

# UNGASS COUNTRY PROGRESS REPORT

## NEW ZEALAND

Reporting Period: January 2006 – December 2007

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## **1. Status at a Glance**

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

The Ministry of Health (the Ministry) acknowledges the support and assistance of HIV/AIDS stakeholders in preparing this report. The initial phase involved requests for information by the Ministry in relation to questions in the Annexes. The draft answered Annexes were then sent to stakeholders for comment. The process of finalising this Country Progress report involved both internal Ministry peer review and external stakeholder peer review.

### ***Status of the Epidemic***

- In New Zealand, the early epidemic of HIV/AIDS was highly concentrated among men who had sex with men (MSM).
- With time the proportion of people diagnosed with AIDS and HIV infection and who have been heterosexually infected has increased.
- Between 2000 and 2005 there was a marked rise in the annual number of people diagnosed with HIV, which was made up both of people infected through male homosexual and heterosexual contact.
- The numbers of HIV cases diagnosed in 2006 and the first half of 2007 were similar to those for 2005.
- 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 is common.
- Anonymised sentinel surveys among sexual health clinic attenders show that in the population of attenders HIV is concentrated among MSM, with few heterosexual men and women, sex workers or injecting drug users infected. The latter is confirmed by studies among injecting drug users utilising needle exchanges. However, while HIV prevalence is low in this group the prevalence of hepatitis C is very high.

- 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.

### ***Policy and Programmatic Response***

In New Zealand the prevalence of HIV infection in the general population is very low. The main risk for acquiring HIV infection in New Zealand is still among MSM.

The response to the epidemic in New Zealand from most quarters has been based on a health promotion approach. Because the health promotion needs of particular at-risk groups vary, specialised programmes are provided by different organisations that are targeted at specific communities. For example:

- the New Zealand AIDS Foundation delivers community education programmes targeting MSM, health promotion, supporting those with HIV/AIDS (Positive Health Programme) and other HIV/AIDS-related services. The Foundation also has specific programmes for gay Maori (Hauora Takaatapu), gay and fa'afine Pacific People and African migrants to New Zealand
- peer support organisations (Body Positive Inc, Poz Plus, Positive Women Inc) provide support and advocacy for people living with HIV and AIDS (and their families). Despite presently not receiving any financial assistance from Government, both organisations are involved in HIV awareness and prevention 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
- the New Zealand Family Planning Association provides sexual and reproductive services including sexually transmitted infections prevention campaigns primarily targeting heterosexual women and men
- other programmes are delivered via District Health Boards, in sexual health clinics and sexual health promotion services
- 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 through Crown Funding Agreements with 21 District Health Boards charged with delivering health care to New Zealanders in their regions.

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. Care and support is also

available from voluntary groups in many areas, supported by the New Zealand AIDS Foundation. 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 are more likely to place themselves at risk. Policies and programmes to address these issues are an important part of HIV prevention. These include programmes to support vulnerable families and children, and programmes to reduce inequalities (including programmes to improve education and increase employment).

### **Overview of UNGASS 2008 Indicator Data**

#### NATIONAL INDICATORS

##### **National Commitment and Action**

Domestic* and international AIDS spending by categories and financing sources	Domestic spending on prevention and antiretrovirals in the order of NZ\$12-14 million and NZ\$21 million respectively for 2 year period. Total international bilateral/regional and multilateral expenditure for 2006/07 was NZ\$23.63 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 residents and those who have two year work permits: 100 percent are treated. Those who are not entitled to receive publicly funded health care (e.g. non NZ residents) 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 2006 and 2007 received antiretrovirals. If the mother is 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 treated 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.	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.	38.8% of surveyed men who have sex with men (1228 sample size) reported they had had an HIV test in previous 12 months. A Programme for antenatal HIV testing is

	being implemented.
Percentage of most-at-risk populations reached with HIV prevention programmes.	No data available.
Percentage of orphaned and vulnerable children aged 0-7 whose households received free basic external support in caring for the child	Not applicable
Percentage of schools that provided life skills-based HIV education in the last academic year.	Sexuality education (includes delaying sexual intercourse & a focus on safer sexual practices) is a component of <i>Health and Physical Education in the New Zealand Curriculum</i> . The curriculum is compulsory up to and including Year 10.

\* **Note:** Present contracts by the Ministry of Health for prevention and health promotion services span from July 2005 to June 2008. The domestic expenditure is therefore an approximation for 2006/07.

