July 2009
Edition 1

NZAF HIV Prevention Plan 2009-2014

Mahere Ārai Mate Āraikore

NEW ZEALAND AIDS FOUNDATION
Te Tūāpapa Mate Āraikore o Aotearoa

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Introduction
He Kupu Whakataki

The New Zealand AIDS Foundation (NZAF) aims to achieve its vision of a world without HIV and AIDS through its mission of preventing the transmission of HIV and supporting those affected by HIV to maximise their health and wellbeing. In the 24 years of the HIV epidemic in Aotearoa New Zealand, the landscape the NZAF works in has changed. Homosexual Law Reform, the internet and the advent of antiretroviral therapies are a few of the significant events that have changed the environment that the NZAF first confronted in 1984.

This plan marks the first comprehensive review of NZAF HIV prevention programme delivery for many years. In 2008, New Zealand recorded the highest number of new HIV diagnoses ever, and with the continued rise in new diagnoses since 2002, it is both timely and necessary for this review to occur.

The NZAF HIV Prevention Plan 2009-14 is knowledge based: robust scientific evidence and the best epidemiological and behavioural surveillance available provided the basis for this plan. This evidence has unequivocally shown that to prevent HIV transmission, prevention initiatives must occur in the places where HIV prevalence is, and those initiatives must be focused on changing the risk behaviours of the groups most at risk. To respond effectively to the changing environment of the epidemic the NZAF must also embrace social marketing and new technology while maintaining the values and principles of the communities we serve, including a clear and sincere commitment to takatāpui and whānau.

Increasing condom use is the core tenet of the plan because using condoms and lube remains the single most effective intervention to prevent the transmission of HIV.

This plan recognises that the people most at risk of HIV are influenced by their partners, whānau, family, friends, colleagues, employers, communities, and the society in which they live. To reduce HIV prevalence, Aotearoa New Zealand must foster a condom culture; a social movement that promotes, supports and demands consistent use of condoms and lube.

The NZAF HIV Prevention Plan 2009-14 and the new directions it heralds are singular in purpose – they will ensure that the NZAF reduces the rate of HIV transmission in Aotearoa New Zealand.

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July 2009

Process
Tikanga

A process that involved close analysis of scientific evidence and surveillance literature has been followed to develop this plan.

The NZAF identified a five stage process to develop this plan. In stage one a group of NZAF staff analysed literature identified as appropriate and useful to develop HIV prevention and intervention programmes. The research included behavioural surveillance data on gay men in New Zealand (Gay Auckland Periodic Sex Survey and Gay Online Sex Survey), HIV epidemiology from the AIDS Epidemiology Group at the University of Otago, data from Youth 2007 (Adolescent Health Research Group, University of Auckland), a specific study into non condom use in Auckland (Massey University), data from HIV Futures NZ[2] (Latrobe University), and a variety of international HIV prevention literature.

The question 'what do we know?' was asked in an externally facilitated discussion and then the information collated was extrapolated to identify key target audiences.

These audiences were then considered by a smaller group of people (stage two), and four key behaviours were identified as the most effective to reduce transmission of HIV in Aotearoa New Zealand. Several health outcomes were proposed for each behaviour and collated into a simple programme logic model. The initial group then reconvened to integrate feedback from the external reviewers of stage two and to develop the programme logic model (stage three). The programme logic model identified specific activities, ensuring that the outcomes proposed matched the goals of the NZAF Strategic Plan 2005-2010 and the service specifications in the existing Ministry of Health contract, and that the activities effectively targeted the groups identified at the beginning of the process.

Stage four focused on detailed organisational planning, including budgeting for the new model and identifying a structure and specific staff roles. Stage five focused on the implementation of the plan and involved organisational change, engaging with key external stakeholders and establishing a reference group of key stakeholders to guide the implementation.

