Te Kāwanatanga o Aotearoa
New Zealand Government

MANATŪ HAUORA
MINISTRY OF HEALTH

# Draft National HIV Action Plan for New Zealand Aotearoa 2022–2032

A New Zealand Aotearoa where HIV transmission is eliminated and all people living with HIV have healthy lives free from stigma and discrimination

2022

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# Mihi

Rārangi maunga, tū te ao, tū te pō, rārangi tangata, ka ngaro noa, ka ngaro noa. Ka whai whakaaro ake rā ki a rātou mā ngā mate tāruru nui o te wā, rātou katoa kua riro i te au o oti atu, i tēnei wiki, i tēnei marama, i te tau kua hori. Me te kī atu ki a rātou mā, haere atu koutou ki te Pūtahitanga o Rēhua, ki te whare whakamoe ariki, ki reira koutou, moe ai, oki oki e. Ko rātou ki a rātou, ko tātou kua whakarērea iho mai, ko tātou te pito ora ki a tātou.

Kei ngā kahu pītongatonga o te motu, koutou e korowai ana i te hapori ki te aroha, ki te manaaki, ki te tiaki, tēnei te reo o te Manatū Hauora me te Kāwanatanga e rere atu rā ki a koutou katoa. Ko koutou ngā pou e tū ai te whare hauora o Aotearoa, me mihi ka tika.

Ka mihi hoki ki ō mātou hoa haere, nā koutou tēnei rautaki i oti ai, nā koutou tēnei rautaki i mana ai, ko koutou te whakatinanatanga o te whakataukī, ko tā tātou toa he toa takitini.

Tēnei te tāpae ake rā i te rautaki nei i runga i te ngākau whakaiti. Koo te wawata ia nei, ka tutuki pai katoa ngā mahi kei mua i te aroaro, katoa ngā mahi kua whakaurua mai ki roto i tēnei rautaki. Ki te mahi takitahi, e kore e pahawa, engari ki te mahi ngātahi tātou katoa, ka ea, ka oti. Nō reira, huri noa i te motu, tēnā koutou, tēnā koutou, tēnā rā tātou katoa.

# Associate Minister of Health’s Foreword

Human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) is an ongoing global epidemic that, to date, has resulted in the deaths of 757 people in New Zealand Aotearoa. When HIV emerged in the early 1980s, those living with it faced intense discrimination, were ostracised from society and were excluded from health care services. Gay and bisexual men were particularly affected by HIV, and this amplified the existing stigma and discrimination this community already faced. As an infectious disease physician who has cared for people living with HIV, I have seen the impact of this stigma first-hand. I have had patients who couldn’t engage in care and felt unable to accept their diagnoses primarily because of the stigma that surrounds HIV.

Progress in our understanding and attitudes towards HIV has been achieved through the consistent and brave efforts of people living with or affected by HIV, community organisations and dedicated clinicians. At the same time, advances in prevention and treatment now mean that HIV is a manageable chronic condition rather than an acute fatal disease. In New Zealand Aotearoa, medications to treat HIV are publicly funded, allowing people living with HIV to supress their viral load and prevent HIV transmission even to sexual partners. Highly effective preventative medication is also publicly funded for people at risk of HIV transmission. All these factors mean we now have a low and decreasing HIV incidence, have eliminated mother-to-child transmission of HIV and have minimal transmission of HIV amongst people who inject drugs and sex workers.

It is now time to mobilise around another ambitious goal: to see local HIV transmission eliminated and people living with HIV leading healthy lives free from stigma and discrimination.

This HIV action plan provides a roadmap of how we can work together to eliminate transmission and support people living with HIV over the next 10 years. The action plan has a strong focus on eliminating inequities and stigma, meeting our Tiriti o Waitangi obligations, ensuring access to care and placing the needs and desires of communities at risk of or living with HIV at the heart of our efforts. Communities have paved the way in our HIV response and will continue to propel us forward and help us to reach those not currently reached by our health system. I am confident that, by working hand in hand with communities, we can achieve our goals for the HIV response in New Zealand Aotearoa. We can look towards the future with hope.

**Hon Dr Ayesha Verrall**
Associate Minister of Health

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# Introduction

In 2022, we have the knowledge and tools to prevent every human immunodeficiency virus (HIV) infection and acquired immune deficiency syndrome (AIDS) related death. This is a significant milestone in the global response to this epidemic which has resulted in over 36 million deaths. However, prevention and treatment tools have not been equally or fully accessed and we need new approaches that ensure equitable access to testing, treatment and care.

In response to this challenge, the Joint United Nations Programme on HIV and AIDS (UNAIDS) launched the 2021 Political Declaration on HIV and AIDS to set ambitious targets to guide global efforts in eliminating HIV transmission and ending AIDS as a public health threat. New Zealand Aotearoa is a signatory to this declaration.

In New Zealand Aotearoa, we are in a strong position to achieve these targets and eliminate HIV transmission. Compared with many other countries, we already have a low incidence of HIV, well-established harm reduction programmes (such as the needle exchange programme) and publicly funded HIV combination prevention and treatment. This includes pre-exposure prophylaxis (PrEP), which lowers the risk of a person acquiring HIV by 99 percent and highly effective antiretroviral treatment, which prevents HIV from being sexually transmitted.

This plan outlines the actions we need to take over the next 10 years to meet the UNAIDS targets, eliminate HIV transmission and ensure that people living with HIV have healthy lives free from stigma and discrimination. This includes reducing HIV incidence; improving outcomes for Māori; reducing stigma and discrimination; reducing the morbidity and mortality of HIV and achieving equitable outcomes across all population groups. To get there, we will need to improve our surveillance systems and understanding of HIV, increase support for people living with HIV and address equity barriers to combination prevention, testing and treatment.

The action plan is informed by Te Tiriti o Waitangi (Te Tiriti), the overarching Sexually Transmitted and Blood-borne Infection (STBBI) strategy, the New Zealand Aotearoa consensus statement on comprehensive HIV prevention and the Aotearoa Statement on Closing the Gap on sexually transmitted infections (STIs) and blood-borne viruses (BBVs) among Indigenous Peoples of Australasia. The plan also aligns with global strategies for HIV and the UNAIDS 2021 political declaration as mentioned above.

The next section summarises the epidemiology and experiences of people living with HIV and AIDS in New Zealand Aotearoa. This is followed by a section that outlines the plan's relationship to Te Tiriti. After that, there is a section on the values guiding the plan and another section on the framework for the action plan, including priority groups and settings. From there, the next section describes four areas we will need to focus on in our HIV response, accompanied by a comprehensive list of actions, and the final section provides guidance for implementing the plan.

# HIV and AIDS in New Zealand Aotearoa

For any public health action to be targeted and effective, we need to understand the epidemiology, sexual practices and lived experiences of people living with and affected by HIV. It helps us identify priority populations, behavioural patterns that increase vulnerability to HIV transmission, delayed diagnosis or poor clinical outcomes, as well as factors impacting on the lives of people living with HIV.

## HIV transmission in New Zealand Aotearoa[1]

In 2016, New Zealand Aotearoa had the highest number of HIV notifications ever recorded in a single year. Since then, the number of people diagnosed with HIV has been steadily dropping, driven primarily by reductions in locally acquired infections among gay, bisexual, and other men who have sex with men.

In 2020, 162 people (138 men, 24 women) were notified with HIV in New Zealand, 95 of whom were first diagnosed in New Zealand. Of all infections thought to have been acquired locally with a known route of infection, 79 percent were gay, bisexual, and other men who have sex with men. An analysis by Saxton et al. (2021b) found that gay, bisexual and other men who have sex with men were 348 times more likely to be diagnosed with HIV than heterosexuals. Among the 62 gay, bisexual and other men who have sex with men diagnosed in New Zealand Aotearoa (which includes those acquiring HIV locally and overseas), 50 percent were European, 19 percent Asian, 13 percent Māori, 10 percent Pacific peoples and 8 percent were of other ethnicities. The age range at diagnosis was 18–73 years, with 35 percent aged under 30 years old.

Despite the uncertainties surrounding HIV testing provision and access during the COVID-19 epidemic, the number and proportion of men who have sex with men diagnosed with high CD4 cell count[2] in 2020 (suggesting early diagnosis of HIV) were lower than in the preceding five-year average, indicating declining incidence.