### Knowledge and Behaviour

Current school attendance among orphans and non-orphans aged 10-14	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.	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.	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 Youth2000 survey undertaken in 2001 show that of youth 12-18 years, by age 14 years 28.7 % of males and 21.6% of females have had sexual intercourse. 33% of males and 33.5% of females at age 15 had ever had 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.	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.	No data available.
Percentage of female and male sex workers reporting the use of a condom with their most recent client.	No 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.	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.	26% reported using a condom the last time they had sex.
Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected.	50% reported using a new needle & syringe each time they injected drugs and a further 40% reported doing so most of the time.

## Impact

Percentage of young people aged 15-24 who are HIV infected.	From 1985 to September 2007, of the total 2,828 people reported to be infected with HIV in New Zealand, 258 (175 males / 83 females) are young people aged 15-24. HIV antenatal screening data (March 2006 to March 2007 in Waikato region) shows 2 cases out of 3,052 tests in 15-24 years old females (0.06%).
Percentage of most-at-risk populations who are HIV-infected.	2005/06 SHC 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.	All, except any deaths, are followed up and remain on treatment. Clinical advice is that death from HIV is uncommon these days in New Zealand.
Percentage of infants born to HIV-infected mothers who are infected	<i>To be undertaken by UNAIDS Headquarters.</i>

### 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 expenditure for 2006/07 was NZ\$23.63M with NZ\$24.66 planned as expenditure for 2007/08.
Amount of public funds for research and development of preventive HIV vaccines and microbicides.	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.	Comment: New Zealand endorsed the APEC document " <i>Guidelines for APEC member economies for creating an enabling environment for employers to implement effective workplace practices for people living with HIV/AIDS and prevention in workplace settings</i> " which was endorsed by APEC Health Ministers in June 2007.
Percentage of international organisations that have workplace HIV policies and programmes.	Comment: See above comment re APEC guidelines.

## 2. Overview of the HIV/AIDS Epidemic

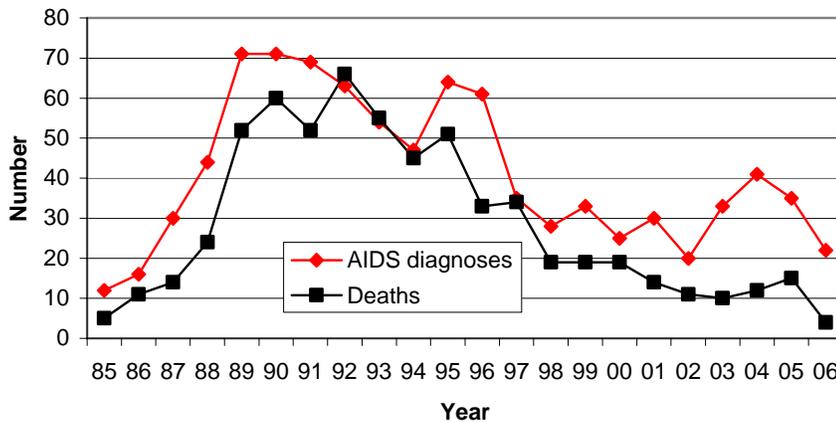
### Case Reports of AIDS <sup>1</sup>

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 on following page). Analyses currently being undertaken linking the timing of the diagnoses of AIDS and HIV infection show that while in 1996 most (72%) of those diagnosed with AIDS had been diagnosed with HIV more than 3 months, in recent years this is true for a minority (27% in 2006). Hence, the majority of people currently meeting AIDS criteria are "late testers".

<sup>1</sup> AIDS – New Zealand. Issue 59. AIDS Epidemiology Group, University of Otago, Dunedin, February 2007.

