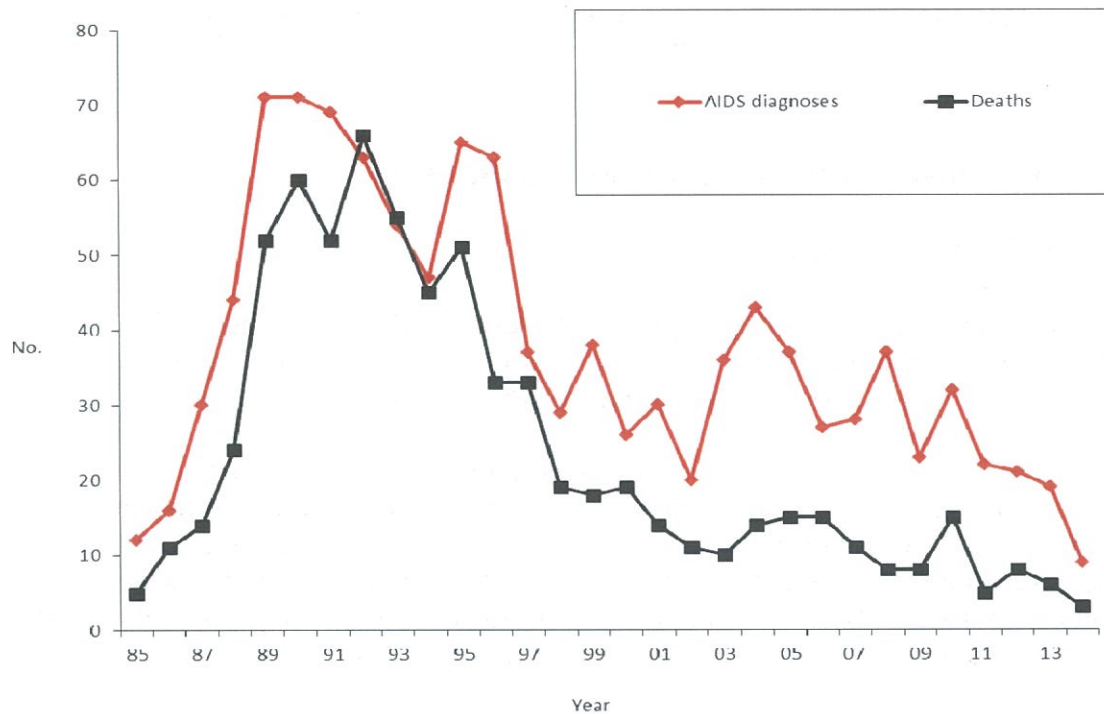
In New Zealand the number of people developing AIDS declined in the mid 1990s as it did in many developed countries as a result of improved treatments for people with HIV infection (see Figure 1).

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

While in 1996 most (72%) of those diagnosed with AIDS had been diagnosed with HIV more than 3 months before, in recent years this is true for a minority (26% in 2013-2014). Hence, most people currently meeting AIDS criteria are 'late testers'.

⁵ Data supplied by the AIDS Epidemiology Group, University of Otago under contract to the Ministry of Health to provide AIDS epidemiological research services.