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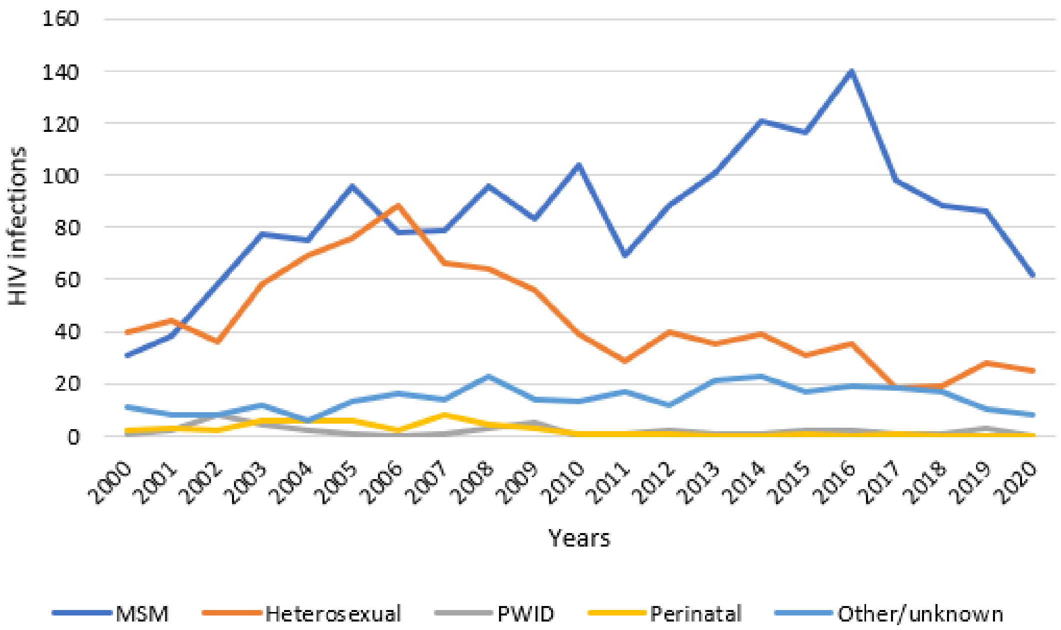
[1] The AIDS Epidemiology Group at the University of Otago is responsible for national surveillance of HIV infection and AIDS. Data has been extracted from annual reports. For more information, see the group's AIDS – New Zealand newsletters at: **www.otago.ac.nz/aidsepigroup/newsletters/index.html**

[2] CD4 cells are the body's white blood cells. They help fight infection. They are also known as CD4+T cells.

**Figure 1: Locally acquired HIV infections 2000-2020**



Since the beginning of the epidemic, the numbers of HIV notifications among those who acquired HIV through heterosexual contacts have been lower than among gay, bisexual and other men who have sex with men. Most HIV infections recorded among heterosexuals are thought to have been acquired overseas. In 2020, there were 36 HIV notifications among heterosexuals, with 13 (10 women and 3 men) of those acquired locally. However, between 2016 and 2020, 52 percent of heterosexuals who acquired HIV locally were diagnosed with CD4 cell counts lower than 350, compared with 38 percent of gay, bisexual and other men who have sex with men. Low CD4 cell counts indicate a delay between infection and diagnosis, which may result in poor health outcomes and advanced disease at diagnosis, but also ongoing HIV transmissions. The low rates of HIV infection among heterosexual men and women may result in clinicians not offering appropriate testing, even in cases where people present with clinical symptoms of HIV, leading to underdiagnoses (Dickson et al 2012; Hopkins et al 2019).

In 2020, three women were diagnosed with HIV as part of antenatal testing. One individual was notified to be living with HIV acquired through mother-to-child transmission overseas. Since 2007, there have been no local mother-to-child transmission of HIV in New Zealand Aotearoa.

Groups internationally reported to be disproportionately affected by HIV who may also be vulnerable to the rapid spread of HIV include people who inject drugs (Larney et al 2017) and sex workers (Shannon et al 2015). The groups affected are different in New Zealand Aotearoa due to the early introduction of needle exchange programmes and the decriminalisation of sex work (Healy 2006). In 2020, there were no local HIV transmissions among people who inject drugs. In an audit of 358 sex workers (predominantly female) presenting to an Auckland community outreach clinic for sexually transmitted infections (STIs) and HIV screening, there was only one seropositive person with HIV between 1 December 2019 and 21 December 2020. The person was known to be living with and being treated for HIV.[3]

## HIV prevalence in New Zealand Aotearoa

While we don't know the current total number of people living with HIV in New Zealand Aotearoa, community dispensing data indicates 2,839 people (2,381 men, 447 women and 11 children) were receiving subsidised antiretroviral therapy as at the end of June 2020.[4]

Between 1985 and 2020, a total of 5,363 people were notified as having HIV in New Zealand Aotearoa. The majority (58.6 percent) were among gay, bisexual, and other men who have sex with men, followed by those thought to have acquired HIV through heterosexual contacts (24.5 percent). In all, 15.9 percent of recorded HIV diagnoses were among women. Māori represented 7.7 percent of all HIV diagnoses between 1985 and 2020. During the same period, the African community, despite constituting a relatively small ethnic group in New Zealand Aotearoa (less than 0.4 percent), represented 13.5 percent of all HIV notifications and over 40 percent of the women found to be living with HIV in New Zealand Aotearoa.

## AIDS and associated mortality in New Zealand Aotearoa

Early HIV diagnosis, prompt links to care, treatment initiation and retention in care are crucial to preventing poor clinical outcomes from HIV infection. In most cases, when HIV is diagnosed early, the clinical outcome of AIDS can be prevented with effective antiretroviral therapy, and the life expectancy remains similar to that of the general population (Marcus et al 2020).

The numbers of AIDS diagnoses and AIDS-related deaths have reduced significantly compared with in the late 1980s and early 1990s, before the introduction of effective antiretroviral treatment. For several years in that former period, there were over 60 AIDS diagnoses and 50 AIDS deaths per year in New Zealand Aotearoa. In 2020, 14 people were diagnosed with AIDS. Of these, six were gay, bisexual and other men who have sex with men, six were heterosexual and in the remaining cases, the route of transmission was unknown. Notably, 86 percent of these cases were diagnosed with AIDS within three months of HIV diagnosis, when the initiation of treatment would be unlikely to prevent progression of HIV infection. Two people died of AIDS in 2020.

## Living with HIV in New Zealand Aotearoa

Despite great advances in treatment and clinical outcomes for people living with HIV, a significant proportion of people living with HIV in New Zealand Aotearoa report not having a high quality of life and experiencing stigma and discrimination (The Aotearoa

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[3] Sunita Azariah, personal communication, November 2021.

[4] Data current to the end of June 2020, provided by the Pharmaceutical Management Agency (PHARMAC), July 2021.

New Zealand PLHIV Stigma Index 2020). Within the health care system, there are reports of testing for HIV without consent or under pressure and staff avoiding physical contact with people living with HIV. In many cases, people living with HIV do not disclose their HIV status because of the fear of discrimination. This adversely impacts on the quality of care such people receive and becomes a barrier to seeking testing and treatment.

We also know that stigma and discrimination are often compounded by experiences of negative attitudes associated with practices that increase vulnerability to HIV, such as same-sex sexual practices between gay, bisexual and other men who have sex with men, injecting drug use and sex work. The experience of stigma can also be amplified because of intersecting forms of discrimination, such as racism that exists within and outside the health care system (Talamaivao et al 2020).

Stigma and discrimination experienced by women living with HIV is often compounded by societal perceptions and double standards around female sexuality (Bennett 2007). Women living with HIV also report issues in accessing appropriate sexual health, reproductive and antenatal services, including receiving inappropriate guidance about their reproductive rights and breastfeeding.

## Comorbidity

International evidence shows that the comorbidity burden among people living with HIV remains high, with increased rates of cardiovascular disease, liver diseases, mental health disorders, substance use, dyslipidaemia and cancers (Collins and Armstrong 2020; Lorenc et al 2014). Little data is available on the comorbidity burden among people living with HIV in New Zealand Aotearoa. In the ageing population of people living with HIV, the impacts of comorbidity will likely increase. Māori and Pacific peoples living with HIV may also have an increased risk of comorbidity given that Māori and Pacific peoples are generally more likely to experience health inequities (Hobbs et al 2019).

We also know that gay, bisexual and other men who have sex with men living with HIV experience an increased burden of other STIs, including syphilis. Surveillance data shows that among gay, bisexual and other men who have sex with men diagnosed with syphilis in 2019, almost 15 percent were living with HIV.[5]

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[5] Institute of Environmental Science and Research (ESR) data presented at the HIV forum in March 2020.

# Te Tiriti o Waitangi

This action plan gives effect to the Ministry of Health's (the Ministry's) obligations under Te Tiriti o Waitangi (Te Tiriti) as responsible Tiriti partners and stewards of the health and disability system. As outlined in the document *Whakamaua: Māori Health Action Plan 2020–2025* (Ministry of Health 2020b), our country's health and disability system is committed to giving effect to Te Tiriti in the relationship between Māori and the Crown.

