Your Voice Matters

Understanding the Impact of HIV and Criminalisation in Aotearoa New Zealand

Burnett Foundation Aotearoa

Positive Women
Wāhine Kaha

Body Positive
New Zealand
Tinana Ora Aotearoa

Toitu Te Ao

Contents

Executive Summary

This report presents the findings of the first national study in Aotearoa New Zealand to examine how HIV criminalisation affects the lives, relationships, and wellbeing of people living with HIV.

- **A total of 247 adults** living with HIV completed the anonymous online survey. Participants represented a wide range of populations and communities, including Māori, Pacific, Asian, and migrant respondents; people of diverse genders and sexualities; and people living with HIV across different age groups. This diversity allowed the study to explore how criminalisation is experienced differently across communities.
- The findings show that HIV **criminalisation has significant impacts** on the everyday lives of people living with HIV.
- While most participants were aware of their disclosure obligations, **many were unclear** about the legal processes and the distinction between criminal and public health pathways.
- The legal environment generated **considerable anxiety**: 60% reported worry about criminal liability, and over half expressed concern about disclosure expectations with sexual partners.
- Criminalisation also shaped behaviour, as 45% of respondents reported **avoiding sexual encounters** because of the law and 30% reported increased condom use despite the effectiveness of treatment as prevention.
- The study highlights **clear inequities**. Recent migrants reported the highest levels of fear and avoidance, with rates more than double those of long-term residents. Māori, Pacific, and other non-European participants were more likely to report avoiding sex and fearing prosecution. Women were more than twice as likely as men to say the law encouraged greater condom use. Participants aged under 55 also expressed heightened concern about being charged.
- Overall, the findings demonstrate that HIV criminalisation in Aotearoa New Zealand produces measurable harms and **disproportionately affects already marginalised groups**. The results underscore the need for evidence-aligned policy reform, clearer public information, and culturally safe, community-led approaches that uphold the rights and wellbeing of people living with HIV.

Summary of Recommendations

Shift from criminalisation to public health-led responses

- Introduce clear Police investigation guidelines grounded in contemporary HIV science
- Conduct early viral load assessment and rapid referral to Public Health to close no-risk cases quickly
- Provide culturally safe and non-stigmatising frontline practice, applying harm minimisation principles, and embedding community codesign across education, investigations, and reform

Align prosecution with intent, evidence, and human rights

- Develop national prosecutorial guidelines that limit prosecution to intentional or deliberate transmission, setting clear evidentiary thresholds for intent and actual transmission
- Introduce monitoring and accountability to track case handling, alignment with science, and the upholding of human rights standards

Embed the Government's U=U[*] endorsement across systems through alignment of Police, prosecutorial, and judicial practice.

- Deliver co-designed training for Police, judges, prosecutors, and defence lawyers
- Invest in culturally responsive public health messaging grounded in community leadership

Strengthen legal literacy and community knowledge

- Expand community-led education on HIV-related rights, disclosure, and Public Health Act powers, with targeted, accessible resources for Māori and Pacific people, women, trans and nonbinary people, and recent migrants and other under-served communities
- Increase transparency about public health responses

Strengthen health, support, and equity responses

- Ensure clinicians consistently communicate U=U and zero transmission risk
- Expand peer support and counselling
- Equip healthcare providers to create safe, judgement-free spaces, providing targeted support
- Regularly review the impacts of criminalisation to inform evidence-based reform

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[*] Undetectable = Untransmittable: A person living with HIV who is on treatment and maintains an undetectable viral load has zero risk of transmitting HIV to their sexual partners.

Acknowledgements

We extend our deepest thanks to all people living with HIV who shared their experiences, insights, and reflections through this survey. Your willingness to speak openly about how HIV criminalisation affects your lives, health, and wellbeing made this research possible and meaningful. Your voices are central to this work and to ongoing efforts to improve policy, practice, and community support in Aotearoa New Zealand.

We thank the members of the Working Group who contributed to the development and implementation of this project for their leadership, expertise, and commitment to advancing evidence-informed and rights-based approaches to HIV, and who ensured that this survey was designed and delivered in ways that prioritised safety, care, and respect for our communities. We acknowledge the contributions of the co-authors Dr Brooke Hollingshead (Positive Women Inc., Toitū te Ao) and Pete Hanl (Burnett Foundation Aotearoa), as well as representatives from Body Positive (Mark Fisher), Toitū te Ao (Milly Stewart), Positive Women Inc. (Jane Bruning), and Burnett Foundation Aotearoa (Rodrigo Olin, Forrester McKee), whose collective knowledge and collaboration shaped the design, delivery, and interpretation of this research. Thank you to Kate Macpherson (Burnett Foundation Aotearoa) for her support developing the survey.

We also acknowledge and thank our translators for their work in developing the te reo Māori version of the survey. He mihi nūnui tenei kia Taharākau rāua ko Moeau Stewart. Na rāua kē i whakamāoritia ngā mahi nei.

We are grateful to Kataraina Davis for providing tikanga guidance and support throughout the development of this work, helping to ensure the research was grounded in respect, care, and cultural integrity.

Finally, we acknowledge the trust placed in us by participants and the wider HIV community. This research was undertaken with a strong commitment to confidentiality, care, and the principle of nothing about us without us, which has guided HIV research, advocacy, and community leadership for more than four decades.

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Introduction

Introduction

This report presents the findings of the first national study in Aotearoa New Zealand to explore how HIV criminalisation affects people living with HIV. Although HIV criminalisation dates back to the early years of the epidemic, its real-world impacts on wellbeing, relationships, and everyday life have never been systematically documented in the local context. This study was developed to fill that gap and to provide evidence that reflects the experiences, concerns, and priorities of people living with HIV.

Across the HIV sector, there has long been recognition that progress toward decriminalisation was needed, but uncertainty about how best to approach it. Community organisations knew that advocacy would be stronger and more effective if grounded in robust evidence to point to when engaging with policymakers, funders, and the wider public. The absence of local data made it difficult to demonstrate the lived impacts of criminalisation or to articulate why reform matters. Establishing an evidence base therefore became a critical first step.

Planning for this project began in 2023, with a shared commitment to take the time needed to do it well. From the outset, the organisations involved wanted to ensure the survey was safe and comfortable to engage with, avoiding language or scenarios that could be triggering or emotionally difficult for participants. This meant taking care with how questions were framed, checking for clarity and tone, and ensuring people could move through the survey at their own pace. The team also wanted the study to be grounded in lived experience, aligned with Te Tiriti o Waitangi, and respectful of the diversity of people living with HIV in Aotearoa New Zealand. Taking a deliberate, thoughtful approach strengthened the quality of the research and helped create a survey that participants could engage with confidently and on their own terms.

This report is structured to guide readers through the study in a clear and accessible way. It begins with background and context, followed by the study objectives and methods. The results are then presented in detail, including demographic patterns and key themes. While some terms used in the report are academic, we have aimed to keep the language as accessible as possible. We are also committed to ensuring these findings are translated into policy briefs, community resources, and other formats that support meaningful change.

Meaningful Involvement of People Living with HIV

The meaningful involvement of people living with HIV (MIPA) is a strengths-based principle that amplifies the motto "nothing about us without us" ("E kore mātou, e kore tātou"). Research must uphold the MIPA principle, acknowledging the universal rights of people living with HIV to self-determination and participation in decisions that affect their lives.

Since the beginning of the response to the HIV epidemic, people living with HIV have been at the centre driving action. First articulated in the Denver Principles in 1983, these principles were formalised in the 1994 Paris Declaration and have been endorsed by the Joint United Nations Programme on HIV/AIDS (UNAIDS).

MIPA calls for the active, full and meaningful involvement of people living with HIV in the initiation, development, implementation, monitoring and evaluation of HIV research, policies and programmes. It states that when informed by people living with HIV, the HIV response is better able to respond to the needs and priorities of the community, increase access to programmes, challenge negative attitudes, and build capacity of services. It promotes the personal development of people living with HIV, respecting their knowledge and abilities while promoting confidence, upskilling, and creating support networks.

For this project, people living with HIV and peer organisations were central to the design, development, and implementation, ensuring that the research reflected lived experience and community priorities. The project was undertaken as a participatory process, intended to inform advocacy and policy change alongside, rather than about, the community.

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Te Tiriti o Waitangi

A key priority for the HIV sector in Aotearoa New Zealand is ensuring Māori leadership, decision-making, and lived experience shape the work from the outset. Embedding Te Tiriti o Waitangi in the design and implementation of this study was essential to upholding the rights and tino rangatiratanga of Māori living with HIV, and to ensuring the research reflected Māori approaches and tikanga.

Toitū te Ao provided vital leadership throughout the project, guiding the Working Group in kaupapa Māori approaches, supporting culturally grounded adaptation of the study, and ensuring Māori perspectives were centred rather than added later. Their role as a core partner strengthened the integrity and accountability of the work.

The principles of Te Tiriti are lived through tikanga. Approaches such as MIPA align with these principles, which emphasise meaningful involvement, shared decision-making, and leadership by those most affected. Māori have the right to good sexual health and wellbeing, and the Crown has an obligation to uphold this, including meeting the health aspirations and needs of Māori living with HIV (1-4).

Context

HIV criminalisation in Aotearoa New Zealand occurs within both criminal (Crimes Act 1961) and public health law (Public Health Act 1956). People living with HIV can face legal consequences for non-disclosure, exposure, or transmission, even when the risk of passing on HIV is very low or zero. This section provides an overview of the legal framework, including the main laws involved and how they are applied, before moving on to the research context that informed this survey.

Legal context

HIV criminalisation occurs globally and refers to the use of criminal and similar laws against people living with HIV based on their HIV, perceived HIV, or potential risk of transmission. There are different ways criminalisation occurs, as countries can criminalise non-disclosure of HIV, exposure and/or transmission; some jurisdictions and countries criminalise all three. These laws are often applied irrespective of intent, actual risk, or contemporary scientific evidence regarding HIV transmission.

It is also important to distinguish intentional or deliberate HIV transmission, where a person knows their HIV-positive status and acts with the specific intent to transmit the virus, from other situations where HIV may be transmitted unintentionally. Intentional or deliberate transmission is different from consensual sex where transmission might happen without intent, or where risk is negligible or zero. UNAIDS guidance recommends that criminal law should be limited to rare cases of intentional or deliberate transmission and should not be applied in situations of non-disclosure, exposure, or where effective treatment eliminates transmission risk (5, 6).

Globally, the legal frameworks used to criminalise HIV vary. Some countries have enacted HIV-specific criminal laws, which explicitly target people living with HIV and often criminalise non-disclosure or exposure regardless of harm. Other countries rely on general criminal laws, such as assault, grievous bodily harm, or endangerment provisions, which are applied to HIV despite being developed prior to modern scientific understanding of transmission and treatment. According to the HIV Justice Network, HIV-specific criminal laws are most prevalent in parts of sub-Saharan Africa, Eastern Europe, Central Asia, and Latin America, while high-income countries, including those in Western Europe, North America, and Australasia, more commonly apply general criminal law to HIV-related cases (7).

The HIV Justice Network has documented HIV criminalisation is frequently enforced in ways that disproportionately affect already marginalised populations, including migrants, women, sex workers, gay and bisexual men, and Indigenous peoples.

In Aotearoa New Zealand, HIV is criminalised under general criminal law. People living with HIV can face criminal prosecution under the Crimes Act 1961 for:

- Non-disclosure of HIV to sexual partners,
- Transmission of HIV, or
- Exposure

These charges relate to criminal nuisance (s145), the duty of person in charge of dangerous things (an infectious disease) (s156), the need to take reasonable precautions to avoid harm(s156), wounding with intent for grievous bodily harm (s188), and wilfully infecting with disease for intentional transmission (s201). Importantly, prosecution under several of these provisions is possible in cases where there has been transmission, and when there has not.

These provisions have resulted in Aotearoa New Zealand having one of the highest per capita rates of HIV criminalisation globally between 2015–2018, with at least 14 prosecutions recorded since 1993 (7, 8).

In Aotearoa New Zealand, there has been a legal precedent through the Courts for condom use as evidence of taking "reasonable precautions" to prevent HIV transmission. This has been cited in several prosecutions as a mitigating factor or as grounds not to proceed.

By contrast, evidence relating to treatment and an undetectable viral load (U=U[1]) has not yet been recognised in case law as meeting the threshold of reasonable precautions, despite strong scientific consensus that an undetectable viral load eliminates transmission risk to sexual partners. While there have been occasional references to treatment status in sentencing, U=U has not been systematically incorporated into legal reasoning in the same way that condom use has, reflecting a lag between scientific evidence and legal practice.

In 2017, HIV was added to Infectious Disease Management under the Public Health Act (1956), providing a framework for managing HIV transmission, including pathways with levels of intervention increasing where considered necessary to protect public health (9). While measures such as contact tracing, counselling, and testing are widely understood, other powers available under the Act can be more intrusive, and impose significant constraints on people, such as mandatory medical examinations. Failure to comply with public health orders may result in legal consequences, including prosecution under the Act. However, it is unclear the extent to which these pathways are used in practice, and awareness levels of them among people living with HIV.

> [Aotearoa New Zealand had] one of the highest per capita rates of HIV criminalisation globally…

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[1] An undetectable viral load is defined as fewer than 200 copies of HIV per millilitre of blood

Research context

Criminalisation of HIV conflicts with public health goals and scientific evidence by discouraging testing and treatment, thereby creating barriers to care and increasing transmission risk. Laws that punish non-disclosure or exposure ignore the well-evidenced science and principle of U=U, opening the door to prosecutions where there is zero risk, while perpetuating stigma, and fear of disclosure. This disproportionately impacts Māori, Pacific peoples, recent migrants, and other vulnerable communities. Moreover, international evidence shows that such criminal laws provide little evidence of any reduction in HIV transmission or risk behaviour instead reinforcing inequities and undermining harm-reduction strategies (10, 11). Global scientific consensus, including an international Expert Consensus Statement and guidance from UNAIDS, emphasises that prosecutions often happen in situations of negligible or no transmission risk and that overly broad criminalisation undermines public health and contradicts contemporary evidence on HIV transmission and treatment (6, 12).

In October 2021, Immigration New Zealand removed HIV from the list of medical conditions that automatically disqualify visa applicants, meaning people living with HIV are now assessed individually rather than excluded on the basis of diagnosis.

Since then, national surveillance data show that the number of people living with HIV migrating to NZ has increased (13, 14). This appears to be driven by higher overall migration as migration data show that the proportion of migrants living with HIV has remained relatively stable. Between 2017 and 2021, people living with HIV accounted for approximately 3–7% of migrants arriving in Aotearoa New Zealand, compared with an estimated 5–12% between 2022 and 2024.

> International evidence shows that such criminal laws provide little evidence of any reduction in HIV transmission or risk behaviour...

Study objectives

The study examines the real-world impacts of HIV criminalisation, recognising that people living with HIV who are undetectable cannot transmit the virus, yet may still be subject to policies and regulatory responses that do not reflect contemporary science. As a result, individuals may face accusations or criminal justice involvement despite zero transmission risk.

The findings aim to inform more evidence-aligned, proportionate institutional responses reflecting contemporary science.

The study aims to:

- Understand awareness and interpretations of HIV-related laws and regulations
- Assess attitudes toward HIV criminalisation and public health–led management, including preferred responses
- Examine the behavioural, relational, and psychological impacts of HIV criminalisation
- Identify inequities in how criminalisation is experienced across different communities

Methods

Working Group

This work was guided by the MIPA principle, ensuring those most affected were central to the design process. The survey was co-designed in a partnership between Aotearoa New Zealand's four HIV community organisations: Positive Women Inc., Toitū te Ao, Body Positive, and Burnett Foundation Aotearoa.

Study Design

This study comprised a voluntary, cross-sectional, anonymous online survey. The 24-question survey included closed- and open- ended items examining:

- awareness of the legal and policy context
- personal beliefs and attitudes about criminalisation
- the impact of HIV criminalisation on wellbeing, relationships and healthcare engagement

The survey questions were co-created by members of the Working Group, drawing on lived experience, legal expertise, and insights from community organisations supporting people living with HIV.

Questions were informed by *HIV Futures 8*, an Australian survey examining the impacts of HIV criminalisation, including items developed with people living with HIV and a validated scale measuring legal environment related anxiety (11, 15). These items were adapted for Aotearoa and refined by the Working Group for clarity, cultural appropriateness, and alignment with current legal and public health settings.

The survey was available in English and Te Reo Māori, with an option for in-person participation.