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



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

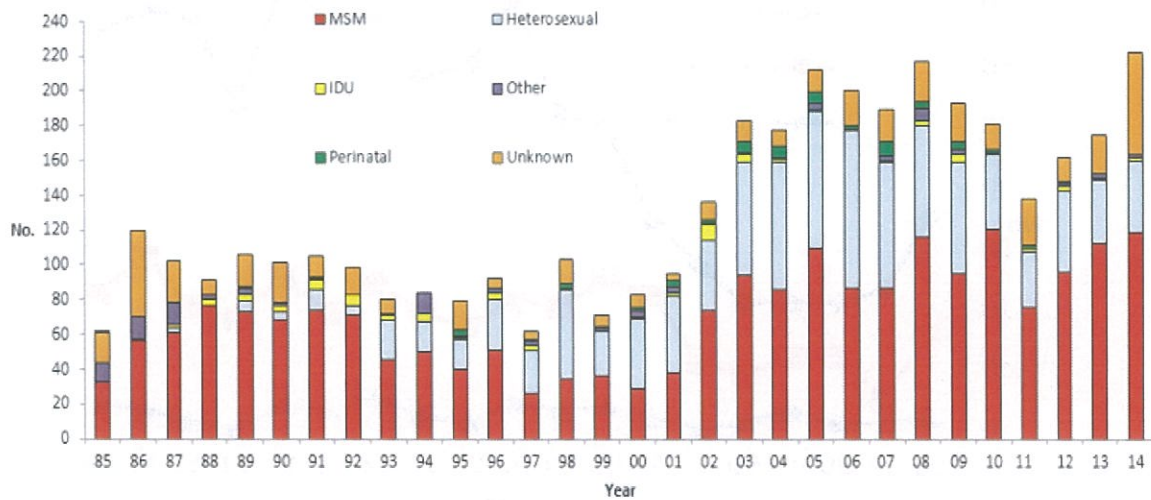
In the early years of the epidemic in New Zealand the vast majority of people with AIDS were MSM. While this has remained the major affected group, the proportion of people with AIDS who were heterosexually infected has increased. As will be discussed under case reports of HIV infection, the majority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

Case Reports of HIV Infection

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

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

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

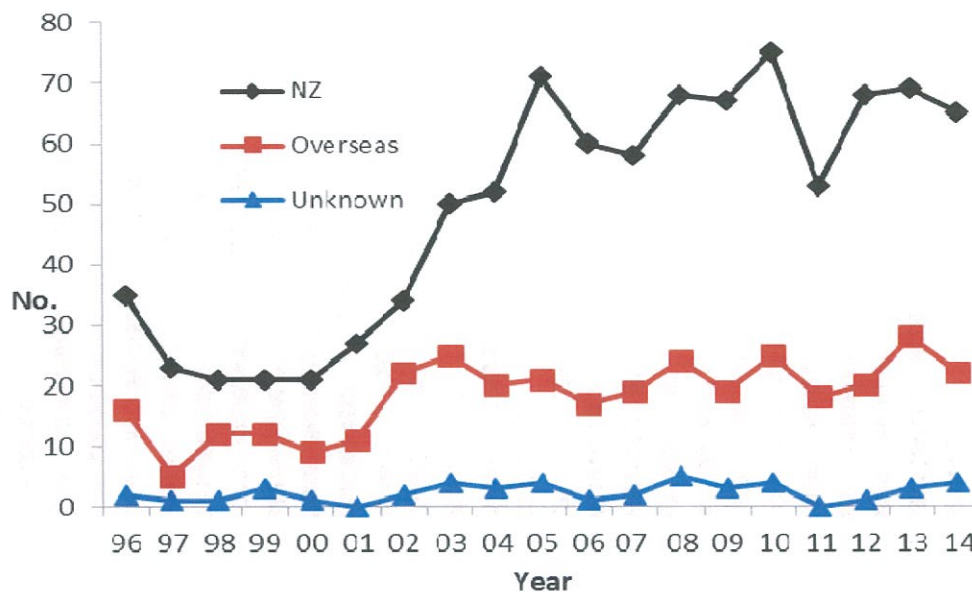


The annual number of people diagnosed with HIV in New Zealand was relatively stable for the first decade after HIV testing became available, and dropped slightly in the late 1990s. Subsequently there was a striking change with a steady rise in the number of diagnoses between 2000 and 2005. Since 2005, this number has fluctuated with an overall slight downward trend driven by a drop in the number of people heterosexually infected being diagnosed. The relatively high proportion of “unknown” means of infection in the 2014 data is mainly a reflection of the number of people for whom information is currently awaited.

HIV diagnoses among Gay, Bisexual and other men who have sex with men

Figure 3 shows the place of infection of MSM first diagnosed with HIV in New Zealand since 1996. The number of MSM diagnosed in 2014 may rise as information has not yet been received on all people diagnosed in 2014.

