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AIDS – New Zealand

AIDS AND HIV INFECTION IN NEW ZEALAND TO END OF JUNE 2004

In the first half of 2004, there were 14 notifications of AIDS (9 males and 5 females), and 67 people (52 males and 15 females) were found to be infected with HIV, in New Zealand. To the end of June 2004 a total of 819 people (754 males and 65 females) have been notified with AIDS, and 2153 (1823 males, 313 females, and 18 sex not stated) have been found to be infected with HIV. This total includes 268 persons whose infections were reported through viral load testing.

14th INTERNATIONAL AIDS CONFERENCE

The 14th International AIDS Conference was held in July in Bangkok, Thailand. Organized every two years, this Conference acts as a centerpiece of the world's efforts to combat AIDS bringing together thousands of scientists, physicians, activists, companies, journalists, political leaders and increasingly, people living with HIV.

The theme this year was "Access for All". This reflects the concern that despite enormous commitment of resources and efforts at country and global level, access to AIDS related services remains limited in many of the most affected parts of the world.

In this *AIDS – New Zealand* we have highlighted some of the key issues discussed at the Conference.

UNAIDS update of the worldwide epidemic

UNAIDS, the joint United Nations Programme on HIV/AIDS, estimates that in 2003 around 4.8 million people worldwide were newly infected with HIV, more than in any previous year. Over 20 million people have died of HIV since the first cases of AIDS were identified in 1981.

The worldwide epidemic is made up of a number of epidemics. How it affects populations is different is various regions of the world.

The following key issues have been highlighted by UNAIDS:

- The number of people living with HIV continues to rise in all parts of the world despite the fact that effective prevention strategies exist.
- Sub-Saharan Africa remains the hardest-hit region with an extremely high HIV prevalence among pregnant women aged 15-24 reported in a number of countries.
- In Asia, the HIV epidemic remains largely concentrated among injecting drug users,

men who have sex with men, sex workers, clients of sex workers and their immediate sexual partners. Effective prevention programme coverage in these populations is however inadequate in many countries.

- Dynamic epidemics are underway in Eastern Europe and Central Asia. Injecting drug use is the major driving force in these regions.
- In many high-income countries, sex between men plays an important role in the epidemic, and drug injecting plays a varying role. In 2002, drug use accounted for more than 10% of all reported infections in Western Europe and was responsible for 24% of HIV infections in North America.
- In Latin America and the Caribbean, nearly a dozen countries have an estimated national prevalence of 1% or more.

Worldwide, in the early years of the epidemic the number of men infected with HIV vastly outnumbered women. This, however, has changed and now half of those infected are women and girls. Overall young people are disproportionably affected, with half of all new infections occurring among 15-24 year olds. Globally, those most at risk are young, poor - often married - women.

Prevention

On many occasions at the Conference it was vehemently argued that preventive efforts must not be compromised by ideological debates about the morality of prevention, when the alternative is the clearly immoral outcome of needlessly exposing people to a life threatening disease.

Over the past few years much work has been undertaken around a broad range of ways that HIV transmission can be prevented, as well as through behavioural changes. Trials to assess the effectiveness of these that include use of the diaphragm, vaginal microbicides, vaccines, male circumcision and treatment of HSV-2, are now underway, or close to implementation. Although it will be several years before the first results are known there is a renewed mood of optimism that one or more of these will be able to have a real impact on HIV transmission globally.
While it is important to assess new strategies, it was emphasized that there is a need to expand, or "scale-up", successful prevention programmes as much as possible. An example is the need to implement more widespread access to HIV testing in pregnancy, and that when HIV is diagnosed in pregnant women interventions that can greatly reduce the risk of mother to child transmission are available, accessible and affordable.

Social issues

All aspects of the HIV/AIDS epidemic are closely interwoven with an array of social issues, possibly more so that any other worldwide health problem. At this year's Conference, the social sciences were recognised as having been successful in developing an understanding of the socioeconomic, structural and cultural drivers of the epidemic. A challenge laid down was how this knowledge could be used to design, implement and evaluate further interventions, while grappling with the methodological and ethical challenges of assessing their impact.

One immediate challenge is how best to "mature" the response to the epidemic when resources are limited and there has been uneven development in the fields of treatment, care and prevention.

Many of the issues raised were relevant to New Zealand. For example, how best to include groups affected with HIV in the response to the epidemic, when these – or the individual behaviour of members of the group – risk being stigmatised.

Community Involvement

Community involvement is often quoted as being important in the control of HIV. In one Conference session the following points, drawn from a number of studies, on how to promote community mobilization were made:

- Community members must play the lead role in assessing their needs and capacities, defining their priorities, and establishing their goals.
- Peers can play a crucial role in programme/project design, delivery and evaluation, at both leadership and on the ground levels.
- Communities are not homogenous.

- Community mobilization must start where people are, and recognize their current knowledge, lived experience and expertise.
- Information is often not enough. Individuals and communities must be supported to explore their own understandings, interpretations and adoption of information.
- Given the support and tools, communities can reach their own conclusions and can develop their own solutions. Social change and transformation can often be the result.
- Skilled facilitation can be a key to successful community mobilization. Community facilitators need training and ongoing support.