The principles of Te Tiriti, as articulated by the courts and the Waitangi Tribunal,[6] underpin the Ministry's commitment to Te Tiriti and related responsibility to ensure the HIV sector and the wider primary health sector give effect to the principles as outlined in *Whakamaua*. The Waitangi Tribunal concluded in *Hauora: Stage One Report on the Health Service and Outcomes Inquiry* that persistent health inequities experienced by Māori across almost every disease state were the consequence of the failure to apply the principles of Te Tiriti at the structural, organisational and health practitioner levels of the health and disability system (Waitangi Tribunal 2019, pages 30–33).

Meeting our Te Tiriti obligations will require taking action to ensure inequities and gaps for Māori at risk of HIV (Māori gay and bisexual men and other men who have sex with men, Māori people who inject drugs, Māori sex workers and Māori transgender and non-binary people) and Māori living with HIV are addressed. Giving effect to Te Tiriti is required in order to achieve, at a minimum, equitable health outcomes for Māori people at risk of or living with HIV.

The HIV action plan implements the following principles of Te Tiriti as they apply to Māori.

## Tino rangatiratanga

The principle of tino rangatiratanga guarantees Māori the right to collectively exercise tino rangatiratanga (self-determination) and to live according to Māori philosophies, values and tikanga Māori (Māori customs). This principle encompasses effective and appropriate kaitiakitanga (stewardship) over the health and disability system. This includes decision making over the design, delivery, monitoring and implementation of high-quality, culturally safe services for Māori at risk of transmission of HIV or living with HIV.

## Partnership

Māori at risk of HIV or living with and affected by HIV will work with the Crown to initiate and develop the relationship through the process of initiating, developing, implementing and monitoring the action plan. The partnership principle requires HIV

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[6] For example, New Zealand Maori Council v Attorney-General [1987] 1 NZLR 641; New Zealand Maori Council v Attorney-General [1989] 2 NZLR 142; New Zealand Maori Council v Attorney-General [1991] WL 12012744; New Zealand Maori Council v Attorney-General [1992] 2 NZLR 576; New Zealand Maori Council v Attorney-General [2013] NZSC 6; The Ngai Tahu report 1991 (Waitangi Tribunal 1991); Report of the Waitangi Tribunal on the Orakei claim (Waitangi Tribunal 1987); Report of the Waitangi Tribunal on the Muriwhenua fishing claim (Waitangi Tribunal 1988).

and related health services to genuinely partner with Māori to design, deliver and prioritise actions where inequities in health outcomes for Māori are known or likely to exist. Working in partnership with Māori in the governance, design, delivery and monitoring of services is essential to ensure prevention and treatment services are effective and achieve positive health outcomes for Māori.

## Active protection

The Ministry has a responsibility to actively protect the tino rangatiratanga and mana motuhake (autonomy) of Māori to manage their health in accordance with tikanga Māori and mātauranga Māori (Māori knowledge). Until known and likely inequities are resolved, HIV-related health services have a Tiriti obligation to prioritise Māori health outcomes and set goals to achieve those outcomes (Waitangi Tribunal 2019, pages 30–33).

## Equity

Te Tiriti confirms that Māori, as citizens of New Zealand Aotearoa, have all the rights and privileges of other New Zealanders, including freedom from HIV-related stigma and discrimination and intersecting stigma and discrimination, including racism, homophobia, transphobia and misogyny. The principle of equity recognises that Māori require different approaches and resources to achieve equitable health outcomes. This includes identifying barriers that lead to inequities for Māori people at risk of HIV transmission or living with HIV, including service-level stigma and discrimination and, where barriers exist or are likely to exist, addressing these barriers as a priority. All systems and services used by Māori people at risk of transmission of or living with HIV must be equitably accessible and funded (Waitangi Tribunal 2019, pages 33–35).

## Options

Māori are guaranteed the right to live as Māori and in accordance with their practices and knowledges whilst retaining the right to live as citizens of wider New Zealand Aotearoa. Accordingly, kaupapa Māori (Māori initiatives) health services and networks for Māori at risk of or living with and affected by HIV must be fostered and protected. All other (that is, mainstream) HIV and related health services must also provide high-quality and culturally safe models of hauora (health) and services so that Māori at risk of or living with and affected by HIV are not disadvantaged by their choice of service (Waitangi Tribunal 2019, pages 35–36).

## Strategic approaches to meet Te Tiriti o Waitangi obligations

The action plan has an explicit goal of giving effect to Te Tiriti obligations, including increasing equity for Māori across all outcomes for HIV. This will require specific actions for Māori in the action plan. We will also partner with Māori, particularly Māori at risk of and living with HIV, in implementing and monitoring the action plan.

# Guiding values

The values set out in this section support the development of this action plan and will guide us to achieve our vision of ensuring HIV transmission is prevented and all people living with or affected by HIV have healthy lives free from stigma and discrimination. The values intersect with Te Tiriti principles and support meeting Te Tiriti obligations, for example, through being accountable for achieving equitable outcomes and meaningful involvement of priority groups.

The values have been informed by the overarching STBBI strategy, but there are two values specific to the HIV action plan: courage and innovation, and a focus on communities. The action plan is grounded in our commitment to equity and the meaningful involvement of people living with and affected by HIV. These are outlined in further detail in standalone sections to follow.

| **Values** | |
|---|---|
| **Equity** | In New Zealand Aotearoa, people experience differences in health that are not only avoidable but unfair and unjust. Equity recognises that different people with different levels of advantage require different approaches and resources to achieve optimal health outcomes.[7] This action plan is committed to achieving health equity for those at risk of HIV transmission and improving the health and wellbeing of people who are living with HIV. |
| **Meaningful involvement of people living with or affected by HIV** | We recognise the rights of people living with HIV and communities affected by HIV, including their right to self-determination and participation in decision-making processes around the issues that affect their lives. We will promote meaningful involvement of people living with HIV and affected communities. |
| **Manaakitanga** | We show care, inclusion, respect, support, trust and kindness to each other. This includes addressing stigma and discrimination and preserving the mana of people accessing prevention tools and services, such as PrEP, and testing and care for people living with HIV. |
| **Evidence** | We are committed to developing evidence-based policy and programmes recognising different forms of knowledge, including mātauranga Māori and knowledge of the communities affected. |
| **Courage and innovation** | We will set bold and ambitious targets that will require us to be courageous and innovative in our response to HIV. This includes taking advantage of new and innovative approaches, treatments and system level changes. |
| **Accountability** | We take accountability for developing the action plan, implementing it and achieving the stated outcomes. This will require governance and further leadership around HIV prevention and care. It is also important there is enough resourcing for the HIV response so that the health sector can deliver on priority areas to achieve the desired outcomes. Designing measurable key performance indicators and monitoring progress as a part of the implementation plan is crucial for accountability. |

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[7] This is from the Ministry's official working definition of equity. For more information, see the Achieving equity webpage on the Ministry's website at: **http://www.health.govt.New-Zealand/about-ministry/what-we-do/work-programme-2019-20/achieving-equity**

| | |
|---|---|
| **Community focused** | We recognise that community organisations are critical to achieving effective and equitable outcomes because they have a strong understanding of the needs and aspirations of their communities. We will promote meaningful involvement of community organisations and develop actions that strengthen their ability to best serve their communities. |

# Equity

In 2020, UNAIDS identified inequities between and within countries as a key reason why the world had failed to meet the global 90-90-90 HIV and AIDS targets (UNAIDS 2021). In the latest UNAIDS strategy and the 2021 political declaration, addressing inequities is made central to any HIV and AIDS response as both a human rights imperative and a public health necessity.

In New Zealand Aotearoa, some inequities have been clearly identified. Gay, bisexual and other men who have sex with men are the community most disproportionately affected by HIV and are 348 times more likely to be diagnosed with HIV than the heterosexual population (Saxton et al 2021b). There are, however, further and intersecting inequities within this population group. For example, while Māori and Pacific gay, bisexual and other men who have sex with men are no more likely to be living with HIV than non-Māori gay, bisexual and other men who have sex with men, they are more than twice as likely to be diagnosed late and present with advanced HIV (Dickson et al 2012).

International and local research shows that the drivers of HIV and AIDS inequities are complex and include an inequitable distribution of the determinants of health, such as income and housing (Hamlet 2019; ASHM 2021). The drivers may impact people's access to and uptake of prevention, testing, treatment and support (Hamlet 2019). These inequities are also intersecting and experienced differently depending on which communities a person belongs to (Hamlet 2019; AFAO 2021). For example, a person who identifies as a gay man from an ethnic community may have a different experience with the health care system compared with a European gay man. This means that our approach to reducing inequities should seek to influence not only the health care system but also determinants of health, such as stigma and discrimination. This approach is emphasised across the key public health frameworks, including the Ottawa Charter for Health Promotion (the Ottawa Charter).[8]

There are also gaps in our ability to identify inequities in certain population groups. For example, transgender and non-binary people and people in prisons are key groups identified as vulnerable to HIV in the UNAIDS strategy and international HIV action plans, but we do not currently have accurate data on HIV prevalence and prevention practices among these communities in New Zealand Aotearoa.