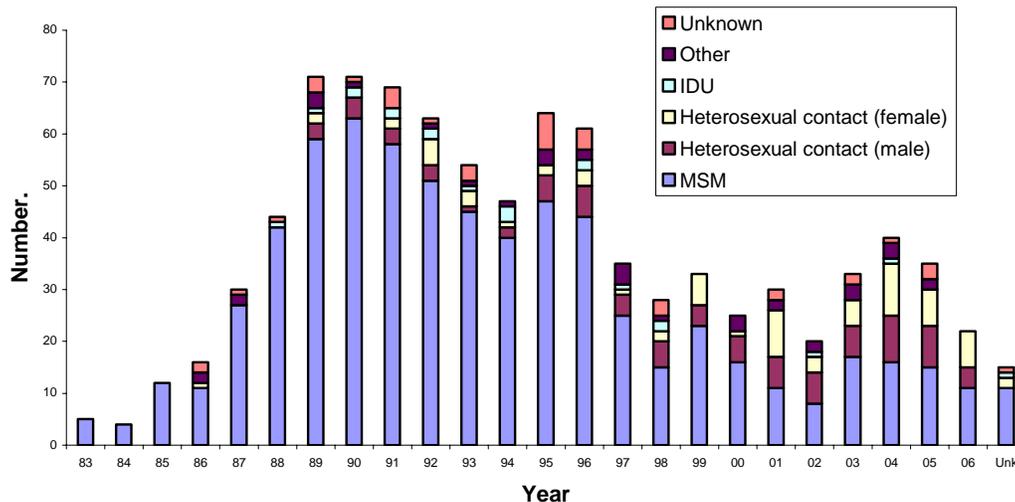
The number of people reported with AIDS who are known to have died is also shown in Figure 1. The annual number is now consistently less than the number notified with AIDS. This is in contrast to the early years of the epidemic when the numbers dying were similar to the number notified a year or so earlier. 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**



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 group in the population affected, the proportion of people with AIDS who were heterosexually infected 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 diagnosed with AIDS and means of infection with HIV**



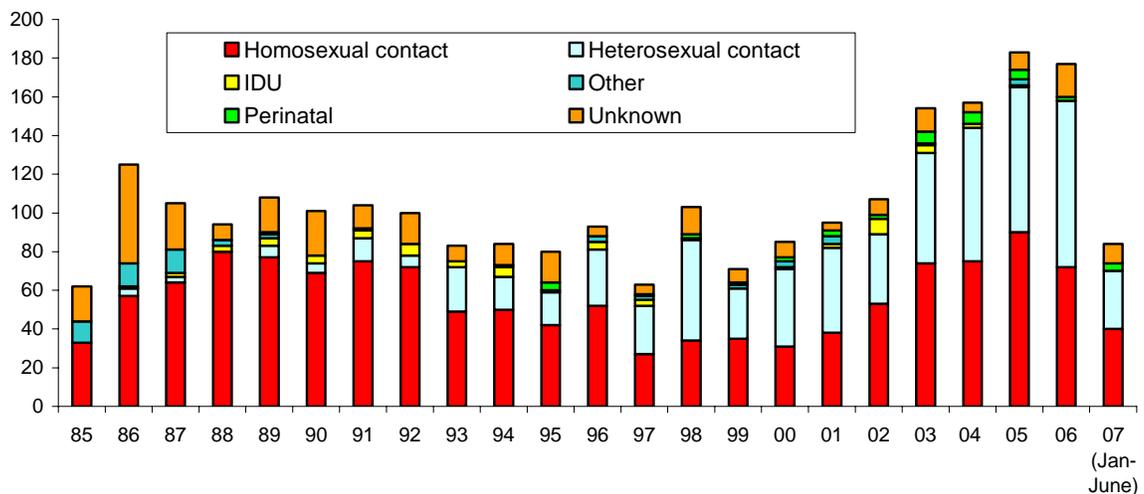
\* Unk in last bar denotes mode of infection is unknown

## 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 from 2000 to 2005.

In 2006, and for the first half of 2007, the numbers were similar to 2005. The pattern of an increase in the number of MSM diagnosed 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 2 below.

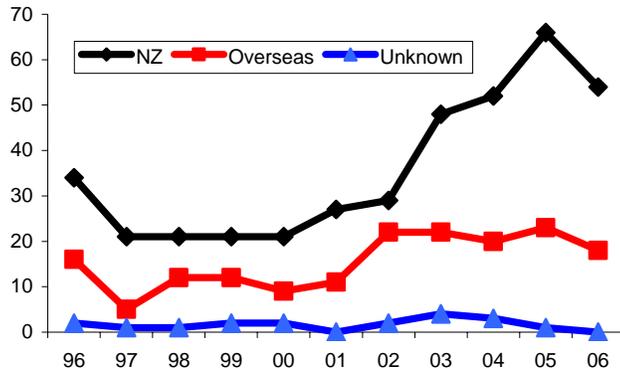
**Figure 2: Number of people diagnosed with HIV each year by means of infection**



