

AIDS – New Zealand

AIDS AND HIV INFECTION IN NEW ZEALAND TO END OF JUNE 2000

In the second quarter of 2000, there were 11 notifications of AIDS (9 were males and 2 were females) and 25 people (16 males and 9 females) were found to be infected with HIV. To the end of June 2000, a total of 719 people (679 males and 40 females) have been notified with AIDS, and 1456 people (1259 males, 178 females, and 19 sex not stated) have been found to be infected with HIV.

Highlights of the XIII International AIDS Conference, Durban, South Africa, 9-14 July 2000

For the first time, the International AIDS Conference was hosted this year by a country in sub-Saharan Africa, a region in which more than two-thirds of all HIV-infected people live. More than 10,000 scientists, health care providers, public health professionals, activists, people with HIV and others gathered in Durban, South Africa, to address the many challenges that confront the global struggle against HIV/AIDS at the start of the 21st century.

With a theme of “Break the Silence,” the conference sought to build bridges between developed and developing countries through the sharing of knowledge and experience in such areas as HIV prevention, education and treatment. With its setting in South Africa, the conference drew world attention to the explosive spread of HIV in Africa’s most highly developed country. As conference attendees learned, the AIDS-related devastation that awaits South Africa is astonishing:

- HIV infection among antenatal clinic attenders has risen to 23% or more, from less than 1% in 1990. In KwaZulu-Natal province, where the conference was

held, fully one-third of pregnant women are now infected.

- 500 children are infected with HIV through mother-to-child transmission every day.
- 4.2 million people are now living with HIV, more than 10 percent of all HIV-infected people worldwide.
- 1 in 2 South African teenagers can expect to die from AIDS.

Nelson Mandela, the former president of South Africa, noted in his address that closed the conference that “a tragedy of unprecedented proportions is unfolding in Africa.” He said that in face of the grave threat posed by HIV/AIDS, “we have to rise above our differences and combine our efforts to save our people. History will judge us harshly if we fail to do so now, and right now.”

Success in controlling HIV/AIDS in Uganda

Not all the news from resource-poor countries of sub-Saharan Africa was grim. Uganda’s national AIDS strategy was held up as a model for other cash-strapped countries grappling with a high burden of HIV. With only modest international donor support, Uganda has witnessed declining trends in HIV infection since 1993 thanks to a candid and aggressive public health effort

involving central government, employers, religious communities and associations of people living with HIV/AIDS. The new approach has resulted in the voluntary testing and counseling of 400,000 people, the distribution of 30 million condoms each year and the provision of care and support for more than 100,000 infected people. As a result of the new strategy there has been a change in social norms regarding sexual risk reduction and a decrease in discrimination against HIV-infected people, researchers reported.

Funding for similar interventions in other impoverished countries of sub-Saharan Africa could be linked to overseas debt relief, several speakers noted, including Paul Zeitz of UNAIDS. This is starting to happen in Zambia, an extremely poor country in southern Africa where 1 in 5 adults is infected with HIV. Recently the Zambian government has been spending US\$130 million each year servicing its overseas debt, an amount more than double its entire health sector budget. But under a new agreement with the government of Japan, every dollar Zambia spends on repaying its debt to Japanese banks will be returned, with 50 percent earmarked to fund programs for orphans and other vulnerable children. Zambia is thought to have nearly one million children orphaned because of AIDS.

Female Controlled Protection

With the conference being held in the one continent where women who are infected with HIV outnumber men, attention at several sessions was focussed on ways to empower women to negotiate safer sex. Several countries have begun female condom programs, in which these condoms are distributed free with education about their proper use. But female condoms are not acceptable to all women, and often women who wish to use them face objections from their partners.

As an alternative, much hope has gone into investigations of potential microbicides, substances that will prevent the transmission of HIV by chemical or mechanical means

when applied vaginally or rectally. The leading compound to date has been nonoxynol-9, a cheap and readily available spermicide that has shown in vitro activity against HIV. Unfortunately, it now appears ineffective, or even harmful as an anti-HIV agent.

