

AIDS – New Zealand

AIDS AND HIV INFECTION IN NEW ZEALAND TO END OF JUNE 2003

In the first half of 2003, there were 16 notifications of AIDS (14 males and 2 females) and 87 people (69 males and 18 females) were found to be infected with HIV in New Zealand. To the end of June 2003, a total of 788 people (731 males and 57 females) have been notified with AIDS, and 1974 people (1677 males, 279 females, and 18 sex not stated) have been found to be infected with HIV. This total includes 241 persons whose infections were reported through viral load testing.

HIV Testing

HIV testing in New Zealand

While the current rate and pattern of HIV testing in New Zealand is not known, there is evidence that a significant proportion of people with HIV are being diagnosed relatively late in the course of their infection.

Overall nearly 70% (38/55) of the people diagnosed with AIDS between the start of 2001 and mid-2003 had first been found to be infected with HIV within a month of their AIDS diagnosis. This was 14% (38/270) of all people diagnosed with HIV over that period, nearly a third (87/270) of whom had been diagnosed because of symptoms. Earlier diagnosis and treatment could confidently have been expected to have delayed the progression of the disease in many of these people.

Similar results were found in the 2001 *HIV Futures New Zealand* study, in which slightly more than a quarter of 226 people with HIV interviewed reported they had first been tested as they became ill.¹

In the 2002 GAPPS survey of Auckland gay men, a quarter of the sample had had an HIV test within the previous six months. There is less information from other groups in the population, although data from one sexual health clinic reported that fewer than 8% of all who attended in a recent 12 month period were recorded as having had an HIV test at that visit.

All findings suggest not enough HIV testing is occurring among people at risk of infection.

Benefits and risk of early diagnosis of HIV

There are both individual and public health benefits of early diagnosis of HIV infection.

Infected individuals can benefit from combination antiretroviral therapy (ART) and prophylaxis against opportunistic infections. The appropriate use of the former has had a dramatic effect on morbidity and mortality from HIV, although for some it can have significant side effects.

Public health benefits related to early diagnosis accrue from less risk of transmission. People with HIV are more likely to take steps to protect their partners after they have been diagnosed with HIV. In addition, while the current evidence is still indirect, it is likely that ART, through its effect on viral load, reduces the infectivity of a person with HIV. There will however be exceptions and it cannot be assumed that people diagnosed with HIV will always have safe sex, nor that all on effective treatments have low levels of infectivity.

These potential advantages of early diagnosis have to be balanced against potential disadvantages. These are not only the stress of having to deal with the knowledge of having a serious condition, but also the risk of stigma and discrimination an infected individual faces when suffering from HIV infection or AIDS.

HIV/AIDS stigma and discrimination

While there have been many diseases in history, for example leprosy, that resulted in affected

¹ Grierson J, Pitts M, Whyte M, Mission S *et al.* (2002) *HIV Futures New Zealand*. Monograph Series Number 32. Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne.

people risking stigma, HIV/AIDS is probably the most prevalent one today.

Stigmatisation occurs as the result of having an attribute that is considered to be so discrediting, that those with it are less valued in their society.² In the area of HIV/AIDS, this could relate to having HIV infection, or being involved in behaviours such as homosexual activity or injecting drug use that put an individual at increased risk of acquiring HIV.

Possible shame, and concerns about the potential for others to discover their HIV status, contribute to the reluctance of some people to be tested. The relationship between HIV testing and views on how stigmatising sexually transmitted diseases (STD) are, was investigated at a number of clinics in the US.³ Those who thought STDs were most stigmatising, as measured by 5 questions such as "Getting examined for an STD makes people think I have poor morals", were significantly less likely to have been tested for HIV in the past year.

It has been found that young people are highly attuned to the attitudes of health care workers. In general they are less likely to seek HIV testing where they perceive the workers to be judgemental about their behaviours.

There is evidence of discrimination against people infected with HIV in New Zealand. Of the 226 HIV infected people enrolled in the *HIV Futures New Zealand* study, 12% reported discrimination in relation to housing (5% in the previous 2 years), and 31% in relation to health services (20% in the previous 2 years).¹ The most common forms in the health service were additional infection control measures (48%) – presumably that those interviewed felt were unnecessary - confidentiality problems (45%) and avoidance (43%).

Addressing HIV/AIDS stigma

Not surprisingly the complexity of the underlying causes of stigma - which lie in the domains of attitudes to gender, ethnicity, class, sexuality, and culture - means that there is no easy way to address the issue.⁴ However, to ignore it will limit the ability to address the HIV/AIDS epidemic at both a personal and public health level.