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



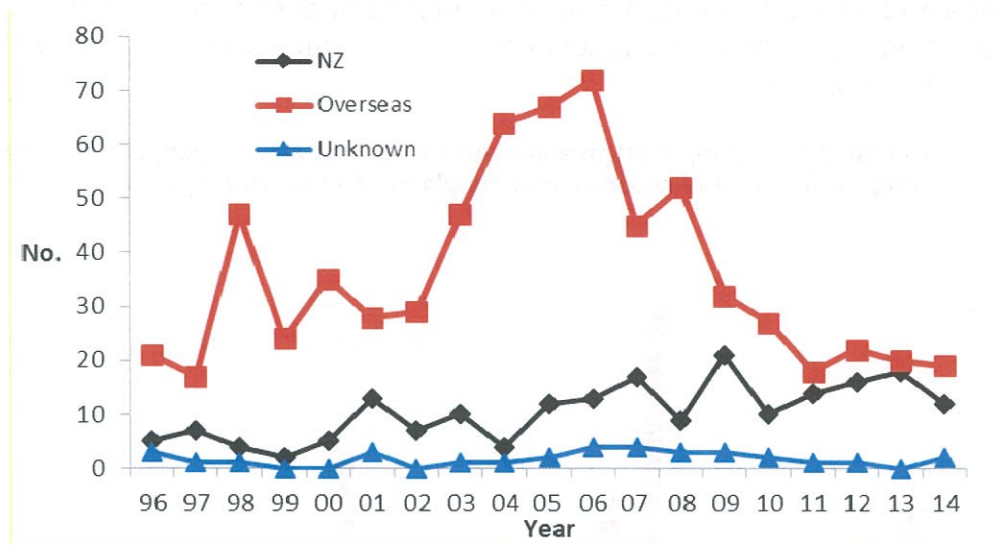
In the late 1990s a low and stable number of MSM were diagnosed with HIV annually in New Zealand. This number rose between 2001 and 2005, mainly due to a steady increase in the number infected in New Zealand. A similar rise was noted in many high income countries at this time. Since then there has been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

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

HIV diagnoses among heterosexualy infected men and women

Figure 4 shows the place of infection of men and women heterosexualy infected and first diagnosed with HIV in New Zealand since 1996. The numbers of people heterosexualy infected in 2014 may rise as information has not yet been received on all people diagnosed in 2014.

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



As with MSM, the number with heterosexually-acquired HIV rose in the early 2000s, however in this group it was mainly due to an increase in people infected overseas.

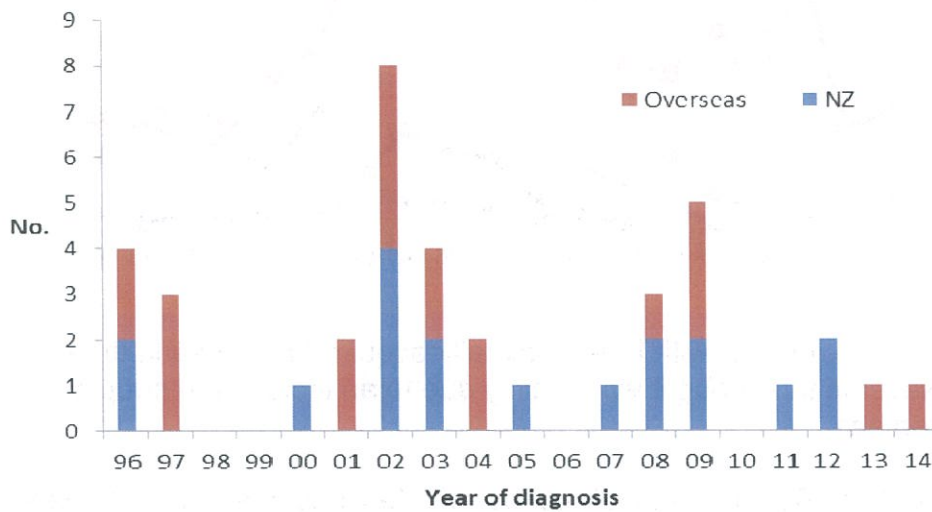
Since the peak in 2006, the annual number of infections has dropped due to fewer people infected overseas. Overall the annual number infected in New Zealand has risen gradually since the mid-1990s, and over the past four years has been only just below the number infected overseas. The annual number of infections has remained very much lower than the number of MSM infections.