Data from two clinical trials presented at the conference showed that nonoxynol-9 had no protective effect among HIV-negative female sex workers. In fact, in one study there were more seroconversions in the treatment group than in those using a placebo compound. Researchers suggested that nonoxynol-9 not be used in populations with women at high risk of HIV infection. Several other compounds with potential use as microbicides are still under development.

Mother-to-Child Transmission

Many papers at the conference demonstrated short-term benefits of reducing mother-to-child transmission of HIV with nevirapine, zidovudine or zidovudine/lamivudine combinations. Unfortunately, it now seems that in predominantly breast-feeding populations, the benefits of drug treatment are easily lost. In an 18-month follow-up of the largely breast-fed children from one study that had shown a benefit from drug treatment in pregnancy there were no longer any differences in overall HIV acquisition between the treatment and placebo groups.

In resource-poor countries like those suffering most from AIDS in Africa, the usual advice for an HIV-infected mother to avoid breast feeding is simply impractical, unaffordable and culturally inappropriate. Bottle feeding puts infants at risk of other life-threatening diseases where mothers lack access to adequate amounts of formula or clean water, and in many communities women who do not breastfeed are likely to be stigmatised. Safe bottle feeding programmes and intensive community education are needed before HIV-infected mothers can confidently adopt artificial feeding as an alternative to breastfeeding.

Injecting Drug Use in India

One presentation highlighted a study of 224 male injecting drug users living on the street in Delhi, India. Forty percent of these men were already infected with HIV. Fully one-third of the men surveyed had never heard of AIDS, and two-thirds did not believe they were at risk for infection with HIV. Their health was generally very poor, and most of them engaged in very risky injection and sexual behaviour.

At present, 114 countries report HIV infections related to injecting drug use. This is up from 103 countries in 1998.

Structured Intermittent Therapy (SIT)

SIT is a new approach to HIV treatment which involves a complete discontinuation of highly active antiretroviral therapy (HAART) followed by a resumption of HAART in a planned cyclic manner. The aim of SIT is to give patients periods free of HAART while still controlling the amount of virus circulating in the blood. It has the potential to reduce the overall time a patient spends on HAART by as much as 30% to 50%, thus reducing the toxicities and costs associated with the medications.

To date the SIT concept is too new to draw definite conclusions. Anthony Fauci, director of the US National Institute of Allergy and Infectious Diseases, cautioned that it is still unknown whether this approach would precipitate drug resistance in an individual, and whether SIT would be as effective as continuous HAART in achieving clinical stability. He warned that infected persons on HAART should not experiment with treatment interruptions on their own outside of the closely controlled clinical trials of SIT that are now underway.

“Care for us and accept us”

One of the most moving moments of the conference came when 11-year-old Nkhosi Johnson spoke. Nkhosi, who was born HIV positive, now has AIDS and lives with his foster mother in Johannesburg. Together

they run a care centre for HIV-infected mothers and children. He told the opening session of the conference: “Care for us and accept us. We are all human beings. We are normal. We have hands, we have feet, we can walk, we can talk. We have needs just like everyone else. Don’t be afraid of us! We are all the same!”

AIDS and HIV Infection in New Zealand

The AIDS Epidemiology Group received 11 notifications of people (9 males and 2 females) with AIDS during the second quarter of 2000. Seven of the men were reported to have been infected through sex with men, one was reported to have been heterosexually infected when he lived in sub-Saharan Africa, and one was reported to have been heterosexually infected in a Pacific Islands country. One of the women was reported to have been heterosexually infected when she lived in sub-Saharan Africa.

The Group has been informed of 25 people (16 males and 9 females) found to be infected during the second quarter of 2000. So far information on the likely mode of infection has been obtained on 23. Of these 23, 5 were men who were reported to have had sex with men, 15 (8 men and 7 women) were reported to have been heterosexually infected (all except one overseas), one child was reported to have been perinatally infected in sub-Saharan Africa, one woman was reported to have been infected through an occupational needlestick injury overseas, and one man was reported to have injected drugs after sharing needles with other users.