2 Goffman E. (1963). *Stigma: Notes on the management of a spoiled identity*. New York: Simon & Schuster

3 Fortenberry JD, McFarlane M, Bleakley A, Bull S et al. Relationships of Stigma and Shame to Gonorrhoea and HIV Screening. *American Journal of Public Health* 2001;92:378-381

4 Valdiserri RO. HIV/AIDS~ Stigma: An Impediment to Public Health. *American Journal of Public Health* 2002;92:341-2

A recent review found that while there have been interventions that result in superficial changes in attitudes to people with HIV infection, less change was found in deep seated fears.⁵ It was noted that that there had been no studies testing national level approaches to combat stigma, even though mass media programmes could have great potential in this area.

A more radical approach to combating stigma has been advocated by Parker and Aggleton.⁶ They argue that individual level actions need to be complimented by those that have as their starting point the deeper social, political and economic causes of stigma. This can only be achieved by engaging with communities rather than individuals.

Link between HIV testing and care

While primary prevention, whereby individuals are encouraged to engage only in safer sex, must remain the lynchpin of any plan for HIV control, the US Centre for Diseases Control is incorporating into its 2003 strategy an initiative aimed specifically at individuals with HIV, including those who are unaware they are infected.⁷ This has been called the Serostatus Approach to Fighting the Epidemic (SAFE). For this to be successful a starting point must be to ensure a high rate of testing among people at risk, which can only be achieved if the environment is made safer for people to be tested.

The objectives of the SAFE are to:

- diagnose HIV infection in all infected people
- provide access to high-quality care and treatment services
- facilitate adherence to HIV therapy
- encourage individuals with HIV to adopt and sustain HIV risk reduction behaviour.

As shown by these objectives and how they link (Figure), SAFE aims to instigate a more integrated approach to care and prevention services, which will advantage the individual and communities. It is important that this approach compliments, rather than overrides, the need to engage in safer sex.

5 Brown L, Macintyre K, Trujillo L. Interventions to reduce HIV/AIDS stigma: What have we learned? *AIDS Education and Prevention* 2003;15:49

6 Parker R, Aggleton P. HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action. *Social Science and Medicine* 2003;57:13-24

7 Janssen RS, Holtgrave DR, Valdiserri RO, Shepherd M et al The Serostatus Approach to Fighting the HIV Epidemic: Prevention Strategies for Infected Individuals. *American Journal of Public Health* 2001;91:1019-1024

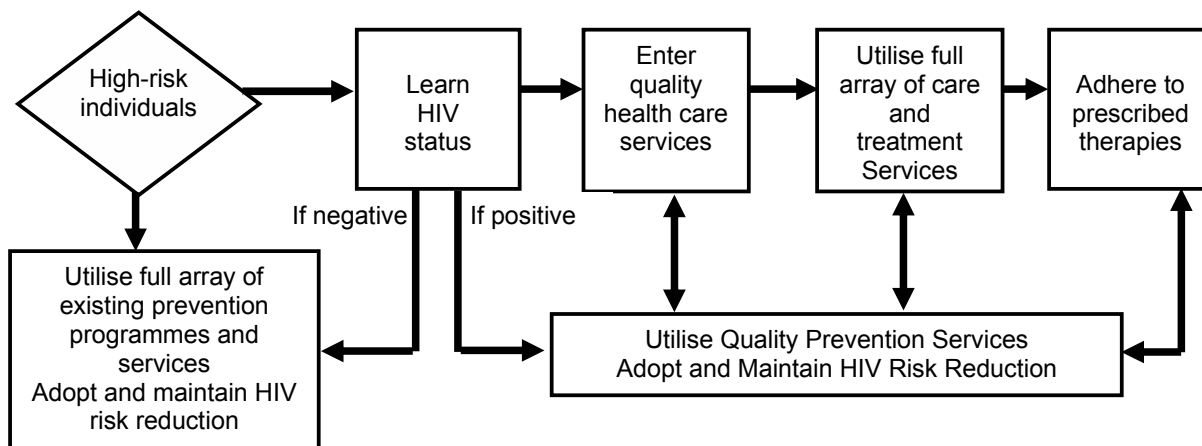


Figure Serostatus Approach to Fighting the Epidemic (SAFE) ⁷

AIDS AND HIV INFECTION IN NEW ZEALAND

AIDS

The AIDS Epidemiology Group received notifications of 14 men and 2 females (one a child) with AIDS during the first half of 2003. Seven of the men were reported infected through sex with another man, 4 through heterosexual contact, and the means of the other 3 was not known. One female was infected heterosexually, and the other was a child infected perinatally overseas.

The number of cases of AIDS is not presented in a table. However, to the end of June 2003, a total of 788 people (731 males and 57 females) have been notified with AIDS. Overall 610 (76%) were men infected through sex with another man, 98 (13%) were men and women infected through heterosexual contact, 18 (2%) through injecting drug use, 19 (2%) as a result of a blood product or transfusion, 8 (1%) through perinatal transmission, and for 35 (4%) the mode of infection remains unknown.