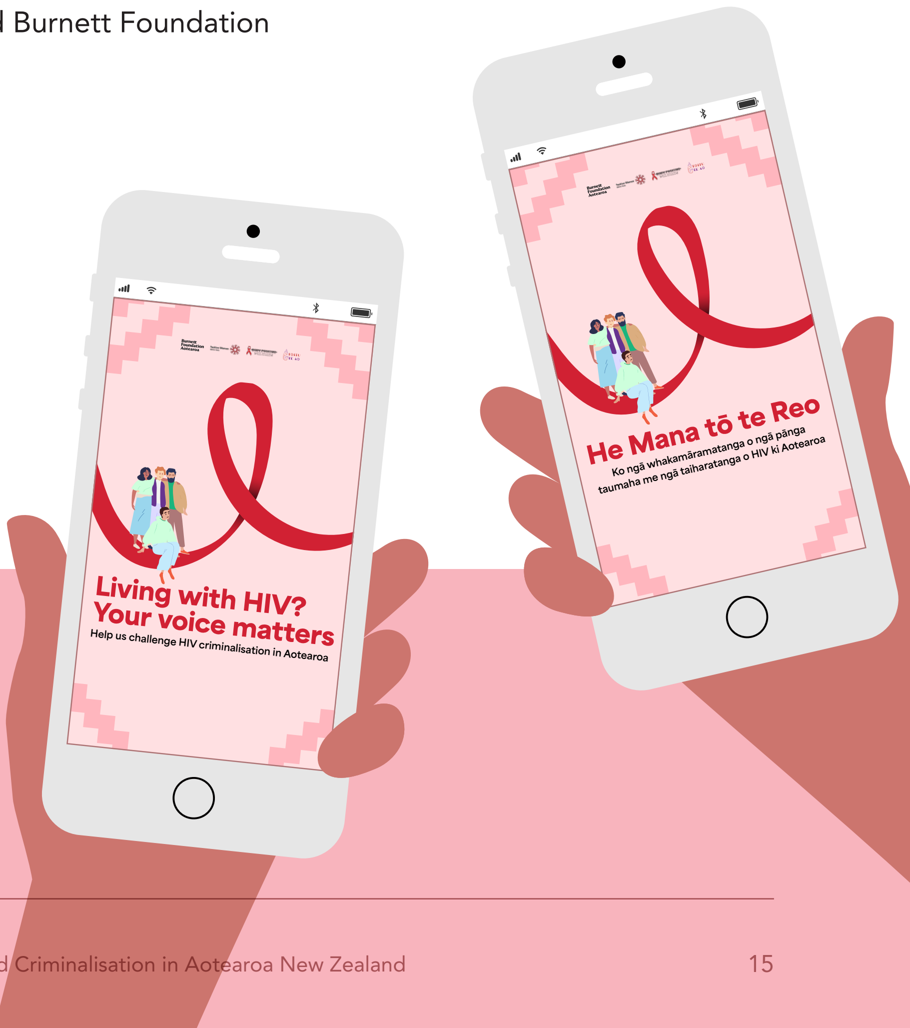
Recruitment

The survey was promoted through community-led channels including social media, word of mouth, and sector networks.

Survey promotion was community-led and distributed through member mailing lists of community HIV organisations and networks of people living with HIV. Posters with QR codes linking people to the survey were also developed and made available to sexual health and infectious disease clinics. Instagram and Facebook were also used to extend reach and support broad and diverse participation across Aotearoa.

Multiple support options were provided, including the ability to pause or stop the survey at any time and clear guidance on accessing support, such as crisis helplines, peer-support, and Burnett Foundation Aotearoa counselling services

People living with HIV could indicate their survey participation when enrolling for counselling and were prioritised for support, with counsellors briefed in advance. These multi-layered measures ensured participation was safe, respectful, and trauma informed.



Eligibility Criteria

Only people living with HIV, aged 18 years or older, and living in Aotearoa New Zealand were able to take part in the survey.

Survey population and sample size

The survey used a non-probability, self-selected convenience sample and participation was voluntary.

Data collection

Prior to launch, the survey was piloted with 18 men living with HIV attending the Annual HIV+ Men's Retreat in March 2025, to check clarity and acceptability of questions to ensure the questions were interpreted as intended and gather preliminary feedback. While no changes to questionnaire items were made, the feedback informed how the survey was promoted.

The survey was open from 20 June to 29 August 2025 and was available online using the SurveyMonkey platform.

Data analysis

Quantitative data was analysed by using MS Excel and RStudio.

Data are reported according to the following groups.

- **Age** of participants (collected in 10-year brackets i.e. 18-24, 25-34, 35-44, 45-54, 55-64, 75+, prefer not to say) was categorised as below 55 years and above 55 years of age for analysis. This cut-off was chosen because the population of people living with HIV in Aotearoa New Zealand is ageing, with approximately 49- 61% over the age of 50 (16).
- **Migrant status** (less than two years, two to five years, or longer/ being born here) was categorised as less than 5 years since migrating to Aotearoa New Zealand versus New Zealand-born or more than 5 years in New Zealand, based on the assumption that recent migrants may face unique challenges in accessing healthcare and support services.
- **Gender** was categorised as male, female, and 'another gender' (with an open text box) to reflect the diversity of gender identities among people living with HIV and differences across these groups.
- **Ethnicity** was self-reported, and participants could select multiple options (collected as Māori, NZ European/Pākehā, Pacific people, Asian, Middle Eastern, Latin American, African, another ethnicity, prefer not to say) and was categorised as Pākehā, Māori/Pacific peoples, and people of another ethnicity. This grouping was based on the assumption that New Zealand European/ Pākehā, as the largest ethnic group, may have different experiences compared

to Māori and Pacific peoples, who are known to have inequitable health outcomes. Asian, Latin American, African, people of another ethnicity and those who preferred not to say were combined as 'Another ethnicity' due to small numbers that do not allow for meaningful subgroup analysis.

- **Time reported to be living with HIV** (collected as 0-2 years, 3-5 years, 6-10 years, 11-15 years, 16-20 years, 20+ years) was categorised as < 5 years, 6-20 years and 20+ years to reflect distinct experiences such as people diagnosed within the past five years are typically in the early adjustment phase.

In this report, data are reported as numbers and percentages. Pearson's chi-square test was used to examine associations between variables and differences between populations are reported if differences were statistically significant, defined as p-value <0.05.[‡] Responses with missing data were excluded, and extremely small or noninformative categories were removed, as these cell sizes do not provide interpretable statistical information.

The survey also included open-ended text boxes, allowing participants to respond in their own words. **Qualitative data** were imported into NVivo for analysis and inductively (i.e. starting with the raw data, noticing recurring ideas, and building conclusions from these patterns, rather than a pre-set theory), and coded by Brooke Hollingshead and Pete Hanl, working independently to identify patterns and themes. Analysis followed Braun and Clarke's reflexive thematic analysis approach (17). Initial codes and candidate themes were compared and discussed to ensure alignment, with distinctions made between primary themes and sub-themes. These interpretations were then shared with the wider Working Group as part of the write-up for this report, for collective sense-checking and refinement, supporting analytic rigour and transparency.

Confidentiality

The survey was anonymous and no identifying information was collected. Any open-text responses that could potentially risk confidentiality were removed prior to analysis.

[‡] When the assumptions for Pearson's chi-square test were not met, the Fisher–Freeman–Halton exact test was applied.

Burnett Foundation Aotearoa

Positive Women
Wāhine Kaha

BODY POSITIVE
NEW ZEALAND
Tinana Ora Aotearoa

TOITU TE AO

He Mana tō te Reo

Ko ngā whakamāramatanga o ngā pānga taumaha me ngā taiharatanga o HIV ki Aotearoa

surveymonkey.com/r/HIVCriminalisationSurveyMaori

[QR Code removed as no longer active]

Example poster used for survey recruitment

Results

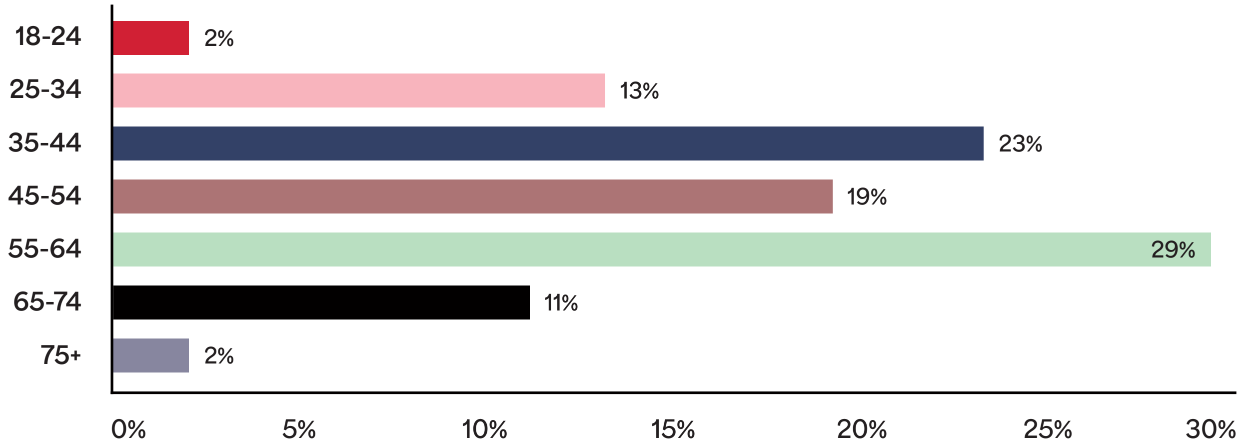
Section 1: Who took part

A total of 329 people started the survey. After excluding people who did not meet the eligibility criteria (including those not living with HIV, not residing in NZ, and incomplete results), 247 eligible responses remained and were included in the analysis. No participants took up the option of doing the survey in person.

The demographic characteristics of participants who completed the survey largely mirrored the HIV epidemic in Aotearoa New Zealand in terms of age, gender and sexuality (Figures 1,2,3).

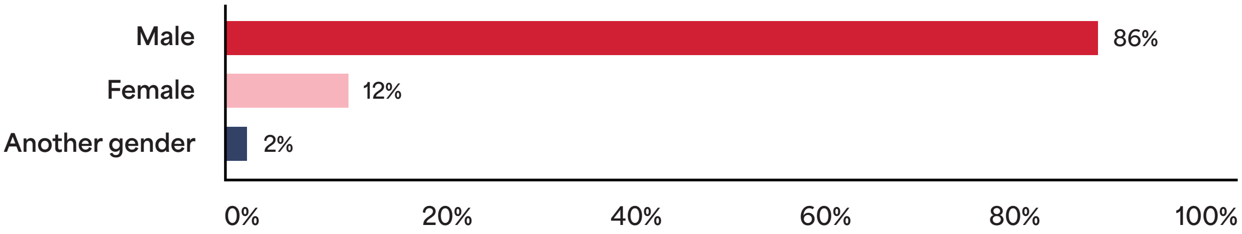
Forty-two percent of participants were aged over 55 years which is slightly less than the estimated 49%-61% of the current population of people living with HIV in Aotearoa New Zealand over the age of 50 (16) (Figure 1).

Figure 1: Age of survey respondents (n=246)§



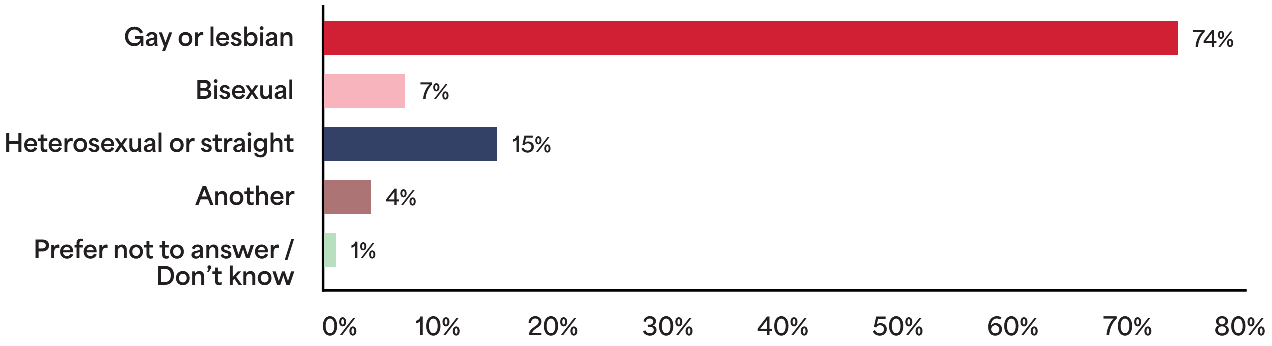
Most respondents were male (86.2%) and identified as gay (73.7%) (Figures 2 and 3), mirroring the concentrated nature of the HIV epidemic among cisgender men who have sex with men (MSM) in Aotearoa New Zealand.

Figure 2: Gender of survey respondents (n=247)



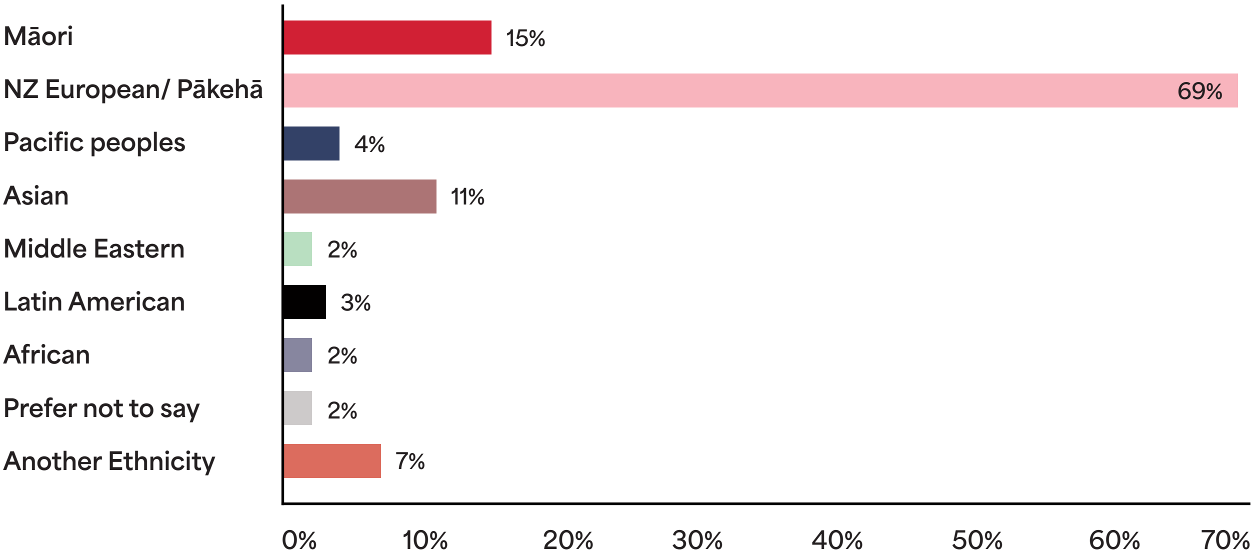
§ One respondent was excluded from the figure and chi-square test due to missing age data

Figure 3: Sexuality of survey respondents (n=247)



The majority of participants identified as New Zealand European/Pākehā (69.2%), followed by Māori (15%), and Asian participants (10.5%). The number and proportion for people of another ethnicity were small (Figure 4).

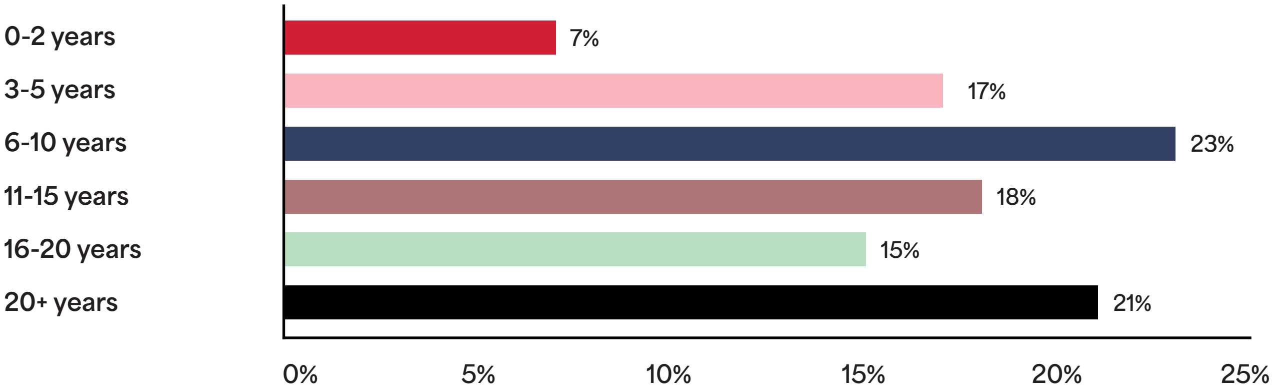
Figure 4: Ethnicity of survey respondents (n=282; multiple answers possible therefore total more than 100%)



> …mirroring the concentrated nature of the HIV epidemic among cisgender men who have sex with men…

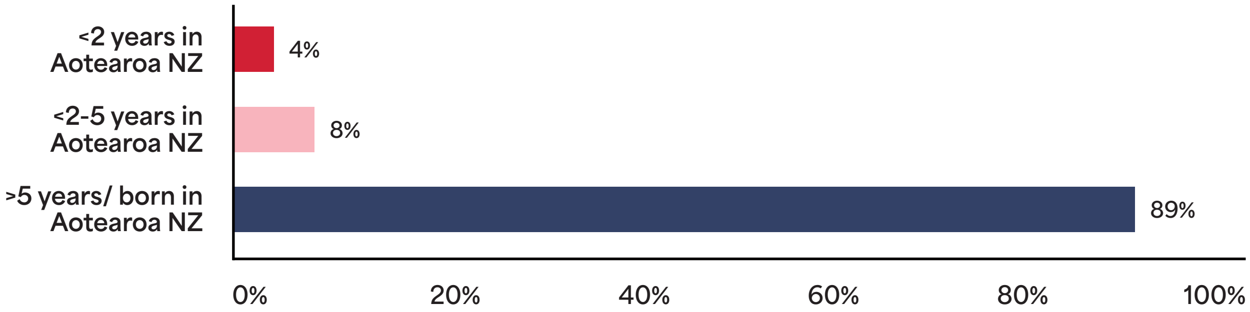
Participants reported a wide range of time living with HIV (Figure 5). More than half (53.4%) had been living with HIV for 11 or more years, consistent with an ageing population.