We can address these inequities if our response is grounded in, and driven by, Te Tiriti and an equity-first approach. We can commit to this by:

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[8] For information on the Ottawa Charter for Health Promotion, see the Ottawa charter for health promotion webpage on the World Health Organization website at: www.who.int/publications/i/item/ottawa-charter-for-health-promotion

1. ensuring meaningful involvement of people living with and affected by HIV and priority groups when developing and implementing our action plan
2. designing and prioritising actions based on Te Tiriti[9] and an equity-first prioritisation process that will influence the determinants of health, including stigma and discrimination
3. monitoring the success of the action plan, including specific equity indicators.

# Meaningful involvement of people living with or affected by HIV

Promoting the ongoing and meaningful involvement of people living with HIV in accordance with the Meaningful Involvement of People with HIV and AIDS/Greater Involvement of People with HIV and AIDS (MIPA/GIPA) Principle[10] and communities affected by HIV is important to achieving our vision of eliminating HIV transmission and ensuring all people living with HIV can lead healthy lives free from stigma and discrimination. This includes meaningfully involving whānau/families, if desired by people living with or affected by HIV.

This approach realises the communities' right to self-determination and participation in decision-making processes that affect their lives and helps improve the quality, effectiveness and acceptability of our response to HIV.

Recognising MIPA/GIPA in our HIV response also honours our commitment to the UNAIDS 2021 Political Declaration on HIV and AIDS, which calls for the greater involvement of people living with, at risk of and affected by HIV in leading the response. This approach aligns with key public health frameworks and underlines the commitment of New Zealand Aotearoa to the values embedded in the Ottawa Charter, which recognises the need to involve communities in setting priorities, making decisions, planning and implementing strategies that have an impact on their lives.

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[9] It is important to remember that Te Tiriti does not equate to equity, but rather it includes equity and Māori aspirations.

[10] The importance of the lived experience of people with HIV in shaping the HIV response was first noted in the Denver Principles in 1983. The MIPA/GIPA Principle was first internationally recognised in the Paris AIDS Summit Declaration in 1994 and was later adopted by UNAIDS in 2001. More information is available here: **https://data.unaids.org/pub/briefingnote/2007/jc1299_policy_brief_gipa.pdf**

# The framework of the HIV action plan

## Vision

A New Zealand Aotearoa where HIV transmission is eliminated
and all people living with HIV have healthy lives
free from stigma and discrimination

To realise this vision, we have set clear goals and objectives in our action plan. These goals have been informed by the UNAIDS Global AIDS Strategy 2021–2026,[11] the 2021 Political Declaration on HIV and AIDS and our country's STBBI Strategy.

We have also set targets for 2025 that are informed by the current UNAIDS strategy and 2021 Political Declaration on HIV and AIDS. The targets in this action plan will be updated with the global targets for 2030 when the next UNAIDS strategy is released.

### Goal 1: Reduced number of new locally acquired HIV infections

Our targets for 2025 are to:

- meet the UNAIDS target of a 90 percent reduction in locally acquired infections compared with a 2010 baseline
- sustain the low incidence of HIV among sex workers and people who inject drugs
- maintain zero cases of mother-to-child transmission.

To achieve this goal, we need to focus on increasing our knowledge and understanding of new infections and behaviours that are driving HIV transmission and increasing the uptake of combination prevention. This includes meeting the UNAIDS target of 95 percent of people who are at risk of HIV using combination prevention.

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[11] For more details, see the Global AIDS Strategy 2021–2026 webpage on the UNAIDS website at: **https://unaids.org.ua/en/about-unaids/global-aids-strategy-2021-2026**

## Goal 2: Improved Māori health and wellbeing in relation to HIV by delivering on our Tiriti o Waitangi obligations

To achieve this goal, we need to have specific actions that focus on increasing equity for Māori across outcomes for HIV. This includes ensuring we have the necessary information and surveillance to identify, understand and monitor progress on inequities and have specific actions for Māori that improve their access to combination prevention, testing, treatment, support for Māori living with HIV and reduce stigma and discrimination.

## Goal 3: Decreased mortality and the negative consequences of HIV on health and wellbeing

Our targets for 2025 are to have:

- 95 percent of people living with HIV know their status
- 95 percent of people who are diagnosed with HIV on treatment
- 95 percent of people who are on HIV treatment have viral suppression.
- no AIDS-related deaths.

To be able to achieve this, we need to focus our efforts on ensuring that people living with HIV are diagnosed early, have timely access to treatment and are able to access suitable support services. This includes ensuring we have the information necessary to continually improve HIV services and programmes.

## Goal 4: Decreased experiences of stigma and discrimination for people living with HIV

The target we aim to achieve for 2025 is the UNAIDS target of no more than 10 percent of people living with HIV experiencing stigma and discrimination.

To achieve this goal, we need to ensure that people have a better understanding of HIV and that we have better regulatory frameworks and practices that help reduce stigma and discrimination experienced by people living with HIV. We also need to address the intersecting types of stigma and discrimination experienced by different communities living with HIV, for example, racism and homophobia.

## Goal 5: Increased equity in relation to all HIV goals and objectives

To achieve this goal, we need to increase our ability to identify inequities and focus our efforts on populations that are more likely to experience HIV transmission, delayed diagnosis, poor clinical outcomes and complex and layered stigma and discrimination.

While most of our actions will focus on these key population groups, we will also develop actions for others affected by HIV.

# Priority groups

To reach our goals, we must prioritise actions for people living with HIV and communities most affected by HIV based on local epidemiology and international evidence (where local epidemiological data is limited) and our Te Tiriti obligations.

Priority groups are not fixed over time and may change according to emerging epidemiological trends. We will review the evidence for these priority groups in 2025 when we update the targets for the action plan in accordance with the latest UNAIDS strategy.

Actions implemented under this plan can also be targeted for groups that are not listed as a priority group, where relevant. The priority groups, in no particular order, are:

- people living with HIV
- gay, bisexual and other men who have sex with men
- Māori at risk of and living with HIV
- sex workers[12]
- people who inject drugs
- people who have migrated from high HIV prevalence countries[13]
- transgender and non-binary people.

## People living with HIV

A key component of our vision for New Zealand Aotearoa is for people living with HIV across all populations, including different demographics and geographical areas, to live healthy lives free from stigma and discrimination. While we have made sound progress with increasing access to effective antiretroviral treatment, we know there is much more we can do.

People living with HIV experience complex and layered stigma and discrimination which varies depending on their characteristics, such as gender and sexuality, and living conditions, such as living in rural or urban settings. Experiences of stigma and discrimination can have profound impacts on wellbeing. This includes feelings of isolation and an increased risk of developing mental health conditions such as depression and anxiety. It is important that people living with HIV can access appropriate mental health and support services when required.

There are diverse people living with HIV in New Zealand Aotearoa, and that brings a diverse range of needs. For example, women living with HIV have additional health needs, including reproductive health care, such as cervical screening and advice on breastfeeding. Likewise, older people living with HIV may require additional supports to prevent and treat comorbidities. It is important that our response to HIV recognises the broad range of health care needs of people living with HIV.

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[12] Including migrant sex workers.

[13] Including people who may be ineligible for funded health care.

## People who inject drugs

In New Zealand Aotearoa, we have a low incidence of HIV transmission among people who inject drugs compared with other countries. We need to maintain this trend. People who inject drugs are a priority group because of the potential risks associated with needle and syringe sharing, the increased challenges surrounding accessing adequate health care for people who inject drugs and the risk of rapid spread if HIV were to enter these networks.

## Gay, bisexual and other men who have sex with men

Gay, bisexual and other men who have sex with men constitute the largest population at risk of HIV transmission among those living with HIV in New Zealand Aotearoa. Targeted action is needed to reduce the number of new infections among this group. Among gay, bisexual and other men who have sex with men, there are subgroups whose vulnerability to HIV impacts is amplified by other factors. Even though we have started to see decreases in local HIV incidence among gay, bisexual and other men who have sex with men, not all are equitably accessing and benefitting from combination prevention. Sub-communities who may require a tailored response to fully benefit from HIV prevention and care include Māori, Asian and Pacific peoples; recent migrants and international students; people who are ineligible for publicly funded health care; those engaging in transactional sex and those who do not identify as gay or bisexual but have sexual contacts with other men.

## Māori at risk of and living with HIV

Māori at risk of HIV include Māori gay, bisexual and other men who have sex with men, Māori who inject drugs, Māori sex workers and Māori transgender and non-binary people. Prioritising Māori communities at risk of HIV, along with Māori living with HIV, is an integral part of honouring our commitment to the principles of Te Tiriti: tino rangatiranga, partnership, active protection and equity. This includes taking action to address the stigma and discrimination experienced by Māori people living with HIV and reducing the inequitable outcomes of Māori gay, bisexual and other men who have sex with men presenting late to health care services with advanced HIV.