In 2014, a similar number of men and women were diagnosed with HIV acquired in New Zealand; these people were from New Zealand European, Māori, Pacific, Asian and African ethnic groups.

HIV diagnoses among people who inject drugs

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

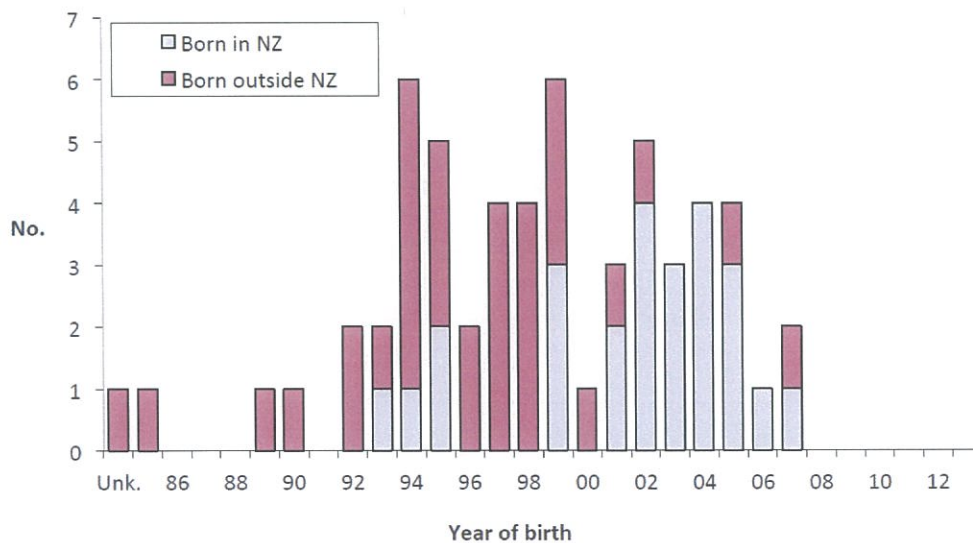
Figure 5 The number of people diagnosed with HIV among among people who inject drugs with no other reported risk, by place and year of diagnosis



Children infected with HIV through mother to child transmission

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

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



While most pregnant women in New Zealand are now tested for HIV, the number being diagnosed each year is low; only four pregnant women were diagnosed in the four-year period 2011-2014, indicating a very low prevalence among pregnant women.

Total number of people with HIV in New Zealand.

From 1985 to the end of 2014, a total of 4,174 people in New Zealand had been found to be infected with HIV. 1,149 had been notified with AIDS, of whom 713 were known to have died. The number of those diagnosed with HIV who have gone overseas, or died without meeting the criteria for AIDS (and therefore being notified), is not known.

The New Zealand drug-purchasing agency PHARMAC reported in June 2014 there were 1,886 people receiving subsidised ARTs, compared with 1,737 for 2013; at the end of 2014 it is estimated that approximately 1,960 people are receiving subsidised ARTs. Assuming that 85% of people in care are on subsidised ART, there would be 2305 people under care for their HIV at the end of 2014. If 20% of infected people are undiagnosed or diagnosed but not in care, the total number of people in New Zealand would be approximately 2,900. This suggests a low total prevalence of around 64 per 100,000 total population.

3. National Response to the HIV/AIDS Epidemic

Primary prevention continues to be at the centre of New Zealand's response to the HIV/AIDS epidemic. New Zealand continues to face challenges in adapting interventions to meet changes in sexual practices, attitudes towards HIV and safer sex behaviour amongst MSM. For example, in a subset of New Zealand MSM, new patterns of sexual partnering facilitated by the internet and other electronic media have links with HIV risk behaviour. The control of other STIs in people with and without HIV infection also has a role in containing HIV spread.