Figure 5: Time reported to be living with HIV of survey respondents (n=246)**



Migrant status was also explored, and the majority (88.7%) were either born in Aotearoa New Zealand or had been in the country for more than five years. Only one in ten (11.3%) of respondents had been in Aotearoa New Zealand for five years or less (Figure 6).

Figure 6: Migrant status of survey respondents (n=247)



> More than half had been living with HIV for 11 or more years...

** One respondent was excluded from the figure and chi-square test due to missing age data

Limitations

While the survey achieved good representation of Aotearoa New Zealand's population living with HIV, certain limitations remain.

Participation was by self-selection, which may introduce bias, as people who chose to take part in the survey may differ from those who did not. In particular, the survey is likely to have reached people who are more connected to HIV services, community organisations, or peer networks, potentially under-representing those who are more socially isolated or disengaged from care.

Numbers for some ethnicities were low, particularly Pacific peoples and people of another ethnicity (Figure 4). This is consistent with epidemiological data, as Pacific peoples account for a small proportion of people living with HIV and are often underrepresented in HIV research due to lower engagement with sexual health services—an ongoing challenge in Aotearoa New Zealand.

Breaking down data into specific demographic groups resulted in very small sample sizes for some categories. While this limits the ability to draw statistically robust conclusions, these small groups can still provide valuable insights, as their perspectives may highlight distinct experiences and needs.

Section 2: Understanding HIV Criminal Laws

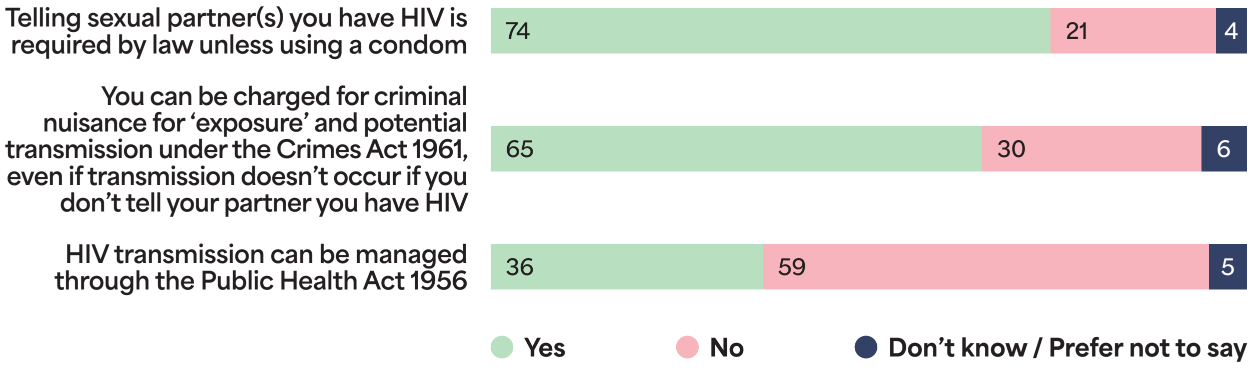
In this section, participants were asked about their knowledge of the current laws and policies relating to HIV transmission.

Three in four (74%) participants knew they were required to disclose their HIV to their sexual partners unless using a condom, even if the person living with HIV had an undetectable viral load (Figure 7).

There was less knowledge that people could be prosecuted under the Crimes Act (1961). Only two in three (65%) knew they could be prosecuted for criminal nuisance for 'exposure' if they do not tell their sexual partner they have HIV and do not use a condom, even if transmission does not occur. While this was still most participants, it is important to highlight a significant proportion still did not know their rights and legal duties or obligations.

Only one in three (36%) participants knew there is an alternative way to manage HIV transmission through the Public Health Act 1956, which enables powers to support (and in rare cases direct) people with suspected or diagnosed HIV to access testing, treatment and other services to protect public health.

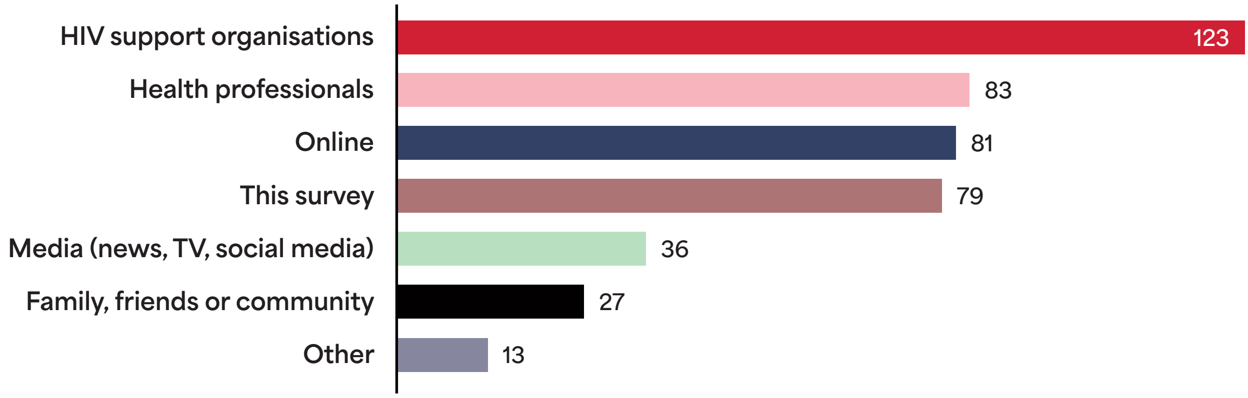
Figure 7: Understanding of HIV-related laws (in %) (n=247)



> …it is important to highlight a significant proportion still did not know their rights and legal duties or obligations.

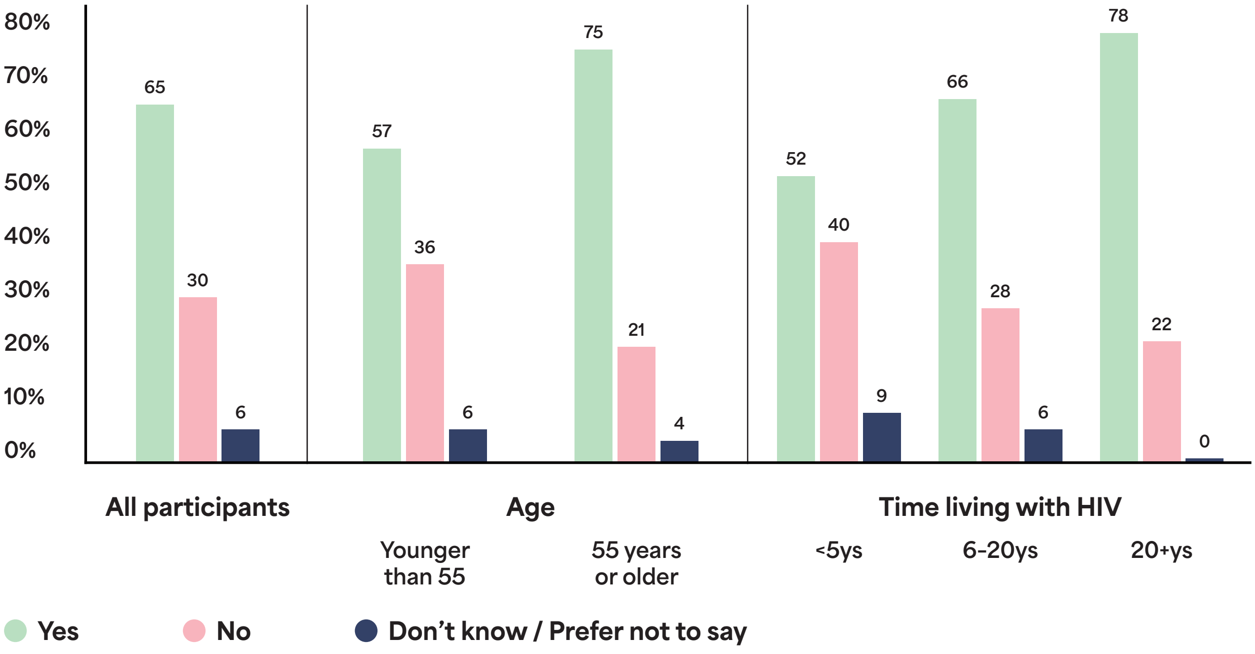
Most participants (n=123) learnt about these laws through Aotearoa New Zealand's HIV support organisations, followed by health professionals (n=83), and online sources (n=81) (Figure 8). Interestingly, some participants only became aware of this legal context through this survey, suggesting knowledge of the legal context may have been limited prior to participation.

Figure 8: Where people learnt about HIV-related laws (count data, multiple answers possible)



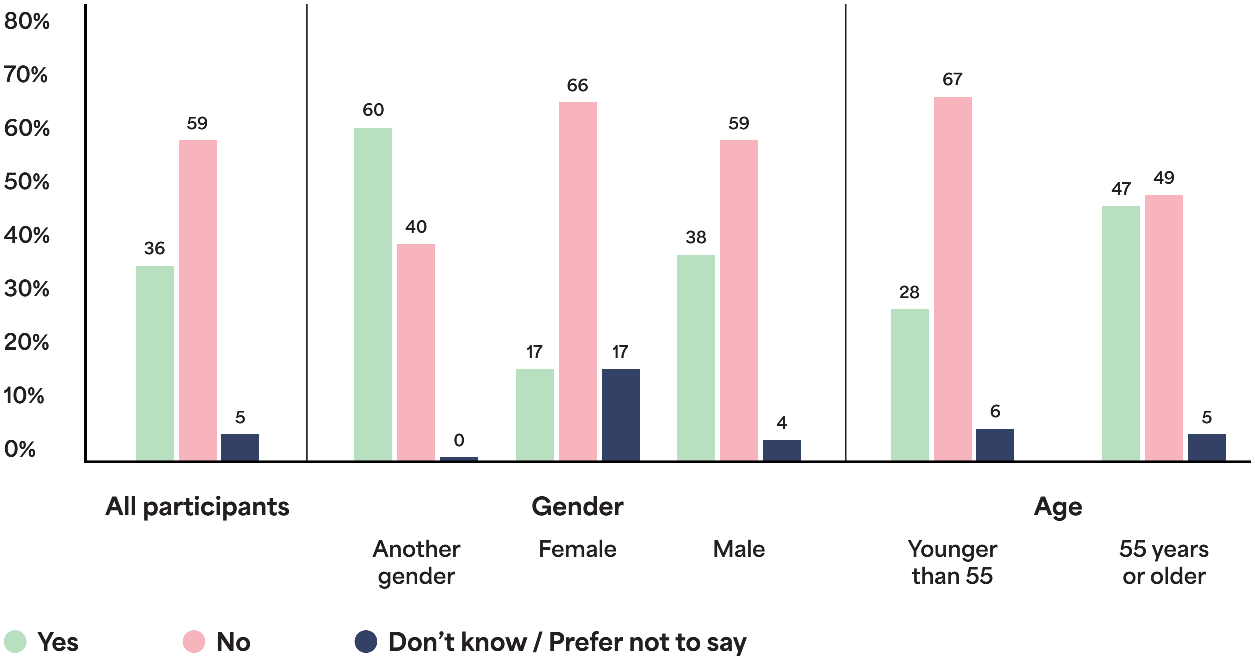
Participants aged 55 and over (75%), and those who had been living with HIV for 20 years or longer (78%), showed a greater understanding of the risk of prosecution, compared to those who have been diagnosed in the last five year (52%).

Figure 9: Knowledge of possible prosecution due to HIV exposure if sexual partner hasn't been told about HIV (in %) for all participants and by age group and time reported to be living with HIV



When broken down by gender, women were less likely to know about the public health pathways (17%, or less than one in five), compared to men (38%, one in three) and respondents of 'another' gender (60%). While the numbers of women and people of 'another gender' in the sample was smaller, the statistical test shows this difference is unlikely to be due to chance.

Figure 10: Knowledge that HIV transmission can be handled through Public Health Act (1956) (in %) for all participants and by gender and age group



> Interestingly, some participants only became aware of this legal context through this survey, suggesting knowledge of the legal context may have been limited prior to participation.

Discussion/ What have we learnt?

Knowledge gaps remain about legal rights and disclosure obligations among people living with HIV, even within well-connected communities. Lower levels of awareness across several legal and public health issues highlight the ongoing need for clear, accessible opportunities for discussion and education about HIV-related laws in Aotearoa New Zealand. Notably, results suggest the act of participating in the survey itself increased awareness for some respondents, reinforcing the value of community-led research as both a data-gathering and educational tool.

Differences since time of HIV diagnosis may suggest people who are newly diagnosed are preoccupied with other priorities, such as processing their diagnosis and adjusting to treatment, leaving the policy and legal implications less prominent in their minds (18). It could also reflect sexual activity may not be a primary concern during the early stages of diagnosis, although further research would be needed to confirm this. However, those who have lived with HIV for more than two decades may be older and have witnessed earlier prominent media coverage of prosecutions, with a case not being widely reported since 2018 (19). Their greater awareness could also indicate higher levels of community engagement and access to resources over time (20, 21).

Gender differences in awareness are particularly significant and indicate generic one-size-fits-all education approaches miss key populations. Lower levels of knowledge among women, trans, and non-binary participants point to potential gaps in how legal information is reaching these populations, including information about rights, legal processes, and the possible implications of public health orders.

Disclosure remains a source of uncertainty and anxiety, particularly in the context of U=U and outdated laws. A clear distinction is needed between legal requirements and social expectations on disclosure.

Recommendations

- **More resources** and more widespread education for community members living with HIV to improve knowledge about their rights, including when disclosure is needed, and powers under the Public Health Act.
- **Targeted resources** are needed to ensure women, trans, non-binary people, and other communities have legal and rights-based information.
- **Community-led conversations** about disclosure and criminalisation are essential to reduce fear, support informed decision-making, and strengthen advocacy for policy reform aligned with current science.
- **More data and transparency** are needed on the full range of public health responses available, including how and when they may be used by healthcare professionals and Medical Officers of Health.

Section 3: Attitudes

In this section, participants were asked to indicate their level of agreement (in green) or disagreement (in red) with a series of statements exploring attitudes towards HIV and how it should be managed.

Most respondents expressed strong views on how HIV should be managed.

There were three statements that saw strong disagreement, as can be seen in the red of Figure 11. Nearly nine in ten respondents (87%) disagreed that the Police should manage HIV transmission. Two thirds (63%) opposed the current requirement for people with an undetectable viral load to always tell their sexual partners their status, and 64% disagreed that the current state of criminalisation in Aotearoa New Zealand is fair.

On the other hand, 72% agreed Public Health Authorities should manage HIV transmission, and a large majority (81%) also agreed only intentional or deliberate HIV transmission should be criminalised.

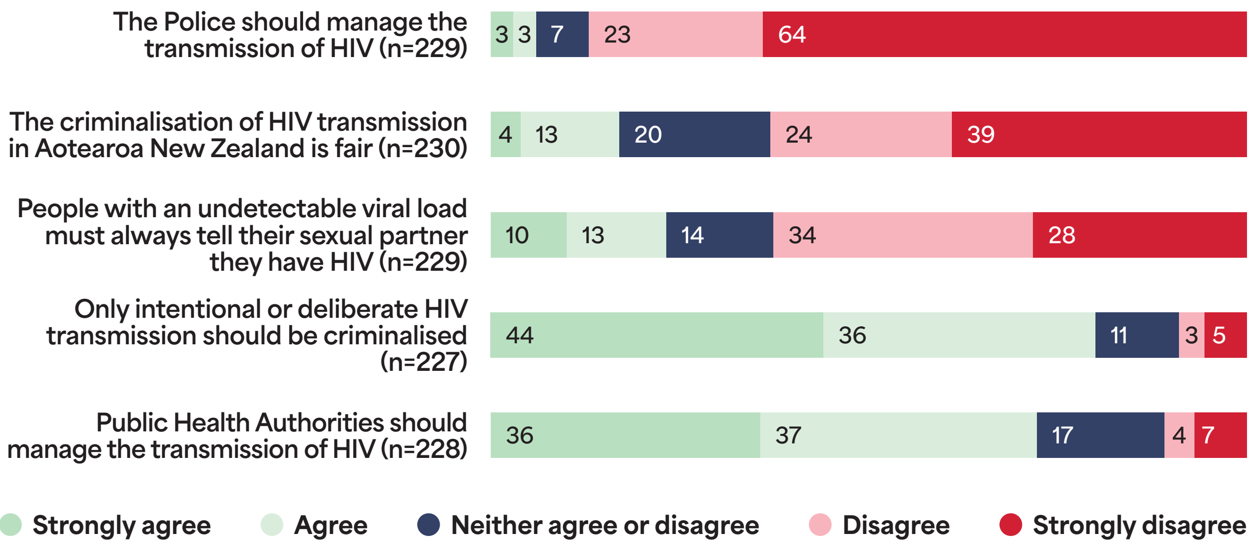


Figure 11: Attitudes towards HIV management (in %)

> Most respondents expressed strong views on how HIV should be managed.

HIV is not a crime

Across the free-text responses, participants during this section of the survey frequently emphasised that HIV transmission is a health issue rather than a criminal matter, and therefore, it should be addressed by health professionals rather than the criminal justice system.

- *HIV is a public health thing, not a criminal one.* (45-54, gay, male, Pākehā)
- *How can an illness be a crime?* (65-74, gay, male, Pākehā)
- *I have a well-managed medical condition and am not a crime scene or criminal and should not be treated as one.* (55-64, gay, male, European)

Many respondents highlighted the perceived inappropriateness of police involvement in what they viewed as a public health concern. They noted that police lack the specialist skills, training, and expertise required to manage HIV-related issues, and several argued that police resources could be better directed toward other priorities.