## Sex workers

The prevalence of HIV among sex workers is low in New Zealand Aotearoa compared with other countries. However, sex workers (including those who only engage in sex work occasionally) remain a key priority group because they face additional barriers to health care, such as stigma and discrimination, and the risk of rapid spread could be increased if HIV were to enter this network.

## People who have migrated from high HIV prevalence countries

Refugees and migrants from countries with high HIV prevalence may have experienced substantially higher levels of HIV risk throughout their lives. This is particularly relevant for ethnic communities living in New Zealand Aotearoa. For example, despite the African community only accounting for less than 0.4 percent of our country's population, 13.4 percent of people who ever reported to be living with HIV in New Zealand Aotearoa have been African. Most of the infections among African people have been acquired overseas before moving to New Zealand Aotearoa.

Changing global epidemiological patterns can lead to shifts in HIV prevalence among migrants, and our response needs to be driven by high-quality data that is able to identify populations most affected in a timely manner.[14]

We also need to improve access to HIV prevention, testing and care for refugees and migrants from high HIV prevalence countries, including people who are ineligible for funded health care (for example, seasonal workers and international students). It is also important that we focus on improving the cultural responsiveness of the health care system for minority groups, including ethnic communities.

## Transgender and non-binary people

Internationally, transgender and non-binary people are more likely to be affected by HIV than the general population (Kirwan et al 2021). In New Zealand Aotearoa, we may have a low incidence of HIV in the transgender and non-binary communities. Overseas, the high HIV incidence among transgender communities may be driven by increased risk associated with sex work or injecting drug use. These practices may be more common among some transgender and non-binary populations globally (Poteat et al 2017), however, they carry relatively lower risk for HIV acquisition in New Zealand Aotearoa compared with many other countries. The most vulnerable parts of the transgender and non-binary community in New Zealand Aotearoa are likely to be people whose sexual networks include gay, bisexual and other men who have sex with men.

There is limited local data on transgender and non-binary people and HIV, and this knowledge gap needs to be addressed.

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[14] In New Zealand Aotearoa, HIV testing is a mandatory requirement for quota refugees and migrants applying for long-term visas. Other refugees may have an HIV test once they are in New Zealand Aotearoa as part of a resettlement health check.

# Priority settings

Priority settings are places where key activities such as prevention and health promotion, testing, treatment and support for people living with HIV can take place.

For this action plan, the priority settings, in no particular order, are:

- primary health care
- community-led HIV health promotion, services and outreach
- prisons
- kaupapa Māori services
- specialised health care.

Most of our actions will take place in priority settings. However, we acknowledge there are other settings, such as antenatal care and inpatient settings; mental health, aged care and substance and harm reduction services; and educational settings that are also important. The HIV action plan will also contain specific actions for these other settings.

## Primary health care

Primary health care is professional health care provided in the community, usually from a general practitioner (GP), practice nurse, nurse practitioner, pharmacist or other health professional working within a general practice.[15] This includes non-governmental organisations that provide primary care sexual health services.

Primary health care is usually the first point of contact within the health care system and reaches a large proportion of our priority populations. Only half of gay, bisexual and other men who have sex with men in New Zealand Aotearoa believe their GPs are aware of their sexual orientation (Ludlam et al 2015), and we know that only 29 percent of HIV-negative gay, bisexual and other men who have sex with men reported having a comprehensive sexual health screening in the previous year (Kolodziej and Saxton 2021). Actions are needed to improve responsiveness to priority populations.

## Community-led HIV health promotion, services and outreach

The UNAIDS 2021 Political Declaration on HIV and AIDS places a strong focus on building the capacity and capability of community-led health promotion, services and outreach. Community organisations have a strong understanding of the needs and desires of the communities they serve and have easier access to provide services and messaging to these communities. The community settings are wide ranging and may include sex-on-site venues, online spaces (for example, dating applications) and peer

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[15] You can find out more about the Ministry's official definition of primary care from the Primary health care webpage at: **www.health.govt.nz/our-work/primary-health-care**

support in non-clinical settings. A range of activities can take place here, such as prevention, testing, links to care options and support for people living with HIV.

## Prisons

There are currently gaps in knowledge on HIV prevalence, transmission, treatment and support within prisons in New Zealand Aotearoa. We need up-to-date and accurate data to ensure people living with HIV in custodial settings can access the care they need, and prison populations have access to adequate HIV prevention and testing.

## Specialised health care

For this action plan, specialised health care specifically relates to specialised sexual health and infectious disease care.

It is important that people living with HIV and our other priority populations have good access to culturally competent specialist sexual health prevention, treatment and care. We know that significant barriers to accessing specialised sexual health care persist and include limited geographic coverage and appointment times, as well as cultural barriers (Miller 2010).

We recognise that sexual health clinics may continue to be the first point of contact for many people from priority populations for whom there are barriers to accessing basic sexual health care through primary health care services. This requires capacity building and support to continue providing these services and better integrate specialist expertise with primary health care to best serve people in their communities. Innovative ways of working that engage with community organisations and people in their environments will also be encouraged and supported.

## Kaupapa Māori services

Focusing on kaupapa Māori health services is a part of honouring our obligations under Te Tiriti. Kaupapa Māori health services include those provided by Māori health organisations, mainstream organisations providing kaupapa Māori services and Māori health providers that sit outside an organisation, such as rongoā practitioners. Supporting kaupapa Māori health organisations will be critical in reducing inequities for Māori at risk of and living with HIV as such organisations have a strong understanding of the needs and aspirations of Māori communities.

We must ensure that that mainstream health services are also able to provide culturally safe and effective health programmes and interventions so that Māori are not disadvantaged by their choice of services.

# Focus areas

The actions outlined in this plan are grouped into four focus areas that will contribute to our vision over the next 10 years. These focus areas are:

1. surveillance, information and knowledge systems
2. combination prevention and health promotion
3. testing and linkage to care
4. support for people living with HIV, including addressing stigma and discrimination.

Each focus area outlines objectives and the actions that we need to take to address the gaps and challenges in each area. The actions have also been identified based on our obligations to Te Tiriti, equity and meaningful involvement of people living with or affected by HIV.

**Figure 2: Summary of overarching framework of the strategy**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| International and New Zealand Aotearoa strategic context | Te Tiriti o Waitangi | | | | | | | |
| | UNAIDS Global AIDS Strategy 2021–2026 | UNAIDS 2021 Political Declaration on HIV and AIDS | Global Health Sector Strategy on HIV 2016–2021 (WHO 2016) | | | | | |
| | New Zealand Health Strategy: Future directions (Ministry of Health 2016) | Sexually Transmitted and Blood Borne Infection Strategy | He Korowai Oranga: Māori Health Strategy (Ministry of Health 2002) | | | | | |
| | Whakamaua: Māori Health Action Plan 2020–2025 (Ministry of Health 2020b) | Ola Manuia: Pacific Health and Wellbeing Action Plan 2020–2025 (Ministry of Health 2020a) | | | | | | |
| | Consensus statement on comprehensive HIV prevention | Aotearoa Statement on Closing the Gap on STIs and BBVs among Indigenous Peoples of Australasia | | | | | | |
| Vision | A New Zealand Aotearoa where HIV transmission is eliminated and all people living with HIV have healthy lives free from stigma and discrimination | | | | | | | Evaluation and monitoring |
| Goals | Reduced number of new locally acquired HIV infections<br>(UNAIDS target: 90% reduction)<br>(Sustain the low incidence of HIV among sex workers, people who inject drugs, and zero cases of mother-to-child transmission of HIV) | Improved Māori health and wellbeing in relation to HIV by delivering on our Tiriti o Waitangi obligations | Decreased mortality and the negative consequences of HIV on health and wellbeing<br>(No AIDS-related deaths) | Decreased experiences of stigma and discrimination for people living with HIV<br>(UNAIDS target: No more than 10% of people living with HIV experiencing stigma and discrimination) | Increased equity in relation to all HIV goals and objectives | | | |
| Objectives | Increased ability to identify inequities in HIV outcomes and monitor progress towards our goals | Increased information to improve HIV prevention and care programmes | Increased uptake of combination prevention<br>(UNAIDS target: 95% of people who are at risk of HIV use combination prevention) | Increased timely testing, diagnosis, and treatment<br>(UNAIDS target: 95% of people living with HIV know their status)<br>(UNAIDS target: 95% of people diagnosed with HIV are on treatment and 95% of people on HIV treatment have viral suppression) | Increased access to culturally appropriate support services for people living with HIV | Improved regulatory frameworks and practices to reduce stigma and discrimination against people living with HIV | | |
| Focus areas | Surveillance, information and knowledge systems | Combination prevention and health promotion | Testing and linkage to care | Support for people living with HIV, including addressing stigma and discrimination | | | | |
| Priority groups | People living with HIV | People who inject drugs | Gay, bisexual and other men who have sex with men | Māori at risk of and living with HIV | Sex workers | People who have migrated from high HIV prevalence countries | Transgender and non-binary people | |
| Priority settings | Primary health care | Community-led HIV health promotion, services and outreach | Prisons | | | | | |
| | Kaupapa Māori services | Specialised health care | | | | | | |

# Surveillance, information and knowledge systems

Surveillance, information and knowledge systems are essential for targeted and effective public health actions. These systems provide the information we need to identify gaps in our HIV response, including inequitable HIV outcomes, and what actions we can take and prioritise to make our HIV response better.