However data on MSM status is not routinely collected on STIs,⁶ other than for syphilis.⁷ There is an urgent need to remedy this as epidemiological studies show that MSM are disproportionately affected and STIs can facilitate HIV transmission.⁸

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

⁶ The Institute of Environmental Science and Research Ltd. *Sexually Transmitted Infections in New Zealand: Annual Surveillance Report 2013* Porirua, New Zealand, 2014.

⁷ The Institute of Environmental Science and Research Ltd. *Enhanced Surveillance of Infectious Syphilis in New Zealand Sexual Health Clinics - 2013* Porirua, New Zealand, 2014b.

⁸ Dickson N, Ludlam A, Saxton P, Hughes A. Self-reported STIs and sexual health checks in a cross-sectional study of gay and bisexual men in New Zealand. *Sex Transm Infect* 2015;91:49-54.

Prevention

The Ministry of Health continues to contract for a range of effective HIV and AIDS-related services including health promotion and promotion of safer sexual behaviour to minimise the incidence of HIV and AIDS, prevention and awareness activities, surveillance services, programmes for refugees and new immigrants, and independent HIV confirmatory testing services.

Behavioural surveys in New Zealand between 2002 and 2014 have shown that the level of condom use among gay and bisexual men is being sustained. However, rates of condom use need to continue to rise to counteract the impact of a larger population of people living with HIV in New Zealand.⁹

The majority of respondents to the 2011 GAPSS and GOSS surveys reported favourable attitudes towards condoms and safe sex. There was almost universal personal acceptance of condoms as a way to avoid HIV transmission, and most respondents also believed that other gay and bisexual men supported condom use. Thus there is strong evidence of a cultural norm to have safe sex among New Zealand MSM. While this is encouraging some men nevertheless report difficulties using condoms or negotiating condom use in practice.¹⁰

The 2014 surveys GAPPSS and GOSS surveys indicate that these patterns have continued, but need to be understood in the context of a steady decline in perceptions that the HIV/AIDS epidemic is as serious as it used to be.¹¹

According to the findings of the GAPPSS and GOSS surveys multiple factors influence condom use between MSM casual partners. Attitudes to condoms were strongly predictive of actual condom use, and their effect remained strong after taking into account socio-demographic and behavioural factors. There appeared to be a strong link between the extent of exposure to condom social marketing, attitudes to condoms, and actual condom use.¹¹

Encouragingly, MSM's exposure to condom social marketing appeared to be high in the year preceding 2014. Ninety-three percent of MSM recruited offline and 85% of MSM recruited online had seen condoms promoted "very frequently", "often" or "occasionally" in the previous 12 months.¹¹ Sixty-one percent of MSM recruited from Auckland community settings had seen condom promotion in at least three channels over this period (e.g billboards, online ads, condom packs).¹² Normalisation of condom use is important as

⁹ Saxton P, Dickson N, Ludlam A, Hughes A. Condom use among gay and bisexual men in New Zealand: Findings from the GAPSS and GOSS surveys 2002-2011. Research brief to the Ministry of Health. Dunedin: AIDS Epidemiology Group, University of Otago, 2012.

¹⁰ Ludlam A, Saxton P, Dickson N, Hughes A. Attitudes towards safe sex among men who have sex with men in New Zealand: Findings from the GAPSS and GOSS surveys 2002-2011. Research brief to the Ministry of Health. Dunedin: AIDS Epidemiology Group, University of Otago, 2012.

¹¹ Saxton P, Dickson N, Hughes A, Ludlam A. *GAPSS/GOSS Research Brief: Infrequent condom use between casual male partners*. Auckland: The University of Auckland, 2014.

