

HIV and AIDS Policies Globally: A New Zealand perspective

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Introduction

This chapter outlines the historical, social, political and economic context of Aotearoa/New Zealand focusing on the impact HIV and AIDS has had upon women. It also highlights several policy and educational strategies that have contributed to the prevention of the spread of the HIV and AIDS epidemic in this country.

Aotearoa/New Zealand has a low prevalence of HIV and AIDS. It has a relatively well organised public health and social security system, less overt stigma and relatively open minded attitudes towards men who have sex with men (MSM). However, the position of women living with HIV is still marginalised and many of these women report feelings of stigma, isolation and prejudice.

Policies are often reactive and follow inductive logic as will be illustrated in the examples discussed in the chapter. Aotearoa/New Zealand is a relatively wealthy country with robust social services. Unfortunately, HIV and AIDS prevention and support tends to fall to non-government and grassroots voluntary agencies. Nevertheless some inspiring, exceptionally high-quality policies and practices have emerged through Government policies and engagement of people living with HIV.

It is a country full of paradoxes. Where women were the first in the world to get the vote in 1893 but could not stand for Parliament until 1919 (New Zealand Parliament, 2006). It is a country where colonization was not as brutal as in other parts of the world, yet the influence of colonization has had a profound impact on the indigenous Māori culture and identity. It is a country which prides itself on being bi-cultural. Yet paradoxically, the country's founding bicultural document, Te Tiriti O Waitangi, the Treaty of Waitangi, signed in 1840, has never been truly honoured.

This chapter grapples with the paradoxical nature of New Zealand society and discusses some of the ways in which underpinning paradoxes have been tackled in order to bring about a just and safe multicultural country which can further build on its bi-cultural heritage.

Information about the Country

Aotearoa, meaning ‘The Land of the Long White Cloud’, is the Māori name for New Zealand. Increasingly, there is a trend to combine both the Māori and European names as, Aotearoa/New Zealand (N. Z. Statistics, 2002). The country is situated in the South Pacific Ocean in Oceania and is made up of two main Islands. The North Island or *Te-ika-a-Maui* which means ‘The Fish of Maui’ and the South Island, or *Te-Wai-Pounamu*, meaning ‘The Waters of Greenstone’. Its total land mass of around 268,680 square kilometers makes it slightly larger than the United Kingdom but smaller than Italy or Japan. The Cook Islands, Niue and Tokelau, while self governing, are included in the Realm of Aotearoa/New Zealand. Geographically isolated, some 2000 km southeast of Australia, the country’s nearest neighbours are; New Caledonia, Fiji and Tonga (N.Z. Statistics, 2002).

One of the more recently settled major landmasses, it is thought that the first people to arrive in Aotearoa/New Zealand may have originated from Eastern Polynesia, and arrived in a series of migrations sometime between 700 and 2000 years ago. Over time these settlers developed into a distinct culture divided into tribes (*Iwi*), and sub-tribes (*hapu*) now known as Māori (King, 2003).

The first wave of European explorers visited the Pacific in the 17th century with the Dutch explorer, Abel Tasman being the first to reach Aotearoa/New Zealand in 1642. In 1769 the English explorer James Cook rediscovered the country and mapped most of the coastline of both islands. Following Cook’s rediscovery the country was visited by many European and North American whalers and sealers and became a significant stop for trading ships which traded food and goods with the local Māori tribes. Christian missionaries began to settle in the early nineteenth century, converting many of the Māori population to Christianity (King, 2003).

Queen Elizabeth II is the country's Head of State however she has no real political influence. Political power is held by a democratically elected parliament under the leadership of a Prime Minister who is the Head of Government.

Māori also have their own 'monarchy' formed in the nineteenth century under the Kingitanga movement which hoped to achieve unity for Māori under a Māori King (King, 2003). The colonial government viewed the Kingitanga movement as a threat to the British Crown and attempted to disestablish it. Nevertheless, it survived albeit as a symbolic movement and the current King, Te Arikinui Tuheitia Pahi, is the seventh Māori monarch since its investiture, (Origins of the Maori King Movement, 2006).

English is the predominant language with 98% of the population speaking English. In 1987 with the implementation of the Māori Language Act, (Government, 1987) Māori became the second official language and there are now around 4.1% of the population speaking Māori. In 2006 the New Zealand Sign Language Act (Government, 2006) was enacted and Sign Language became New Zealand's third official language. Samoan is spoken by 2.3% of the population which is the most widely spoken of the non-official languages followed by French, Hindi, Yue and Northern Chinese.

Christianity is the foremost religion at 55.6% with 34.7% indicating no religious affiliation. The main Christian denominations are Anglican, Roman Catholic, Presbyterian and Methodist with a significant number identifying as Pentecostal, Baptist and Mormon. There are increasing minority religions such as Hinduism, Buddhism and Islam, while many Māori adhere to the New Zealand based Ratana Church (N.Z. Statistics, 2002).

Aotearoa/New Zealand has a population of 4.3 million. Most of the country's population is of European descent with approximately 78% identifying as European. The indigenous Māori are the largest non-European ethnic group, accounting for 14.6% of the population, while Asian

ethnic groups make up 9.2% of the population and 6.9% of people are of Pacific Island descent¹. (N.Z. Statistics, 2002).

The country's immigration policy is relatively open as it is committed to increasing its population by 1% annually. As a result approximately 23% of the population is born overseas, one of the highest rates in the world. Immigrants from the United Kingdom and Ireland still constitute the largest single groups but immigrants are increasingly coming from East Asia, mostly mainland China, but also Korea, Taiwan, Japan and Hong Kong (N.Z. Statistics, 2002).

Most European New Zealanders are from British or Irish descent although there has been significant migration from Holland, Dalmatia, Italy and Germany as well as some indirect immigration through Australia from North and South America and South Africa (N.Z. Statistics, 2002).

While generally known as New Zealanders, informally New Zealanders like to refer to themselves as Kiwis although the indigenous people prefer to identify as Māori, (King, 2003).

The country's male to female ratio in 2001 was 104 females to every 100 males. This number is projected to decrease slightly by 2051 with an expected 103 females to every 100 males (Statistics, 2005). This is comparable to global statistics which in 2000 indicated that in most major regions there was a larger female to male ratio, with Europe at 107, North America 104 and Africa 101. The United Nations projects that populations by 2050 will increase in regions such as Asia and Oceania (Statistics, 2005).

Historically, women in Aotearoa/New Zealand have been active participants in social, economic, legal and political reform although some of the struggles faced by women, such as pay equity have endured lengthy battles².

There have however, been disparities between Māori women and Pakeha women. Traditionally, prior to colonization, Māori women's status was linked to their whanau (family)

¹ These percentages come to more than 100% because people can identify with more than one ethnic group (N.Z. Statistics, 2002).