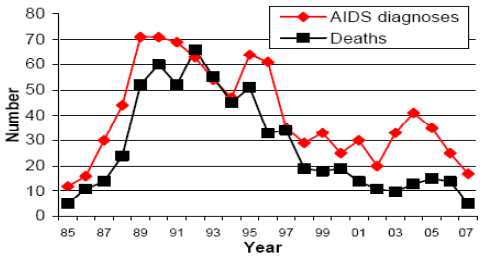
NZAF staff were engaged in this process and had the opportunity to participate in the process.

HIV in Aotearoa New Zealand
Mate Āraikore Aotearoa

Since 1985, AIDS has been notifiable (by anonymous coding) in New Zealand. HIV is not notifiable (as at June 2009) but a voluntary system of anonymous surveillance has been in place since 1986. Since the mid-1990s, AIDS deaths have decreased due to the availability of antiretroviral therapies. Antiretroviral therapies delay the progression of HIV infection to AIDS. The decrease in AIDS diagnoses has led to AIDS being less useful as a means of tracking the HIV epidemic. Since 1996, an enhanced surveillance system for HIV diagnoses has provided detailed information on HIV diagnoses and improved understanding of patterns of HIV infection (Saxton, Dickson & Hughes, 2006).

AIDS diagnoses peaked in 1989 (see Figure 1). New Zealand was one of the first countries in the world to experience a decline in AIDS incidence (Sharples, et al, 1996), and the major factors responsible for this are likely to have been the reduction in HIV infection among men who have sex with men (MSM) in the late 1980s, and the effective prevention of epidemics in other at risk populations (sex workers and injecting drug users (IDU)).

Figure 1



Annual number of diagnoses of AIDS and deaths among people notified with AIDS (The number of notifications and deaths for 2007 might rise due to delayed reports).
(Source: AIDS Epidemiology Group, University of Otago, 2008)

HIV tests may not be carried out until years after HIV has been acquired so the number of HIV diagnoses should not be interpreted as the number of people annually infected with HIV. In addition, not all people at risk will have been tested.

Exposure categories of annual HIV diagnoses via Western blot antibody testing.
(Note: Does not distinguish between infections acquired in NZ and overseas).

Data provided by AIDS Epidemiology Group, Department of Preventitive and Social Medicine, University of Otago.
Graph produced by Research, Analysis and Information Unit, New Zealand AIDS Foundation; 2008.

The HIV epidemic in New Zealand is comprised of two distinct sub-epidemics, one among MSM and one among heterosexual migrants.

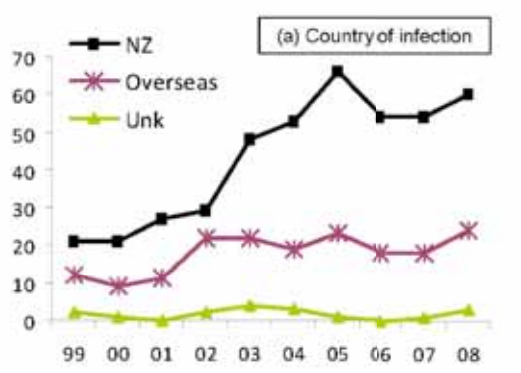
Throughout the past decade (1999-2008) the majority of MSM were infected in New Zealand. Since 2002 the number of infections acquired in New Zealand has risen while the number acquired overseas has remained level. In most years over the past decade, there have been more diagnoses of HIV among MSM in Auckland than in the rest of New Zealand combined.

The number of people diagnosed with HIV acquired through heterosexual contact peaked in 2006, probably a reflection of legislative changes requiring more HIV testing for immigration purposes in November 2005. In contrast to the situation with MSM, the majority of people with heterosexually acquired HIV over the period 1999-2008 were infected overseas; 81% in 2008. These infections were mainly acquired in countries where there is a high prevalence of HIV in the heterosexual population.