¹² Saxton P, Ludlam A. *Snapshots: Gay Auckland Periodic Sex Survey*. Factsheet. Auckland: University of Auckland. Accessible at: <https://cdn.auckland.ac.nz/assets/fmhs/soph/sch/gmsh/docs/BGO%20Poster%20GAPSS%202014%20Final.pdf>

younger MSM tend to report habitual condom use or non-use across casual and regular partners.¹³

Behavioural surveys have also shown an increase in HIV testing rates. For example, the percentage of people testing at an interval of less than 12 months has risen from 35% in 2002 to 49% in 2014 among those surveyed in Auckland community settings.¹⁴

The behavioural surveys which are conducted with MSM in a range of community settings offline (fair day, gay bars, sex-on-site venues) and online (internet dating sites and apps) show that gay and bisexual men are diverse and targeted interventions should respond to these needs. MSM recruited online have lower condom use, test for HIV less often, have more complex partnering patterns, worse attitudes to HIV and safe sex, and are younger and more bisexually identified compared to those recruited offline.¹⁵ Of the MSM recruited offline, those surveyed in sex-on-site venues have much higher rates of sexual partner change, and are older and less gay community affiliated.^{16,17,18}

Approval of female condom in New Zealand

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

Community-based HIV Rapid Testing Service

There are both individual and public health benefits of early diagnosis of HIV infection. Early diagnosis means that the most effective treatment can be offered and people can be given advice and support to prevent further spread.

The HIV sector in New Zealand strongly support HIV rapid testing services as an effective approach for increasing testing rates and reaching key affected populations. The support for rapid testing is limited to settings where testing can be linked to the immediate offer of counselling for those who test positive or negative. Self-testing (home testing) for HIV is not supported by the HIV sector in New Zealand.

¹³ Lachowsky N, Dewey C, Dickson N, Saxton P, Hughes A, Summerlee A. Habitual condom use across partner type and sexual position among younger gay and bisexual men: findings from New Zealand HIV behavioural surveillance 2006–2011. *Sexually Transmitted Infections*, January 2015 0:1–6.

¹⁴ Saxton P, Dickson N, Hughes A. Condom use stable and more HIV testing: location-based HIV behavioural surveillance among MSM in Auckland, New Zealand 2002-2011. *Sexually Transmitted Infections* 2013. Online First doi:10.1136/sextrans-2013-051160.

¹⁵ Saxton P, Dickson N, Hughes A. Who is omitted from repeated offline HIV behavioural surveillance among MSM?: Implications for interpreting trends. *AIDS & Behavior* 2013. 17: 3133-3144.

¹⁶ Saxton P, Dickson N, Ludlam A, Hughes A. Characteristics of men who have sex with men surveyed in sex-on-site venues: Findings from the GAPSS and GOSS surveys 2002-2011. Research brief to the Ministry of Health. Dunedin: AIDS Epidemiology Group, University of Otago, 2012.

¹⁷ Saxton P, Dickson N, Hughes A. Condom use stable and more HIV testing: location-based HIV behavioural surveillance among MSM in Auckland, New Zealand 2002-2011. *Sexually Transmitted Infections* 2014; 90 (2), 133-138.

¹⁸ Saxton P, Dickson N, Hughes A. Trends in web-based HIV behavioural surveillance among gay and bisexual men in New Zealand: Complementing location-based surveillance. *AIDS Care*, 2015, online first.

Care, Treatment and Support

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

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

In 2013, approval was given to allow access to antiretroviral medication for post-exposure prophylaxis to patients who had non-consensual intercourse and for whom their clinician considers prophylaxis is required.

Trends in patient numbers and expenditure (New Zealand dollars) over the last 10 years (PHARMAC financial year runs 1 July – 30 June) are shown in the following tables.