² The Government Service Equal Pay Act was passed in 1960 for workers in the Public Service though paradoxically, female workers in the private sector had to wait until 1972 for pay equity. Refer to: <http://www.dol.govt.nz/services/PayAndEmploymentEquity/history.asp>

status within their hapu (sub-tribe) and iwi (tribe). Traditional Māori society was hierarchical and those Māori women who were of Rangitara (chiefly) status could own land and would not lose it upon marriage. With the advent of colonization, Māori women's status gradually shifted over time to conform with the colonisers' concepts of women as being inherently inferior to men. With the added layer of racism, Māori women tended to be constructed as having lower status than white women and were frequently eroticised within a colonial discourse that constructed them as being sexually promiscuous and 'naturally wanton' (Connor, 1994).

Pākehā settler women in the 19th century were seen as being essential to the new colony but only in their roles of wives, mothers, homemakers and house keepers (Dalziel, 1986). However, the colonial context where the woman's role became that of the 'helpmeet'³, created a situation where women were called upon to make far greater contributions to the home and economy than their sisters in Great Britain.

Women's status in the political arena of New Zealand life is relatively robust. Pakeha women won the right to vote in 1893 and in 1897 Māori women were granted the vote (Statistics New Zealand, 2005). In 1993, the centennial of women's suffrage in New Zealand, Sandra Lee was elected MP for Auckland Central, making her the first Māori woman to be elected in a general seat and the first woman MP for a third party. In the same year, Helen Clark became the first woman to lead a major political party, the Labour Party, and she eventually became the first elected woman Prime Minister⁴ when Labour won the elections in 1999 (Statistics New Zealand, 2005).

The economic status of women tends to be less than that of men. In 2008, the median weekly income for women was 40.1% lower than men and women are on average, much less likely to receive high incomes. These figures reflect the combination of women being less likely to be in

³ The term 'helpmeet' was frequently used to describe the colonial woman's role. Its origins come from Genesis: 'It is not good that the man should be alone; I will make him an helpmeet for him', (Cited in Dalziel, 1986, p. 59).

⁴ Dame Jennifer "Jenny" Mary Shipley, [DNZM](#) (born 4 February 1952, [Gore, New Zealand](#)), was the [36th Prime Minister of New Zealand](#) from December 1997 to December 1999. While, she was the first woman Prime Minister of New Zealand, she was not elected. She bid for the leadership of the National Party and replaced Prime Minister James Brendan "Jim" Bolger, [ONZ](#) (born 31 May 1935 who was the [35th Prime Minister of New Zealand](#) from 1990 to 1997) when he no longer had the support of his party and resigned, (http://en.wikipedia.org/wiki/Jenny_Shipley).

paid work, more likely to work part-time, and earning less per hour worked (Ministry of Women's Affairs, 2010). Women remain under-represented in leadership positions, particularly in the private sector though they make up almost half of the workforce. Women's representation tends to be greater in fields where they have traditionally predominated, such as education (51.9% on school boards of trustees) and health (43.4% on district health boards). However, women continue to have low representation in Parliament, on private sector boards, and in the judiciary (Ministry of Women's Affairs, 2010).

Cancer and heart disease are the main causes of all deaths for women in Aotearoa/New Zealand with breast cancer being the leading type of cancer. Women also have higher rates of arthritis, osteoporosis, asthma and chronic obstructive respiratory disease than males (Statistics, 2005).

The country is lacking epidemiology information in regards to Sexually Transmitted Infections (STIs) as surveillance systems are based predominantly on reporting from clinics such as Sexual Health and Family Planning clinics. Laboratory data is collected for surveillance on gonorrhoea and Chlamydia but only complete in three District Health Board⁵ regions of the country (Coughlan & Sherwood, 2007).

Chlamydia is the mostly commonly reported STI, followed closely by gonorrhoea with a rise of 65.5% during the five year period from 1999-2004, which was six times higher than in Australia and four times higher than in the UK (Perkins, 2004). Even from this limited information it is clear that New Zealand is lagging significantly compared to other Organization for Economic Cooperation and Development (OECD) countries in the control of gonorrhoea and particularly chlamydia (Azariah & Perkins, 2007; Perkins, 2004).

The most affected by these are young people under the age of 25, particularly Māori and Pacific Island people, with most reporting multiple sexual partners and an early onset of

⁵ The NZ Public Health and Disability Act 2000 came into force on 1 January 2001 which included the establishment of 21 District Health Boards. The objectives of the DHBs' are to improve, promote and protect the health of communities to promote the integration of health services, especially primary and secondary care services and to promote effective care or support of those in need of personal health services or disability support. The DHB's are government departments and are government funded, but each are self governed (MOH, 2009).

sexual activity. Sexual orientation of recorded cases of gonorrhoea are 43% heterosexual males, 38% heterosexual females, 1% bisexual females and 18% MSM (Azariah & Perkins, 2007; Perkins, 2004), while Chlamydia rates are 653.0 per 100,000 population (Fernando, MacBride, Johnston, 2005). These statistics are of significant concern in regards to the risk of HIV transmission.

Women account for nearly two-thirds of hospitalisations for self-inflicted injury and a study undertaken by the Public Health Research Unit (Bhatta, Caswell, Habgood, & Pledger, 2002), found there was a significant increase in the consumption of alcohol and frequency of consumption by young women between the ages of 15-24 years. While European women were more likely to drink than other ethnic groups, Māori women were more inclined to hazardous drinking patterns than other ethnic groups (Statistics, 2005).

HIV and AIDS in New Zealand

Aotearoa/New Zealand meets the UNAIDS/WHO criteria for a “low-level” HIV and AIDS epidemic because infection is largely confined to individuals with higher risk behaviour and because HIV prevalence has not consistently exceeded five percent in any defined sub-population. On this basis Aotearoa/New Zealand has chosen to focus largely on high-risk groups and behaviours in their HIV and AIDS policies, which has resulted in a strong focus on men-who-have-sex-with-men (MSM) and African communities (AEG, 2009). This continued focus on high risk groups only serves to further marginalize and stigmatize MSM and African communities and to isolate women who do not belong to these groups.

AIDS identification is not guided by a person’s CD4 count in Aotearoa/New Zealand, instead a person is considered to have AIDS when they develop one of 25 opportunistic infections commonly associated with AIDS (AEG, 2009).

Under the New Zealand Health Act, 1956, notification of AIDS has been a statutory requirement since August 1984. It is currently not mandatory to report people who have received a positive HIV antibody test. However, an amendment to the Health Act is currently

(2010) before Parliament, which is attempting to make HIV a notifiable disease. The amendment is significantly supported by epidemiologists, medical professionals and the New Zealand AIDS Foundation who feel that doing so will provide a more timely assessment of the epidemic (Davis, 1996). However, there is some trepidation by those living with HIV who believe this further stigmatizes and discriminates against those living with HIV.

Notification of AIDS is done by the completion of a 'Case Report Form for AIDS' by a patient's Clinician or General Practitioner (GP). These forms are anonymous in that they do not identify the patient's name but are completed using a non-identifying code. On completion, the form is sent to the Medical Officer of Health who then forwards the information to the AIDS Epidemiology Group (AEG) for monitoring and evaluation (AEG, 2009) .