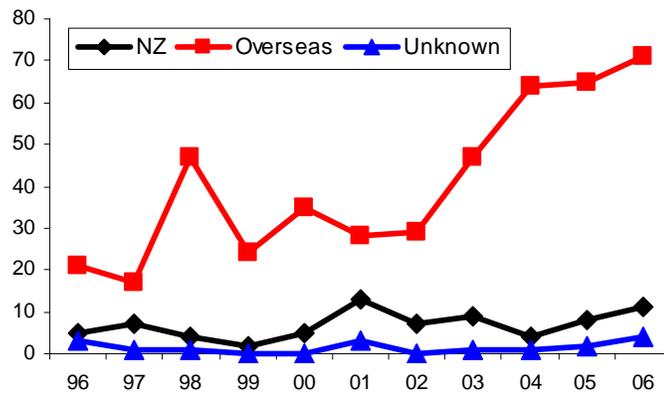
As for AIDS, early in the epidemic most diagnoses were among MSM, and over time the proportion of non-MSM diagnosed has increased. There are, however, clear differences between these two groups. Firstly, the ethnic profile of MSM is very similar to that of adult men in New Zealand. In contrast people heterosexually infected are predominately of African or Asian ethnicity. Secondly, 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 3(a) and 3(b) the rise among MSM, since 1999, has predominantly been due to MSM who were infected in New Zealand whereas the rise in heterosexual men and women was related to people who were infected overseas.

**Figure 3(a) and 3(b): Number of (a) MSM and (b) people heterosexually infected with HIV by year and place of infection**

**Figure 3(a)**



**Figure 3(b)**



### **Sentinel Surveillance**

An unlinked anonymous HIV prevalence survey was undertaken among sexual health clinic attenders in six main cities in New Zealand for a twelve month period between March 2005 and February 2006.<sup>2</sup> Leftover blood, drawn for hepatitis B and/or syphilis serology, was anonymised then tested for HIV. The results could be linked to demographic and behavioural information.

The overall prevalence, and prevalence of those previously undiagnosed, by sex and sexual behaviour are shown in Table 1. As shown, HIV is concentrated among MSM in this high risk sentinel group.

<sup>2</sup> Unlinked anonymous study of HIV prevalence among attenders at Sexual Health Clinics: 2005/06. Report to the Ministry of Health. AIDS Epidemiology Group, University of Otago, Dunedin, 2007.

**Table 1: Overall HIV prevalence and prevalence of previously undiagnosed HIV, by sex and sexual behaviour in New Zealand unlinked anonymous HIV prevalence survey: 2005/6**

		Overall			Previously undiagnosed		
		No.	per 1000	95% CI	No.	per 1000	95% CI
Men	Heterosexual	6/4795	1.2	0.5-2.7	2/4791	0.4	0.05-1.5
	MSM <sup>*</sup>	36/817	44.1	31.0-60.5	16/797	20.1	11.5-32.4
Women	Heterosexual	5/3639	1.4	0.5-3.2	2/3636	0.6	0.07-2.0
	WSW <sup>**</sup>	0/146	0.0	0.0-24.9	0/146	0.0	0.0-24.9
Transsexual		0/26	0.0		0/26	0.0	
Unknown		0/16	0.0		0/16	0.0	
<b>Total</b>		47/9439	5.0	3.7-6.6	20/9412	2.1	1.3-3.3

\* MSM (men who have sex with men) are men reported as either homosexual or bisexual

\*\* WSW (women who have sex with women) are women reported as either homosexual or bisexual

The trend in prevalence of previously undiagnosed HIV in the two largest cities where a similar sentinel study was undertaken (Auckland and Christchurch) in 1991/2, and in 1996/7, is shown in Table 2.

**Table 2: Comparison of prevalence of previously undiagnosed HIV (per 1000) by sexual behaviour and study year in Auckland and Christchurch in New Zealand unlinked anonymous HIV prevalence survey: 2005/6**

	1991/92	1996/97	2005/06
<b>MSM</b>	7/289=24.2	3/159=18.9	13/539=24.1
<b>Heterosexual men</b>	4/4484=0.89	1/2970=0.34	2/3100=0.64
<b>Heterosexual women</b>	3/3630=0.83	1/2137=0.47	2/1956=1.0

While this shows a slight decrease and subsequent increase in the prevalence among MSM expressed as a rate, what is more striking is the increase in the number of MSM tested between the 1996/7 and 2005/6 studies. This was not a reflection of more people being tested overall in these clinics and whether it indicates an increase in MSM in the population or an increase in their sexual risk behaviour is unclear.