EXPOSURE CATEGORIES AND ETHNICITY OF PEOPLE NOTIFIED WITH AIDS AND FOUND TO BE INFECTED WITH HIV

Information on the categories of risk, sex and ethnicity, of the 719 people notified as having AIDS and the 1456 people diagnosed with HIV in New Zealand to the end of June 2000 is shown in Tables 1 and 2 (overleaf).

Table 1. Exposure category by time of notification of people with AIDS, and by time of diagnosis for those found to be infected with HIV. A small number of transsexuals are included with the males.

Exposure category	Sex	AIDS				HIV Infection*			
		12 months to 31.12.00		Total to 31.12.00		12 months to 31.12.00		Total to 31.12.00	
		No.	%	No.	%	No.	%	No.	%
Homosexual contact	Male	17	63.0	579	79.4	30	34.0	778	52.6
Homosexual contact & IDU	Male	0	0.0	10	1.4	2	2.3	15	1.0
Heterosexual contact	Male	4	14.8	40	5.5	18	20.5	118	8.0
	Female	1	3.7	28	3.8	19	21.6	135	9.1
Injecting drug use (IDU)	Male	1	3.7	13	1.8	1	1.1	32	2.2
	Female	0	0.0	5	0.7	0	0.0	8	0.5
Blood product recipient	Male	1	3.7	16	2.2	0	0.0	29	2.0
Transfusion recipient	Male	0	0.0	1†	0.1	1	1.1	6	0.4
	Female	0	0.0	1†	0.1	0	1.2	6	0.4
	NS	0	0.0	0	0.0	0	0.0	5	0.3
Perinatal	Male	0	0.0	1	0.1	0	0.0	6	0.4
	Female	1	3.7	3	0.4	2	2.3	6	0.4
Awaiting information/ undetermined	Male	0	0.0	29	4.0	8	9.1	284	19.2
	Female	1	3.7	2	0.3	4	4.5	27	1.8
	NS	0	0.0	0	0.0	0	0.0	14	0.9
Other	Male	0	0.0	0	0.0	0	0.0	2	0.1
	Female	1	3.7	1	0.1	3	3.4	7	0.5
TOTAL		27	100.0	729	100.0	88	100.0	1478	100.0

NS = Not stated

*Includes people who have developed AIDS

†Acquired overseas

Table 2. Ethnicity by time of notification for people with AIDS, and by time of diagnosis for those found to be infected with HIV. Information on ethnicity of people found to be infected with HIV is only available since 1996. A small number of transsexuals are included with the males.

Ethnicity	Sex	AIDS				HIV Infection*			
		12 months to 31.12.00		Total to 31.12.00		12 months to 31.12.00		1.1.96 to 31.12.00	
		No.	%	No.	%	No.	%	No.	%
European/Pakeha	Male	13	48.1	549	75.3	33	37.5	178	42.5
	Female	1	3.7	23	3.1	4	4.5	18	4.3
Maori †	Male	4	14.8	76	10.4	4	4.5	20	4.8
	Female	0	0.0	3	0.4	0	0.0	4	1.0
Pacific Island	Male	2	7.4	17	2.3	2	2.3	6	1.4
	Female	1	3.7	4	0.5	3	3.4	7	1.7
Other	Male	5	18.5	38	5.2	16	18.2	96	22.3
	Female	1	3.7	12	1.6	18	20.4	66	15.8
Awaiting information/ undetermined	Male	0	0.0	7	1.0	5	5.7	19	4.5
	Female	0	0.0	0	0.0	3	3.4	5	1.2
TOTAL		27	100	729	100.0	88	100.0	419	100.0

NS = Not stated

* Includes people who have developed AIDS

† Includes people who belong to Maori and another ethnic group

For further information about the occurrence of AIDS in New Zealand contact
 Dr Jason Eberhart-Phillips, AIDS Epidemiology Group, Department of Preventive and Social
 Medicine, University of Otago Medical School, PO Box 913, Dunedin, New Zealand
 Phone: (03) 479 7201, Fax: (03) 479 7298, or Email jeberhart@gandalf.otago.ac.nz