	FY ending Jun 2005	FY ending Jun 2006	FY ending Jun 2007	FY ending Jun 2008	FY ending Jun 2009	FY ending Jun 2010	FY ending Jun 2011	FY ending Jun 2012	FY ending Jun 2013	FY ending Jun 2014
Patients receiving funded antiretroviral therapy	863	917	1,010	1,090	1,204	1,348	1,518	1,616	1,737	1,886
Antiretrovirals expenditure	\$8.9 Million	\$10.4 Million	\$11.6 Million	\$12.3 Million	\$13.0 Million	\$14.5 Million	\$16.8 Million	\$17.8 Million	\$21.0 Million	\$26.4 Million

		FY ending Jun 2005	FY ending Jun 2006	FY ending Jun 2007	FY ending Jun 2008	FY ending Jun 2009	FY ending Jun 2010	FY ending Jun 2011	FY ending Jun 2012	FY ending Jun 2013	FY ending Jun 2014
0 to 14	Female	11	12	13	10	9	4	4	6	7	5
	Male	7	7	9	20	18	19	24	22	20	15
15+	Female	178	178	196	213	232	257	294	300	317	340
	Male	666	721	793	847	945	1068	1195	1288	1393	1526
Total		863	917	1010	1090	1204	1348	1518	1616	1737	1886

Although access to treatment and support is widely available in New Zealand, civil society have previously noted that stigma, discrimination and geographic

isolation are some of the known barriers to accessing specialist clinical services and support.

Global Commitment and Action

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

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

New Zealand works with a range of multilateral partners to help address HIV/AIDS. In 2013/14 NZ\$1.5 million was provided in core, unearmarked, funding to the United Nations Joint Programme on HIV/AIDS (UNAIDS). In 2013/14 core contributions were also provided to the following UN and international voluntary agencies engaged in addressing HIV: UNFPA (\$6 million), UNDP (\$8 million), UNICEF (\$6 million), WFP (\$6 million), UNHCR (\$6 million), UN Women (\$2.5 million) and the International Planned Parenthood Federation (\$2.5 million). Funding was also provided for the World Bank's International Development Association (\$19.140 million in 2013/14).

With regard to relevant non-core funding, New Zealand will provide UNFPA Pacific a total of \$ 6,000,080 to deliver the Pacific Regional Sexual and Reproductive Health Initiative (PRSRHI) over 5 years (2014-18). The PRSRHI will support five Pacific Island Countries - Kiribati, Solomon Islands, Vanuatu, Tonga, and Samoa, to improve clinical skills of health practitioners, deliver targeted health promotion and training and create an environment, particularly for young women, men and marginalised groups, to make informed choices about their sexual and reproductive health. There is a growing understanding of the value and effectiveness of integrating HIV services with sexual and reproductive health services. This will increase access to both HIV and sexual and reproductive health services, decrease duplication, decrease stigma, increase quality of care and lead to more effective use of human resources.

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

4. Major Challenges and Remedial Actions

Health Protection Amendment Bill

Currently New Zealand lacks legislation to support use of effective public health policy response mechanisms for managing people with HIV who

recklessly and knowingly place others at risk of infection. 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.

To better support public health practice, the Health Protection Amendment Bill is currently going through the New Zealand Parliament. In relation to disease prevention and management the provisions designed to support public health practice are:

- increasing the range of infectious diseases that are notifiable, including HIV
- incremental options for the management of individuals with significant infectious diseases whose behaviour puts other people at risk of contracting a disease,
- strengthening provisions for contact tracing those people who may have an infectious disease, or may have been exposed to one.

5. 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 on HIV and AIDS in New Zealand (examples shown below) and ensure that the analyses of HIV and AIDS data are linked to key public health policies and relevant Government processes.

DOCUMENT / PUBLICATION	DESCRIPTION
AIDS – New Zealand	Ministry of Health/NZ AIDS Epidemiology Group report gives an up-to-date view of the national situation (twice yearly).
Gay Auckland Periodic Sex Survey (GAPSS 2002, 2004,2006, 2008, 2011 and 2014) and Gay Online Sex Survey (GOSS 2006, 2008, 2011 and 2014)	GAPSS assesses sexual behaviour in respect to HIV risk practices amongst MSM in the Auckland area (two-yearly). GOSS is the same survey but accessible to all MSM on a specific internet dating site nationally.
National 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 and 2013).
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 funds meetings of the National HIV and AIDS Forum, a defined membership of those involved in the HIV and AIDS sector that includes civil society, government, District Health Board clinical staff, tertiary

based researchers and organisations representing people living with HIV and AIDS.

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

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