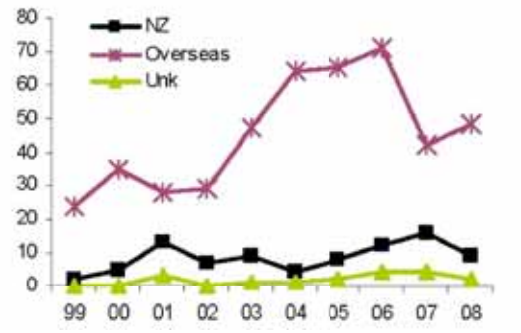
Perinatal infection (HIV transmission from mother to child) primarily occurs in another country and is later diagnosed in New Zealand. Perinatal HIV transmission has not occurred in NZ, by a woman who knew she was HIV positive, since 1995.

In 2008, 184 people were newly diagnosed with HIV in New Zealand through antibody testing. This is one more than the previous high of 183 new diagnoses in 2005. 91 were men infected through sex with other men, 61 (39 men and 22 women) through heterosexual contact, 2 through injecting drug use, 2 through a transfusion (overseas), 4 were children infected through mother-to-child transmission (3 overseas and 1 in New Zealand), 3 people had another means of infection, and for 21 people the means of infection was unknown or unreported.

Over the five years from 2004 to 2008 inclusive, MSM have accounted for 79% of the total HIV diagnoses by antibody testing in New Zealand, where HIV infection has occurred in New Zealand.



Place of infection of MSM diagnosed by antibody test, by year of diagnosis
(Source: AIDS Epidemiology Group, AIDS-New Zealand, 2009)



Place of infection of those infected through heterosexual contact, diagnosed by antibody test, by year of diagnosis
(Source: AIDS Epidemiology Group, AIDS-New Zealand, 2009)

Ethnicity† by time of diagnosis in New Zealand for those found to be infected with HIV by antibody test and first viral load test.
(A small number of transsexuals are included with the males).
(Source: AIDS Epidemiology Group, AIDS-New Zealand, 2009)

		HIV Infection*									
		1996-1999		2000-2004		2005-2007		2008		Total	
Ethnicity	**Sex**	No.	%	No.	%	No.	%	No.	%	No.	%
European/ Pakeha	Male	257	53.5	337	46.4	250	40.5	97	42.7	941	45.8
	Female	25	5.2	30	4.1	21	3.4	7	3.1	83	4.0
Maori†	Male	29	6.0	41	5.6	46	7.4	17	7.5	133	6.5
	Female	4	0.8	5	0.7	5	0.8	1	0.4	15	0.7
Pacific Island	Male	4	0.8	19	2.6	16	2.6	4	1.8	43	2.1
	Female	4	0.8	10	1.4	7	1.1	2	0.9	23	1.1
African	Male	55	11.4	70	9.6	77	12.5	21	9.2	223	10.9
	Female	33	6.9	85	11.6	81	13.1	18	7.9	217	10.6
Asian	Male	32	6.7	69	9.5	52	8.4	19	8.3	172	8.4
	Female	16	3.3	32	4.4	19	3.1	5	2.2	72	3.5
Other	Male	7	1.4	16	2.2	17	2.7	13	5.7	53	2.6
	Female	0	0.0	2	0.3	7	1.1	1	0.4	10	0.5
Awaiting information/ undetermined	Male	13	2.7	13	1.8	12	1.9	19	8.3	57	2.8
	Female	1	0.2	0	0.0	7	1.1	3	1.3	11	0.5
TOTAL		480	100.0	729	100.0	617	100.0	227	100.0	2053	100.0

* Includes people who have developed AIDS. HIV numbers are recorded by time of diagnosis for those reported through antibody testing and by time of first viral load for those reported through viral load testing. The latter include many who have initially been diagnosed overseas and not had an antibody test here. The date of initial diagnosis may have preceded the viral load date by months or years.
‡ Information on ethnicity of people diagnosed with HIV only collected since 1996
† Includes people who belong to Maori and another ethnic group