## What are the current opportunities and challenges?

The World Health Organization (WHO) recommends that in countries with concentrated epidemics, such as New Zealand Aotearoa, where incident infections are concentrated among gay, bisexual and other men who have sex with men, surveillance should focus on groups with high HIV prevalence and on behaviours that may lead to rapid spread of HIV (WHO 2013). We currently have inconsistent surveillance of these behaviours, and this limits our understanding of what action is needed in our HIV response.

We do not conduct seroprevalence studies and behavioural surveillance at regular intervals or systematically collect data on the use of combination prevention, including PrEP, testing rates and quality of care. This makes it difficult to prioritise actions and limits our ability to evaluate our response and monitor progress towards our goals and targets.

We also have gaps in our understanding of the experiences of communities at risk of and living with HIV, including identifying and addressing inequities. At a national level, we need to improve our surveillance systems to better capture the experiences of transgender and non-binary people and ensure that we have accessible data disaggregated by ethnicity and sexuality, and we need to promote meaningful inclusion of communities affected by or living with HIV in our data collection. At a local level, we need to support the HIV workforce to be able to do appropriate evaluations and to support community-led monitoring of the HIV response.

We also have research gaps for people living with or at increased risk of HIV. This includes understanding the factors that may lead to increased risk of late diagnosis, identifying opportunities for earlier linkage to care and understanding ageing-related co-morbidity, mortality, and quality of life among people living with HIV. We also need to better understand the experiences of people living with HIV who are not part of a support organisation, older people, transgender and non-binary people, and Māori living with HIV.

## What can we do?

We need to have a better understanding of recent HIV infections (including undiagnosed infections) across geographical areas and demographics to ensure we can be more targeted in our HIV response. We also need to have a better understanding of modifiable behaviours that are driving HIV transmission to inform prevention efforts.

Achieving this will require improved data collection, analysis and application. At the national level, we can improve systematic collection of data on the use of combination prevention, including PrEP eligibility and uptake, testing rates, quality of care and seroprevalence and behavioural studies for populations most affected by HIV. At a local level, we can support clinical services and community organisations to undertake research and data analysis through clinical audits, programme evaluations and community-led monitoring. We also need to foster innovation and research to help us understand transmission clusters and emerging trends and bring together national and local HIV actors to encourage data-sharing and using data to drive action. The specific actions we need to undertake are outlined below.

# Focus area 1: Surveillance, information and knowledge system actions

## Improving national surveillance

1a) Conduct regular behavioural surveillance among gay, bisexual and other men who have sex with men (at least every two to three years) to track modifiable behaviours driving HIV transmission, including combination prevention knowledge, uptake, access and acceptability, for example, through PrEP cascade. Data should be carefully disaggregated to enable equity to be monitored as well.

1b) Conduct regular seroprevalence surveillance to identify: the prevalence of HIV among relevant priority populations at risk of local acquisition of HIV, the proportion of people living with HIV who are undiagnosed and the factors that may lead to living with undiagnosed HIV. Opportunities to collect seroprevalence data on co-infections should also be maximised.

1c) Work with Ara Poutama Aotearoa, the Department of Corrections, to improve HIV monitoring for people in prisons.

1d) Ensure HIV surveillance captures the experiences and needs of transgender and non-binary people.

1e) Increase Māori data sovereignty in HIV-related surveillance and ensure that Māori at risk of or living with HIV are meaningfully involved in the process.[16]

## Increasing regular and consistent monitoring and evaluation at a national and local level

1f) Ensure regular monitoring of HIV testing rates, disaggregated by key demographics and sexual behaviour where possible. This should involve reviewing HIV testing data collection and anonymised data sharing with relevant agencies tasked with HIV and AIDS surveillance, including community-led testing.

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[16] An approach to data sovereignty from whakamaua is being developed by the Ministry of Health.

1g) Develop a framework to enable consistent monitoring of issues affecting people living with HIV, such as stigma and discrimination, ageing-related co-morbidity and quality of life measures (for example, through patient-reported outcomes).

1h) Develop a monitoring plan and undertake regular reporting on progress towards the goals and targets outlined in this action plan.

1i) Strengthen the ability of the HIV workforce and community organisations to undertake research and data analysis, for example, by undertaking clinical audits, community-led monitoring and programme evaluations. The focus should be on identifying and addressing inequities.

## Increasing innovation and research

1j) Explore the feasibility of using novel technologies, such as phylogenetic analysis and recency testing, to improve our understanding of transmission clusters and emerging trends in incident infections. This process must involve people living with HIV in a meaningful way to ensure we develop an ethical process for data collection and analysis.

1k) Encourage future HIV research to address knowledge gaps for people living with HIV. This includes understanding the factors that may lead to an increased risk of late diagnosis, identifying opportunities for earlier links to care and understanding the experiences of people who are not part of a support organisation, older people, women, transgender and non-binary people, and Māori living with HIV.

## Increasing national and local leadership and collaboration

1l) Establish an expert advisory group to guide the implementation and monitoring of the action plan. This group must include people living with and affected by HIV, Māori and the health sector.

1m) Continue funding and supporting the six-monthly HIV forum to support collaboration and sharing innovative and successful approaches. This includes improving mainstream services’ responsiveness to the needs of people living with and affected by HIV, Māori health development and supporting kaupapa Māori approaches.

# Combination prevention and health promotion

The HIV action plan supports the combination prevention approach as defined by UNAIDS. UNAIDS defines combination HIV prevention as being rights-, evidence-, and community-based programmes that promote a combination of biomedical, behavioural and structural interventions designed to meet the HIV prevention needs of specific people and communities (UNAIDS 2010). This includes supporting a range of prevention tools, programmes and strategies, such as the use of condoms, in conjunction with lubricants, PrEP, (post-exposure prophylaxis) PEP, harm reduction among people who inject drugs (such as needle exchange programmes), STI vaccination, screening and treatment and early HIV diagnosis followed by prompt initiation of antiretroviral therapy (ART) with appropriate support to remain in care and achieve and maintain viral suppression. The purpose of having a sustained and specific focus on combination prevention is to reduce new HIV infections. This will be particularly important because making gains in prevention may become more challenging as we move closer to the goal of eliminating HIV transmission.

## What are the current opportunities and challenges?

In New Zealand Aotearoa, the current uptake of combination prevention falls short of the 95 percent target outlined in the action plan. Recent research (Saxton et al 2021a) showed that, among a cohort of New Zealand Aotearoa gay, bisexual and other men who have sex with men reporting casual sex, only 27.4 percent consistently used condoms for anal sex, 22.7 percent used PrEP, 6.2 percent reported living with HIV and relying on undetectable viral load as a method of HIV prevention and 31.8 percent of the study participants reported condomless anal sex and no PrEP use.

Condoms continue to be an important component of the combination prevention toolbox. They are inexpensive and are not only effective in preventing HIV transmission but can also reduce the risk of transmitting other STIs and prevent unwanted pregnancies. Condom use has likely been decreasing in New Zealand Aotearoa for several years. We need to ensure there is sustained action to support condom use among the general population, but with a particular focus on those at increased risk of acquiring HIV.

There are also access barriers and inequities in PrEP uptake that need to be addressed. In New Zealand Aotearoa, it is estimated that 5,847 individuals meet the criteria for PrEP. However, according to community dispensing data, only 1,648 individuals (one-quarter of those eligible) had their PrEP prescriptions initiated or renewed in the previous three months, indicating continuous PrEP use.[17] Moreover, PrEP uptake may be lower among Māori and Pacific gay, bisexual and other men who have sex with men than among those of European ethnicity, suggesting additional barriers to accessing culturally appropriate health care. Other barriers include insufficient knowledge about PrEP and PEP among communities at risk of HIV, only a small number of prescribers

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[17] Requested from PHARMAC as of February 2021

willing to offer PrEP (especially in rural areas), the need to disclose sensitive information to the prescriber and inconsistent criteria to access PrEP and PEP.