Since 1985 to year end ~~2009~~2012, there have been a total of ~~3294~~3778 people reported to be living with HIV. Of these, ~~2705~~3118 are men with exposure categories as follows: ~~1738~~2032 homosexual contact, ~~42~~45 homosexual through intravenous drug use (IDU), ~~437~~506 Heterosexual contact, ~~65~~69 IDU, 34 blood product recipients, 13 through blood transfusion and ~~35~~38 through Perinatal transmission and ~~341~~381 through other or unknown transmission.

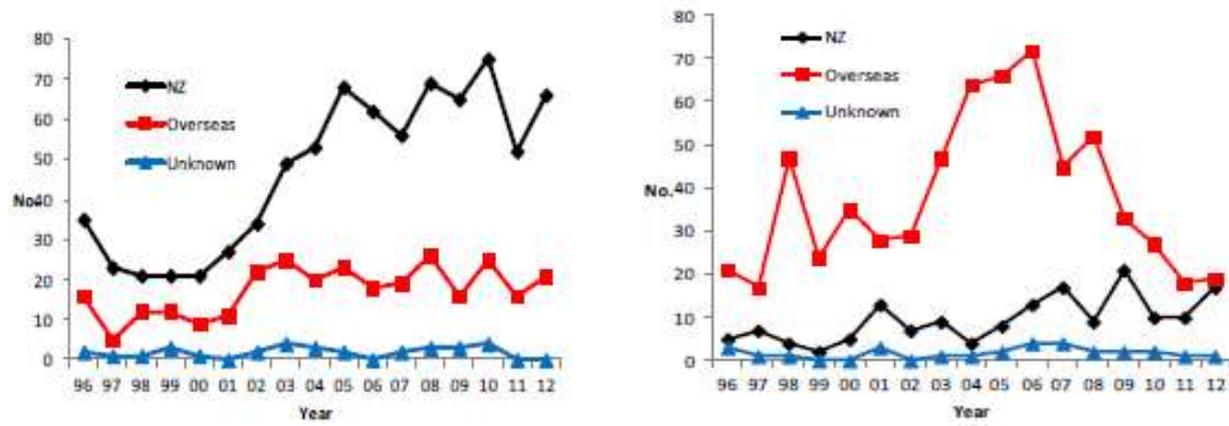
Of the ~~561~~631 women reported, exposure categories were, ~~454~~512 through heterosexual contact, ~~11~~12 through IDU, 10 as a result of being blood transfusion recipients, 20 through perinatal transmission and ~~66~~77 through other or unknown transmission.

A further ~~10~~11 exposure categories were transgender, 5 through blood transfusion recipient where no sexual orientation records were and a further 13 where means of exposure was unknown (McAllister, ~~2010~~2013).

These figures represent those who were found to be infected by antibody and first viral load test. Many people recorded through first viral load test where initially diagnosed overseas and did not have an antibody test in Aotearoa/New Zealand (McAllister, ~~2010~~2013).

As is evident by these statistics, the single highest risk group for HIV in Aotearoa/New Zealand are homosexual men. However since the mid 1990's there has been an evidential shift with an increase in the number of heterosexually acquired HIV.

As visible in Table 2-1 The majority of heterosexually acquired HIV (81%) is acquired overseas, in contrast to MSM where 71.76% have acquired HIV within Aotearoa/New Zealand (McAllister, 2009b, 2013).



MSM Heterosexual

Table 1: Place of infection of people diagnosed with HIV

(McAllister, 2009b, 2013)

This has been a consistent trend since 1985 and statistics such as these have been the underlying basis of all national policy and funding decisions on HIV prevention and awareness since that time, as outlined in the HIV/AIDS Action Plan (Government, 2003). Since the 1980's heterosexual HIV has not been considered a 'national problem' which was highlighted in a statement in the 2009 issue (63) of AIDS New Zealand, "Fortunately heterosexual spread of HIV is rare in New Zealand" (McAllister, 2009b). While the heterosexual spread of HIV may be rare within New Zealand's borders, the country's continued focus on this factor negates that, regardless of where HIV has been contracted; there are however a significant number of heterosexual people living with HIV in Aotearoa/New Zealand, a factor which appears to be repeatedly ignored as something of insignificance. This is discussed in more detail later in this chapter.

Recording of ethnicity of people who have acquired HIV was only undertaken in Aotearoa/New Zealand from 1996.

For women, the rates were higher among Māori, Pacific and Asian compared to European women - in the order of 2 to 4 times higher but these results are based on very small numbers. While this is likely to be an indicator of the infection rate, this assumes that the number of tests were the same between various ethnic groups, which may not be so.

In 2005/06 the AIDS Epidemiology Group undertook an unlinked anonymous⁶ study of HIV prevalence among (9439) attendees at six sexual health clinics throughout the country over a 12 month period as a means to detect early changes in the pattern of HIV spread in Aotearoa/New Zealand (Coughlan et al., 2008; McAllister 2009).

Two previous unlinked anonymous prevalence surveys were undertaken in 1991/92 and 1996/97. The aim of the 2005/06 study was to compare the findings with these previous studies. It was identified there had been an increase in the annual number of people being diagnosed with HIV during 2000 to 2006 and the most affected group continued to be men who have sex with men with an overall prevalence of 44.1 per 1000 and most common in men aged 30-49 years while prevalence among heterosexual men and women remained low with an overall prevalence of 1.3 per 1000 with heterosexual men at 1.2 per 1000 and heterosexual women at 1.4 per 1000 (Coughlan et al., 2008; McAllister, 2009). It is significant to note that testing was only done on blood taken for syphilis and/or hepatitis B serology and of the 9439 participants who took part in the study, 8699 were MSM or bisexual men. As a consequence outcomes may not truly reflect actual prevalence especially considering the total number of clients who attended the six clinics in 2005 (base population) was 63,223 and of that figure 44.5% were males and 55.5% were females (Coughlan et al., 2008; McAllister, 2009). Findings in the study are however consistent with those from national surveillance where prevalence continues to be higher amongst MSM (McAllister, 2010).

⁶ This is when blood is collected from people for another purpose such as syphilis or hepatitis testing and then also tested for HIV. It is done with no way of being able to link the result to anyone. While a controversial means of prevalence testing this method has been recommended by the World Health Organisation as an accurate and effective method of surveillance of HIV infection (Dickson, 2007).

Ethnicity of clients attending the six clinics in the study undertaken by Coughlan et al. (2008), were identified as: European 67.6%, Māori 15.5%, Pacific 4.3% and other/unknown 12.6% which is reflective of the base population on all demographics yet the study did not consider HIV prevalence was significant to any specific ethnic group. This is in contrast to the 2009 report done by the AIDS Epidemiology Group which identified rates were seen to be higher among Māori, Pacific and Asian ethnicities compared to European women - in the order of 2 to 4 times higher (McAllister, 2009b).

This is corroborated by the Māori, Indigenous and Pacific Island HIV/AIDS Foundation (INA), which claimed data collection was flawed and inaccurate on the bases that in a 2002 epidemiology report it was stated only 5 Māori women were infected but an HIV Futures survey conducted in the same year stated 7 Māori women were recruited to complete the survey. It is felt that Māori may be underrepresented as ethnicity may not be accurately identified. INA advocate that Māori women represent the *fourth* highest ethnic group being affected by HIV and are at a higher risk of infection in Aotearoa/New Zealand compared to European Women.