- *I believe that they [Public Health Authorities] are more qualified to handle the situation than the police.* (55-64, gay, male, Pākehā)
- *I strongly disagree with the notion that the Police should manage the transmission of HIV. Public health issues should be addressed through education, medical support, and community engagement—not criminalisation or policing. Involving law enforcement in managing HIV risks further stigmatising people living with the virus, discourages testing, and undermines trust in healthcare systems. Transmission is best addressed through comprehensive health services, access to treatment, and honest, informed conversations between individuals. The role of the Police is not to intervene in personal health matters, particularly when HIV is a manageable condition and undetectable = untransmittable (U=U) is a well-established scientific fact.* (55-64, gay, male, Māori)
- *It is a medical condition it should be managed by health professionals. The police should not be involved in people's health or what they do in bed.* (65-74, gay, male, Pākehā)

> Many respondents highlighted the perceived inappropriateness of police involvement in what they viewed as a public health concern.

Participants also commented on HIV exceptionalism, where HIV is treated differently from other viruses or infections, despite comparable or lower levels of risk. This exceptionalism was seen as both unnecessary and harmful. Participants noted this exceptionalism was rooted in stigma rather than science.

- *HIV is a viral infection, not a criminal activity. How is it different from other viral infections to warrant criminalization, unless transmission is malicious?* (45-54, gay, male, Pākehā)
- *HIV is now like many other diseases that people live with successfully and manage and yet very few of these other diseases carry the stigma and danger of criminal action. It is likely that criminalisation of HIV is still tied to homophobia and misunderstanding.* (65-74, gay, male, European)
- *Do we criminalise cancer, should have we criminalized covid-19? It is the inherent homophobia in society that feels it is justified to engage in such criminalization. Times have changed so does the law need to.* (35-44, gay, male, Australian)
- *I'm not really sure on why, but if people who intentionally spread other diseases are not prosecuted then why should people who spread HIV, it is no longer a deadly disease in NZ. Special treatment in criminal law reflects outdated community and legal attitudes to infectiousness, even to exposure. Punitive approach ignores how people with HIV live their lives and manage/ negotiate living with HIV at work and in relationships.* (35-44, gay, male, Pākehā)
- *We are not criminals. People who have the HPV virus that causes cancer of the cervix or throat are not criminalized, people that get these cancers are not criminalized either, they are helped and supported because it's 'cancer'.* (55-64, straight, female, Pākehā)

> HIV is a viral infection, not a criminal activity. How is it different from other viral infections?

Mistrust of the Police was a recurring theme. Numerous participants expressed concern that police engagement in HIV transmission cases reinforces stigma and exacerbates negative public perceptions. One participant with direct experience of police, criminal justice, and media involvement described the significant stigma and personal impact that followed.

- *Many people have huge and deep-rooted distrust for the police and they lack the connection, understanding and resources to handle what is a health issue.* (35-44, gay, male, Pākehā)
- *I don't trust the police and I don't trust that they are qualified to deal with such a complex reality as it is the reality of people living with HIV or even the LGBTQ community. The values of empathy, scientific research and medical care are way out of the scope of the duties of Police as institution.* (35-44, gay, male, Latin American)
- *The Police are not a health organisation. They have been and still are very homophobic.* (55-64, gay, male, Middle Eastern)
- *They are not public health experts and do not have the skills. It's also a negative implication to have such control governed by the police, thereby continuing the stigma that is problematic from many angles.* (65-74, gay, male, Pākehā)

However, not all participants shared this view. A minority felt police should retain some role in managing cases of alleged transmission.

- *You could have certain people trained in the job and that way it is done adequately, sensitively and not necessarily done by the police. If they are trained properly, then no stone is left uncovered.* (65-74, straight, female, Pākehā)
- *There does need to be something in place that makes sure a positive person with detectable load does not purposefully try to infect others none the wiser.* (25-34, straight, female, Pākehā)

Some respondents were unaware police involvement is part of the current legal and policy environment. As a result, they interpreted the survey as suggesting increased police involvement, and their responses reflected this misunderstanding.

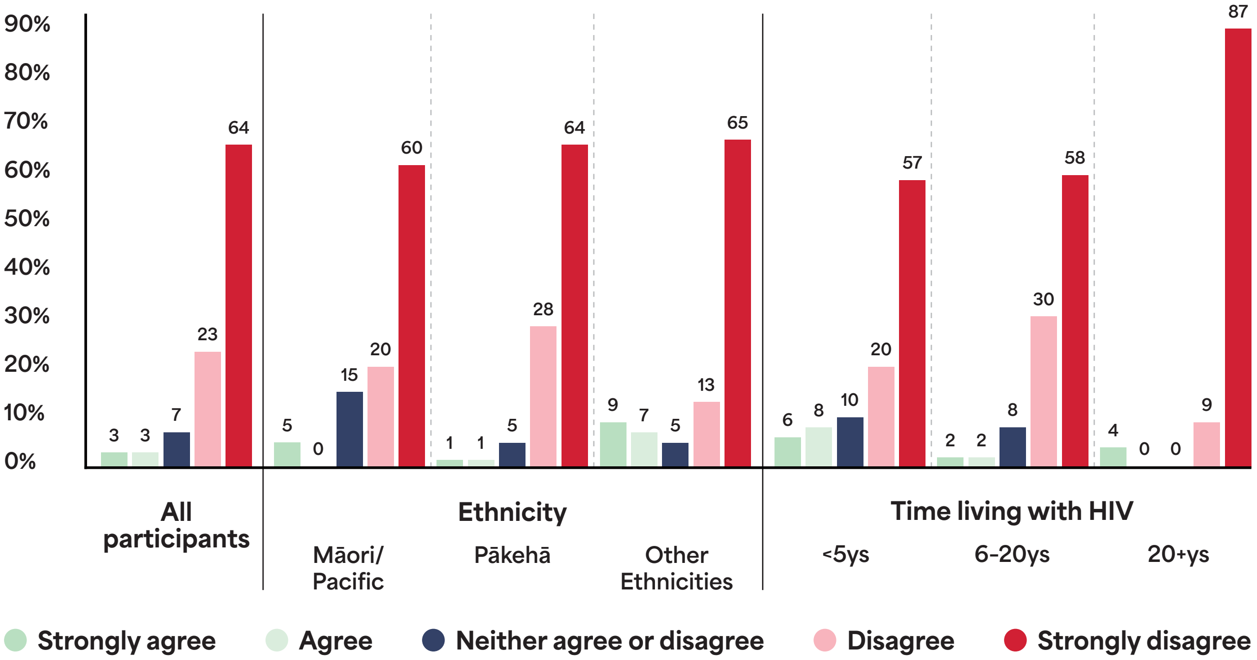
- *This is a barbaric and disgusting proposition!!! People living with HIV are not criminals.* (55-64, straight, female, Pākehā)
- *[…] Shifting responsibility to the criminal justice system is not only ineffective—it's dangerous and unjust.* (55-64, gay, male, Māori)

Analysis across populations revealed several notable differences in attitudes toward HIV criminalisation and management.

Participants were asked whether the police should manage HIV transmission. Responses varied by ethnicity, with higher agreement among respondents from another ethnicity (16%), 5% of Māori and Pacific respondents and 2% of Pākehā. Māori and Pacific respondents were more likely to select "neither agree nor disagree" (15%), suggesting greater uncertainty or ambivalence.

Differences were also observed based on time living with HIV. People diagnosed within the last five years were more likely to agree (14%) that police should manage transmission than those living with HIV 20 or more years (4%).

Figure 12: Police should manage HIV transmission (in %) for all participants and by ethnicity and time reported to be living with HIV



> People diagnosed within the last five years were more likely to agree that police should manage transmission...

Public health authorities and experts are best placed to manage HIV transmission

Most participants argued that healthcare professionals are best positioned to manage HIV transmission. Respondents frequently referred to the specialised expertise of clinicians and public health practitioners—particularly their knowledge of HIV, treatment options, and transmission risk—as justification for a health-led approach.

- *As a virus the public health team are a more appropriately trained and have more applicable skills to help stop transmission than police do.* (35-44, gay, male, Pākehā)
- *Yes as they are the correct sector to give correct info expertise and recommendations.* (25-34, gay, male, Māori)
- *Health authorities should absolutely manage the transmission of HIV. Health authorities are trained, educated and will know best how to manage the transmission with education, medicine options and connect the person to support groups and organizations.* (45-54, straight, female, Pacific)

Participants also reported higher levels of trust in healthcare professionals compared with the Police. This trust was often linked to perceptions of competence, confidentiality, and a more supportive, non-punishing orientation within healthcare settings.

- *It is a health issue so this would be appropriate. I trust a health professional 100 times more than I trust the police.* (35-44, gay, male, Pākehā)
- *This is a public health issue, that should be dealt with by public health authorities, not by police or people who fundamentally don't understand HIV.* (18-24, gay, male, Pākehā)

> Most participants argued that healthcare professionals are best positioned to manage HIV transmission.

However, this view was not universal. Some participants argued that while healthcare professionals should play a role—such as providing education, facilitating access to treatment, or offering support—managing transmission itself was not always appropriate, nor was mandatory treatment. For these respondents, involvement should be limited to situations where there was a genuine risk of transmission, such as if a person was not on treatment, or not using condoms.

- *Not in their purview either. They should contribute to Education around HIV transmission and manage treatment, not transmission.* (45-54, gay, male, Pākehā)
- *While I understand that there should be an institution addressing the problematic to a certain extent I still believe that individuals should be enabled through educational public campaigns to be able to look after themselves. To have a doctor policing people to stick to their treatment is unsustainable and a violation of the universal right of freedom that every person has over their own life and it's stepping in a dangerous path of authoritarianism and mass control. Protect people with agency and information not with paternalism.* (35-44, gay, male, Latin American)

Several participants again emphasised self-responsibility, arguing people living with HIV should be able to manage their own health, either independently or in partnership with a trusted healthcare provider.

- *How about self-responsibility from poz and neg people rather than making it someone else's problem.* (55-64, gay, male, Pākehā)
- *People with HIV aren't risks to manage, but people with rights and dignity.* (35-44, gay, male, Pākehā)

Others questioned what was meant by "Public Health Authorities" noting their views varied depending on whether this referred to clinicians, public health units, government agencies, or other bodies. In these responses, themes of surveillance and intrusion emerged. Participants described feeling scrutinised or monitored and pushed back against what they saw as unnecessary involvement from health officials, emphasising their right to privacy and autonomy in managing risk.

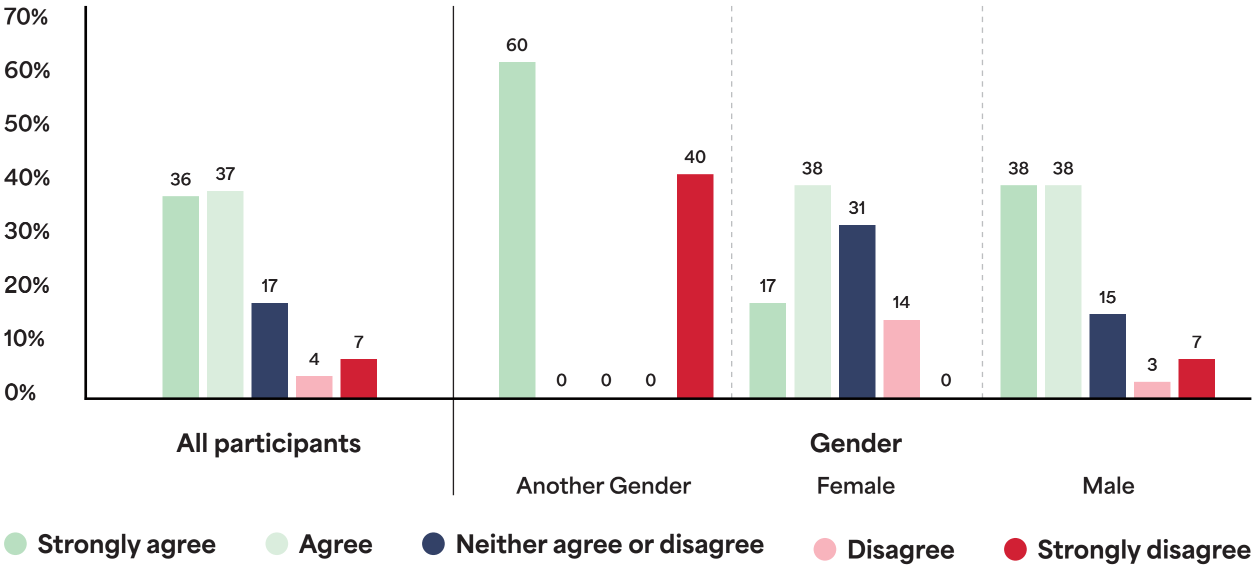
- *In what respect apart from ID consultant, doctor, who else would you envisage as a Public Health Authority.* (75+, gay, male, Pākehā)
- *I am not sure what is meant by public health authorities. My infectious disease doctor manages my HIV with my compliance because I want to live a long and normal life. If she is a public health authority then yes. But if a public health authority refers to some officious busybody social worker type person trying to manage my life and how [to] live it then no.* (55-64, straight, female, Pākehā)

Participants also acknowledged healthcare professionals operate within constraints. They pointed to outdated policies, limited resources, and systemic barriers that can restrict the ability of health services to respond effectively.

- *Public health is best placed to manage this but will be hamstrung by public health spend budgets and sometimes outdated laws or procedures.* (65-74, gay, male, Pākehā)
- *Kaore ratou e mohio ana ki nga tikanga [They do not know the customs/ protocols]* (55-64, straight, female, Māori)

Support for public health management of HIV was strong overall but varied by gender. Three-quarters of male respondents (75%) agreed, compared to 55% of females and 60% of respondents identifying as another gender (Figure 13).

Figure 13: Public Health Authorities should manage HIV transmission (in %) for all participants and by gender



> Participants also acknowledged healthcare professionals operate within constraints.

Role of community and peer organisations

Some participants highlighted the important role community and peer-led organisations could play in supporting the management of HIV transmission. These respondents expressed interest in greater involvement from support agencies, community groups, and peer networks, noting these organisations often have strong relationships with people living with HIV and a deep understanding of their needs.

- *I prefer an HIV support group does this for confidentiality.* (45-54, straight, female, Pākehā)

Participants suggested community and peer organisations are well placed to provide education, advocacy, and practical support, and may be better trusted than statutory bodies. For some, these organisations were seen as essential partners in promoting shared responsibility, reducing stigma, and ensuring people living with HIV feel supported rather than scrutinised.

- *If this means any authority other than an HIV support group then I disagree that any other organization or body should have access to this information.* (45-54, straight, female, Pākehā)
- *Agree as long as a management framework is designed or contains meaningful input from people living with HIV.* (35-44, gay, male, Latin American)

Intentions matter

While most participants opposed criminalisation, many made an exception for cases involving intentional transmission or non-consensual sexual encounters. Respondents drew a clear distinction between intentional and deliberate transmission versus unintentional transmission, such as when a person was unaware of their HIV status.

- *Intentionally bringing harm to someone should be a criminal offence.* (55-64, gay, male, Pākehā)
- *If it is intentional, it should be punished because there's still no cure for HIV. even though HIV is now manageable, it comes with stigma and discrimination.* (35-44, gay, male, European)
- *Because this is done with malicious intentions.* (35-44, non-binary, gay or lesbian, Pākehā)

At the same time, many participants emphasised transmission is not possible with an undetectable viral load, meaning in most cases where transmission occurs, the person is undiagnosed. For these participants, this scientific reality made the concept of "intention" largely irrelevant and hard to prove in practice.

- *As a person living with HIV you cannot pass on the virus. Passing of HIV will be done by someone who doesn't know they have the virus or are not taking medicine.* (65-74, gay, male, Pākehā)
- *Only in that case, because undetectable people normally are safer than "normal" people, because we are more responsible getting information and check our test all the time. I agree with irresponsible people.* (35-44, gay, male, Latin American)
- *If there is not any risk, it's not necessary the police participation.* (35-44, gay, male, Latin American)

Some respondents maintained intentional or deliberate transmission should remain within the scope of public health rather than policing, arguing a health-based response would be more effective and less harmful.

- *Intentional or deliberate transmission of a HIV or another notifiable infection or disease should be met with a public health response and appropriate support but not criminal repercussions.* (25-34, gay, male, Māori)

Others reiterated the importance of shared responsibility, emphasising all partners should be aware of their status and take steps to protect themselves.

- *No transmission should be criminalised. The person who lives with HIV is not responsible for the safe sex choices of other people, they are responsible for their risks and decisions.* (65-74, gay, male, Pākehā)
- *It would depend on a case-by-case circumstance but in general NO. HIV in NZ is a treatable manageable chronic disease. Being safe during sex should be a shared responsibility.* (55-64, straight, female, Pākehā)
- *In all instances sexual partners must all bear responsibility for their own protection and health.* (65-74, gay, male, African)

> …many participants emphasised transmission is not possible with an undetectable viral load…

A small number referenced "bug chasers" (people who actively seek infection), and one participant suggested criminalisation could extend beyond sexual encounters.

- *Some others and their actions are concerning, bug chasers are something that blows my mind and those offering to infect others through dating apps.* (35-44, gay, male, Pākehā)
- *Anyone who is HIV positive should be disclosing or taking precautionary measures to prevent transmission, there is no excuses for this. Having said that, accidental transmission such as infected blood transfusions should also be criminalised.* (25-34, straight, female, Pākehā)

Several participants also pointed out that HIV is no longer the life-threatening condition it used to be in the 1980s and early 1990s and therefore questioned why it should be treated differently from other viruses.