Of those 788 notified with AIDS, 597 (76%) were European, 86 (11%) Maori, 22 (3%) Pacific Island, 76 (10%) of “other” ethnicity and for 7 (1%) information on their ethnicity was not provided.

HIV infection

The Group has been informed of 68 people (53 males and 15 females) found to be infected with HIV during the first half of 2003 through HIV antibody testing. A further 19 people (16 males

and 3 females) had viral load testing in this period who were not known to have had an antibody test in this country. So far information has been obtained on 77 of all these 87 people.

The likely means of infection and ethnicity of the 87 people diagnosed with HIV in the first half of 2003 are shown in Table 1 and 2 (overleaf) which are in a slightly different format than previously. The results are now shown for three time periods, rather than just the total cumulative numbers and for the preceeding 12 months as in past issues of *AIDS – New Zealand*. This will more usefully present the changes occurring with HIV diagnoses in New Zealand.

Of the 77 people for whom information has been obtained, 40 were infected through sex with another man (including one man who had also injected drugs). Of these 40, 21 were reported infected in New Zealand and 19 overseas. Of the 24 people infected through heterosexual contact 5 were reported infected in New Zealand, 18 overseas and for one the country of infection was not reported. There were 3 children perinatally infected. Two of these were born overseas, and the remaining child was born in New Zealand, however her mother’s HIV was not diagnosed until after the pregnancy.

Overall there were 119 people found infected thorough antibody or viral load testing in 2001, of whom 51 were infected through sex with another man, and 48 through heterosexual contact. In 2002 the number was 136, with 71 and 39 respectively being infected through homosexual and heterosexual contact.

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.

		Year of diagnosis of HIV Infection*							
		<1998		1998-2002		2003 (to end of June)		Total	
Exposure category	Sex	No.	%	No.	%	No.	%	No.	%
Homosexual contact	Male	686	56.5	333	49.6	39	44.8	1058	53.6
Homosexual & IDU	Male	15	1.2	8	1.2	1	1.1	24	1.2
Heterosexual contact	Male	54	4.4	118	17.6	13	14.9	185	9.4
	Female	88	7.2	112	16.7	11	12.6	211	10.7
Injecting drug use (IDU)	Male	32	2.6	14	2.1	4	4.6	50	2.5
	Female	8	0.7	3	0.5	0	0.0	11	0.6
Blood product recipient	Male	30	2.5	4	0.6	0	0.0	34	1.7
Transfusion recipient	Male	3	0.2	6	0.9	0	0.0	9	0.5
	Female	5	0.4	2	0.3	0	0.0	7	0.3
	NS	5	0.4	0	0.0	0	0.0	5	0.2
Perinatal	Male	5	0.4	4	0.6	1	1.1	10	0.5
	Female	2	0.2	7	1.0	2	2.3	11	0.6
Awaiting information/ undetermined	Male	249	20.5	43	6.4	11	12.6	303	15.3
	Female	16	1.3	11	1.6	5	5.7	32	1.6
	NS	13	1.1	0	0.0	0	0.0	13	0.6
Other	Male	1	0.1	3	0.5	0	0.0	4	0.2
	Female	3	0.2	4	0.6	0	0.0	7	0.3
TOTAL		1215	100.0	672	100.0	87	100.0	1974	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.

		Year of diagnosis of HIV Infection*							
		1996-1997		1998-2002		2003 (to end of June)		Total	
Ethnicity	Sex	No.	%	No.	%	No.	%	No.	%
European/Pakeha	Male	88	52.4	337	50.1	40	46.0	465	50.2
	Female	9	5.4	41	6.1	2	2.3	52	5.6
Maori†	Male	13	7.7	35	5.2	6	6.9	54	5.8
	Female	2	1.2	4	0.6	0	0.0	6	0.6
Pacific Island	Male	3	1.8	6	0.9	1	1.1	10	1.1
	Female	3	1.8	8	1.2	1	1.1	12	1.3
Other	Male	24	14.3	139	20.7	16	18.4	179	19.3
	Female	19	11.3	86	12.8	11	12.6	116	12.5
Awaiting information/ undetermined	Male	6	3.6	16	2.4	6	6.9	28	3.0
	Female	1	0.6	0	0.0	4	4.6	5	0.5
TOTAL		168	100.0	672	100.0	87	100.0	927	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.

For further information about the occurrence of AIDS in New Zealand contact
Sue McAllister, AIDS Epidemiology Group, Department of Preventive and Social Medicine,
University of Otago Medical School, PO Box 913, Dunedin, New Zealand
Phone: (03) 479 7201, Fax: (03) 479 7298, or Email sue.mcallister@stonebow.otago.ac.nz