Historical overview of responses to HIV/AIDS and their impact on women

Initially, the government's response to HIV and AIDS in Aotearoa/New Zealand was slow and cautious, as was the case in many OECD countries (Carter, Howden-Chapman, Park, & Scott, 1996). The first suspected case of 'acute HIV infection' was diagnosed in Aotearoa/New Zealand in 1983 and by 1985 a further five people had been diagnosed with AIDS, all were men who identified as men-who-have-sex-with-men (Dickson, 1998). As was being seen in the United States and the United Kingdom, survival prognoses was poor with a median time from diagnosis to death of around 58 weeks although by 1990 some patients survived for up to two years after being diagnosed (Carlson, Paul, Skegg, & Spears, 1991).

AIDS emerged in Aotearoa/New Zealand amongst the MSM community at a time that homosexuality was still classified as illegal. The movement for homosexual reform had started sometime before the onset of AIDS, but it is undeniable the AIDS epidemic which was evolving

around the world in the 80's, spurred action in this area. *The Homosexual Law Reform Act 1986*, which was an amendment to the Crimes Act 1961 removed criminal sanctions against consensual homosexual conduct between males, and as a consequence amended the law relating to consensual anal intercourse (*Homosexual Law Reform Act 1986*). This was also significant for women because the homosexual law reform, together with the politicisation of the gay community, provided a space to openly discuss both sex and issues related to HIV.

Around this time there was also a drive to mobilise grassroots and health officials called for the establishment of an AIDS Support Network (ASN) for people living with AIDS. Volunteers were being trained to provide homecare and peer counselling together with peer education which was available for people living with AIDS. Unfortunately, without leadership, after the death of Bruce Burnette, the organisation faltered. Dissent was apparent amongst the gay community in 1990 who accused the NZAF of 'strategic delinquency', 'misappropriation of power' and 'complicity with the government' (Lindberg & McMorland, 1996 pg 104) and as a result some members formed a new organisation called the Auckland Community AIDS Services (ACAS), while the standoff between NZAF and ASN continued to become further entrenched.

During this dissent, other grassroots organisations began to evolve, one of these was the Māori HIV prevention group, Te Roopu Tautoko (TRT) which was created in 1988 with a mandate to undertake HIV prevention work among Māori.

By the late 1980's a need for a women's support network was identified by two female social workers employed by the Community AIDS Resource Team (CART), a government funded department connected closely with the Infectious Diseases Clinic based out of Auckland Hospital. By the late 1980's there was a notable increase in the number of women being diagnosed with HIV yet this was largely being ignored and little attention was given to the unique features of HIV infection in women (Bennett, 2007). Seeing a gap in service need CART, together with a number of women living with HIV began the process of establishing

Positive Women Inc.⁷ This is significant because two professional social workers started an agency which was then passed on to HIV+ women to manage, improve its programmes and be truly helpful to women who live with HIV.

Increasing evidence out of the United Kingdom indicated that intravenous drug users (IDUs) were at significant risk of contracting and transmitting HIV. Due to its geographical isolation in the 1980's, there was a scarcity of imported heroin in Aotearoa/New Zealand which meant that intravenous drug use was significantly lower to that found overseas. However, local methods of producing opiates were developed and intravenously transmitted HIV became a concern and in 1986 the New Zealand IV League was formed. The main instigators of the league were two men who were both intravenous drug users (IDUs) and openly HIV positive. The league was an alliance of concerned IDUs and health professionals whose aim was to create a better understanding of AIDS in a New Zealand context and to prevent its spread (Kemp, 1996).

An early preventative measure advocated by the IV League was the implementation of the Needle Exchange Programme (NEP) under the *Health (Needles and Syringes) Regulations 1987*. The New Zealand NEP was one of the first national NEPs in the world and meant the sale of needles and syringes to IDUs was decriminalised as long as their sale was part of the Needle Exchange Programme (NEP) (*Health (Needle and Syringes) Regulations 1987*).

A review conducted in 2001 by the Centre of Harm Reduction in Australia, concluded that New Zealand's NEP has been effective in preventing HIV and Hepatitis C infections among injecting drug users. It found there had been a gradual decline in needle sharing since the late 1980's and believed this was as a result of the NEP (Campbell, 2003; Henderson, 2009).

⁷ Positive Women Inc. was established in 1990 as a peer support network for women living with HIV or AIDS. In the early days it was run by the CART team with the input of women living with HIV but over the years management of the organisations was taken over by the community itself (women living with HIV). The organisation receives no government funding and for many years was not acknowledged or included in any major HIV policy or decision making, yet the number of women (and heterosexual men) living with HIV in New Zealand continued to increase. As a result of its own fundraising initiatives, in 2004 Positive Women Inc. employed its first full time National Coordinator. At this time the organisation also amended its constitution to include families and incorporated HIV advocacy, awareness and destigmatisation as part of its mandated. The organisation is now a significant participator and contributor in HIV policy and decision making (Bennett, 2007)

Subsequently there have been no recorded cases of HIV diagnoses of women through IDU since 2003 (McAllister, 2010).

When it became apparent that blood supplies could be contaminated with HIV, Aotearoa/New Zealand was quick to respond by introducing a policy requiring the screening of all blood products and blood screening for HIV which began in 1985. This was followed in 1987 by an endorsement from the communicable Diseases Centre, supported by the Pan American Health Organisation, that people likely to transmit HIV infection should refrain from donating blood. As a result there have been no recorded cases of people contracting HIV through blood transfusions or blood products since testing began. However it is believed that 42 people did acquire HIV as a result of receiving infected blood prior to the availability of an HIV antigen test was available (Carter et al., 1996).

Laws governing sex workers in the 1980's were contradictory in that prostitution was legal yet soliciting was not, which meant it was legal to be a sex worker but illegal, under the Crimes Act 1961, to seek that work (Woods, 1996). This is consistent with the many paradoxes in regards to the response to HIV and AIDS and attitudes to sex as a whole in Aotearoa/New Zealand. Ironically, amongst all these contradictions, the New Zealand Prostitutes Collective (NZPC) was established in 1987. As prostitution was not illegal there were no legal obstacles in creating such a collective and it was unique that the NZPC was actually funded and supported by the government's Ministry of Health (Chetwynd, 1996 pg 137).

A significant factor in regards to the establishment of the NZPC was the threat of the HIV and AIDS epidemic and the need for health authorities to work together with the sex worker industry around HIV awareness and prevention programmes with a focus on promoting condom use. Alongside this, was an increasing realisation that it was important to acknowledge the rights and needs of sex workers and the sex worker industry. This was highlighted as increasingly inaccurate reports suggested sex workers where a major source of the spread of HIV and AIDS, especially (as was being reported) many were also IDUs (Chetwynd, 1996 pg 138). This was in fact largely incorrect in a New Zealand context because

there had been no documented reports of heterosexual transmission of HIV during the first 10 years of the epidemic as a result of sex workers and in fact condom use was high amongst sex workers particularly amongst those working in parlours (Woods, 1996 pg 123).