# What can we do?

To increase uptake of combination prevention, we need improve access to and awareness of prevention tools. We can achieve this through social marketing and education programmes as well as by improving clinical services' ability to provide culturally appropriate care. We also need to explore opportunities for community-led outreach, removing barriers to accessing PrEP and PEP and ensuring access to new and innovative technologies, such as injectable PrEP.

The specific actions we need to take are outlined in further detail below.

# Focus area 2: Combination prevention and health promotion actions

## Social marketing and programmes for communities at risk of HIV

2a) Support community-led social marketing and education programmes for gay, bisexual and other men who have sex with men to increase demand and uptake of combination prevention,  particularly amongst groups with low uptake such as Pacific gay, bisexual and other men who have sex with men. This includes destigmatising PrEP and PEP use, increasing knowledge of dosing regimens, appropriate maintenance testing and ways to access combination prevention.

2b) Support Māori health organisations to delivery community-led social marketing for Māori at risk of HIV to increase the uptake of HIV combination prevention. Māori at risk of HIV should be meaningfully involved in the developing and implementing the campaign.

2c) Support the delivery of programmes that increase knowledge and access to combination and HIV prevention for communities that have migrated from high HIV prevalence countries.

2d) Sustain investment in prevention initiatives for priority groups that currently have a low incidence of HIV, such as sex workers and people who inject drugs. This includes initiatives to increase access to combination prevention and harm reduction initiatives, such as access to sterile injecting equipment.

2e) Deliver programmes that address emerging practices that may increase the risk of HIV acquisition, such as sexualised drug use and chemsex[18] amongst gay, bisexual and other men who have sex with men.

## New and innovative technologies and service delivery methods

2f) Investigate piloting new combination prevention technologies, such as injectable PrEP or other emerging methods of combination prevention.

2g) Investigate removing special authority criteria for PrEP and aligning PrEP and PEP prescribing to increase access.

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[18] Engaging in sexual acts while under the influence of stimulant drugs, such as methamphetamines.

2h) Expand and promote telehealth services in rural areas to increase access to combination prevention.

2i) Investigate new models to increase access to PrEP and PEP delivery. This could include establishing models for nurse-led PrEP and PEP delivery (including nurse prescribers in primary health care services) and piloting new models for delivery, such as telehealth, community-led and delivered initiatives, and provision in pharmacies.

2j) Investigate new sustainable models to increase access to PrEP and PEP for migrants at risk of HIV who are unable to access funded health care, for example, seasonal workers and international students.

## Workforce training, guidelines and resources

2k) Work with Māori and community health organisations to develop and deliver culturally appropriate health promotion resources on combination prevention for health care providers to use and distribute to patients at risk of HIV. A single repository should be created for these resources.

2l) Promote and regularly review clinical guidance for appropriate PrEP and PEP prescribing in primary health care services. This includes reviewing guidance for partners of people living with HIV.

2m) Work with community organisations to develop and promote continuing medical education accredited national training and education for primary health care services, including in rural areas. This includes training and education to:

- increase knowledge and awareness of HIV and combination prevention
- increase the number and availability of PrEP and PEP prescribers
- encourage HIV prevention methods to be delivered in combination with education on STI prevention and regular testing.

## Cross-government actions on HIV combination prevention

2n) Work with Ara Poutama Aotearoa, the Department of Corrections, to ensure people in prisons have access to up-to-date and effective health education and combination prevention, such as condoms, PrEP, PEP and treatment as prevention (TasP).

2o) Work with the Ministry of Education and schools on the inclusion of information on HIV in relationships and sexuality education in English Māori-medium settings. This includes information on combination prevention, testing, access to confidential care, and HIV stigma and discrimination.

2p) Encourage regulatory environments to support harm reduction measures that reduces the risk of HIV and STI transmission. This includes safer alkyl nitrites use among gay, bisexual and other men who have sex with men and other harm reduction interventions for sexualised drug use.

2q) Sustain the current delivery of combination prevention tools, such as condoms and lubricants, to populations at risk of HIV and explore opportunities to fund and promote non-latex and internal condoms and lubricants.

# Testing and linkage to care

Early detection of HIV and prompt linkage to appropriate care is critical to ensure people living with HIV can enjoy healthy lives and no secondary HIV transmission occurs. Those who have tested negative can also be linked to prevention programmes.

## What are the current opportunities and challenges?

In New Zealand Aotearoa, we know there are barriers to accessing testing. For example, research suggests one-fifth of people living with HIV may be unaware of their HIV status (Saxton et al 2012) and preliminary data from the AIDS Epidemiology Group at the University of Otago shows that, between 2016 and 2020, 38.3 percent of newly diagnosed gay, bisexual and other men who have sex with men, and 52.2 percent of newly diagnosed heterosexuals had CD4 cell counts of less than 350 cells/mm$^3$ or an AIDS diagnosis within three months of their HIV diagnosis, suggesting late diagnosis.

We also know that barriers to testing are particularly worse for certain communities, such as rural communities, recent migrants including international students and seasonal workers, and people who experience stigma and discrimination related to their identities or practices. For example, accessing testing is expensive for migrants who are not eligible for publicly funded health care. Additional barriers exist for those at increased risk of HIV acquisition, including a lack of Rainbow-friendly services[19] for gay, bisexual and other men who have sex with men especially in rural areas and for Māori.

There are also specific challenges in treating HIV in New Zealand Aotearoa for different communities. For example, there may be an unmet health need for those with chronic hepatitis B co-infection and other significant co-morbidities and a need for improved and holistic health management for ageing people living with HIV. There are also reports that women living with HIV do not always receive appropriate access to reproductive services and advice.

Timely and comprehensive contact tracing for HIV are important when a person is recently diagnosed with HIV. Currently, there is limited capacity to conduct contact tracing and there is a need to ensure that people recently diagnosed with HIV are well supported through the contact tracing process.

## What can we do?

We need to ensure there is access to culturally appropriate HIV testing for people concerned about HIV acquisition, especially priority populations. For people who are diagnosed with HIV, initiating rapid access to treatment and support services is crucial alongside timely and sensitive contact tracing. To achieve this, we need to increase awareness about the importance of HIV testing and treatment and improve the capacity and quality of clinical services. This includes exploring new service delivery methods that reach into communities, improving the capability of primary health care

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[19] 'Rainbow' is the umbrella term commonly used to encompass the community of people who identify as lesbian, gay, bisexual, transgender, queer and/or questioning, intersex, asexual and or ally.

services to provide HIV treatments and investigating new testing technologies, such as dried blood-spot testing.

The specific actions that we need to take are outlined in further detail below.

# Focus area 3: Testing and linkage to care actions

## Workforce training and guidance

3a) Regularly review and promote guidelines for STI and HIV testing for primary health care services.

3b) Develop guidance on anal cancer screening for gay, bisexual and other men who have sex with men living with HIV.

3c) Develop and promote continuing medical education (CME) accredited national training and education for the primary health care sector on testing, screening and linkage to care to ensure:

- provision of comprehensive HIV and STI screening for gay, bisexual and other men who have sex with men, especially if they are accessing PrEP
- HIV testing is offered to people with clinical presentation suggestive of HIV infection or with indicator conditions, including to people who do not belong to populations that are identified at higher risk of HIV
- appropriate links to treatment and support for people newly diagnosed with HIV, including education about 'undetectable equals untransmissible' (U=U, ASHM 2020) and the rights of people living with HIV.

3d) Develop and promote workforce training and guidance to primary health care services and sexual health clinics to improve contact tracing and partner notification for people who are newly diagnosed with HIV and those who do not have viral suppression. Community organisations and people living with HIV must be meaningfully involved in the process of developing training and guidance.

3e) Work with community organisations to develop and promote workforce guidance and training to improve the Rainbow friendliness of primary care services, including for gay, bisexual and other men who have sex with men and transgender and non-binary people.

3f) Work with Māori health organisations to develop and promote workforce training and guidance to improve the cultural competency of primary health care services and increase access to testing for Māori at risk of acquiring HIV.

3g) Work with local providers to support regular clinical audits to identify and understand the experiences of people living with HIV who have poor treatment outcomes and identify opportunities for improvement.

3h) Work with the New Zealand College of Midwives to develop national guidance and training for Lead Maternity Carers (LMCs) and midwives on providing appropriate care and advice to women living with HIV.

## New and innovative technologies and service delivery methods

3i) Pilot dried blood-spot testing and investigate opportunities for scaling up.

3j) Explore expanding and promoting innovative testing and outreach delivery models for people at risk of HIV, including telehealth, self-testing, community-based testing and rapid point-of-care testing and in a variety of settings, such as pharmacies.

3k) Explore piloting new and innovative ways to improve the capacity of the clinical workforce to contact trace, such as developing contacting tracing apps or peer-led models of contact tracing.

3l) Investigate the feasibility and cost effectiveness of increasing opportunistic testing in primary health care and hospital settings to ensure early detection of HIV. This includes investigating opt-out models for testing in collaboration with community organisations.