Background and Context
Horopaki

The NZAF and the Ottawa Charter

The NZAF has a commitment to the Ottawa Charter for Health Promotion, and like many public health organisations across the world, the NZAF has developed its HIV prevention work using the five action areas of health promotion identified within the charter. The NZAF can align much of its prevention work since 1985 to this model of health promotion:

1. Building healthy public policy – the NZAF recognised early in its history that advocating for changes to legislation and public policy that discriminated against gay and bisexual men, sex workers, injecting drug users, and people living with HIV was a critical step in the fight against HIV and AIDS.
2. Strengthening community action – the NZAF has contributed to the development of gay communities and African communities across New Zealand in the form of practical assistance (venues, funding) and facilitation, recognising strong communities as protective factors against HIV.
3. Creating supportive environments – the NZAF has put significant energy into organising, promoting and advocating for venues, events, social and leisure groups that contribute to healthy social environments for gay and bisexual men and African communities.
4. Developing personal skills – over many years the NZAF has provided workshops for gay and bisexual men, young people and people from African communities and has developed and distributed significant amounts of sexual health and HIV information through a range of mediums.
5. Re-orientating health care services toward prevention of illness and promotion of health – the NZAF has worked to support and train professionals working with the communities most at risk of HIV, has worked to provide new and innovative services for gay men and advocated for the reorientation of services provided by others to gay and bisexual men.

The NZAF has not reviewed this overall approach to the delivery of HIV prevention programmes since 2001. As new funding or ideas emerged they were added to the current programme without rethinking the programme's content and approach.

Commitment to Tangata Whenua: Takatāpui and Whānau

The NZAF is committed to honouring the spirit of Te Tiriti o Waitangi through a practical commitment to biculturalism. For the past thirteen years this has included a parallel model of bicultural development for HIV prevention focused on takatāpui tane.

Unlike many health issues in Aotearoa New Zealand, for example sexually transmitted infections (STIs), there is no significant inequality between Māori and non-Māori in terms of HIV transmission. 155 Māori (137 men and 18 women) have been diagnosed with HIV since 1998, compared to 1,069 Pākehā (982 men and 87 women). The total number of HIV diagnoses since 1998 is 2,146, therefore 7.2% of diagnoses were Māori.

Māori are also not under represented in HIV testing or over represented in AIDS diagnosis statistics, which would suggest that it is unlikely there is a significantly higher level of undiagnosed HIV within Māori populations.
The NZAF HIV Prevention Plan 2009-14 ensures a continued commitment to appropriate and effective interventions for Māori by targeting takatāpui and whānau. Organisational strengthening measures will ensure staff with strong skills in Māori public health, especially especially in relation to takatāpui health are in key programme management, social marketing and community engagement roles.

Changing Epidemic – Changing Communities

As the HIV epidemic has changed, so have the communities it affects. New generations of gay and bisexual men live in vastly different social and political environments than the men who first responded to HIV.

Earlier generations of gay and bisexual men were part of a subculture united in part, by shared criminality. Homosexual behaviour was seen by many as rebellion against staid norms and unjust laws. Some men created an underground, outlaw culture based on desire.

In the decades after 1970 many gay men were increasing politicised as part of a wider sexual liberation movement. Over time the goal became less radical and now in developed countries the movement has generally become a 'rights' movement.

Today, homosexual and bisexual behaviour between men is no longer illegal in New Zealand; gay and bisexual men have human rights and can enter into legally sanctioned civil unions. This means that young men will experience their sexuality – and the HIV epidemic – very differently to men of earlier generations.

Socially the young gay couple has little reason to see themselves as being very different from any other young couple and want what is perceived as the same freedoms.

Today, it is a far more complicated world than that in which HIV first emerged. Segmentation of the audiences is vital. The audiences now include the 'mainstream' and the 'significant others' of gay and bisexual men who influence and support behaviour change.

