Twenty five years of HIV prevention for gay men in New Zealand
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New Zealand AIDS Foundation **18 September, 2010**

(Slide one here: Title page)
Tēnā koutou katoa. Welcome everyone.

We're here tonight to mark 25 years of HIV prevention and support in New Zealand, so I'd like to open by casting memory back to the circumstances under which this work was started in 1985.

I want to begin by asking you to take a moment to think about a group of your friends. They are healthy, and mostly in their twenties, thirties and forties. Now imagine a situation where over just a few months, and without any warning, large numbers of them become seriously ill. No-one has any idea what is causing this, and you are afraid that you too may become sick at any time.

That is exactly the position that gay men living in San Francisco, New York and Los Angeles found themselves in between 1983 and 1984. In that two year period alone, more than six and a half thousand deaths from AIDS were reported in the United States.

It was awareness of this appalling health crisis, and the realisation that it was likely to happen here as well if nothing was done, that led a group of people to start building a local response to what we now know as the HIV epidemic.

For those with an interest in politics, this was a classic social movement. It collected together a diverse group of gay men, their friends and families - as well as other key allies from the health, legal, academic and media sectors - to support people with AIDS, prevent the transmission of whatever was causing AIDS, protect the human rights of those most affected by AIDS, and build up science-based knowledge about AIDS.

Those four streams of activity began to flow together in March 1985 when the AIDS Support Network Trust was formed. This became the first national AIDS organisation in New Zealand, and it is very important to acknowledge here that its existence owed most to the compassion, insight and determination of Bruce Burnett. Bruce was unwell himself by this time, and he died of AIDS in June 1985.

The establishment of the Trust also enabled the Department of Health as it was then called to provide over $100,000 to fund the first national advertising campaign on AIDS. This had general reach, but its main target audience was gay and bisexual men.

That campaign was launched in August 1985 - in the same month that the AIDS Support Network was re-named the New Zealand AIDS Foundation - and it included the most accurate safe sex guidelines that we could put together. They were based on Bay Area Physicians for Human Rights and San Francisco AIDS Foundation models, updated with the latest data from the First International AIDS

Conference which had been held in April, and at which it was officially announced that HIV was the cause of AIDS. **(Slide two here: HIV picture)**

In retrospect it is clear that one of the greatest strengths of the early New Zealand health response was a willingness to empower the groups that were at highest risk to design their own prevention programmes. Grass roots involvement was the primary determinant of success, and local medical leaders strongly encouraged community organisations to do the things that would work best to increase awareness of the threat posed by the epidemic and reduce high risk behaviour. **(Slide three here: Safe sex guidelines)** Some people were at times a little surprised by the subject matter we discussed, but they continued to support and fund us nevertheless!

Enormous amounts of community activism took place throughout the country over the next two years to spread the safe sex message, and to challenge laws that criminalised sex between men and the possession of needles and syringes - both of which made effective HIV prevention work extremely difficult. These two important legal reforms were completed in July 1986 and by the end of 1987 respectively.

In marked contrast, at the same time in the United States the Senate passed the Helms Amendment by an overwhelming margin of 98 votes to 2. This little piece of legislation, known by its fundamentalist backers as "*no promo homo*", was extremely destructive. It outlawed Federal funding for positive condom promotion and needle exchange programmes, and kick-started the decline of HIV prevention by behavior change in the US. We were fortunate to live in a different world where targeted campaigns on risk behaviour were given high level political support.

Towards the end of 1987 enough scientific evidence had also accumulated to make us confident that our safe sex guidelines for gay and bisexual men could be greatly simplified. The data pointed clearly towards anal sex without condoms as the major risk, and so we moved to focus our prevention messages for gay men primarily on to condom promotion.

In April of this year (2010) a major review of scientific papers was published in the International Journal of Epidemiology which indicated that receptive anal sex without condoms is eighteen times riskier than receptive vaginal sex without condoms **(Slide four here: Red bar graph)** - and orders of magnitude riskier than insertive anal and vaginal sex, oral sex and all other sexual activities.

So the decision we took back in 1987 to maximise condom use for anal sex was undoubtedly correct, and it remains the Foundation's primary public health goal.

The next question - *the really central one* - is what effect has our HIV prevention programme had over the last 25 years?