Comparisons with an ongoing similar surveillance study undertaken in the United Kingdom have shown that overall in the New Zealand clinics there is a similar prevalence rate to that of England and Wales for clinics outside of London. Those clinics have also seen a similar rise in the number of MSM enrolled in their study.

### **Prevalence Among Sex Workers**

In the 2005/6 unlinked anonymous HIV prevalence survey in sexual health clinics there was no HIV infection amongst the 298 female, 32 male and 13 transsexual current sex workers. The upper 95 percent confidence limits were 12.3 per 1000 for such women, 115.3 per 1000 for such men and 283.8 per 1000 for transsexual sex workers.

### **Prevalence Among Injecting Drug Users**

Also in this sexual health clinic sample, the prevalence among those who reported ever injecting drugs, who did not report any current or past homosexual activity was 3.2 per 1000 (95% CI 0.1-17.6).

The most recent prevalence study among injecting drug users attending needle exchanges was undertaken in 2004 and involved nine sites.<sup>3</sup> Just over 400 people provided finger-prick blood samples, of whom four (1%) were HIV positive. In contrast the overall prevalence of hepatitis C was high (70%).

The relatively low prevalence of HIV is consistent with previous studies undertaken during the 1990s in this sentinel population that have ranged from 0.3 to one percent.

### **Diagnosed HIV Among Pregnant Women**

Information on the number of women with diagnosed HIV giving birth is collected via specialist paediatricians throughout New Zealand.<sup>4</sup>

In 2006, reports were received of 8 infants born in New Zealand to women with HIV diagnosed prior to giving birth, a rate of approximately 1.3/10,000 women. Three quarters of these were to women from high prevalence parts of the world. All of the mothers were given antiretroviral treatment during pregnancy, 6 gave birth by caesarean section, and none of the babies were breastfed. None of the children are believed to be infected with HIV (although some are still awaiting final confirmation).

These results provide valuable information on pregnant women with recognised HIV infection. There will however have been women with undiagnosed HIV who gave birth.

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

The 2006 Report to UNAIDS (the 2006 Report) identified major challenges and actions needed in New Zealand in relation to HIV/AIDS. These are briefly summarised below.

- Adapt existing interventions to meet changes in sexual practices, and attitudes towards HIV and safer sex behaviour amongst MSM so that the increase in HIV transmission within New Zealand among this group can be reversed.

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<sup>3</sup> Brunton C, Mackay K, Henderson C. Report of the National Needle Exchange Blood-borne Virus Seroprevalence Survey. University of Otago, 2005.

<sup>4</sup> New Zealand Paediatric Surveillance Unit. Annual Report 2006. New Zealand Paediatric Surveillance Unit, Department of Women and Children's Health, University of Otago, November 2007.

- Mobilise additional resources to expand health promotion, behavioural change and support programmes to the general population to prevent New Zealand-based heterosexual transmission.
- Provide support and challenge stigmatisation/discrimination towards African groups affected by HIV by developing capacities in the planning, design and coordination of specific interventions in order to manage the epidemic within African communities.
- Accelerate implementation of a national antenatal HIV screening programme in order to reduce mother-to-child transmissions.
- Increase access to the latest antiretroviral agents for New Zealanders.
- Work with Pacific group partners in supporting HIV prevention activities in the Pacific People.

The following sections reflect the changes made in New Zealand's national commitment since writing the 2006 Report.

### ***Prevention***

The Ministry of Health contracts for a range of HIV and AIDS-related services including health promotion and promotion of responsible 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 2005 to June 2008. Collective funding for the series of contracts for the range of services is in the order of NZ\$21.7 million over three years. Also, additional funding for primary healthcare, clinics and some nongovernmental organisations was provided.

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

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

In December 2006 the New Zealand AIDS Foundation commenced a free community-based HIV rapid testing pilot service. This pilot 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. The pilot also impacted on increasing the levels of awareness and understanding around HIV and safer sex practices. Evaluation of the pilot has resulted in the free rapid testing service being progressively rolled out to some other community centres.

### **Antenatal HIV Screening**

The 2006 Report made reference to the June 2005 policy shift by the Government to change from a “risk-based” approach to antenatal HIV screening, to one of a routine universal offer of testing.

Progressive implementation of the Universal Routine-Offer Antenatal HIV Screening Programme (the Programme) commenced in March 2006. Whilst only Waikato District Health Board has fully implemented the programme, eight other District Health Boards have appointed screening coordinators who are in the process of implementing the programme and are due to start early in 2008. All other District Health Boards should have signed the Programme Agreement by the end of June 2008. The cost of the fully implemented programme will be approximately \$1.3 million per annum.