Changing Epidemic – Changing Direction

Some commentators suggest that we are in a time that is 'post health promotion'. While this discourse poses interesting opportunity for debate, the NZAF HIV Prevention Plan 2009-14 does not support the 'disposal of health promotion', but does seek to respond to the HIV epidemic as it is now in New Zealand, and to use new and innovative approaches. Many of the activities suggested in the new programme are easily aligned to the Ottawa Charter framework. However, the proposed new programme does acknowledge that:

- The NZAF has already done a significant amount of work over its 24 year history to build positive social environments; develop personal skills and strengthen community action.
- The changing HIV epidemic and improvements in HIV treatment mean that people living with HIV will live well and for longer, increasing the potential risk of onward transmission for each positive person – this means the HIV prevention response must have a greater impact than it currently does to reverse the trend of increasing HIV infection rates.
- Information-only approaches (either through health education sessions or resources , although still a necessary component of a wider programme, on their own have limited impact on behaviour change.
- The increased challenge for HIV prevention as a result of the changing epidemic requires that the NZAF use the resources available in a way that most efficiently and cost-effectively leads to behaviour change, and some activities within current programmes may not be the most effective response.

Improvements in treatment mean that a person may now live with HIV for forty years or more. Rather than being removed from the sexual network upon death at around ten years, HIV will remain present for significantly longer. Condom use throughout an HIV positive person's lifetime must be supported and sustained. This means that NZAF initiatives must be appropriate for those people who are HIV positive. The increase in HIV prevalence increases the risk of infection among risk populations. Put simply, the NZAF must work much harder to reduce the rate of new infection.

Health Information

Many early health promotion approaches to risk behaviour, including HIV prevention approaches were based on an information deficit model. The principal assumption of this model was the belief that 'providing information' about the negative consequences of risks, would effectively deter risk behaviour (e.g. if we tell you unprotected anal intercourse is high risk for HIV infection, you will not have unprotected anal intercourse). For this to be effective, a necessary additional belief was that people behave in a rational manner and that given this new information, they would then alter their behaviour accordingly. It is now clear that both these assumptions are seriously flawed and that the 'information only strategy' by itself is ineffective. (Paglia et all, 1999; Bonell at al, 2000).

While providing information does increase knowledge and awareness, and at times negative attitudes, it does not necessarily have a direct impact on behaviour. Furthermore, providing information about the dangers and risks may even be counterproductive for those who seek adventure, and it may also arouse curiosity in others. Though an information-only approach is not sufficient on its own to affect safe sexual behaviour, it is still recognised that providing facts is a necessary component of a comprehensive HIV prevention programme. Gay men themselves advocate that non-judgemental facts about HIV risk should be provided regularly. (Adams and Neville, 2008).

Events

Building healthy social environments has been a core component of the NZAF HIV prevention programme for many years and the NZAF has been involved in a range of activities including extensive involvement in Pride events in Dunedin, Christchurch, Wellington, Hamilton and Auckland; and involvement in other gay community events.

The new programme proposes a move away from intensive event involvement, and advocates using NZAF sponsorship approaches to support events initiated by others that will carry the core messages of the HIV prevention programme. Additionally, the new programme seeks to ensure that information is integrated into a wider set of activities that carry the core messages (for example, there will not be any brochures or posters that do not fit into a wider programme of work).

Social Marketing

The NZAF HIV prevention response must lead to more men using condoms regularly for anal sex – that means more than the current reality. The proposed new programme has a focus on using more campaign-style media, communications and marketing approaches with a sufficiently large reach to target key populations. New investment is proposed in activities that will build social movements for safe sex; develop cultures of condom use; and market safe sexual behaviour to gay and bisexual men in the environments (both virtual and physical), social networks and media with which they connect.
Social marketing approaches provide opportunities for the NZAF to affect more people which leads to behaviour change.