First of all, it is important to acknowledge that taken across the board we have done well compared to most other countries. **(Slide five here: Green bar graph)** New Zealand, the smallest bar at the top of this graph, has 34 HIV cases in total per 100

thousand people, Australia has 83, the United Kingdom has 127 and the United States has 600.

Our epidemiological data also clearly indicates that it is gay men who are at greatest risk from HIV here. **(Slide six here: Two pie charts)** Over the last ten years, 76 % of all those diagnosed with HIV and *infected in New Zealand* were gay and bisexual men. In 2004 that figure reached 90% - despite the fact we account for only 2.5% of the total population. The next slide presents that data in a different way. **(Slide seven here: Blue bar graph)** The blue bars show infections in gay and bisexual men that occurred *in* New Zealand by year, and the red bars show gay and bisexual men who were infected overseas.

The changes that have taken place over time are also significant. New diagnoses peaked first among gay men in 1988 at 80 cases *in total* - that data is not shown on this slide - and then fell steadily over the next nine years to a low point in 1997. In each year from 1997 to 2000, just over 20 gay men newly diagnosed with HIV in New Zealand were *also infected in New Zealand*.

To my knowledge our 1997-2000 results for gay men have not been improved on anywhere else when expressed as a proportion of the adult male population. That low transmission benchmark is as good as it gets.

The recent picture is clearly worse, as I think everyone in this room can see, but it is still significantly better than in most other countries - including Australia, the UK, Canada and especially the US, which has the highest HIV infection rates in gay men in the developed world.

New HIV diagnoses increased rapidly in New Zealand between 2001 and 2005, but that rise came off a very low base. Taken overall, the best summary since 2005 is that new HIV diagnoses in gay men *where infection occurred here* appear to have stabilised at just under 60 cases per year on average. This is three times the number we had between 1997 and 2000.

There are complex reasons for the sharp increase seen between 2001 and 2005 but they can be summarised into four main points:

First, since the introduction of effective combination drug therapies in 1997, HIV infection is no longer uniformly fatal. The number of gay men living with HIV in the population is going up all the time as a direct result.

Second, because the fear of death from AIDS has been substantially reduced, condom use is harder to sustain - especially in groups of gay men with the highest levels of sexual activity, and also within relationships. Maintenance of behavior change is always difficult, and this declining perception of threat means that advocacy and responsiveness at community level is now more important than ever before.

Third, the internet and new social media have enormously enlarged the sexual market place, and each fresh “network connection” can be followed by HIV to move from one person to another if condoms are not used. For the last decade the internet has exerted a very powerful influence indeed on sexual health outcomes.

And fourth, we now have a new generation of gay men that has little experience of the AIDS crisis of the eighties and limited knowledge about other sexually transmitted diseases. They are therefore particularly vulnerable to HIV and STI infection.

Those four things all need to be addressed if HIV levels in gay men are to be reduced, and their combined effect has been to make prevention targets much harder to reach. The good news is that effective prevention is still fully achievable, but no currently available intervention other than condom use will work under the present circumstances. **(Slide eight here: Condom picture)** Until a vaccine which is close to 100% successful in stopping the transmission of HIV across mucosal surfaces is developed, condoms remain *by far* the most effective prevention tool we have to protect sexually active gay men from HIV infection.

HIV prevention by sexual behavior change is not easy, and like all major public health endeavors it is a marathon and not a sprint. To start with it is vital to be clear about the scientific, strategic and tactical challenges, and also to understand how they change over time. Then if we want to succeed in this field we must stay on course for the long haul. Even after 25 years there are no convenient short cuts.

It is important to keep in mind that preventive vaccines remain at least a decade away. They have been *at least a decade away every single year* since 1987! The daunting biological difficulties that confront HIV vaccine designers mean that they are probably a far more distant prospect even than that.

Above all - in the here and now - it is essential to remember that condoms work *extremely well* to prevent the transmission of HIV when they are used consistently. They also significantly reduce the spread of most other sexually transmitted infections, which is a double benefit.

So our central task for the foreseeable future remains to encourage as many gay and bisexual men to use condoms as we can, and to support them to maintain their condom use for as long as necessary.

Thank you very much.