- *HIV is a manageable condition you can't or shouldn't be able to charge someone with endangering someone's health because once they start medication they aren't endangered. No other health condition is treated like this.* (55-64, gay, male, Pākehā)
- *I'm not really sure on why, but if people who intentionally spread other diseases are not prosecuted then why should people who spread HIV, it is no longer a deadly disease in NZ.* (35-44, gay, male, Pākehā)

Concerns were also raised about the practicality of criminalising intentional transmission. Participants questioned how intention could be reliably proven and whether such laws were effective in managing HIV transmission or would achieve their intended purpose.

- *Yes, I would agree with the statement - although proving intention and deliberate may be a matter of interpretation for the courts.* (45-54, gay, male, Pākehā)
- *This adds in a layer of complexity and subjectivity that simply does not exist today. It will require courts to understand intent and subject everyone to drawn out legal processes.* (35-44, gay, male, ethnicity not stated)

> Several participants also pointed out that HIV is no longer the life-threatening condition it used to be in the 1980s and early 1990s...

A few respondents warned that any form of criminalisation—even if limited to intentional transmission—could reinforce stigma, deter testing, and create barriers to accessing healthcare.

- *[…] even limited criminalisation might still discourage people from getting tested or seeking treatment due to fear of legal consequences. Ultimately, any legal approach should be carefully considered alongside public health evidence and should aim to reduce transmission while safeguarding the rights and dignity of people living with HIV.* (55-64, gay, male, Māori)
- *Clearly someone shouldn't be criminalised for unintentionally transmitting HIV. That makes it harder for people to be honest and prevents people from getting tested or accessing care. The vast majority of people who transmit HIV do so unintentionally (i.e. before they know their own status) and I personally don't blame the person I got HIV from, since I know it was completely unintentional.* (18-24, gay, male, Pākehā)

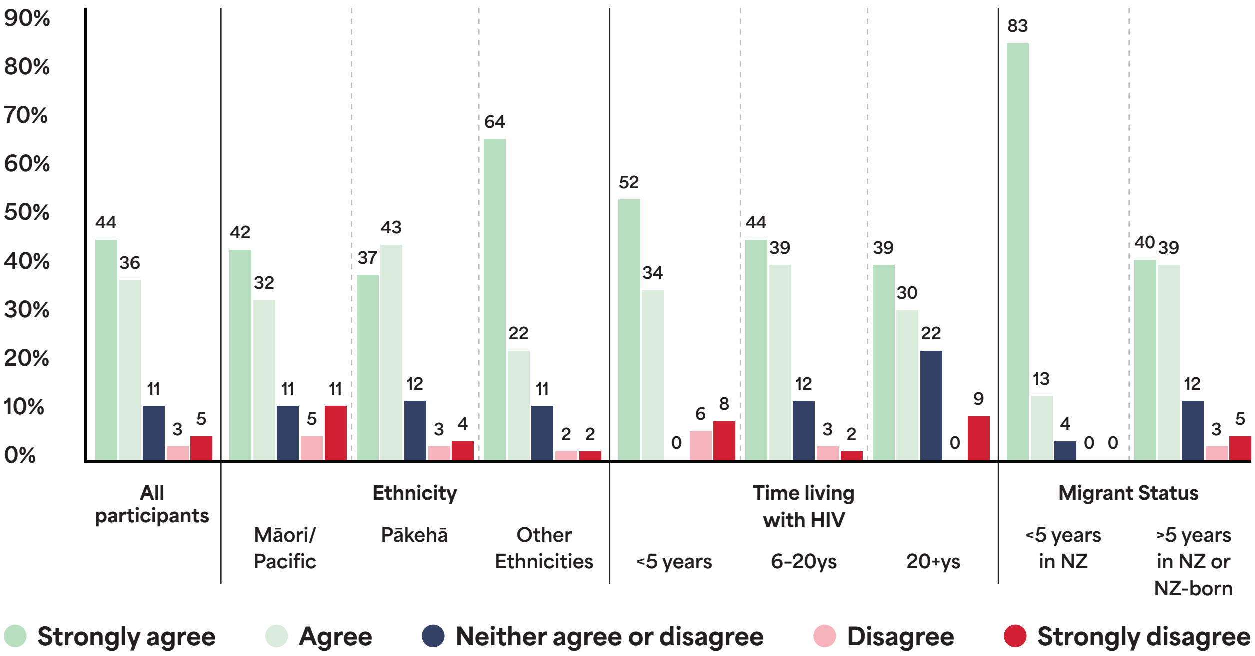
For many participants, this was an area marked by uncertainty. They described the issue as complex, context-dependent, and difficult to resolve through simple legal or policy measures.

- *As in everything, this is not black or white. Did the person receive appropriate agency support both at the beginning of diagnosis and for a while to come so as to orient themselves accordingly. Did they receive counselling options around newly navigating sexual relations? Have all the appropriate health supports been put into play first? If all of the above has been attended to, and the person either consciously or unconsciously is not prepared to ensure safety of potential partners re HIV contraction, this is a public health issue and police oversight may be required. It must however be hand in hand with therapeutic oversight.* (55-64, gay, male, Pākehā)
- *This really needs to be dealt with on a case-by-case basis as the mental health issues are probably at play here.* (55-64, gay, male, Pākehā)

> ...could reinforce stigma, deter testing, and create barriers to accessing healthcare.

Attitudes toward the statement that only intentional transmission should be criminalised varied across populations (Figure 14). By ethnicity, 64% of respondents identifying with another ethnicity strongly agreed, compared with 42% Māori and Pacific participants and 37% of Pākehā. Māori and Pacific respondents also had the largest proportion disagreeing (16%, compared to 4% among those of another ethnicity). Differences were also observed according to the length of time living with HIV: participants diagnosed within the last five years were more likely to agree (86%) than those living with HIV for 20+ years (70%), while longer-term respondents were more likely to select "neither agree nor disagree" (20%). Migrant status also influenced responses, as recent migrants showed stronger agreement (96%) compared to permanent residents (79%).

Figure 14: Only intentional/deliberate HIV transmission should be criminalised (in %) for all participants and by ethnicity, time living with HIV and migrant status



> Attitudes toward the statement that only intentional transmission should be criminalised varied across populations.

Disclosure as necessary?

From the free-text responses during this section of the survey, many participants argued that disclosure was unnecessary when a person living with HIV had an undetectable viral load. For these participants, confidence in U=U clearly underpinned their views on when disclosure should or should not be required.

- *Science shows that being undetectable and taking your medications and having regular checks means u cannot pass HIV on so u should not need to disclose it.* (65-74, gay, male, Pākehā)
- *The world's sum total cases of transmission of HIV when the positive individual is undetectable, is zero. Zero risk is impossible, so call the risk immeasurably negligible. Imposing criminal sanctions, for an act carrying negligible risk, is pure discrimination, and protects no one. Indeed, it incentivises ignorance of one's HIV status, which endangers all.* (45-54, transfeminine, pansexual, Pākehā)
- *mo te aha ke? [What exactly for?]* (55-64, straight, female, Māori)

A substantial number of respondents felt U=U should be formally recognised by the Courts and accepted as constituting "reasonable precautions." They argued that the law should reflect contemporary scientific evidence and criminal liability should not apply when transmission is not possible.

- *If you're undetectable, you should NOT be required to disclose your HIV Status. U=U is equivalent to condom use and should be considered as a form of "precaution".* (25-34, gay, male, Asian)
- *Undetectable = Untransmittable, the law needs to reflect the science and research. I thought the law for a HIV + person was when having sex with a partner that they must use "reasonable precaution" and I'm 100% sure being on antiretroviral meds and being undetectable is the most precaution an HIV + person could do.* (45-54, straight, female, Pacific)
- *U=U, this should be used as a defence* (65-74, gay, male, Pākehā)
- *Those who have never been tested are not subjected to any form of discrimination, and those who do what they must to keep healthy, and others healthy, shouldn't be pressured into divulging aspects that may have caused pain and anxiety.* (35-44, gay, male, Asian)

However, not all participants shared this position. Some maintained that disclosure remained important during sexual encounters, and several emphasised condom use as an additional safeguard when disclosure had not occurred.

- *Infected people have a duty to make sure they don't infect another. I agree with the law as it is you should have to either wear condoms or disclose your condition.* (45-54, bisexual, male, Pākehā)
- *If your viral load is undetectable and you are using condoms you don't need to disclose.* (55-64, straight, female, Pacific)

For others, decisions about disclosure were context-dependent, shaped by the nature of the relationship or the level of trust between partners.

- *If you are undetectable I think it is the individual's decisions to disclose or not. (35-44, straight, female, Pākehā)*

A number of participants thought of disclosure as a moral or ethical obligation, regardless of transmission risk.

- *While it should never be a legal requirement, everyone should consider that it's much more difficult to establish a trusting relationship with someone if disclosure isn't made early.* (65-74, gay, male, Pākehā)
- *It's the right thing to do. Moral responsibility, common courtesy.* (55-64, gay, male, Pākehā)
- *Te pono me te marika kia piritahi ke [Truth and integrity go together]* (55-64, straight, female, Māori)
- *It should no longer be necessary however I believe it to be courtesy to tell the partner.* (45-54, gay, male, Pākehā)
- *Deeply unethical to say nothing. It's grossly reckless to keep it hidden.* (35-44, gay, male, ethnicity not stated)

The current context is not specific enough, and driven by stigma and homophobia

In response to the statement that the criminalisation of HIV transmission in Aotearoa New Zealand is fair, most participants expressed disagreement. Their comments framed criminalisation as a reflection of ongoing stigma, discrimination, and homophobia, and highlighted the lack of recognition given to the role of undetectable viral loads in eliminating transmission risk.

- *No way is it fair. To require disclosure when not able to transmit HIV = serious risk to life and limb including penis!* (55-64, gay, male, Māori)
- *The current criminalisation of HIV in Aotearoa is inherently unfair and discriminatory. It fails to recognise the individual with HIV as someone affected by the virus, and places additional obligations to disclose sensitive health information unnecessarily. Furthermore, the current status of criminalisation fails to account for progress in health measures where transmission cannot occur (such as U=U) or precautions that a prospective partner can take to reduce or negate transmission such as Prep. In addition, the criminalisation itself has added to the stigmatisation of HIV by framing it as something harmful or dangerous as opposed to a chronic illness which can be managed. As a health problem, it should be managed with a health response.* (25-34, gay, male, Māori)

- *HIV is now like many other diseases that people live with successfully and manage and yet very few of these other diseases carry the stigma and danger of criminal action. It is likely that criminalisation of HIV is still tied to homophobia and misunderstanding.* (65-74, gay, male, European)
- *It adds stigma and a punishment to people living with HIV we are humans who happen to have a disease, we should be supported not made to feel less valuable. If you think we should be criminalised, then why don't you criminalise people with other conditions that can be transmitted.* (65-74, gay, male, Pākehā)

Many respondents argued that the current laws are outdated and have not kept pace with scientific developments. They emphasised undetectable viral loads should be acknowledged as constituting reasonable precautions, and the legal framework should reflect contemporary evidence.

- *We are archaic in having this law in our society where sexual orientation and freedom is widespread and mostly accepted.* (65-74, gay, male, Pākehā)
- *Times have changed and so has HIV, criminalisation feeds into the stigma and discrimination that surrounds HIV, which makes it more difficult to talk about and be open about.* (55-64, gay, male, Pākehā)
- *I am undetectable and I cannot pass on HIV. The fact that I could be prosecuted for having unprotected sex albeit there is no risk of transmission impacts heavily on my mental wellbeing, is unfair, unfounded and makes me live in fear that I can get blackmailed.* (45-54, gay, male, Pākehā)
- *Outdated laws aren't relevant to undetectable viral load.* (25-34, gay, male, Māori/Pacific)

Participants also criticised the legal and policy context as overly broad. They argued that blanket approaches fail to account for the diverse circumstances in which HIV transmission risk is absent or negligible, and the current framework does not allow for situations where criminalisation is inappropriate.

- *The law criminalises all those living with HIV. Those of us who are undetectable are responsible and taking steps to avoid transmission.* (55-64, gay, male, Middle Eastern)
- *It is too broad there are so many different circumstances which should not be criminalised.* (65-74, straight, female, Pākehā)
- *It is not fair to have a blanket approach for this.* (25-34, gay, male, Asian)

Overall, most participants viewed the current legal and policy environment as outdated and contributing to ongoing stigma. Many expressed concern that the existing framework discourages testing and effectively penalises people for knowing their HIV status.

- *[…] Criminalisation of "criminal nuisance due to exposure" reinforces stigma and discrimination of the HIV positive person, depicting them as a potential "criminal" who puts others at potential risk of harm when there is no potential for exposure if the person has an undetectable viral load an therefore the potential for exposure is non-existent, so therefore it is INACCURATE and a FALSE LAW based on outdated information.* (55-64, straight, female, Māori)
- *It's a long outdated and discriminatory piece of law with echoes of past (current?) homophobia and reflects a lack of political courage to grasp the nettle of change.* (65-74, gay, male, Pākehā)
- *This is archaic.* (35-44, gay, male, Pākehā)
- *With PrEP and U=U now changing the whole landscape of HIV transmission and sexual encounters, this new landscape must be legally shifted to honouring those who clinically cannot pass on HIV.* (55-64, gay, male, Pākehā)

Some participants, however, felt the existing laws were fair when applied to cases of deliberate or intentional transmission.

- *Only if done on purpose.* (65-74, straight, female, Pākehā)
- *I think there should be criminalisation only if there is malicious intent or gross negligence involved. Accidental and incidental infection could be on a case-by-case basis or should be reviewed by a health professional.* (55-64, straight, female, Pacific)

At the same time, many respondents acknowledged uncertainty about the issue. Some felt they lacked sufficient knowledge to comment confidently, while others noted their understanding was shaped primarily by high-profile malicious cases reported in the media.

- *As stated, I wasn't totally aware of the criminal legislation on this issue.* (65-74, gay, male, Pākehā)
- *[…] The police and mainstream media definitely contributed to the hate, stigma, discrimination and death threats I received and ultimately shaped the public's perception of someone living with HIV in a negative way […]* (45-54, female, straight, Pacific)

> Participants also criticised the legal and policy context as overly broad.

Discussion

The findings show a strong preference for HIV to be managed through public health rather than the criminal justice system. This reflects a clear understanding among respondents that public health-based approaches are more effective and less harmful than penalising measures.

Although most participants supported a public health approach, there were noticeable differences by gender. Men were more likely to trust public health authorities compared to women. While this pattern may reflect broader differences in experiences with health services, including stigma or discrimination, it is also important to recognise that some women—particularly those who have experienced harm from a partner who did not disclose their HIV status—strongly support prosecution. These perspectives sit alongside the overall trends in the data. Building trust will require culturally safe and gender-responsive strategies that make public health pathways accessible and supportive for everyone.

Police involvement was generally viewed negatively, with many participants seeing it as punitive, stigmatising, and counterproductive to health goals. However, some differences emerged across ethnic groups and among people recently diagnosed with HIV. Māori and Pacific respondents were more likely to express uncertainty, which may reflect historical experiences with policing and systemic inequities. People who were recently diagnosed showed more support for police involvement than those living with HIV for longer.

Most participants felt current laws are unfair, particularly because criminalisation can apply even when there is no risk of transmission. There was strong agreement that criminalisation should only apply to deliberate transmission, but views varied by ethnicity, time living with HIV, and migrant status. Some ethnic minority groups expressed stronger support for limiting criminalisation, while Māori and Pacific respondents showed more diverse opinions, including higher levels of disagreement. Recently diagnosed people and recent migrants were more likely to support limiting criminalisation to cases of intentional transmission. In contrast, permanent residents showed a more varied and divergent range of views on how criminalisation should apply.

Overall, these patterns reinforce concerns that criminalisation perpetuates stigma and creates barriers to testing and care. They highlight the need for policy reform and education that is informed by community voices and tailored to different groups ensuring that HIV is treated as a health issue rather than a criminal one.

> Most participants felt
> current laws are unfair...

Recommendations

Shift from criminalisation to public health management

Establish clear Police investigation guidelines for HIV-related cases and standardise frontline procedures reflecting contemporary HIV science for investigations relating to HIV accusations, including accurate understanding of PrEP and transmission risk.

- Ask about viral load status early, and ensure rapid referral to Public Health, enabling prompt closure of cases where no risk exists.
- Mandate culturally safe, non-stigmatising approaches among frontline staff to prevent unnecessary escalation and harm.
- Apply harm-minimisation principles, recognising criminal investigations rarely improve health or safety outcomes.
- Embed community co-design in all education and reform efforts to ensure they are equitable, culturally grounded, and scientifically accurate.
- Develop national prosecutorial guidelines for HIV cases
  - Limit prosecution to cases of intentional or deliberate transmission only
  - Work with Police and HIV community organisations to define clear thresholds, including proof of intent and confirmed transmission.
- Establish monitoring and accountability mechanisms to track how allegations are handled, how often cases progress, and whether responses align with contemporary HIV science and human rights standards.

Embed the government's U=U endorsement

Policy-level action

- Align Police, prosecutorial and judicial systems with U=U to ensure consistent, evidence-based decision-making.
- Deliver targeted professional education for those handling HIV-related cases, using short online modules and case studies co-developed with HIV organisations. Priority audiences would include Police frontline staff, judges, defence lawyers, and prosecutors.
- Ensure HIV policy reform and education initiatives are grounded in community leadership and tailored to diverse population needs.
- Invest in tailored, culturally responsive public health messaging to improve knowledge, trust, and engagement among Māori, Pacific peoples, women, gender-diverse people, recent migrants, and newly diagnosed people.