While the NZAF has worked on many campaigns, much of this work has been missing some of the essential ingredients of social marketing. Social marketing uses the techniques of marketing to improve people's health and social conditions. Social marketing is focused on behaviour change, not primarily on improving knowledge and awareness. Significantly, social marketing needs to be sustained over the long term (all previous NZAF campaigns have been three to 12 months in duration). Rather than a focus on the behaviour of the subject, social marketing's starting point is the audience. Social marketing is focused on what the audience takes out, rather than what the organisation wants to put in. Effective social marketing co-ordinates multiple messages across a range of media, and will evaluate and evolve over time. (Bridges and Farlans, 2003).

Results from a range of evaluative research indicate that successful mass media campaigns have a number of common elements, including:

- more effective campaigns use multiple media to promote or challenge a lifestyle norm
- more effective campaigns utilise multiple complementary components and combine and/or link media messages with direct service delivery - e.g. information hotlines and support services and other various prevention efforts
- campaigns should emphasise positive behaviour change rather than negative consequences, and current rewards rather than the avoidance of distant negative consequences
- any anxiety provoking media messages should be accompanied by mechanisms for reducing that anxiety by dealing with it in a productive fashion
- audience segmentation is likely to be more productive if it is based on 'psychographics' (e.g. beliefs, values) rather than on demographics (e.g. social class, gender)
- role models should be carefully selected, as it is essential to be sure that the target group identifies with the models selected and that the role models continue to retain their appeal and credibility
- more effective campaigns avoid fear and moral tactics, and blatant 'hard sells' and should avoid using the organisational logo when possible. (Paglia et al, 1999; Shanahan, 2008; Bonell et al, 2000; Kotler and Lee, 2008).

The goals, outcomes and activities within this plan will all be part of one overall social marketing programme and will begin with the development and launch of a new social marketing brand. Instead of this brand lasting for six or 12 months as previous NZAF campaigns have, the new brand and social marketing programme would last the length of the NZAF HIV Prevention Plan 2009-2014.

The Plan
Te Mahere

Outcome Based Planning

The plan has been developed using a programme logic approach, also referred to as outcomes-based planning. A health outcome indicates a change in the health status of an individual or population that is attributable to a planned programme or programmes, regardless of whether a specific individual programme was intended to change that particular health status. The increased use of health outcomes in public health planning reflects a growing understanding that organisational goals alone will not influence actions that will lead to the desired result. Activities that will result in a desirable health outcome for a population must be carried out by many people in a variety of organisations over a number of years.

The sections that follow detail:

- target populations and sub groups
- the overall health goal of the plan
- four target behaviour change goals
- health outcomes for each of the four behaviour change goals
- activities that will be undertaken to achieve each of the outcomes.

The activities have been identified based on an understanding that they will lead to the achievement of the health outcome. The plan suggests combined achievement of the health outcomes under a behaviour change goal will lead to achievement of that goal.

The plan will be evaluated by assessing the impact of the activities on the respective health outcome and overall assessment of behaviour change.

Target Audiences

The primary target population for the NZAF HIV Prevention Plan 2009-14 is gay and bisexual men.

In certain activities, audience segmentation will be used to focus on particular sub-groups that have a significant impact on the behaviour change the programme is seeking to effect. Segmenting the audience based on ethnicity alone is not proposed. The literature states that effective segmenting is based on commonalities of values, beliefs and behaviours as they relate to the behaviour change the programme is seeking.

In the development of the new NZAF HIV Prevention Plan 2009-14, particular groups have been focused on:

- Gay and bisexual men over thirty years of age who have high numbers of sexual partners (more than twenty sexual partners in the last six months)
- Gay and bisexual men who use condoms regularly (around 60%
- Gay and bisexual men under thirty years of age (the only age cohort with a declining rate of condom use .

Using this segmentation in certain interventions or activities does not imply that other groups will be neglected. For example, there is a focus on men under thirty years of age for some interventions to increase the declining rate of condom use within this group. However, in the majority of interventions, men over thirty years of age will be the principle audience.

The secondary target audience is New Zealand-based African communities.

