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AIDS - New Zealand

INTRODUCTION

This, the thirty first issue of AIDS - New Zealand, provides information about the occurrence of acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV) infection in New Zealand to 30 September 1996.

These reports are produced quarterly by the AIDS Epidemiology Group, which is funded by the Ministry of Health. We aim to give timely and relevant details about the problem of HIV/AIDS in New Zealand and elsewhere.

The publication of this edition of AIDS -New Zealand coincides with World AIDS Day on 1 December 1996

AIDS IN NEW ZEALAND

Nineteen people were notified as having AIDS in the third quarter of 1996. Of these 19, 15 were male and 4 female.

The total number notified since monitoring began (to 30 September 1996) was 576. The cumulative incidence rate to that time was 16.8 per 100,000 total population.

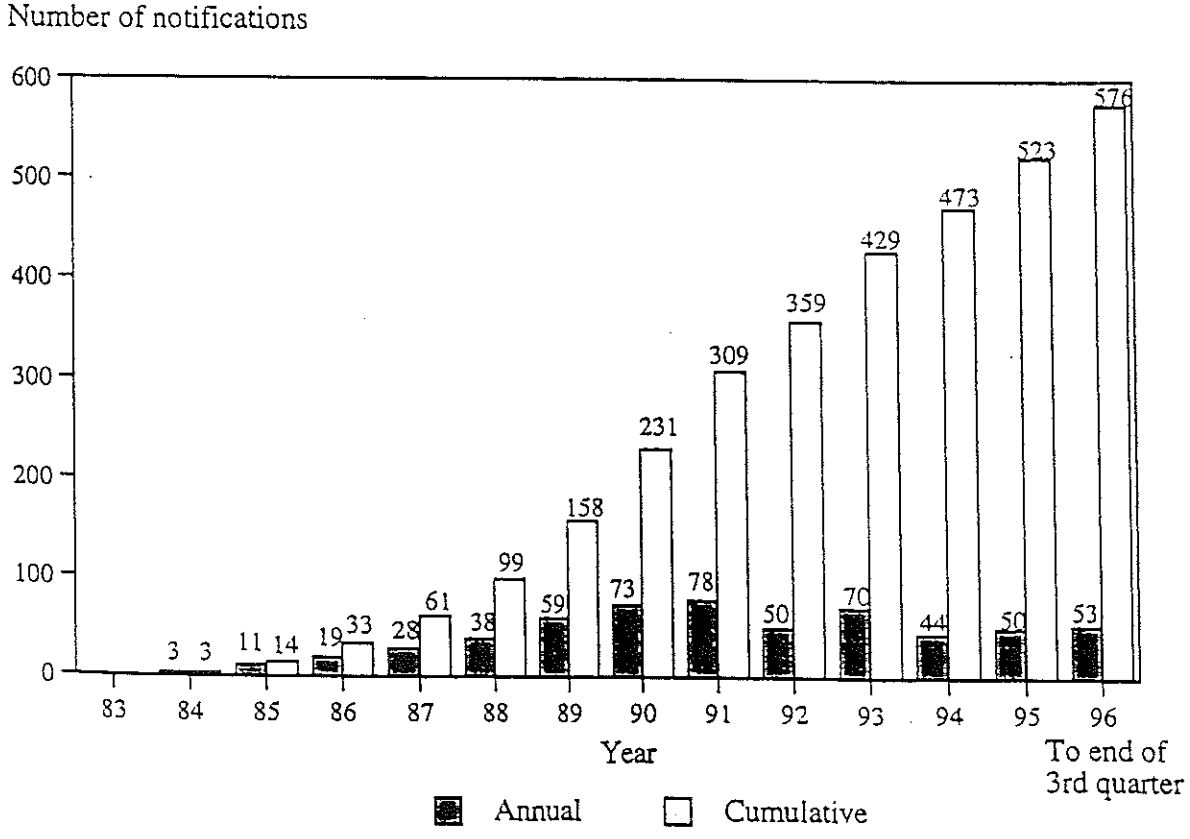

Figure 1 AIDS notifications in New Zealand

Figure 1 shows the annual and cumulative numbers of notifications since 1984. The year relates to the year of notification, which does not always correspond to the year of diagnosis, due to delays in reporting.