Community-level actions

- Strengthen support for applying U=U in real-life contexts. Although participants understood HIV combination prevention broadly, references to condom and PrEP use with partners despite U=U—and to condom use for oral sex—indicate that people may still need clearer, more practical guidance on how to confidently apply U=U in their own sexual decision-making.
  - Share real stories and bust myths through peer-led storytelling, supported by trusted clinicians.

Healthcare staff

- Secure clinician support and alignment for U=U messaging and evidence of zero transmission risk, recognising clinicians' key role in informing patients and influencing reporting, documentation, and interactions with authorities.

Burnett Foundation Aotearoa

Positive Women Wāhine Kaha

Body Positive New Zealand Tinana Ora Aotearoa

Toitū Te Ao

Living with HIV? Your voice matters

Help us challenge
HIV criminalisation in Aotearoa

surveymonkey.com/r/HIVCrimP

[QR Code removed as no longer active]

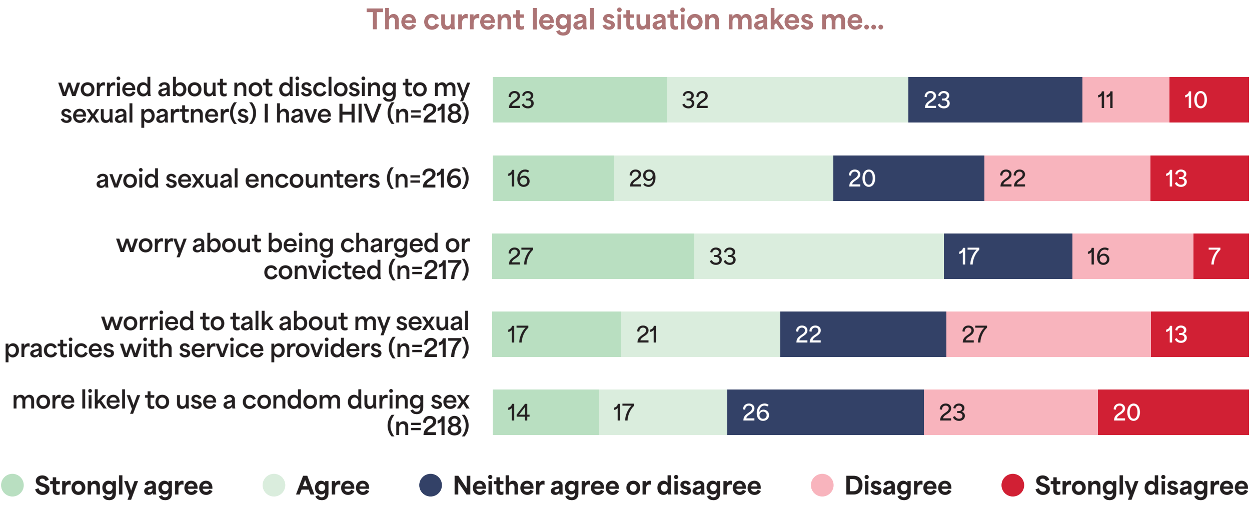
Example poster used for survey recruitment

Section 4: Impact - How these laws affect people living with HIV

This section looks at the impact of the current legal situation on people's behaviour.

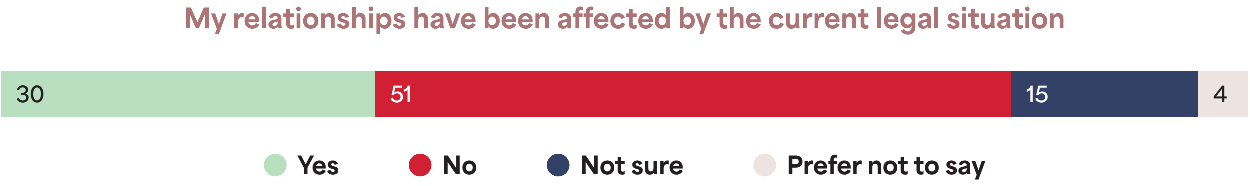
Over half of respondents reported worries about being charged or convicted (60%) or disclosing their HIV to their sexual partner(s) (55%), and 38% indicated being worried talking about their sexual practices with service providers. Nearly half of respondents (45%) reported avoided sexual encounters due to the current legal situation, and 31% stated it was more likely to prompt them to use a condom.

Figure 15: Impact of the current legal situation on respondents' behaviour (in %)



Three in ten respondents (30%) said that their relationships have been affected by their legal situation, while half of the respondents said it had no effect (51%).

Figure 16: Effect of the current legal situation on respondents' relationships (in %) (n=218)



Worry about the legal consequences

Many participants described significant worry about the legal consequences of not disclosing their HIV status. For some, this anxiety had a direct impact on their mental health.

- *I worry that I might be convicted due to someone's prejudice or discontentment.* (35-44, bisexual, male, Asian)
- *This diagnosis capsizes people's lives and then it severely impacts their mental health, self-esteem and confidence to open up to others due to guilt, self-accusations and lack of proper understanding from the community/family/society. It definitely makes people nervous to even meet new people or even think about a relationship! It can affect the ability to think, work or even live a normal life. Criminalising makes it way worse!* (25-34, gay, male, Asian)
- *Under the current legislation I could be taken to court, that's a worry.* (65-74, gay, male, Pākehā)
- *Yes, as the law is still the Law, even if the courts defer to the science of now re HIV - and heading to court and living through the process is very stressful all the same.* (55-64, gay, male, Pākehā)
- *I don't put myself in that situation. But that is really sad and has had a bad impact on my life for over 20 years now.* (65-74, straight, female, Pākehā)
- *I have had countless sleepless nights over 25 years worrying about this.* (55-64, straight, female, Pākehā)

Alongside concerns about legal consequences, many participants also expressed fear of harassment, rejection, or negative reactions if they did disclose. Among those who had disclosed in the past, several recounted experiences of stigma or discrimination following disclosure.

- *It leaves me open to retribution... Even telling is no guarantee of safety from prosecution.* (55-64, gay, male, Middle Eastern)
- *Knowledge can be weaponised.* (55-64, gay, male, Pākehā)
- *Yes - with a previous boyfriend threatening to press criminal charges once we had broken up.* (45-54, gay, male, Pākehā)
- *Last year I told a closeted man I was undetectable. He chose to fuck me with a condom, despite me giving him several chances to stop. He later regretted it and threatened to go to the police claiming I'd never told him. This caused me deep distress, potentially being in a he-said scenario all because of his insecurities/guilt.* (55-64, gay, male, Middle Eastern)
- *Yes, I don't tell them due safety and it causes mental anguish and guilt feelings, yet I am U=U for many years. Eff that law that brings that upon me!* (55-64, gay, male, Māori)

- *I tell nobody so that there is nobody that could use it against me.* (35-44, gay, male, Pākehā)
- *There is a lot of misinformation and lack of education but also this current legal frame leaves me vulnerable to people with ulterior motivations that could take advantage and this could take the form of blackmailing. The number of times I have told people and they are not interested or I am blocked.* (35-44, gay, male, Latin American)
- *Partners are unpredictable and can often become abusive when they are not clear of matters.* (65-64, gay, male, Pākehā)

Some participants worried that once they disclosed to a sexual partner, their HIV status might be shared more widely without their consent (for example, with colleagues or within their social networks). This fear of onward disclosure shaped how, when, and to whom they chose to disclose.

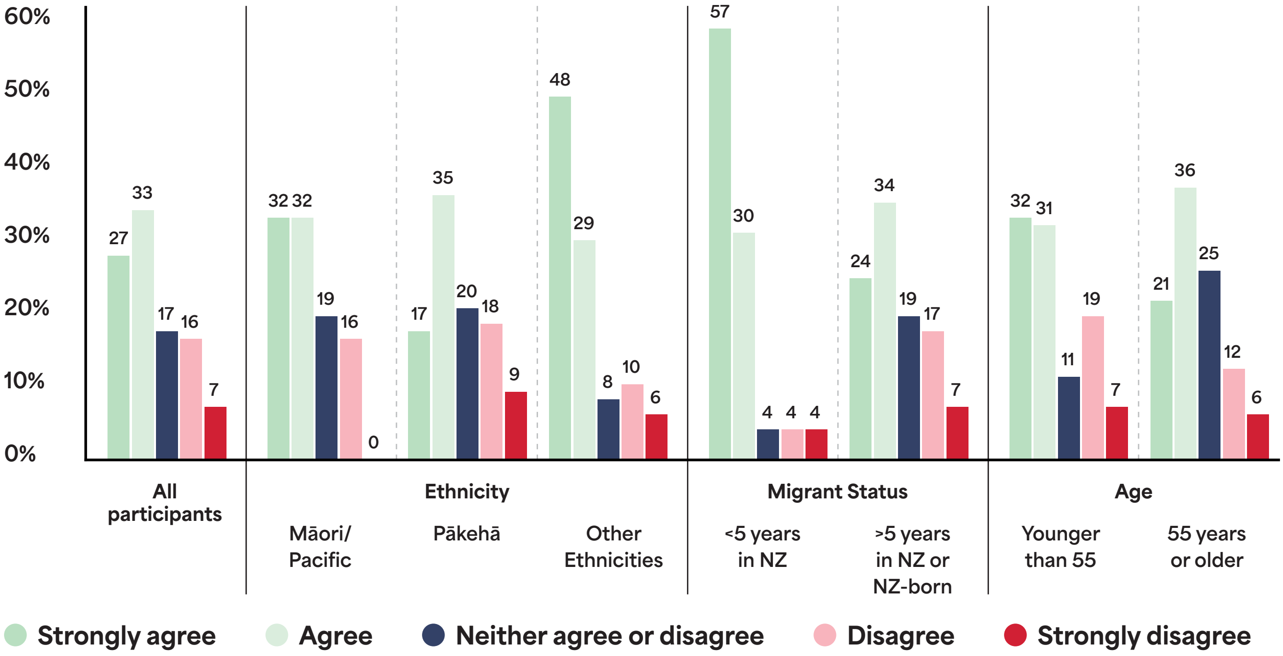
- *The legal obligation to disclose HIV status can compromise other situations, e.g. workplace discretion.* (55-64, gay, male, Pākehā)
- *If someone is truly undetectable, then there is no risk to the partner and only risk is to that person. That partner could tell other people, they could do a lot more harm to the person with HIV, especially those who are not publicly out about their status.* (35-44, gay, male, Māori)

Analysis of responses to the statement *"The current legal situation makes me worried about being charged"* demonstrated clear differences across demographic groups (Figure 17). Agreement was highest among respondents from another ethnicity, with 48% strongly agreeing, followed by 32% of Māori and Pacific peoples, and just 7% of Pākehā. Conversely, Pākehā respondents were most likely to disagree, with 27% selecting this option, compared to 16% among other ethnicities and Māori and Pacific peoples.

> ...worried that once they disclosed to a sexual partner, their HIV status might be shared more widely without their consent...

Migrant status also influenced perceptions of risk, with 57% of recent migrants strongly agreeing that the legal environment made them worried about being charged, compared to 24% of permanent residents. Age differences were evident as well: respondents under 55 years were more likely to agree (63%), while one in four respondents over 55 (25%) selected "neither agree nor disagree."

Figure 17: The current legal situation makes me worry about being charged or convicted for HIV exposure, for not telling my sexual partner I have HIV (in %) for all participants and by ethnicity, migrant status and age



> Migrant status also influenced perceptions of risk, with 57% of recent migrants strongly agreeing that the legal environment made them worried about being charged…

Navigating sexual encounters

Participants described a range of strategies for navigating sexual encounters in the context of legal, social, and emotional pressures. Some chose to have sex exclusively with people they trust or other people living with HIV (so-called 'sero-sorting'), explaining that this reduced anxiety about disclosure, transmission, and potential legal consequences. Others preferred anonymous sexual encounters, which they felt allowed them to avoid difficult conversations or minimise the emotional weight of disclosure.

- *Usually when I engage in sexual activity they are at venues that are anonymous.* (25-34, gay, male, ethnicity not stated)
- *I tend to stick to partners I can trust so it isn't that scary, but it gets on my mind when having a new partner.* (18-24, pansexual, genderfluid, African)
- *U=U = zero risk. Why should I risk being bashed because I might cruise up some nice anonymous sex and be required to say something that can have ZERO EFFECT on the other party (they cannot get HIV) yet may see me bashed? Seriously how is that catering to the lifestyles of some? No possibility MUST equate to NO NEED. Why advise something that can have zero relevance to the other party but may cause death severe injury abuse to the person so disclosing? Where is the value in having to make such a statement disclosure? It is lopsided, dangerous and not required due [to] zero risk.* (55-64, gay, male, Māori)
- *I seek partners who are HIV+ or on prep.* (55-64, gay, male, Middle Eastern)

Several respondents also highlighted the importance of shared responsibility for sexual safety. They argued the burden should not fall solely on the person living with HIV; instead, HIV-negative partners should also take steps to protect themselves, such as using condoms or PrEP.

- *[…] everybody should take responsibility for their own heath. It takes two (or more) people to practice a possibly unsafe sexual practice.* (55-64, gay, male, Pākehā)
- *The current status of criminalisation fails to account for progress in health measures where transmission cannot occur (such as U=U) or precautions that a prospective partner can take to reduce or negate transmission such as PrEP.* (25-34, gay, male, Māori)

Across accounts, it was clear that these worries had a significant impact on some participants' mental health. The constant need to assess risk, anticipate partners' reactions, and manage the legal implications of sexual activity created ongoing stress for many.

Avoidance of sexual encounters

A number of respondents reported abstaining from sex altogether to avoid the risk of legal repercussions or having avoided sexual encounters at times. For some, this avoidance was closely tied to feelings of self-stigma, which appeared implicitly throughout their accounts.

- *It is such a crushingly distressing issue for me that I woefully chosen to avoid sexual pleasure with another human for the past 25 years. I am a beautiful, sensual, attractive women bereft of any loving intimate and essential human interaction and sexual expression because of this hideously foreboding law.* (55-64, straight, female, Pākehā)
- *[Avoiding sex is] easier and safer.* (55-64, gay, male, Pākehā)
- *I was celibate for years because it was too complicated.* (45-54, gay, male, Pākehā)

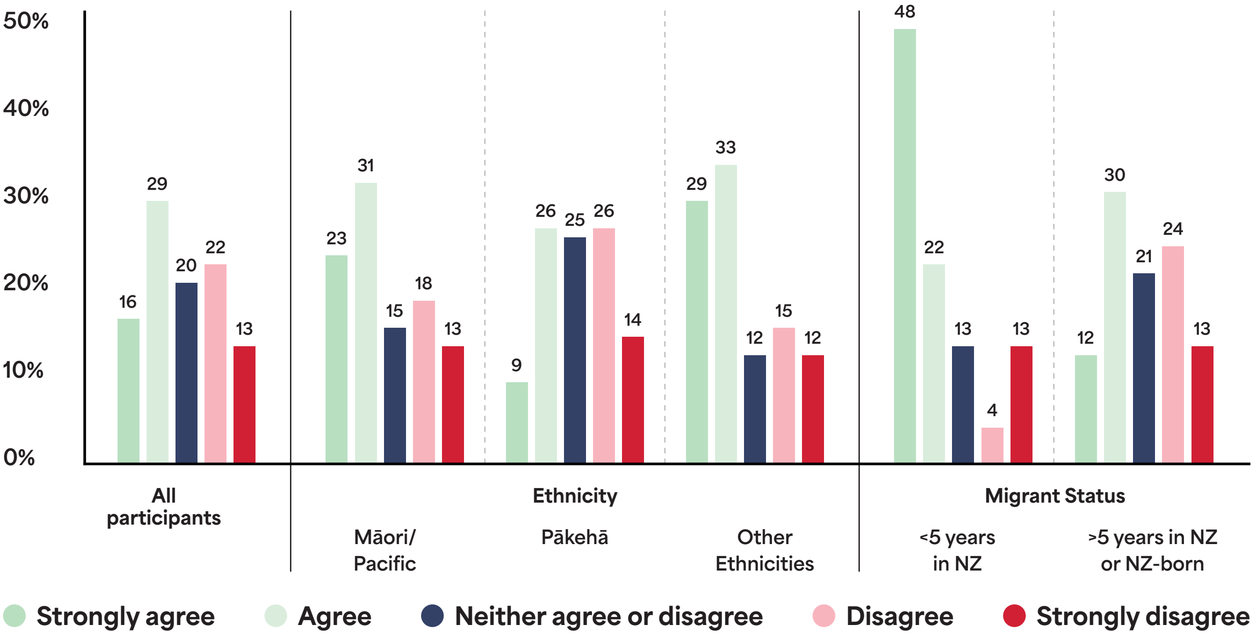
Participants identified a range of factors that contributed to their avoidance, including fear of rejection, concerns about disclosure, and anxiety about potential partners' reactions. Some responses suggest people with an undetectable viral load say they are on PrEP instead, as this avoids stigma or unwanted disclosure, even though it does not meet current legal disclosure requirements.