Behaviours

The four health behaviours that have been identified that will have the greatest impact on the overall health goal of *reducing the incidence of HIV in Aotearoa New Zealand* are:

1. increase rates of condom use for anal sex between men (this goal will have the most significant level of resource and activity)
2. increase STI and HIV testing rates for gay and bisexual men
3. increase rates of condom use for first anal sex between men
4. increase rates of condom use within New Zealand-based African communities.

These behaviours form the four goals for this plan.

Goal 1 Whāinga Tuatahi

Increase rates of condom use for anal sex between men

Outcomes

1. *A condom culture among gay and bisexual men is developed and maintained*
2. *Condoms are used in sex on site venues*
3. *A condom culture is supported by those who influence gay and bisexual men*
4. *Condom use among highly sexualised gay and bisexual men is increased*
5. *Regular condom users maintain healthy behaviours*

Unprotected anal intercourse between gay and bisexual men is the single greatest risk behaviour for HIV transmission in New Zealand. By influencing this behaviour the NZAF stands to make the greatest impact on new HIV transmission. Condom use for anal sex significantly reduces onward HIV transmission. (Pinkerton and Abramson, 1997).

With the highest rate of new HIV diagnoses recorded in New Zealand in 2008, the prevalence of HIV in New Zealand is higher than ever before and understanding the nature of gay and bisexual men's sexual networks is essential to understanding patterns of risk behaviours.

The NZAF, in collaboration with the AIDS Epidemiology Group at the University of Otago, conducts biannual behavioural surveillance in the form of the Gay Auckland Periodic Sex Survey (GAPSS) and Gay Online Sex Survey (GOSS). This provides valuable information about the sexual activity, sexuality, sexual knowledge and other demographic factors that must inform the prevention work on which the NZAF embarks. From GAPSS and GOSS we know that:

- in New Zealand, around 60% of sexually active gay and bisexual men use condoms regularly when they have anal sex with casual partners
- 20% report condom use some or most of the time
- 20% report condom use rarely or never
- 66% of men in relationships do not use condoms with their regular partner. (Saxton et al, 2006 .

This data has remained stable since 2002. It is our task to sustain the large portion of men that regularly use condoms by supporting them to maintain healthy behaviours, while encouraging others to increase their condom use. Even a small increase in the groups reporting condom use regularly or often is likely to have a significant impact on onward HIV transmission.

Developing a Condom Culture

Social learning theory (SLT) asserts that people learn from their own experiences and by observing the actions of others and the benefits of those actions (Glanz and Rimer, 2005). SLT was updated by social cognitive theory (SCT) in which behaviour, cognition, and other personal factors, along with environmental influences operate as interacting determinants that influence one another bidirectionally (Peng et al, 2008; Bandura, 1989). Partnering with appropriate organisations and key individuals that have considerable influence on gay and bisexual men, such as sexual health service providers, key GPs with high numbers of gay and bisexual clientele, and health providers and educators (including Māori and Pacific providers) along with mainstream media communications targeting friends and family of gay and bisexual men, is consistent with the findings of evaluative research that have been conducted on social marketing campaigns. The development of a comprehensive 'condom culture' across all population groups in New Zealand would be an enormously effective advance in sexual health for Aotearoa New Zealand. A condom culture is necessitated in part by a trend toward the assimilation of gay and bisexual men into a hetero-normative society which is often reflected in trends in condom use by men in long term relationships.

Men in Relationships

GAPSS and GOSS data (2002, 2004 and 2006) shows that many gay and bisexual men exist within multiple sexual networks.
Men who are in relationships with other men present a challenge for the HIV prevention response for a variety of reasons, including notions of assimilation (among heterosexual relationships), love, monogamy and perhaps toughest of all to address, trust. Approximately 66% of men in relationships report no condom use with their main partner (Saxton et al, 2006; Saxton, 2008).