Leadership and Policy

For the first time at an International AIDS Conference, there was a stream devoted to "leadership". The importance of this was highlighted by Peter Piot, UNAIDS Executive Director, when he summed up what he believed to be the key elements of a comprehensive AIDS strategy:

- Leadership. Genuine and sustained political leadership at the highest level and embraced locally.
- Comprehensiveness. Success comes from sustained and comprehensive approaches on prevention, care, treatment and impact mitigation.
- Inclusiveness. The epidemic cannot be brought under control by the health sector alone. The broad engagement of every sector from groups of people living with HIV to business and religious leaders is crucial.
- Breaking down stigma and discrimination. The fear of being ostracized by friends and family, of losing one's job and being penalized by state and society are forceful disincentives that discourage people from taking advantage of the care and treatment services that are available to them.
- Timeliness. Africa has learned this lesson the hard way: denial and ignorance do not reverse this epidemic. It is a lesson that the countries of Asia and the Pacific must immediately take to heart.

Nelson Mandela's final words at the closing ceremony challenged everyone to ask themselves "What can I do as a global citizen? We must never forget our own responsibility."

The reports of a number of rapporteur teams are available on the conference web site http://www.aids2004.org/.

AIDS AND HIV INFECTION IN NEW ZEALAND

While the number infected with HIV in New Zealand is small in comparison to many countries in the world, the situation is changing. In 2003, there were 154 people diagnosed in New Zealand with HIV through antibody testing. This was the more than in any previous single year.

For the first six months of 2004, 67 people (52 males and 15 females) have been found to be infected with HIV, through antibody testing. A further 12 people (9 males and 3 females), mostly people diagnosed overseas, who had not had an antibody test here, had viral load testing in this period.

The likely means of infection and ethnicity of the 79 people diagnosed with HIV in the first half of 2004 are shown in Tables 1 and 2 (overleaf).

AIDS

To the end of June 2004 a total of 819 people (754 males and 65 females) have been notified with AIDS. Overall 626 (76%) were men infected through sex with another man; 109 (13%) were men and women infected through heterosexual contact; 19 (2%) through injecting drug use; 20 (2%) as a result of a blood product or transfusion; 8 (1%) through perinatal transmission; and for 37 (5%) the mode of infection remains unknown.

Of those notified with AIDS; 610 (74%) were European; 89 (11%) Maori; 24 (3%) Pacific Island; 89 (11%) of "other" ethnicity; and for 7 (1%) information on their ethnicity was not provided.

Table 1. Exposure category by time of diagnosis for those found to be infected with HIV (A small number of transsexuals are included with the males).

		HIV Infection*							
		<1999		1999-2003		2004 (to end of June)		Total	
Exposure category	**Sex**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Homosexual contact	Male	728	54.8	385	51.6	36	45.6	1149	53.4
Homosexual & IDU	Male	15	1.1	11	1.5	4	5.1	30	1.4
Heterosexual contact	Male	93	7.0	115	15.4	15	19.0	223	10.3
	Female	102	7.7	129	17.3	15	19.0	246	11.4
Injecting drug use (IDU)	Male	33	2.3	18	2.4	1	1.3	52	2.4
	Female	8	0.6	3	0.4	0	0.0	11	0.5
Blood product recipient	Male	30	2.2	4	0.5	0	0.0	34	1.6
Transfusion recipient	Male	4	0.3	5	0.7	0	0.0	9	0.4
	Female	5	0.4	3	0.4	0	0.0	8	0.4
	NS	5	0.4	0	0.0	0	0.0	5	0.2
Perinatal	Male	5	0.4	8	1.1	0	0.0	13	0.6
	Female	4	0.3	7	0.9	3	3.8	14	0.6
Awaiting information/ undetermined	Male	259	19.5	43	5.8	5	6.3	307	14.3
	Female	20	1.5	8	1.1	0	0.0	28	1.3
	NS	13	1.0	0	0.0	0	0.0	13	0.6
Other	Male	1	0.1	3	0.4	0	0.0	4	0.2
	Female	3	0.2	4	0.5	0	0.0	7	0.3
TOTAL		**1328**	**100.0**	**746**	**100.0**	**79**	**100.0**	**2153**	**100.0**

NS = Not stated

* Includes people who have developed AIDS. HIV numbers are recorded by time of diagnosis for those reported through antibody testing and by time of first viral load for those reported through viral load testing. The latter include many who have initially been diagnosed overseas and not had an antibody test here. Also, the date of initial diagnosis may have preceded the viral load date by months or years.

Table 2. Ethnicity by time of diagnosis in New Zealand for those found to be infected with HIV (A small number of transsexuals are included with the males).

		HIV Infection*							
		1996-1998		1999-2003		2004 (to end of June)		Total	
Ethnicity	**Sex**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
European/Pakeha	Male	130	46.3	383	51.3	35	44.3	548	49.5
	Female	13	4.6	40	5.4	2	2.5	55	5.0
Maori†	Male	17	6.0	43	5.8	6	7.6	66	6.0
	Female	2	0.7	5	0.7	0	0.0	7	0.6
Pacific Island	Male	4	1.4	14	1.9	2	2.5	20	1.8
	Female	3	1.0	10	1.3	0	0.0	13	1.2
Other	Male	66	23.5	138	18.5	15	19.0	219	19.8
	Female	35	12.5	98	13.1	16	20.2	149	13.5
Awaiting information/ undetermined	Male	10	3.6	14	1.9	3	3.8	27	2.4
	Female	1	0.3	1	0.1	0	0.0	2	0.2
	NS	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL		**281**	**100.0**	**746**	**100.0**	**79**	**100.0**	**1106**	**100.0**

† Includes people who belong to Maori and another ethnic group

* Includes people who have developed AIDS. HIV numbers are recorded by time of diagnosis for those reported through antibody testing and by time of first viral load for those reported through viral load testing. The latter include many who have initially been diagnosed overseas and not had an antibody test here. Also, the date of initial diagnosis may have preceded the viral load date by months or years.

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