- *I have missed the chance to have relationships because we have already had sex and then when it became more serious, I was too scared to disclose. I have been rejected for disclosing beforehand and then had that person tell me that I shouldn't have been seeking sex because it's against the law and that left me petrified for a time.* (35-44, gay, male, Pākehā)
- *When I was dating, I would avoid sex mostly because of transmission but also legal stuff* (35-44, straight, female, Māori)
- *I prefer to refrain from sex than exposing myself to stigmatisation. […] Eventually the attraction fades away … another story that never was!* (35-44, gay, male, Latin American)
- *I have yet to have sex with someone new since I have become HIV+. I'm very anxious that they will reject me when I tell them.* (45-54, gay, male, Pākehā)
- *I don't have a partner, because the stigma is still strong out there. I'm like damaged goods in the community.* (35-44, non-binary, gay or lesbian, Pākehā)

Analysis of responses to the statement *"The current legal situation makes me avoid sexual relations"* revealed notable differences across populations (Figure 18). Agreement was highest among respondents from another ethnicity, with 29% strongly agreeing, compared to 23% of Māori and Pacific peoples. In contrast, Pākehā respondents were most likely to disagree (40%).

Participants' migrant status also influenced responses, as nearly half of recent migrants (48%) strongly agreed that the legal environment affected their sexual activity, compared to only 12% of those who moved to Aotearoa New Zealand more than 5 years ago or were born here ('permanent residents').

Figure 18: The current legal situation makes me avoid sexual encounters (in %) for all participants and by ethnicity and migrant status



Condom use

Condom use emerged as another strategy participants employed to navigate both legal and interpersonal concerns. Some described relying on condoms as a way to ensure zero transmission risk and to remain protected under the law. For these people, condom use was framed as a form of compliance with the legal context rather than a personal preference. Others emphasised condoms as a means of protecting both themselves and their partners from other sexually transmitted infections.

- *Yes, just complying with the legislation.* (65-74, gay, male, Pākehā)
- *As long as people use condoms and have undetectable viral loads, it is their choice to disclose their HIV status or not.* (25-34, gay, male, Asian)
- *I already know the risks of other stds/stis so I prefer to use it anyway.* (18-24, pansexual, genderfluid, African)

Several participants described managing these situations by stating upfront that they would use condoms, which they felt reduced the need for further discussion. However, some expressed concern that their insistence on condom use inadvertently signalled their HIV status, creating additional anxiety or prompting unwanted questions.

- *I have for years been reluctant to even go near another potential relationship due to fear of rejection if I tell someone. It has happened and it was horrible. More recently with the U+U campaign I was starting to feel like maybe I could go ahead with sex without disclosure if I used a condom. Now seeing this survey and the actual legal situation I need to review that sense that maybe I now had more options :(* (65-74, straight, female, Pākehā)
- *I will always use a condom if I meet someone new. I'm still only having sex with the person that is also HIV+.* (45-54, gay, male, Pākehā)
- *Due to the requirements to disclose where condoms are not used in penetrative sex, I always insist on condom usage with sexual partners.* (25-34, gay, male, Māori Pākehā)
- *If the vibe is good and the person is educated and aware of U=U or is on prep, or they say "I'm not going to catch anything from you" I say no with conviction, cos it's a fact. I feel sometimes in the heat of the moment or other things are influencing the and he just puts it in me without a condom, I almost feel scared to tell them after the fact that I am HIV+ because of the fear how they might react in the moment. I know there is no risk and why would I make someone else panic and go through those painful thought processes, have I/haven't I. It has only been a few times over the last 3yrs. I do use condoms because the outdated law requires me to.* (45-54, straight, female, Pacific)

Several participants noted decisions about condom use were negotiated with partners, reflecting a sense of shared responsibility. However, many also highlighted the challenges of condom use, including what they described as a widespread "anti-condom culture" within some sexual networks. Others reported difficulties maintaining erections when using condoms, which led to inconsistent use or avoidance of condoms altogether.

- *I am a bottom. Even I have an undetectable viral load and I always request my sexual partner to use condoms during anal sex, my partner can possibly claim that I did not use condoms during oral sex, if they find out later that I am HIV positive. That's why I am worried about not telling my sexual partner/s I have HIV. I always insist my partner to use condoms. Even I know that there is zero chance of HIV transmission for oral sex since I am undetectable.* (25-34, gay, male, Asian)

> ... some expressed concern that their insistence on condom use inadvertently signalled their HIV status

- *The culture has changed profoundly from a condom-based culture to a non-condom based one with PrEP as a HIV prevention tool (but of course not an STI control mechanism). At this time, you can be cancelled as it were by a prospective sexual partner for wanting to use a condom- this is the greater sexual culture as it stands presently and it has put pressure on all parties to engage in unsafe sex. This is how I took greater risks in honouring protection for myself prior to contracting HIV- this cultural shift in some not small part (and due my sensitivity to pharmaceutical and specifically some of the components of PrEP which I could not tolerate, with a pre-existing health condition) led to my becoming HIV positive.* (55-64, gay, male, Pākehā)

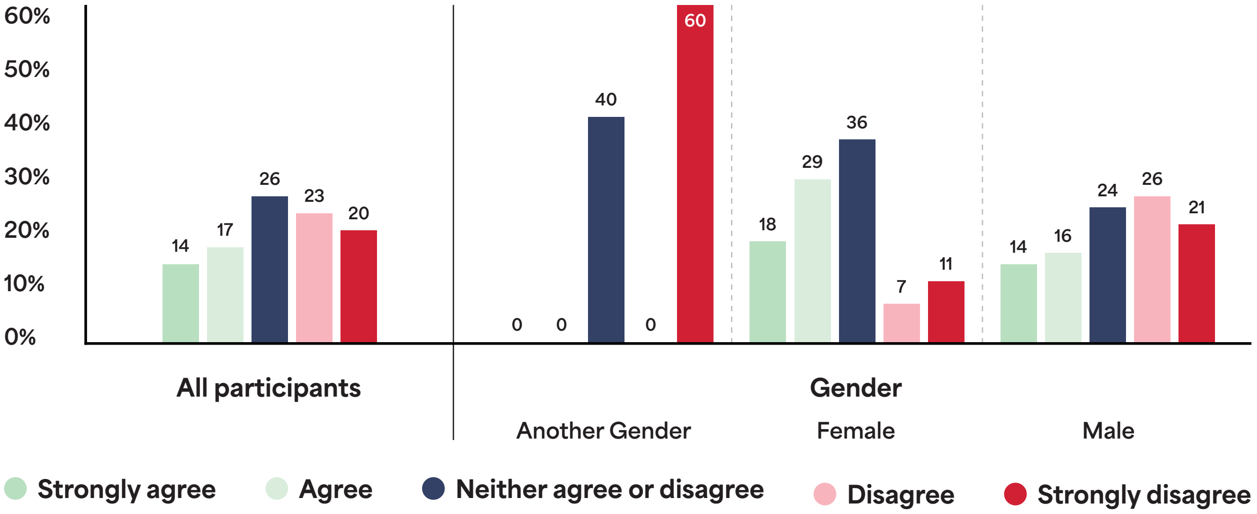
Some participants described encouraging or ensuring their partners were on PrEP, which appeared to provide them with a greater sense of confidence than relying solely on their own undetectable viral load. Conversely, a number of respondents stated they did not use condoms and did not perceive a need to do so.

- *I always would [use condoms] after my diagnosis anyway the criminalisation is not the reason.* (65-74, straight, female, Pākehā)
- *I don't engage in sex, but of course, even though I am far beyond the age of fertility and menstrual flow, I would always choose to have sexual intercourse (if that was ever a possibility for me) with a pleasure depleting condom, because I could be prosecuted if I didn't.* (55-64, straight, female, Pākehā)
- *Can't stay erect while using a condom. Will default to non-penetrative sexual activities if a problem* (45-54, gay, male, Pākehā)
- *I don't like condoms. I do get tested for STIs quarterly.* (45-54, pansexual, transfeminine, Pākehā)
- *[I use condoms] If partner is on PrEP for their peace of mind.* (55-64, gay, male, Pākehā)
- *Nope. I cannot transmit according to my medical advisors. Bloody well end of my security comes NEXT?* (55-64, gay, male, Māori Pākehā)

Analysis of responses to the statement *"HIV criminalisation makes me more likely to use a condom during sex"* revealed differences by gender (Figure 19). Nearly half of female respondents (47%) agreed that criminalisation influenced their condom use, compared to only 20% of male respondents. Conversely, 60% of respondents identifying as another gender disagreed, compared with 47% of male respondents and 18% of female respondents.

> Some participants described encouraging or ensuring their partners were on PrEP...

Figure 19: HIV criminalisation makes me more likely to use a condom during sex (in %) for all participants and by gender



Worries about disclosing, worries about not disclosing

Participants described a range of strategies in response to the pressure of disclosing. Some said they always disclosed to avoid any potential legal or interpersonal issues, often noting confidence in U=U as part of their reasoning. Others emphasised that they disclosed because they valued trust and transparency in their relationships.

- *Ethically I think it's my responsibility to inform partners of my status, so I am not at risk of these laws.* (35-44, gay, male, Pākehā)
- *I disclose to protect myself against prosecution, but I resent having to do it at as an Undetectable Gay Man.* (55-64, gay, male, Pākehā)
- *The strong laws make it an obligation to disclose and that is a good thing.* (35-44, gay, male, ethnicity not stated)
- *If I had a sexual partner, I would hope to have a relationship built in friendship, trust, honesty. For me if they can accept the whole of me they aren't getting a part of me.* (55-64, straight, female, Pākehā)

On the other hand, a smaller group reported they did not disclose because they were confident in U=U and felt prepared to challenge the law if necessary. For these participants, scientific evidence outweighed legal expectations

- *If I know I'm undetectable and I will not infect anyone I don't think it should be the case. There is a lot of stigma attached with HIV. Disclosing this despite of know you won't infect them will give rise to speculations. Also not to forget that it makes life difficult for the individual as information is passed around.* (25-34, bisexual, male, Pacific)

- *I have joked with other HIV+ people that I would be the face of legal change, others have also expressed to me that they would be willing to be charged for not disclosing to sexual partners and take on the legal system with the facts and science behind them.* (45-54, straight, female, Pacific)
- *For many people U=U is a difficult concept to get their head around. And even if they know about, trusting the science behind it is a different story* (35-44, gay, male, European)

Some participants reported including "+" or "undetectable" in their online dating profiles. For a number of them, this was considered a sufficient form of disclosure, while others questioned whether this approach met expectations or legal/ethical requirements.

- *Someone messaged saying "did you miss the prep train" I contracted HIV while I was a refugee in a third world country... I once felt liberated and shared in on my Grindr profile to this day people reject me and quickly say you have HIV right. And it messed with me for a while* (25-34, gay, male, Middle Eastern)

However, participants also noted being open in this way exposed them to discrimination, stigma, rejection, and even harassment.

- *The stigma attached to being HIV is real. and if you share your status then people run away. If you don't share, then you can be arrested and will be publicly shamed.* (65-74, gay, male, Pākehā)
- *I have an obligation to divulge this information to any potential sexual partner whether or not it ends in abuse or rejection.* (25-34, straight, female, Pākehā)
- *Facing the fear of rejection and even that the information will be spread is a horrible thing to live with. We should all be able to find a partner and build a family and the idea of that being impossible because rejection or stigmatisation makes love and life really hard.* (34-35, gay, male, Latin American)
- *I commenced a new relationship, disclosed my HIV+ status prior to engaging in any sexual contact with my partner, […] I also insisted upon condom use and safe sex practices. This relationship was later ended […]. My ex-partner threatened me with going to Police and saying that I didn't disclose my status and had sexually assaulted him. This caused me immense stress and fear for an extended period. […]* (55-64, straight, female, Māori)

A smaller group of participants described not worrying about these issues and reported having a satisfying sex life. A few strongly disagreed with the idea that they should avoid sexual encounters at all.

Discussing sex with service providers

Participants described a wide range of experiences when it came to discussing sexual practices with service providers. Many reported feeling comfortable being open with healthcare workers, noting transparency often led to better, more informed care. This sense of trust was particularly strong in infectious diseases (ID) clinics and sexual health services, where participants felt staff were knowledgeable, non-judgemental, and accustomed to these conversations.

- *Clear communications with my service providers have strengthened all of our practices. They know and support human rights primarily and legal responsibilities therein.* (55-64, gay, male, Pākehā)
- *I'm honest and frank with my service providers and have not felt judged.* (45-54, pansexual, transfeminine, Pākehā)
- *Can't get informed medical care without being honest about sexual activities.* (45-54, gay, male, Pākehā)

Some participants, however, drew distinctions between different types of providers. While they felt at ease discussing sexual matters with ID or sexual health clinicians, they were more hesitant with general practitioners or other healthcare professionals, often due to uncertainty about their level of understanding or comfort with the topic.

- *I'm okay with my GP. He knows. Sexual Health clinic knows and they are very inclusive. Big thanks!!! I hid this fact from dentist ages ago and now kinda worry about it.* (35-44, gay, male, Pākehā)
- *I'm comfortable talking about it with sexual health / ID providers but not GP or other specialities.* (55-64, bisexual, male, Pākehā)
- *[…] With medical professionals and my dentist I am candid about my status and sexual health because it contributes to the full picture of my wider health - but there are circumstances where I am reticent to disclose to services outside of these and have not sought things like insurance or gotten tattoos because of it.* (25-34, gay, male, Māori)
- *Being a female I'd rather talk to a female about sensitive issues Being judged for being human is horrible esp. to males, especially if it's all written down for the likes of student doctors to be in like files to read private stuff and it happens or male drs reading up on your personal stuff their needs to be blocks on this stuff only limited to one or two people.* (65-74, straight, female, Pākehā)

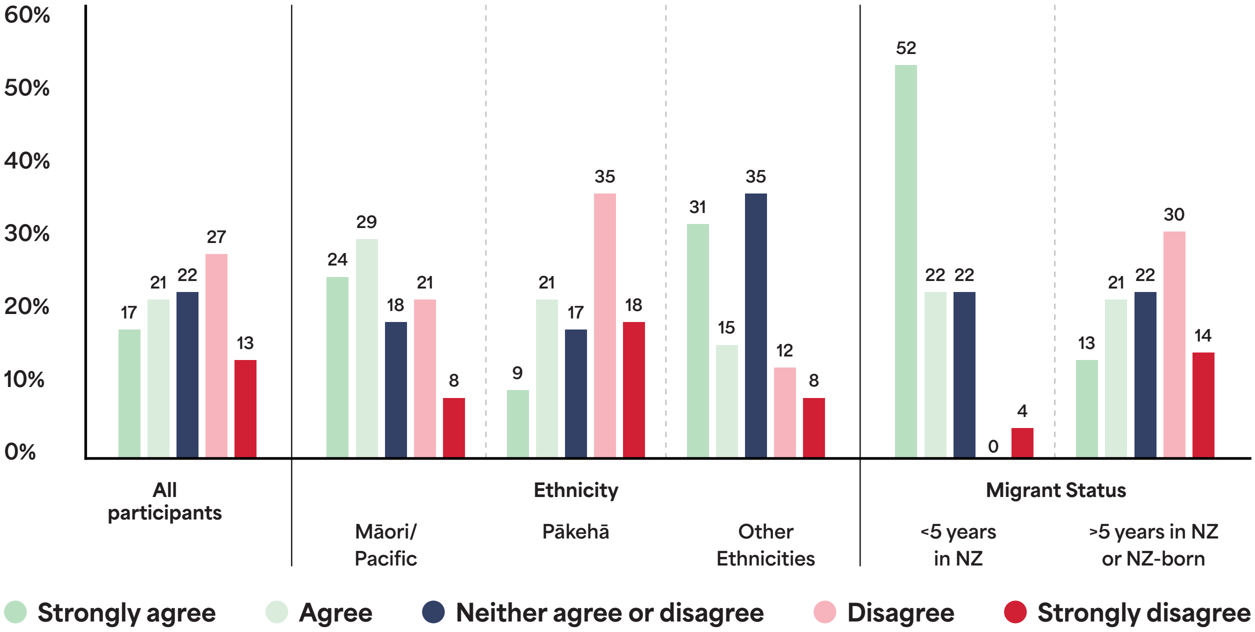
A smaller group expressed concerns or negative experiences. Some worried about being judged or having their behaviour scrutinised by healthcare workers. Others were unsure about confidentiality, specifically whether healthcare workers were required to keep such information private or could report it to the police. This uncertainty led some to fear inadvertently incriminating themselves. A few participants also noted they simply did not like discussing their sexual lives with providers, regardless of the context.

- *I don't know how much to share in case my Dr has to report to Police so I share as little as possible.* (65-74, gay, male, Pākehā)
- *Can I be prosecuted for disclosing a situation to my doctor? How does prosecution contribute to effective prevention strategies?* (55-64, gay, male, Pākehā)
- *It can be awkward talking to service providers and prefer not to* (18-24, pansexual, genderfluid, African)

Analysis of responses to the statement *"The current legal situation makes me worried to talk about my sexual practices with service providers"* revealed significant variation across populations (Figure 20). More than half of Māori and Pacific respondents (53%) agreed with the statement, compared to 46% of respondents from other ethnicities and 30% of Pākehā. In contrast, over half of Pākehā respondents disagreed, compared with just 19% of respondents from another ethnicity.

Migrant status also influenced levels of concern: 52% of recent migrants strongly agreed that the legal environment made them worried about discussing sexual practices with service providers, compared to only 13% of permanent residents.

Figure 20: The current legal situation makes me worried to talk about my sexual practices with service providers (in %) for all participants and by ethnicity and migrant status



Missed connections and isolation

Participants described varied experiences regarding how their diagnosis and the surrounding legal context affected their relationships. Several respondents were not currently in relationships, often noting they avoided pursuing romantic or sexual connections. Some spoke about “the ones that got away”, reflecting on missed opportunities or relationships they felt unable to pursue. Others described deliberately not putting themselves out there, citing fear, uncertainty, or emotional exhaustion.