The NZPC made an important contribution on the debate around prostitution, advocating sex work as a legitimate service occupation and argued for the decriminalisation of the profession during the 80's and 90's and that sex workers should be entitled to the same occupational, health and safety rights as other workers. The collective also drew a distinction between those who chose to enter the sex industry as opposed to those who are forced into it. Most sex workers in Aotearoa/New Zealand fall into the 'choice' category and the NZPC's efforts continue to focus on the promotion of education and rights for sex workers (Chetwynd, 1996).

The NZPC has over the years been credited for the very low HIV infection rate among sex-industry workers in Aotearoa/New Zealand through their successful health promotion efforts and also their influence at policy level. It has been invited to join all major advisory groups and has played an active role in the development of the HIV and AIDS strategies and prevention policies at a national level (Chetwynd, 1996 pg 147). One such policy strategy has been the HIV/AIDS Action Plan.

Phase one of what was initially the Sexual and Reproductive Health Strategy was released in 2001 and provided the overall strategic direction for achieving a national vision of good sexual and reproductive health. At that time it was recognised there needed to be a more detailed plan in areas such as HIV and AIDS. Consequently the HIV/AIDS Action Plan was developed by the Ministry of Health, in consultation with members of a sector reference group, as part of the national Sexual Health and Reproductive Health Strategy in 2003 which ironically did not include representation from any of the People living with HIV (PLHIV) networks (Government, 2003).

The aim of the HIV/AIDS Action Plan is to review and update Aotearoa/New Zealand's response to the HIV and AIDS epidemic which fall into 4 specific goals

1. To promote a greater awareness and understanding across all members of society about the causes, behavioural risk factors and implications of HIV and AIDS for different groups, and a community-wide commitment to preventing HIV transmission and minimizing its personal; and social impacts
2. To ensure individuals, particularly men who have sex with men (MSM), refugees and migrants from high-prevalence countries, injecting drug users sex workers, and people living with HIV or AIDS (PLWHD), have the knowledge, skills, confidence and motivation to protect themselves against HIV or AIDS.
3. To provide accessible and effective programmes and services that are working together regionally and nationally to prevent HIV transmission, particularly for men who have sex with men (MSM), refugees and migrants from high-prevalence countries, injecting drug users and sex workers, and to minimise the personal and social impacts of the HIV epidemic for people living with HIV or AIDS
4. To produce an information and evidence base that enables and supports policy and programme development, surveillance of HIV and AIDS, monitoring of progress and clinical and service decision-making (Government, 2003).

In theory the HIV/AIDS Action Plan appeared to be a proactive and positive move forward after the evident complacency in early 2000, but unfortunately the document seems to have ended up in the bottom drawer of most policy makers and often only referred to in a mostly tokenistic manner.

A consistent theme over the years has been the paradoxical nature of legislation, policies and societal attitudes in Aotearoa/New Zealand in regards to sexual attitudes and HIV and AIDS. On one hand there have been some pioneering initiatives, especially in the early days of the epidemic with work amongst the gay community and areas around sex workers and intravenous drug use yet on the other hand issues for Māori, youth and women have not been fully addressed.

A decline in HIV diagnoses during the late 90's, a combination of restructuring of the health sector and growing social neo-conservatism, shifted the focus from widespread preventative measures (which most likely was the cause of that decline) to further isolation and stigmatization of people infected with HIV. Women living with HIV, being a minority within a minority, were further marginalized. Government funding for HIV prevention and support was drastically cut with only CART (government ministry of health department), NZAF, and Family Planning (both independent NGO's) receiving government funding, leaving PLHIV

networks to either 'sink or swim'. Organisations which emerged in the 1980s in response to the epidemic disappeared, with only NZAF, Body Positive and Positive Women Inc. surviving from those early days.

Medical treatment for people living with HIV through the Infectious Diseases clinics in the major cities has always been available free of charge and while not the same selection of anti retroviral drugs is available as in other OECD countries, adequate HIV medications are both available and subsidised by the government for those who need them.

Complacency around HIV became evident in the first five years of 2000 when HIV was seen to again be on the increase especially amongst the heterosexual population. This phase saw the emergence of two new PLHIV networks. These were the Māori (Indigenous and South Pacific) HIV/AIDS Foundation and a predominantly online peer support network called Absolutely Positively Positive.

It can be concluded that all these preventative and community support measures together with, albeit minimal education provided in some schools, contributed to keep the epidemic under control in New Zealand, yet some well intended reactive policies have resulted in damaging effects on women and the communities where they live.

Policies (impact on women)

Aotearoa/New Zealand is a signatory to international agreements which require governments to commit action and leadership in combating HIV and AIDS, most specifically the United Nations 2001 Declaration of Commitment on HIV and AIDS which acknowledges that in a global context, women are disproportionately affected and must be given priority on the response to HIV and AIDS. However the approach to primary HIV prevention and education in Aotearoa/New Zealand continues to focus on a high risk individual strategy and remains unfocused on women (AAI, 2009) and as a result there has been a slow, steady increase in the number of HIV diagnoses amongst the heterosexual community and in particular amongst women (McAllister, 2009a) with a specific increase amongst Māori , Pacific Island and Asian women where numbers are as much as 2-4 times higher than in European women (McAllister,

2009b). Despite these statistics, women living with HIV reflect a diverse cross section of society in Aotearoa/New Zealand and defy attempts to be stereotyped as particular types or categories of women (Brander & Norton, 1996).

The legislative and policy response to HIV and AIDS in Aotearoa/New Zealand has been restrained and marked by a 'softly, softly' approach and this is particularly pertinent in regards to women who have largely been treated as invisible. There are few HIV specific laws but instead there has been a move towards the enactment of human rights protections particularly in regards to freedom from discrimination and the right to privacy (Paterson, 1996).

The Human Rights Act 1993 was particularly significant as it afforded women equal rights to men in all areas of life. The most significant being that it prohibits discrimination on the grounds of sex, which includes pregnancy and childbirth, marital status or sexual orientation. For people living with HIV this also prohibits discrimination on the grounds of the presence in the body of organisms capable of causing illness like HIV (*Human Rights Act 1993*). The Act recognises the basic human right of a person living with HIV to be free from discriminatory treatment especially in healthcare and supports public health strategies for ensuring compliance with infection control procedures and educating the public in regards to the risk of HIV transmission (Paterson, 1996). Other areas covered in the Act include (non) discrimination in employment by professional and trade bodies, qualifying bodies and vocational training bodies, in access to public places and facilities, in the provision of goods and service, in the provision of land, housing and other accommodation and in access to educational establishments (*Human Rights Act 1993*; Paterson, 1996).

Unfortunately government did not see the need to enforce the same code of behaviour on itself as Section 151 (2) of the Human Right Act 1993, stipulates that nothing in the Act relating to the prohibited grounds of discrimination s 21 (1), shall affect anything done by or on behalf of the Government (*Human Rights Act 1993*). While the Human Rights Act does not override other legislation, it makes a consequential amendment to the New Zealand Bill of Rights Act

1990 with the effect that government practises which are discriminatory could be challenged as a contravention under section 19 in regards to the right to freedom from discrimination, unless specifically sanctioned by statute, however other statutes must wherever possible, be interpreted so as not to permit unlawful discrimination (Paterson, 1996).