Implementation in the Waikato District Health Board has commenced smoothly. There has been a willingness from midwives and general medical practitioners to incorporate the HIV test into their antenatal care. There has been a high uptake in testing, indicating that the HIV screen is acceptable to women. From the beginning of April 2006 to the end of March 2007 there has been a 99.7% uptake (15,723 out of 15,764 women) by women when the test has been offered to them. Over this period 2 women out of 15,723 were diagnosed with HIV through the screening process.

The training that is being provided is also raising awareness and knowledge of other infections as well as helping to reduce the myths and stigma around HIV.

Site data was used to calculate the percentage of young people aged 15-24 years who are HIV infected. For the period March 2006 to March 2007 two HIV infected cases (20 and 21 year olds) were detected out of 3052 tests in 15-24 year old women (0.06%).

### **Sexual Health Social Marketing Campaign**

The 2006 Report commented on a mass information campaign on sexually transmitted infections (STIs) including HIV and stated at the time that it was unclear whether such a campaign would be repeated during the next review period. One of the challenges identified was the need to mobilise additional resources to expand health promotion, behavioural change and support programmes to the general population.

New Zealand has high levels STIs, in particular chlamydia, with increasing levels of gonorrhoea and syphilis. Maori are disproportionately represented in negative sexual and reproductive health statistics including unintended pregnancy, abortion, chlamydia and cervical cancer. Pacific people also have higher incidences of many of these indicators.

In 2007 the Government approved NZ\$18.2 million over six years for sexual health education and reducing sexually transmissible infections. Of the STIs, genital chlamydial infection is the most commonly diagnosed in New Zealand. Young women under the age of 20 were the group with the highest number of

diagnoses of chlamydial infection among sexual health clinic attenders in 2006.

A national survey of knowledge, attitudes and behaviours in relation to sexual and reproductive health (to include questions relating to HIV and STIs) is being planned as well as a sexual health social marketing campaign. The purpose of the social marketing campaign is to reduce STIs (including HIV) in 15-24 year olds, and unintended teenage pregnancy in 15-19 year olds by:

- raising awareness among youth and their parents of STIs; emphasis on chlamydia
- increasing youth knowledge of options to reduce STIs; emphasis on safer sex
- supporting consistent and correct use of condoms and other forms of contraception by sexually active youth
- providing sexual health information via a range of media (e.g. website, written resources) and encouraging youth to access further sources of information
- being effective for Maori and Pacific audiences, and being coordinated with national, regional, and community based sexual health stakeholders.

Milestones for the campaign will be developed along with a monitoring and evaluation programme.

There is now clear evidence of a relationship between the risk of sexual transmission of HIV and other “classic” STIs (syphilis, genital herpes, genital chlamydial and gonococcal infection). In general, a person infected with HIV is more likely to pass on HIV to his or her sexual contacts if also infected with another STI. This appears to be true for both those STIs that cause genital ulcer disease, most commonly genital herpes and syphilis, and also for those that result in inflammation without ulcers such as gonococcal and chlamydial infections. Similarly, an uninfected person tends to be more susceptible to HIV if they have another STI.

The Ministry’s chlamydia work programme focuses on developing guidelines for targeted opportunistic testing and contact tracing for chlamydia as well as improving surveillance of STIs. The chlamydia guidelines are currently being finalised and will be printed and disseminated in March 2008.

The Ministry has been reviewing the legislation that requires the notification (reporting) of diseases. Schedules to the Health Act 1956 contain a list of diseases that are required to be notified to Medical Officers of Health. It is proposed that these Schedules to the Health Act be amended so that diagnoses of chlamydia, gonorrhoea, syphilis and HIV would become notifiable. This proposal is being considered as part of the Public Health Bill which is before Parliament. In addition, laboratory notification of notifiable diseases resulting in mandatory laboratory reporting of high quality unnamed STI data that will inform STI prevention and control policy has been introduced.

## Sexuality Education

The Ministries of Health and Education are working together to implement the recommendations of the Education Review Office report on 'The Teaching of Sexuality Education in Years 7 to 13'. This work includes a review of sexuality education resources and developing further evidence-based best practice information on effective sexuality education to inform the delivery of sexuality programmes.