- *I often avoid potential connections as I often don’t have the energy to address the HIV issue - yet again.* (65-74, gay, male, Pākehā)
- *I do not engage or attempt to have any type of relationship or any type of sexual contact due to the current laws.* (55-64, straight, female, Māori Pākehā)
- *I have ended relations because I have not felt comfortable disclosing to people who I have been dating for over a year. I required condoms to be used whenever we had sex and after that duration and given that we were monogamous it became difficult to keep insisting on condom usage and I didn’t want to disclose my status as that stage because I wasn’t sure how they would react - particularly that far into the relationship.* (25-34, gay, male, Māori)
- *I experienced abuse (physical verbal and psychological) because this legislation was used as an argument and excuse to enact domestic violence. It deeply affected me.* (35-44, gay, male, Latin American)

A number of participants reflected on earlier periods of avoidance but explained their experiences had shifted over time. Some were now in relationships characterised by trust, openness, and mutual understanding. For a few, navigating disclosure and legal concerns had even become an opportunity for education within their relationships, strengthening communication and connection.

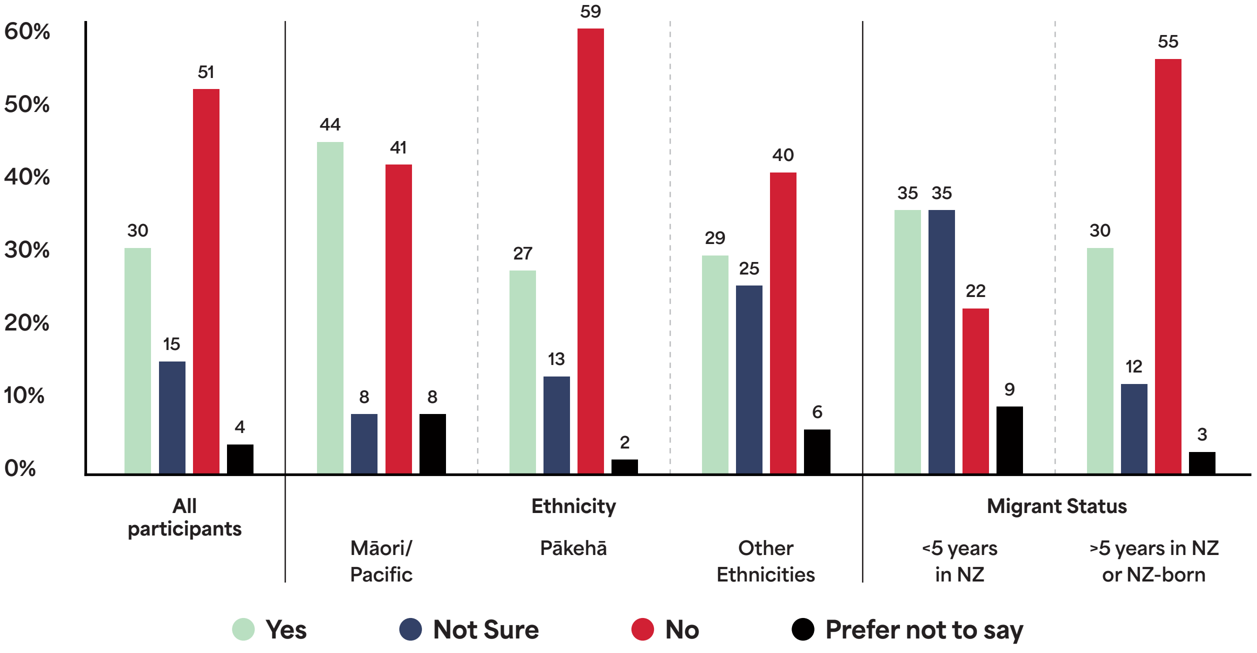
- *Sometimes threatened to be affected; however, this changes when there is better understanding.* (65-74, gay, male, Pākehā)
- *When I was still with my boyfriend, I did mention to him about my status and I gave him options. He ended up getting PrEP as a result.* (35-44, gay, male, Asian)

Some participants reported their relationships were not affected at all. These people explained they chose not to disclose, or that disclosure was not relevant in their particular circumstances, and therefore they experienced no noticeable impact on their relationships.

Analysis of responses to the statement *"My relationships have been affected by the current legal situation"* revealed differences across ethnicity and migrant status (Figure 21). Among ethnic groups, 44% of Māori and Pacific respondents agreed that criminalisation had affected their relationships, compared to 29% of respondents from other ethnicities and 27% of Pākehā. In contrast, three out of five Pākehā respondents (59%) disagreed, compared with 41% of people of another ethnicity and 40% of Māori and Pacific peoples.

Migrant status also shaped responses: over half of respondents born in Aotearoa New Zealand or living here for more than five years (55%) disagreed that the legal situation affected their relationships, while only 22% of recent migrants disagreed.

Figure 21: My relationships have been affected by the current legal situation (in %) for all participants and by ethnicity and time living with HIV



> A number of participants reflected on earlier periods of avoidance but explained their experiences had shifted over time.

Discussion

The findings show the current criminalisation of HIV has a profound and multifaceted impact on the lives of people living with HIV. Over half of respondents reported significant anxiety about criminal liability (60%) and disclosure obligations to their sexual partners (55%), with more than one-third (38%) expressing concern about discussing sexual practices with healthcare providers.

These concerns have real behavioural consequences, including avoidance of sexual encounters, which respondents described as depriving themselves of intimacy, pleasure, and romance. This demonstrates how legal frameworks intended to prevent harm may instead create harm by fostering isolation and reducing quality of life.

Impacts on relationship were also evident. Three in ten respondents (30%) said their relationships had been negatively affected by the current legal situation, while half reported no effect. This variation underscores that the law's influence is uneven, shaped by individual circumstances and intersecting social factors.

Population breakdowns highlight inequities in experience. Māori and Pacific respondents, as well as those from other Non-European ethnic minority groups, were more likely to report strong agreement with statements about avoiding sex and worrying about being charged. These patterns may reflect systemic inequities, cultural stigma, and historical mistrust of legal and health systems, underscoring the need for culturally safe and supportive clinical environments.

Recent migrants were disproportionately affected. Nearly half (48%) strongly agreed that the legal situation made them avoid sexual relations, and 57% strongly agreed they worried about being charged (more than double the rate of long-term residents). Migrants also reported greater discomfort discussing sexual practices with healthcare providers. These findings suggest that lack of familiarity with local laws, combined with cultural and linguistic barriers, amplifies vulnerability and uncertainties related to residency status.

Younger respondents (<55 years) expressed greater concern about prosecution (63% agreed) compared to older respondents, one-quarter of whom neither agreed nor disagreed. This may indicate generational differences in legal awareness or trust in health systems.

Women were more likely than men to report criminalisation influenced condom use (47% versus 20%), highlighting gendered differences in how legal risk is perceived and managed.

Overall, the findings reveal HIV criminalisation does not operate in isolation, but intersects with ethnicity, migrant status, gender, and age, compounding stigma and inequity and highlighting the unequal psychological and behavioural burden of current HIV laws. Fear of prosecution and disclosure obligations appear to discourage open communication with healthcare providers, which is counterproductive to public health goals. The law's negative effect on sexual behaviour and relationships further illustrates its unintended harms.

> ...the current criminalisation of HIV has a profound and multifaceted impact on the lives of people living with HIV.

Recommendations

Education and legal literacy

- Develop community-led education on HIV-related legal obligations and rights, tailored for Māori, Pacific peoples, recent migrants, women and gender-diverse people.
- Produce clear accessible resources in multiple languages and formats to provide clarity and reduce anxiety about legal risks.
- Integrate practical scenarios and case studies to help people apply knowledge to real-life situations.

Support systems

- Expand peer support and counselling for people living with HIV experiencing fear, stress, or relationship due to HIV criminalisation.
- Train healthcare providers to create safe, judgment-free spaces where sexual health and disclosure can be discussed openly.
- Provide targeted support for younger people, recent migrants, and ethnic minority groups, who report higher anxiety and behavioural impacts.

Structural inequities

- Co-design all resources with affected populations, to ensure the voices of those affected are central (i.e. Māori, Pacific peoples, recent migrants, women and gender diverse people)

Legal and policy alignment

- Monitor and review the impact of criminalisation laws to inform evidence-based policy reform and community-focused education.

Next steps

Next steps

Addressing HIV criminalisation in Aotearoa New Zealand requires a multipronged approach. Because HIV is prosecuted under general criminal law rather than a specific HIV statute, change cannot be achieved through a single legislative amendment. Meaningful progress will require shifts in how HIV is interpreted and treated across multiple systems, including policing, legal processes, public health practice, and media reporting. Options such as removing the association between HIV and "grievous bodily harm" in law or formally recognising undetectable viral load as a basis for excluding criminal liability, could reduce harm. However, these pathways are complex and would likely require political sponsorship from a supportive Member of Parliament—an uncertain prospect given the low public visibility of the issue.

While legislative reform remains one avenue, many of the most immediate and impactful changes are likely to occur through policy, practice, and guidance. This includes how police respond when allegations are made, ensuring investigations protect the mana, dignity, and privacy of people living with HIV; how prosecutors interpret risk and intent; and how public health agencies communicate contemporary HIV science. There is a need for monitoring and accountability mechanisms for tracking how allegations are handled, how often cases progress, and whether responses recognise contemporary science and human rights standards.

Alongside legal and policy reform, progress on HIV criminalisation will require sustained engagement across multiple systems. We have appreciated the openness and willingness of New Zealand Police to engage in these conversations, and we look forward to working more closely with the wider criminal justice sector to shift perceptions, improve understanding of HIV, and ensure that any investigations are managed in ways that uphold people's mana, dignity, and privacy.

Greater awareness is also needed of the public health pathways available under the Health Act, including when and how they have been used. Many participants were unclear about the distinction between criminal and public health responses, and clearer guidance for agencies, and for communities, would help ensure these pathways are used appropriately and consistently.

> Alongside legal and policy reform, progress on HIV criminalisation will require sustained engagement across multiple systems.

More resources are needed for people living with HIV to understand their rights, including what to expect if an allegation is made, how to navigate interactions with police or health authorities, and where to seek support. Strengthening rights-based information is essential to reducing fear and uncertainty.

There is also a need for deeper discussion about disclosure: how people currently manage it, how norms differ across communities, and whether expectations are shifting in the era of treatment as prevention. Better understanding these patterns would support more nuanced, culturally grounded guidance for both communities and service providers.

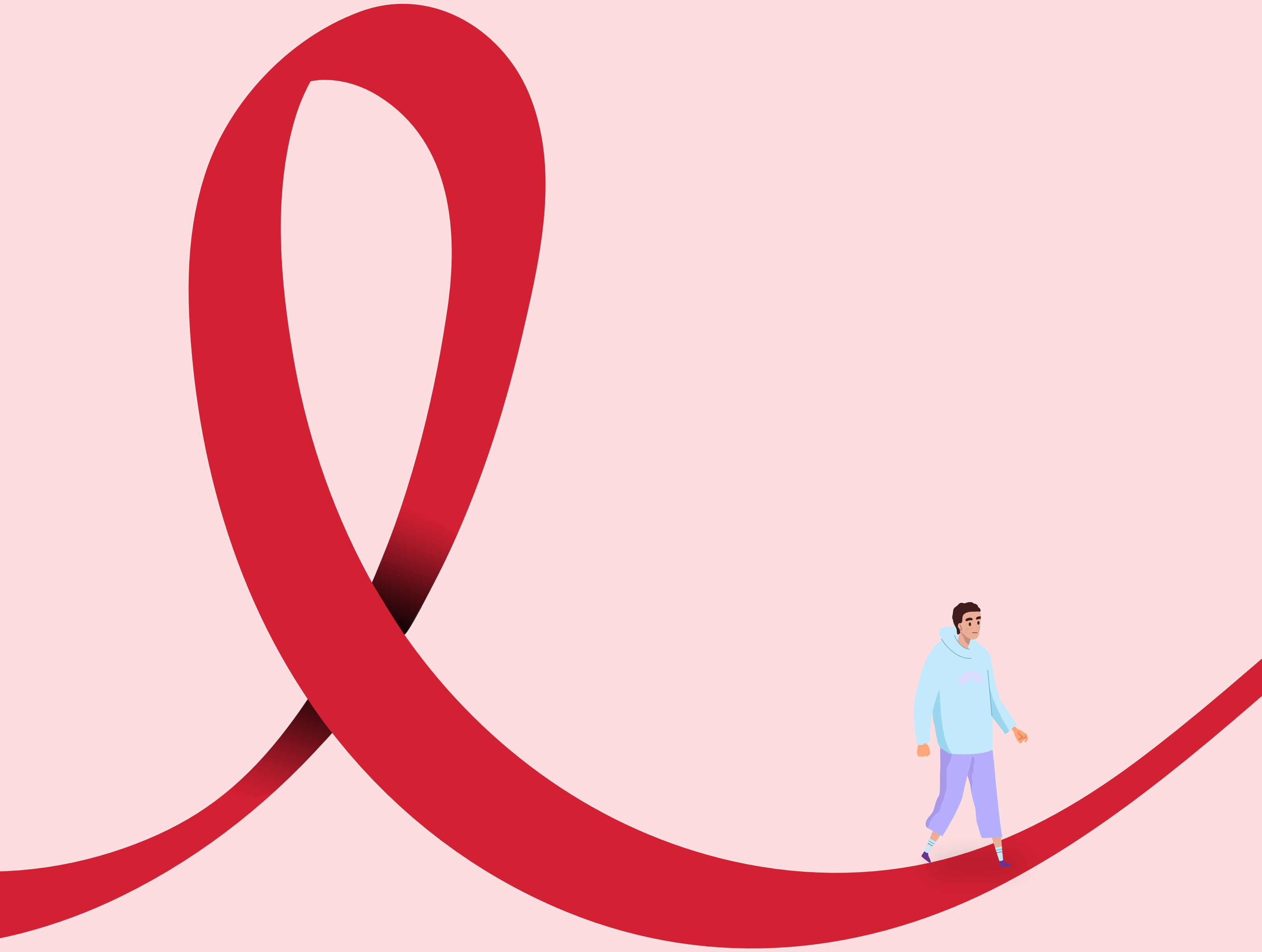
Media reporting also plays a critical role, and clearer guidance is needed to prevent sensationalism, protect confidentiality, and avoid reinforcing stigma.

Recommendations to support all these shifts are outlined throughout the report, recognising that reducing the harms of criminalisation will require coordinated action across multiple sectors rather than reliance on a single legal fix. People living with HIV must be at the forefront of this advocacy. Shifting away from punitive approaches to mechanisms that prioritise safety, communication, science, and wellbeing.

> More resources are needed for people living with HIV to understand their rights...

Glossary

confidentiality and privacy	These terms were used to emphasise no survey results will be shared that include any personal information that might identify survey participants.
Crimes Act 1961	In Aotearoa NZ there are no specific HIV criminal laws; however, people living with HIV have been charged and prosecuted under the Crimes Act 1961, which forms the basis of criminal law in Aotearoa NZ.
criminal nuisance	Criminal nuisance is a legal offense that involves an act or omission that endangers the public or individuals. Specifically, it refers to someone who does any unlawful act, or omits to discharge any legal duty, and that act or omission is one which they knew would endanger the lives, safety, or health of the public, or the life, safety, or health of any individual. Unfortunately, it has been applied to HIV in historic cases.
exposure	This includes situations where HIV transmission did not occur but the law considers it could have happened if condoms were not used, known as 'exposure'.
gay or lesbian	A person who is sexually attracted to the same gender. Lesbian refers to a woman who is sexually attracted to other women.
heterosexual or straight	A person who is sexually attracted to people of the opposite gender.
HIV criminalisation	HIV criminalisation describes the use of criminal law against people living with HIV based solely on their HIV status and is usually related to the management of HIV transmission. HIV criminalisation globally occurs in a range of different ways. *In Aotearoa NZ the Crimes Act 1961 can be used to charge or prosecute people living with HIV for unintentional HIV transmission, perceived or potential HIV exposure, and/or non-disclosure of known HIV-positive status. HIV criminalisation undermines both human rights and public health of people living with HIV.*
intentional or deliberate	This refers to a situation where someone attempts to pass on HIV to another person on purpose.
kaupapa	Issue, initiative
"manage" by Police means	Police should be responsible for investigating allegations of HIV transmission or exposure. This is how HIV is currently criminalised in Aotearoa NZ
"manage" by Public Health Authorities means	Public Health Authorities, under the Public Health Act 1956, have the powers to support and in rare cases, give orders to a person, suspected of having HIV, or diagnosed with HIV, to access testing, treatment and other services to prevent or minimise any risk to public health. If a person living with HIV was taking precautions while having sex i.e. using a condom, being on treatment and having an undetectable viral load and/or their partner was on PrEP, we believe they would not be considered a risk to public health.
people living with HIV	the term most often applied to people who have been diagnosed with HIV
Public Health Act 1956	In Aotearoa NZ, HIV is a notifiable disease under the Public Health Act 1956. This enables the Medical Officer of Health to identify if someone is considered a risk to public health and provide support. In rare cases the Medical Officer of Health may order a person to prevent or minimise their public health risk by testing, accessing treatment, counselling, contact tracing or other actions.
transgender	A person who has a gender identity different from the sex they were assigned at birth.



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Positive Women
Wāhine Kaha

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TOITU TE AO