Risk behaviour categories of people with AIDS

Of the 15 males notified with AIDS in the third quarter of 1996, it was reported that 11 had been infected through sex with other men, 2 had been heterosexually infected, one had haemophilia and was infected through the receipt of infected blood products, and the means of infection of the remaining man was unknown. Of the 4 females notified, 3 were reported to have been heterosexually infected, and one woman to have been an injecting drug user.

Table 1 shows the likely risk behaviour categories of the people notified with AIDS (and those diagnosed as being infected with HIV) for the twelve months to the end of September 1996, and in total to that date.

People found to be infected with HIV in New Zealand

In the third quarter of 1996, 24 people were newly found to be infected with HIV. Of those 24, 19 were male, and 5 female.

Care must be taken in interpreting the HIV antibody data. Not all people at risk will have been tested, and testing may not be requested until many years after infection has occurred.

Risk behaviour categories of people found to be infected with HIV

Of the 19 males found to be infected

Table 1 Category of risk behaviour by date of notification of people with AIDS, and those found to be HIV antibody positive

	AIDS				HIV antibody positive*			
	12 months to 30.9.96		Total to 30.9.96		12 months to 30.9.96		Total to 30.9.96	
	No.	%	No.	%	No.	%	No.	%
Homosexual or bisexual +	47	72.3	473	82.1	52	50.5	651	56.4
Homosexual & IDU +	0	0	10	1.7	1	1.0	12	1.0
Injecting drug user (IDU)								
Male	0	0	8	1.4	3	2.9	28	2.4
Female	1	1.5	5	0.8	1	1.0	8	0.7
Blood product recipient+	3	4.6	13	2.2	0	0	28	2.4
Transfusion related								
Male	0	0	1	0.2	0	0	2	0.2
Female	0	0	1	0.2	0	0	5	0.4
Unknown	0	0	0	0	0	0	5	0.4
Heterosexual								
Male	4	6.2	20	3.4	11	10.7	41	3.6
Female	3	4.6	19	3.3	16	15.5	70	6.1
Perinatal								
Male	0	0	0	0	2	1.9	4	0.3
Female	0	0	1	0.2	0	0	2	0.2
Not stated or unknown								
Male	6	9.2	24	4.2	12	11.6	262	22.7
Female	1	1.5	1	0.2	3	2.9	18	1.6
Unknown	0	0	0	0	0	0	14	1.2
Other								
Male	0	0	0	0	1	1.0	1	0.1
Female	0	0	0	0	1	1.0	3	0.2
TOTAL	65	100.0	576	100.0	103	100.0	1154	100.0

\+ All male *Includes people who have developed AIDS

with HIV, 12 were reported to have been infected through sex with other men (one was also an injecting drug user), 3 to have been heterosexually infected (all were from parts of the world where heterosexual transmission is common), and one was an injecting drug user. No further information is available on the other 3 men.

Of the 5 females found to be infected, 3 were reported to have been heterosexually infected (2 of these women were from parts of the world where heterosexual transmission is common, and one was reported to have had a bisexual partner). One of the other 2 women was reported to have injected drugs overseas, and the remaining woman to have possibly been infected through contaminated needles used in medical treatment overseas.

Sharples KJ, Dickson NP, Paul C, Skegg D. HIV/AIDS in New Zealand: an epidemic in decline? AIDS 1996, 10: 1273-1278

This paper describing the AIDS epidemic in New Zealand, including information to the end of 1994, appeared in the September 1996 issue of the journal AIDS. The AIDS Epidemiology Group will prepare a review in the light of the additional information that is now available.