## Recommendations for HIV Testing of Adults in Healthcare Settings

With the continued increase in cases of HIV infection in New Zealand the need to encourage more widespread and frequent testing of persons with risk behaviours is recognised. Furthermore, it is increasingly accepted that HIV testing is becoming part of "routine" medical care, for example, routinely offering HIV screening as part of standard antenatal care. Consequently, updated recommendations for HIV testing of adults in healthcare settings have been developed. The recommendations aim to promote more frequent HIV testing and to "normalise" the protocols around HIV testing where such testing is being performed in a medical context.

These 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. At the time of writing this report the recommendations are pending release.

## Care, Treatment and Support

The 2006 Report referenced the concern of civil society over the number of subsidised medicines for HIV-positive people and reported their continued advocacy for an expanded range of treatments. Today, access to funded antiretroviral drugs has increased in New Zealand. Today there are 18 antiretroviral drugs fully funded by the Government. This compares with 13 (end of 2005) and 12 (end of 2002). Two further antiretroviral funding applications are under consideration. Annual treatment costs of antiretrovirals to year ending December 2007 was NZ\$11.8 million. Trends in expenditure (New Zealand dollars) over the last 5 years are shown in the table below.

Year	2002	2003	2004	2005	2006	2007
Expenditure	\$6.01 million	\$6.85 million	\$8.05 million	\$9.63 million	\$11.09 million	\$11.8 million

The 2006 Report also indicated that post exposure prophylaxis is available for occupational exposure but not routinely available for non occupational exposures including rape. The possibility of provision of non occupational post exposure prophylaxis is currently under review by PHARMAC, the entity

responsible for managing New Zealand's Pharmaceutical Schedule. The Pharmaceutical Schedule lists the pharmaceuticals available in the community and subsidised by the Government.

#### ***Global Commitment and Action***

New Zealand's overseas development assistance agency, NZAID, regards HIV/AIDS as an international, regional and bilateral development priority and the commitment to halt and reverse the pandemic are evident in our health policy and programmes, and the increased allocation of funds to supporting activities. Total bilateral/regional and multilateral expenditure for 2006/07 was NZ\$23.63 million with NZ\$24.66 million planned expenditure for 2007/08.

While providing support to multilateral agencies and to low income countries in other regions NZAID has a core geographical focus on New Zealand's immediate neighbourhood, the Pacific region. In the five years since its inception NZAID has allocated US\$5 million to the Pacific Regional HIV/AIDS Strategy and Implementation Plan and in 2007/8 more than NZ\$6.5 million for all initiatives in the Pacific region addressing HIV/AIDS and sexual and reproductive health. Activities are implemented through multinational, regional and bilateral programmes.

NZAID's primary multilateral partner for HIV/AIDS is United Nations Joint Programme on HIV/AIDS (UNAIDS). NZAID funded the Secretariat NZ\$2 million in 2007 and will increase this to NZ\$2.5 million in 2008. In 2007 annual funding was also provided to agencies all of which address HIV to some degree: UNFPA (\$4 million), UNDP (\$8 million), UNICEF (\$4.6 million), WFP (\$2 million), UNHCR (\$3.6 million) and the World Bank (\$9.6 million), the Asia Development Bank (\$13.2 million) and the International Planned Parenthood Federation (\$1.3 million). NZAID also funds various small programmes and projects addressing prevention of, and support for those affected by, HIV/AIDS in Asia and Africa including in Indonesia, China, South Africa, Zambia and Zimbabwe. New Zealand has provided core funding for the Pacific Islands AIDS Foundation since its inception.

New Zealand continues to engage in international meetings on HIV/AIDS issues including in support of Pacific Island interests, and has on occasion funded the attendance of Pacific representatives to those meetings.

## **4. Best Practices**

### ***Political Leadership – Humanitarian Action to Protect Public Health***

Under successive governments, New Zealand has been at the forefront of adopting a proactive and pragmatic approach to the management of HIV/AIDS. In July 2005 the Government took action to protect the health of New Zealanders, and Zimbabweans in New Zealand who had fled the Mugabe regime in Zimbabwe. A Special Zimbabwe Residence Policy was introduced as a humanitarian response to the upheaval in Zimbabwe. The policy applied to Zimbabwean nationals who were in New Zealand as at 24 September 2004 and who did not have access to another nationality.

About 500 Zimbabweans were granted residence under the Special Zimbabwe Residence Policy, but many who were eligible did not come forward to apply for residency. It was believed that some of these potential residents were reluctant to come forward because of uncertainty around their HIV status following a policy change to require mandatory HIV screening before approving New Zealand residence applications.