One of the arguments against making HIV a notifiable condition has been the concern that it might deter people from taking an HIV test for fear of discrimination and subsequently drive the epidemic underground. These fears have led to a focus on the privacy of HIV-related information and the enactment of the *Privacy Act 1993* and the *Health Information Privacy Code 1994*.

The Act outlines a set of principles and a code of practise which means employers, medical professional, schools etc should not disclose a person's HIV status (*Privacy Act 1993*). As with the Human Rights Act, in reality this can be misused by employers who regularly assume the defence that disclosure is important for the safety of the person concerned or others in the work place. Queries to the Human Rights and Privacy Commissioners are rarely followed through as loop holes are found as to why disclosure of a person's HIV status is legitimate. Commissions generally appear reluctant to get involved with complaints, especially when against a GP or other such health professionals. Many cases which need to be investigated, often require further disclosure of a person's HIV status and as a consequence people living with HIV often decide to withdraw the complaint.

Case Studies

New Zealand law states people with HIV or other sexually transmitted diseases are only legally required to disclose their conditions if it could endanger their partners. Health experts in the area believe that the use of a condom for sexual intercourse is sufficient for the prevention of the transmission of HIV and so does not require disclosure of one's HIV status (Crimes Act, 1961). This controversial, yet significant, international legal precedent was set in 2005 after a man who did not disclose his HIV positive status to his partner, but used a condom for vaginal sex, was acquitted after the case was brought to court. As a result, it is not

a legal requirement to disclose one's HIV status provided that a condom is properly used for sexual intercourse. By using condoms an HIV positive person fulfils his or her duty to protect sexual partners from HIV infection. However, if an HIV positive person has not taken 'reasonable precautions' (using a condom) to avoid HIV transmission, s/he risks prosecution under s145 or s188 (2) of the Crimes Act 1961. If HIV transmission did not result, s/he could still however be imprisoned for up to one year. If HIV transmission occurred, imprisonment could be up to seven years.

In early 2000, there was a noticeable increase in the number of children being diagnosed with HIV, particularly through mother to child vertical transmission (MTCT). The *HIV Antenatal Screening Programme* was first addressed in a discussion paper in 2003 (NHC, 2003). Due to the availability of interventions to reduce mother to child transmission of HIV and to improve the maternal care of pregnant women with HIV, the aim was to move from the policy of testing which was previously based on HIV screening on a risk assessment basis only, towards a routine offer, with informed consent, of HIV testing for all pregnant women. The programme gained momentum in 2005 when the Ministry of Health decided to go ahead with the programme after a woman and her child were diagnosed with HIV. The woman had not been offered an HIV test even though she appeared to fit the risk need assessment. It was felt the health system had failed the woman and her child and the programme was set to be implemented over a three year time frame. However delays have meant the programme was not nationally executed until June 2010; subsequently all pregnant women in Aotearoa/New Zealand are offered an HIV test along with their other first antenatal blood tests.

Historically sex workers have been blamed for passing on sexually-transmitted diseases and are still perceived by many to be a major vector for the transmission of HIV into the general population. In many parts of the world though, the facts contradict this misapprehension (Healy & Reed, 1994). Since its establishment in 1987, the NZPC highlighted that sex workers know a lot about sex and the thoughts, behaviours and attitudes that go with it and this made them the ideal transmitters of safer sex practices. Continued lobbying on this issue resulted in

the *Prostitutes Reform Act 2003*. A significant piece of legislation which decriminalised prostitution in order to create a framework which would protect the human rights of sex workers, protect them from exploitation, promote the welfare and occupational health and safety of sex workers conducive to public health and to prohibit the use of prostitution for persons under the age of 18. This means prostitution is now recognised as a legitimate service occupation which operates under the same health and safety rules as any New Zealand Industry (*Prostitute Reform Act 2003*). While the sex work industry (for women) was never a high risk group for HIV, the act was nevertheless a proactive move in regards to HIV prevention but just as importantly, in protecting the rights of sex workers.

Calls for the government to tighten immigration policy were first initiated after the trial of Peter Mwai, a Kenyan musician who was seeking permanent residency in Aotearoa/New Zealand. Mwai was charged in October 1993 with a number of offences of infecting (and *possibly* infecting) women with the HIV virus. The charges were that Mwai “wilfully and without lawful justification or excuse caused or produced (in a named complainant) a sickness or disease, namely Human Immuno-Deficiency Virus (HIV)”. While there was insufficient evidence to prove Mwai’s intentions were to wilfully cause infection, he was convicted of six lesser charges as the Crown identified Mwai was aware of his HIV status, aware of the implications of having unprotected sexual intercourse and that he neither revealed this to his partners nor did he use condoms (Worth, 1995). Mwai was convicted and sentenced to seven years imprisonment. After serving two thirds of his sentence Mwai was deported back to Kenya where he died two years later.

The Police Minister at the time, Hon. John Banks, began a call for mandatory HIV testing for people applying for permanent residency and by the end of 1993, after the Mwai case, the possibility of mandatory testing was made part of the government’s review of the Immigration Department (Worth, 1995) and by November 2005, policy was set in place for mandatory testing for all people applying for permanent residency (Government, 2009). At the same time, international students and visitors are not tested, therefore, a policy of this kind does not

prevent the virus from entering the country, it only prevents the national health system from being 'burdened' with another person who requires free medical attention. What this policy disregarded was that mandatory testing for HIV contravenes international conventions which prohibit discrimination against HIV positive travellers and immigrants. Both the World Health Organisation (1987) and the United Nations (1991) have argued that "mandatory testing is impossible to substantiate in epidemiological, political and ethical terms and that no screening programme can halt the introduction and spread of HIV" (Worth, 1995). Therefore, policies that relate to education and destigmatisation are more likely to prevent the epidemic from spreading than prohibiting policies.

The Mwai case also demonstrated the ways women at that time were (and continue to be) positioned in the HIV debate. The women involved were judged in terms of their sexual (in)appropriateness as they willingly had unprotected sex with a man they had only known for a few hours after meeting in a bar. The fact that some of the women felt they had no choice was disregarded. The case offered an excellent opportunity for women's needs to be addressed and to be put on the public health agenda especially as a study carried out at the time indicated that less than 25% of sexually active heterosexual men and women used condoms (Worth, 1995).

It is assumed women in developed countries are better able to negotiate condom use yet, as was again highlighted by one of the women in the Mwai case who explained she had initially discussed the use of a condom but that he (Mwai) would not wear it because he said "it hurts". The woman felt embarrassed to bring up the topic again and in the end 'trusted him'. This behaviour may seem unusual, but in fact it is commonplace for many women to defer to men in this manner (Bennett, 2007; Bruning 2008, Worth 1995).

This case highlighted the government's limited standpoint as it chose to focus on mandatory HIV testing of immigrants, portraying HIV as something 'outside' of Aotearoa/New Zealand with a specific focus on Africans rather than focusing on increasing HIV health promotion for women (and men).