3m) Investigate pathways to increase access to affordable testing for migrants at risk of acquiring HIV who are not eligible for funded health care, such as international students and seasonal workers.

## Collaboration and integration between health services and community organisations

3n) Strengthen links between primary health care services and community organisations to increase access to peer support services for people newly diagnosed with HIV.

3o) Increase the capacity and capability of the peer workforce to conduct contact tracing for people newly diagnosed with HIV in collaboration with primary and sexual health care services.

3p) Work with community organisations to support rapid point-of-care testing in primary health care settings where appropriate.

## Social marketing programmes and services for communities at risk of or living with HIV

3q) Support Māori health organisations to develop initiatives to increase HIV testing among Māori at risk of acquiring HIV.

3r) Pilot community-led targeted interventions to increase HIV and STI screening among gay, bisexual and other men who have sex with men who are engaging in sexualised drug use and chemsex.

3s) Develop and deliver targeted education and promotion of regular HIV and STI screening for gay, bisexual and other men who have sex with men, including promoting the importance of regular asymptomatic screening.

3t) Work with community organisations and people living with HIV to develop social marketing that promotes the benefits of rapid HIV treatment initiation and adherence for people living with HIV.

3u) Investigate scaling up peer education and support services to encourage rapid HIV treatment initiation and improving adherence to treatment for people living with HIV.

## Broader population screening services

3v) Sustain the antenatal screening programme for HIV.

# Support for people living with HIV, including addressing stigma and discrimination

HIV-related stigma and discrimination are common in New Zealand Aotearoa. One-third of people living with HIV who participated in the New Zealand Stigma Index Project reported experiencing stigma and discrimination in 2020. HIV-related stigma and discrimination can also be amplified by intersecting it with the stigma associated with a person's gender, sexuality, drug use or sex work. These experiences of stigma and discrimination have a significant impact on the wellbeing of people living with HIV and health behaviours such as adherence to HIV treatment and retention in care. In 2020, the Stigma Index report showed that one-third of people living with HIV surveyed reported internalised stigma, for example, feeling 'dirty' and 'worthless' and nearly half had a mental health condition, such as depression and anxiety.

## What are the current opportunities and challenges?

People living with HIV experience stigma and discrimination at both a policy and health care delivery level. At the policy level, there are reports of the police and courts disproportionately applying criminal justice approaches to HIV exposures rather than taking a public health approach. In terms of immigration policy, recent migrants at risk of or diagnosed with HIV may be discouraged from timely testing because of a fear of experiencing problems when applying for visas in the future.

At a health care service level, people living with HIV report experiences of stigma and discrimination, particularly in non-HIV-specific health care and in rural areas. This includes experiences of their HIV status being disclosed without their consent. It is particularly concerning in contexts where people living with HIV are unaware of their rights (including their rights to privacy and confidentiality), find the process of reporting discrimination complicated and are either fearful of retaliation or have low trust in the system.

More needs to be done to support Māori people living with HIV. The Stigma Index Māori participant report noted that Māori takatāpui, gay, bisexual and other men who have sex with men living with HIV experienced a poorer sense of belonging within mainstream gay networks and lacked access to culturally appropriate support services. This included services grounded in a kaupapa Māori approach to wellbeing that considered whānau/family, friends and communities, and wider environments (Te Whāriki Takapou 2021).

## What can we do?

We need to challenge stigma experienced by people living with HIV and ensure they have access to appropriate support services. We can achieve this by increasing access to counselling services and focusing on connecting and empowering people living with HIV through support groups, programmes and resources. We also need to drive anti-stigma and anti-discrimination initiatives within and outside the health sector. This includes social marketing initiatives for the wide public and resources and training that can be implemented in the health sector and wider workplaces.

## Focus area 4: Support for people living with HIV, including stigma and discrimination actions

### Initiatives that empower and connect people living with HIV

4a) Investigate scaling up face-to-face and online counselling services to support people living with HIV who are experiencing issues such as anxiety and depression, particularly people living outside the main centres, where stigma and discrimination are reportedly higher.

4b) Work with community organisations, including peer-led organisations, to develop and promote national resources for people living with HIV, with a specific focus on their rights to privacy and confidentiality. This should include information on support seeking, disclosure, how medical records are stored and current complaints processes if they are discriminated against. Resources must also be tailored for Māori and culturally diverse groups.

4c) Work with the Human Rights Commission, Health and Disability Commissioner and Privacy Commissioner to promote existing complaints reporting mechanisms to ensure people living with HIV can report discriminatory practices.

4d) Investigate scaling up peer- and community-led programmes and resources that focus on connecting and empowering people living with HIV, for example, programmes that provide peer support, build life skills, improve health literacy or provide information about the rights and responsibilities of people living with HIV. Programmes and resources must also be tailored for culturally diverse groups.

4e) Support the development of a Māori peer-led organisation that focuses on connecting and empowering Māori people living with HIV.

4f) Support initiatives that increase the ability of people living with HIV to advocate for their rights and health care needs in health services, programmes and policies.

### Cross-government action to reduce stigma and discrimination

4g) Work with government organisations to address legislation, policies and approaches that perpetuate stigma and discrimination against people living with HIV or negatively influence health-seeking behaviours. This includes working with the Ministry of Justice to ensure a public health approach is taken when responding to any concerns about HIV exposure.

### Anti-stigma and discrimination initiatives for the health sector and wider workplaces

4h) Work with community organisations, including peer-led organisations, to develop and promote national resources on HIV for workplaces. This should include focusing on the importance of non-discrimination in the workplace, the consequences of breaching privacy and confidentiality, and how to support colleagues who recently disclose that they are living with HIV.

4i) Develop and deliver workforce education and training to primary health care services to reduce stigma and discrimination against people living with HIV. This includes education and training for:

- clinical staff on how to support people living with HIV
- clinical and non-clinical staff, such as managers and reception staff, on the privacy and confidentiality rights of people living with HIV.

## Anti-stigma and discrimination initiatives for the wider public

4j) Develop a social marketing campaign to challenge stigma and discrimination experienced by people living with HIV. There must be meaningful involvement of Māori and other ethnic groups living with HIV in the development of the campaign.

4k) Support the development of a social marketing campaign that is by and for Māori people living with HIV and their whānau/families.

# Implementation

The HIV action plan will be delivered in phases, with each phase outlined in an implementation plan. The implementation plan is a shorter-term plan that prioritises work for up to four years based on the funding and resources available. The implementation plan includes information on how to best develop activities so they are more likely to meet our Tiriti o Waitangi obligations and reduce inequities. It assigns timeframes, milestones and lead agencies responsible for delivering each action in the plan. The lead agency will be responsible for coordinating and supporting the activity and monitoring and reporting against measures of success.

An implementation plan for 2022 to 2025 will be developed to guide the first phase of work. A Tiriti approach will be taken to implement the action plan, including partnerships between relevant entities, such as Te Aka Whai Ora, the Māori Health Authority, and meaningful involvement of people living with or affected by HIV. Actions that are included in this first phase of work will be determined by using a Tiriti and equity-first prioritisation approach as well as engagement with the sector.

Before developing the implementation plan for the second phase of work, we will update the action plan with the latest UNAIDS targets as well as review the epidemiology to ensure we are prioritising the right populations.

As part of the implementation, we will also develop a monitoring plan. This will monitor the progress and success of our actions as well as whether we are meeting targets. The monitoring plan will specify a small number of indicators selected because they are:

- central to showing the success of the action plan
- cost effective to measure
- SMART (specific, measurable, attributable, realistic and time bound).

There will also be specific indicators to ensure that we are addressing Māori health and enhancing equity.

The monitoring plan will include details of who is responsible for collecting, collating and analysing the data and the mechanisms for reporting back.

We will also use the commissioning cycle and contract management (including monitoring service delivery and outcomes) to ensure we are appropriately commissioning and designing services and programmes, implementing activities in a quality manner and achieving the best outcomes for priority groups and communities.

# Abbreviations

| | |
|---|---|
| AIDS | Acquired immunodeficiency syndrome |
| ART | Antiretroviral therapy |
| CME | Continuing medical education |
| ESR | Institute of Environmental Science and Research |
| GP | General practitioner |
| HIV | Human immunodeficiency virus |
| LMC | Lead Maternity Carer |
| MIPA/GIPA | Meaningful Involvement of People with HIV and AIDS / Greater Involvement of People with HIV and AIDS |
| PHARMAC | Pharmaceutical Management Agency |
| PrEP | Pre-exposure prophylaxis |
| PEP | Post-exposure prophylaxis |
| STI | Sexually transmitted infection |
| STBBI | Sexually transmitted and blood-borne infections |
| TasP | Treatment as prevention |
| UNAIDS | The Joint United Nations Programme on HIV and AIDS |
| U=U | Undetectable equals untransmissible |

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