In August 2006 the Government announced a special health waiver for Zimbabweans covered by the Special Zimbabwe Residence Policy. The health waiver meant eligible Zimbabweans living here did not have to meet usual health standards. It included applicants with HIV and AIDS. Eligible individuals were promised residency regardless of their health status as long as they met other requirements, such as being of good character as shown by police and other checks, in order to promote the best public health outcomes for New Zealand.

The outcome was that 930 Zimbabwe nationals living in New Zealand and entitled to apply for residence in New Zealand under a special policy applied by the deadline.

The decision was made for both public health and humanitarian reasons. The Government considered that this was the right thing to do in order to protect the health of New Zealanders and of those Zimbabweans seeking to become New Zealanders. This was an exceptional case, made for a group of people who might be unable to go home, and who without this decision could not stay in New Zealand lawfully. Without the certainty of the Government decision, people may have been reluctant to seek healthcare, with negative consequences for them and for New Zealand.

### ***Statutory Review of the Prostitution Reform Act 2003***

The purpose of the Prostitution Reform Act 2003 (PRA) is to decriminalise prostitution and to create a framework that:

- safeguards the human rights of sex workers and protects them from exploitation
- promotes the welfare, occupational health, and safety of sex workers
- is conducive to public health
- prohibits the use in prostitution of persons under 18.

Health and safety guidelines for sex workers were also developed and released in 2004. The guidelines cover a broad range of topics and are relevant to all New Zealand sex workers, regardless of their location or mode of work. Where the standards proposed by the guidelines are also legal duties this fact is noted.

The statutory review of the PRA, which will be completed by June 2008, will help determine the extent to which the PRA is achieving its purpose. The review includes an assessment of the operation of the PRA since its

commencement, the impact of the PRA on the number of persons working as sex workers in New Zealand, and the nature and adequacy of the means available to assist persons to avoid or cease working as sex workers. The review will also assess whether amendments need to be made to the law in relation to sex workers or prostitution.

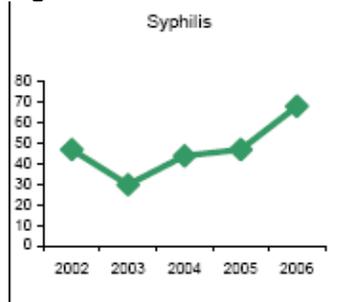
## 5. Major Challenges and Remedial Actions

### *Increase in Diagnoses of Syphilis and Other STIs in New Zealand*

Nearly all STIs reported on in New Zealand have increased in recent years. Some, including syphilis, genital warts and gonorrhoea can facilitate the spread of HIV infection.

The number of cases of infectious syphilis in sexual health clinics has increased by 45 percent between 2002 and 2006.

**Figure 4: Number of cases of syphilis at sexual health clinics from 2002 to 2006**



While heterosexuals account for half of the syphilis infections, MSM account for a disproportionate number of cases (40 percent). This rise in the number of cases of syphilis in New Zealand is similar to the well documented resurgence among MSM in North America and Western Europe.

The remedial actions being taken to address this issue include provision of some additional funding specifically for health promotion and social marketing with an emphasis on promoting testing for syphilis targeting sex on site venues, gay media and gay public events, the leveraging off the future sexual health social marketing campaign referred to earlier in this report, and improved surveillance of STIs.

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

Over the last few years 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. The factors include a decline in safer sexual behaviour, at least in a subset of New Zealand MSM, and new patterns of sexual partnering facilitated by social technologies such as the internet and other electronic media.

Additional funding was provided for placing a series of advertisements promoting safer sex on a local internet dating site. The high cost of placing these advertisements is a constraining factor and limited the number of advertisements placed. The outcome of this initiative will be surveyed in a periodic online/offline sex survey of gay men scheduled for 2008.

## 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, 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/AIDS in New Zealand (examples shown below) and ensure that the analyses of HIV/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)	Assesses HIV risk practices amongst MSM in the Auckland area (two-yearly).
HIV Futures	Surveys on populations of people living with HIV and AIDS in Australia and NZ (every four years). The 2007 Report is due by February 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, 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 quarterly reports. The monitoring follows the screening pathway, from the offer of HIV testing to the resulting health outcomes.

## 9. Annexes

ANNEX 1: Consultation/preparation process for the Country Progress report on monitoring follow-up to the Declaration of Commitment on HIV/AIDS.

ANNEX 2: UNGASS –National Composite Policy Index (NCPI) 2007.