ETHNIC DISTRIBUTION OF PEOPLE WITH AIDS

Table 2 shows the ethnic groups of people with AIDS.

Table 2 Ethnic groups of people notified with AIDS to 30 September 1996

	No.	%
European/Pakeha	475	82.5
Maori	61	10.6
Pacific Islander	14	2.4
Other	19	3.3
Unknown	7	1.2
TOTAL	576	100.0

OUTCOME

The outcome of the 576 people notified with AIDS by 30 September 1996, as reported to the AIDS Epidemiology Group by the end of November 1996, is shown in Table 3.

Table 3 Outcome of people with AIDS

	No.	%
Alive	93	16.1
Known to have died	456	79.2
Lost to follow up	6	1.0
Overseas	21	3.6
Total	576	100.0

AGE AND SEX OF PEOPLE WITH AIDS

Table 4 shows the sex, and the age at diagnosis, of those people notified with AIDS.

AIDS has been notified most frequently from men in the age group 30 - 39 years.

It is important to appreciate that infection with HIV could have occurred many years before the development of AIDS.

Table 4 Age and sex of people notified with AIDS to 30 September 1996

Age (years)	Male	Female	Total
0-9	1	2	3
10-19	5	0	5
20-29	93	6	99
30-39	218	10	228
40-49	158	5	163
50-59	57	3	60
60 or more	17	1	18
Total	549	27	576

Reducing the Risk of HIV among Injecting Drug Users

In many countries in North America and Europe, a high proportion of people with AIDS are injecting drug users (IDUs). Such people became infected with HIV through sharing injecting equipment with infected people. In Europe the proportion of people with AIDS infected in this way increased from 16% in 1985 to 40% in 1993. In the United States currently just over a quarter of adults who develop AIDS are IDUs. In South East Asia too, drug injection has been a major contributor to the emerging HIV epidemic.

In New Zealand the proportion of people with AIDS, and of those found to be infected with HIV, who are IDUs has remained low.

A recent review has considered the prevention measures that appear to have been successfully implemented with IDUs (van Ameilden EJC, Watters JK, van de Hoek JAR, Coutinho RA. Interventions among injecting drug users: do they work? *AIDS* 1995, 9(suppl A):S75-S84).

A common feature found in several closely studied cities where HIV prevalence has remained low, is that preventive action was initiated early. Although different specific measures have been adopted in such places, they all include increasing the level of needle and syringe availability so as to reduce the need to share, and sustaining multiple interventions over a period of years.

Where a relatively high prevalence of HIV infection exists, the effectiveness of prevention programmes has been harder to establish. Nevertheless recently in New York, which is such a city, new infections with HIV were over three times more common among those who did not use a needle and syringe exchange programme compared to those who did. Importantly, the legal provision of sterile injecting equipment has not been found to lead to an increase in illegal drug use.

In New Zealand a needle exchange programme has been operating since 1988. The three components of the programme are the sale of injection equipment to drug users, provision for the safe return and disposal of used needles and syringes, and the promotion of safer drug use and sex behaviours to people who inject drugs.

Needles and syringes are provided from a variety of sources. Currently there are five dedicated needle exchanges, in Auckland, Christchurch, Dunedin, Wellington and Palmerston North, and there are plans to open more next year. There are also over 180 pharmacies, and other sites (such as sexual health centres and methadone clinics) that offer needle exchange services.

Sales at these outlets have increased significantly over the last two years. A major factor is likely to have been awareness of the high prevalence of hepatitis C (which is also caused by a virus easily spread by sharing drug equipment) within the drug using community in New Zealand.

Changes to the programme have recently been introduced. The sale of single needles and syringes is now possible, but only from those outlets enrolled in the programme that meet certain conditions. In addition the price of needles and syringes was reduced at the beginning of September 1996.

Further information on the needle exchange programme is available from the National Coordinator Needle Exchange Programme, P.O. Box 8249, Auckland (Tel 09 827 8422)

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