Major determinants responsible for HIV transmission and possible solutions

There is no denying that MSM are the major risk group in Aotearoa/New Zealand and prevention programmes need to continue to retain a focus on this sector. However, one of the major determinants responsible for HIV transmission amongst women in Aotearoa/New Zealand is the government's resoluteness in maintaining a primary prevention strategy which continues to focus solely on high risk groups even though statistics over the past 18 years indicate a steady increase in the number of females (and heterosexual males) presenting with HIV.

Women are the fastest growing group to be affected by HIV yet the public health commission continues to ignore this which is evident by a resistance to gender mainstreaming and a continued refusal to fund HIV prevention programmes for women or mainstream population (Worth, 1995; McAllister, 2009). One of the reasons for continuing with this outdated focus is based on information that 88% of heterosexual HIV infections are contracted by people while overseas (Bennett, 2007; McAllister, 2006/2009). What is being overlooked is that during 1985 and 2002 the number of short trips by New Zealanders (12 months or less), has increased more than threefold while during the same period the number of overseas visitors to New Zealand had also trebled (N.Z. Statistics, 2002). Subsequently, as a nation we are sending our young people into the world with no understanding of the risks of HIV or education around HIV prevention while at the same time overseas travel by New Zealanders continues to increase.

The Education Review Office (ERO) is a government department which reports publicly on the quality of education in all schools in Aotearoa/New Zealand. The ERO undertook a review of sexual education in secondary schools in 2001 and found there was a significant lack of sexual education. Sexual health education is part of the school curriculum but it depends very much on the Parent Teacher Association (NZPTA) of each school and on the type of school, as to what is taught in regards to sexual health education. In many schools the focus is predominantly on biology and prevention of pregnancy rather than education around STIs.

Many schools require parental consent before a young person is able to attend sexual health classes, and consequently many miss out.

Students who took part in a study to determine the prevalence of selected health risk behaviours indicated that 16.8% of 13 year olds, 33.3% of 15 year olds and 48.7% of 17 year olds reported having had sexual intercourse. More than two thirds of all sexually active students reported using a condom in their (last) sexual encounter but condom use dropped significantly as students reached 16 and 17 years old and were able to access the contraceptive pill, indicating that condom use was more about prevention of pregnancy than STIs. This is evident in other studies which confirm the high rates of gonorrhoea, chlamydia, genital herpes and genital warts (NZMA, 2003; Perkins, 2004; Fernando et al, 2005; Azariah & Perkins, 2007). What is concerning is that STIs are higher, some times as much as three times more, in females aged between 10-29, than for males. A marked sex difference was seen in hospitalisation of women for STIs and their underlying effects such as ectopic pregnancy, pelvic inflammatory disease (PID), cervical dysplasia and neoplasia where rates in women were over ten times more than those of men (Baker, Mills, & Tobias, 2002). These increasing rates of STIs are a considerable public health concern for a number of reasons but significantly in regards to their ability to facilitate the transmission of HIV (Fernando, Johnston, & MacBride-Stewart, 2005).

The sexual health of a country's youth to a large part determines the health of its society. It is therefore imperative that there is a need for further development and implementation of an integrated national policy to address the infectious diseases burden which includes HIV education and prevention, in Aotearoa/New Zealand (Baker et al., 2002).

The health status for Māori continues to be of concern due to a lack of agreement as how to define indigenous status and in the way in which ethnic specific data is collected and recorded. In the 1991 census the biological concept of ethnic origin was replaced with that of self-identification of ethnicity which has made a significant change to how people identify their ethnicity (Bramley, Chassin, Hebert, & Jackson, 2004). While the numbers are still believed to

be relatively small, however this same problem has become evident in regards to under reporting of HIV in Māori and specifically amongst women.

The Ministry of Health 2003 HIV Strategy acknowledges Māori as a vulnerable group with Māori women having the highest recorded rates of STIs and repeat infections yet test trials indicate that only 3.9% of people tested identified as Māori (Clark, 2006), which indicates an under representation. Social and cultural taboos prevent many Māori women from disclosing their HIV status as sometimes loss of life is perceived as less horrific than a loss of status in the community. Internalised stigma and discrimination are major determinants for the further spread of HIV amongst Māori together with a lack of HIV education and prevention programmes which are culturally appropriate (Pala, 2009).

Poverty and low socio economic and educational backgrounds amongst Māori can create a state of disengagement and if we add to this the discrimination within some Māori communities towards sexual diversity and the stigma attached, makes preventative and educative measures difficult. Active involvement in the community and the development of a sense of compassion and belonging may be the way forward in further prevention of the spread of the virus amongst Māori (Pala, 2009).

While HIV and AIDS in New Zealand has been seen predominantly as a disease of homosexuals, due to the Mwai affair and the statistics which indicate transmission of HIV for women occurs predominantly overseas, HIV is increasingly being seen as something external to Aotearoa/New Zealand, and as something 'out of Africa'. An important public health issue which appears to have been overlooked is the fact that many New Zealand women continue to have unprotected sex and a wide-scale health promotion campaign targeted at women has never been developed (Worth, 1995).

One response to the believed 'imported' increase of HIV was a change in policy in November 2005 by the New Zealand Immigration department which requires all refugee, asylum seekers, migrants and people visiting (working) in Aotearoa/New Zealand for longer than 12 months to be tested for HIV as part of their immigration application (Government, 2009).

As a result only 20 refugee/asylum seekers who have HIV are now accepted each year and all other people found to be HIV+ will initially have their application rejected. There is a process for appeal (medical waiver) but predictably this has proved to be a long and costly process. Numerous applications have been declined and removal orders issued, particularly for those from countries such as Zimbabwe and South Africa. However most of these people have been living in the country for many years having established a new life for themselves and their families. They are fearful of returning to countries they have left behind, often in difficult circumstances and in most cases returning to their home land with HIV would most certainly be a death sentence for many who would not be able to gain access to even basic health care, let alone specialised HIV care and management or even access to medications. As a result some people are driven underground and become illegal over-stayers, who, as they are unable to work or gain access to free medical care, seek assistance from PLHIV and other such networks which are not funded by government. These are often women with children and they do not appear in most statistics or feature in research projects. As a consequence of this globally palliative policy, many refugee women raped in refugee camps or others who have contracted HIV from their husbands, who have then left them, are now penalized and further victimized. This is however preferable than returning to their home countries. Such policies go against advice made by the World Health Organization and the United Nations Commission on Human Rights who have strongly condemned policies of mandatory HIV screening and travel restrictions especially as such discriminatory policies have no public health rationale and violate the human rights of PLWHA. This policy highlights the frequent paradoxical nature of social policy within Aotearoa/New Zealand.

Together with a lack of HIV awareness, stigma and the fear of discrimination are key detriments for women in regards to HIV transmission in Aotearoa/New Zealand. This has been evident in the increasing number of cases before the courts involving the transmission (or possible transmission) of HIV from men to women as a result of unprotected sex and non disclosure of HIV status. HIV and AIDS emerged as a disease 'whose charge of stigmatization

is far greater' than that of other diseases where people living with HIV are often seen as the pariahs of society (gay, drug addicts, promiscuous, immoral) so 'deserve what they get' (Goffman, 1959).