However, a high number of men who are in relationships with men also report having other concurrent sexual partners. While condom use with casual partners is often high, when that casual partner becomes a more regular partner (called a 'fuckbuddy' in research and colloquially), then condom use with that partner is more likely to decrease. This is complicated by the effects of concurrency, i.e. that fuckbuddy may have other fuckbuddies with whom he has dispensed condom use with too. International and local evidence shows that around half of new HIV infections are among gay and bisexual men who are in relationships. The NZAF HIV prevention response needs to concentrate on increasing sexual health knowledge, behaviour and skills among men who are in relationships with other men. (Saxton, 2008).

Takatāpui and Whānau

Ensuring appropriate HIV prevention interventions for takatāpui and whānau is important. The NZAF HIV Prevention Plan 2009-14 has a commitment to ensuring all interventions are appropriate for takatāpui and whānau and specific staffing skills and experience will be sought for social marketing and community engagement intervention areas. There will also be key targeted initiatives designed to increase condom use with takatāpui:

- www.broonline.co.nz – an online social networking site which models safe sex for takatāpui tane, whānau and 'friends'
- Hui Takatāpui – the NZAF is committed to building community and leadership among takatāpui and a large scale hui which has been a successful intervention to develop this leadership in the past will continue
- Specific engagement, support and resources for providers of health services to takatāpui and whānau
- A targeted resource for whānau of takatāpui, focused on increasing understanding of sexual and gender diversity and sexual health.

Sex on Site Venues

From GAPSS and GOSS it is known that sex on site venue customers are likely to be older (over 45 years) and many will have high numbers of sexual partners. It is interesting to note that this matches the traditional demographic of new diagnoses among gay and bisexual men in New Zealand (aged 30-49). It is essential then that the NZAF HIV prevention response concentrates on increasing the impact that sex on site venues have on condom use. Work has begun on developing a sex on site Venue Accreditation Programme and it is important that this strategy is fully implemented and maintained. Additionally, the venues themselves provide a critical environment in which to promote condom and lube use and NZAF sexual health testing.

Hooking Up Online

Not all highly sexualised men will be reached by partnering with sex on site venues since a significant proportion of men have turned to the internet to find sexual partners. GOSS has shown that the online sample of respondents were more likely to have casual sex, were most likely not to use condoms for anal sex, and were the least likely to have had an HIV test since their last episode of unprotected anal intercourse. Importantly, this group was likely to be the least knowledgeable about HIV information, and the least connected to traditional concepts of gay communities.

The NZAF HIV prevention response must continue and expand online initiatives. These would include NZAF dedicated websites such as www.broonline.co.nz, a social marketing campaign website, nzaf.org.nz, a high presence on social networking sites such as Facebook, Bebo, Twitter, YouTube, and special initiatives on existing and emerging dating/hook-up sites such as NZDating.com.

Community Engagement

Notions and definitions of community are complex and there is no single or correct answer. Discussions and research were carried out that informed the NZAF HIV Prevention Plan 2009-14 about the changes and developments of 'the gay community' and 'gay communities' in Aotearoa New Zealand. While there was no consensus on what these groupings and group identities were, there is agreement that group interactions of gay and bisexual men have changed significantly over the course of the HIV epidemic.

Working effectively with online technology does not replace the importance of face to face community engagement. However, this plan does acknowledge that face to face contact will not reach the majority of gay and bisexual men. Engaging with those most at risk of HIV requires a combination of different forms of community engagement. Traditional 'physical' or face to face engagement will be complemented by a range of virtual engagement interventions, including NZAF websites, social media, mobile technologies and social marketing campaign material.

A new team will ensure effective community engagement in social environments where gay and bisexual men meet. The team will include a focus on effective relationships with Tangata Whenua and Pasifika Communities.

Porn Depicting Unprotected Anal Intercourse

Bareback pornography has recently become more popular. This appears to be a new genre of porn, different from simply being porn without condoms. This is newly produced porn with an edge, since it is made in the face of all safe sex

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