When sex is a vehicle for infection, sexual identity becomes intertwined with stigmatization and feelings of guilt about being contagious and a danger to society (Gibson & Rohleder, 2006). In extreme cases this can result in denial which is increasingly evident amongst heterosexual men who fear being labeled and engage in a behaviour identified as 'passing' (Goffman, 1959), where they hide the reality of their situation and attempt to 'pass' as unaffected, unfortunately in some case with severe consequences (Ginsberg, 1996).

Despite the rising incidence of HIV within the female population, women continue to be seen as invisible actors in a disease discourse that was constructed by men for men (Bennett, 2007). This continued focus on MSM does not only marginalise and isolate women but it further stigmatizes men and prevents involvement of the whole community for an issue that belongs to the community.

Education for women plays only a very minor role and the male bias dominant in HIV and AIDS research and the lack of sex specific research further compounds women's invisibility (Bennett, 2007). This has been confirmed in findings from two New Zealand research projects on women and HIV, undertaken by J. Bennett (2001/2006) and J. Bruning (2009), which indicated women felt they were not well served by policies and practices which continued to retain such a predominant male focus and while there was an increase in women being diagnosed there was a distinct lack of HIV prevention education messages targeted at women (Bennett, 2007; Bruning, 2009).

Participants in both studies expressed the belief that health care services did not meet the needs of women and that women often felt uncomfortable and reluctant to use services which generally did not meet their needs and which lacked a family friendly focus. It was felt gender specific issues facing women are still ignored, negative stereotypes related to promiscuity are reinforced and while health care workers are encouraged to embrace ideas of cultural safety

and gender specific care, many women felt that health care workers were often unaware of their own personal prejudices and how these were transmitted (Bennett, 2007).

Both research projects identified that the involvement of people living with HIV, especially women, is both paramount and instrumental to all HIV related advocacy, policies and interventions. This is highlighted in recent events in New Zealand where currently PLHIV networks do not receive any government funding and there is no 'Population Strategy' on HIV awareness and prevention. However, more recently, as a result of PLHIV raising awareness of the work they do and advocating on behalf of their communities, the government ~~is currently undertaking~~ ~~undertook~~ a review of services for PLHIV with the aim of evaluating where future investments ~~are~~ might be required. The review resulted in PLHIV support networks receiving government funding in 2011 for the first time ever which consisted of a three year contract of \$NZ100,000.00 per organisation per year with the possibility of being rolled over at the end of the contract depending on reporting of value for money and whomever is in government.

A study on *Stigma and women living with HIV: A Cooperative Inquiry* (Bruning, 2009) was carried out under the auspices of Positive Women Inc. and explored the impact of stigma on women in New Zealand living with HIV using co-operative inquiry as a research methodology. Participating women choose to undertake some actions not only to minimise the impact of stigma in their lives, but to suggest and promote actions and activities in the community which could de-stigmatize and educate appropriately and enabled personal transformation and empowerment for those who took part (Bruning, 2009).

Through the sharing of experience and connecting with other women also affected by living with the stigma of an HIV diagnoses, these women all reached a level of consciousness which they previously had not been connected to (Bruning, 2009). Consciousness-raising is an empowering component for both individual and community development as it enables a move towards action for change. However the possibility to enact on a process of action (for change) must also be made available otherwise there is no purpose in people being able to identify

their needs. Opportunities to initiate and participate in various actions were empowering for the women during this project as they collectively and co-operatively moved through the stages and cycles of the inquiry and undertook actions that they found meaningful and relevant as women living with HIV and for the communities where they live (Bruning, 2009).

The underlying drive which motivated most of the actions during this inquiry was the concern over the lack of awareness and education of HIV for secondary school teachers and students in New Zealand. As a result of the actions undertaken by the women in this group there is now a resource available for secondary school educators on how to teach HIV and AIDS in secondary schools (Positive Women Inc.). This is an example of a grass roots approach and highlights the benefits of women working for, and with, women living with HIV. It also accentuates the important roles NGOs such as Positive Women Inc. can achieve and demonstrates women can be active players in change both at community and policy level.

Conclusions and recommendations

In conclusion, it is suggested that the HIV and AIDS epidemic could provide an opportunity to revisit the ways policies, professional practices and contexts influence people affected by it and to examine how HIV positive people can be heard and engaged in creating and enacting policies in practice in order to destigmatise the already heavily stigmatised population.

AIDS is an easily preventable disease and prejudices and discrimination are the main determinants of the spread of HIV. Engaging and focussed education does not only help to prevent the spread of the virus but has the potential to create communities of care where solutions can be sought within the context of community action.

As HIV is easily preventable with the use of condoms and other prophylactic measures, the main determinants which enable a virus to spread are prejudices and attitudes which often put women in subservient roles and hinder their ability to negotiate safe sex practices. Appreciating and valuing difference contributes to destigmatisation of HIV+ people and at the same time challenges prejudices deeply ingrained within society. Transdisciplinary approaches from educators, medical professionals, policy makers, social workers and people

who live with HIV, has an advantage of addressing the issue politically, professionally and personally.

Education is essential not only for prevention of HIV but also for all STIs and unwanted pregnancies. Involvement of HIV+ people in educational programmes promotes destigmatisation and enables young people to realise the benefits of creating appreciative communities, aware of the risks of unsafe sex but also becoming accepting of people who may have contracted HIV.

Closely linked to prejudice, stigma causes disempowerment, isolation and at times a lack of willingness to live. When stigmatised, or afraid of possible stigmatisation people do not seek medical help when needed and as a result do not feel that they belong to the community and when this is the case it is more likely to engage in activities which may spread the virus intentionally.

New Zealand, with its reputation for robust social policy, equity and social justice has developed significant prevention strategies for the spread of HIV. Yet, more work needs to be undertaken to ensure people with HIV are not subject to discrimination and stigma. As Jillian Bennett pointed out in 2001, women with HIV or AIDS have not benefited from the extensive social and clinical research that homosexual men have had. The gendered neglect and consequent stigma and discrimination of women still need to be addressed. Educational strategies must address this discrepancy and make visible, those hidden faces of 'positive women' living with HIV or AIDS.

Glossary

AEG	AIDS Epidemiology Group
ASN	AIDS Support Network
CART	Community AIDS Resource Team
ERO	Educational Review Office
GP	General Practitioner
IDU	Intravenous Drug Use/r
Maori	Indigenous people of Aotearoa/New Zealand
MP	Minister of Parliament
MTCT	Mother to Child Transmission
MSM	Men who have sex with men
NEP	Needle Exchange Programme
NGO's	Non Governmental Organisations
NZAF	New Zealand AIDS Foundation
NZMA	New Zealand Medical Association
NZPC	New Zealand Prostitutes Collective
NZPTA	New Zealand Parent Teacher Association
OECD	Organization for Economic Cooperation and Development
PID	Pelvic Inflammatory Disease
PLHIV	People living with HIV
PLHIVA	People living with HIV or AIDS
STI's	Sexually Transmitted Infections
TRT	Te Roopu Tautoko Maori HIV prevention Group

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