



FOURTEEN CENTRALLY IMPORTANT STRATEGIC POINTS ABOUT HIV PREVENTION FOR MSM IN NEW ZEALAND IN 2010:

1. HIV is a virus and its core transmission dynamics can only be understood in terms of biology. It is not easy to pass on. A very limited number of specific behaviours can spread HIV efficiently from one person to another.
2. Anal sex, in particular receptive anal sex, is by far the most likely sexual activity to transmit HIV infection. HIV is also easily spread by sharing needles during injecting drug use, but in New Zealand the number of injecting drug users is not high compared to most other comparable countries. Needle exchange programmes have also been well supported here and have successfully controlled HIV transmission so far.
3. MSM are at greatest risk of HIV acquisition and transmission because of the amount and concurrency of the anal sex that is practiced, together with the heightened HIV prevalence levels found in the MSM population. MSM are therefore the primary target group for HIV prevention in New Zealand, accounting for 77% of all HIV diagnoses where infection was acquired in this country over the last five years (2005-2009). MSM comprise about 2.5% of the total New Zealand adult population aged 15-64 years. This means that there were 55 newly diagnosed and locally acquired HIV infections in a pool of approximately 71,000 MSM in 2009. This contrasts with 19 locally acquired heterosexual cases in an adult population of around 2.79 million people in that same year.

4. HIV prevention for MSM is best done by concentrating on modifying particular risk behaviours because of the specifics of HIV transmission biology. Partner number is irrelevant for the male-to-male sexual activities that are safe for HIV spread - in other words, for the great majority of them. The statistical risk of HIV acquisition is substantially increased, of course, if unprotected anal sex is practiced with large numbers of different partners.
5. Condoms are the best individual and population level intervention to control the sexual spread of HIV in MSM, and their correct and consistent use reduces risk by around 95%. They are by far the most important single element in effective HIV and STI management for gay and bisexual men.
6. Condom use not only protects the individual and their immediate sexual partner, but also contributes enormously to the collective control of HIV transmission in the whole MSM population over time. Each person who does not contract HIV is someone who cannot transmit it to their next sexual partner. "Herd immunity" effects operate to amplify the impact of condom use.
7. There is a high level of synergy between HIV and STI transmission in gay and bisexual men, and it is now clear that consistent condom use sharply downregulates the population spread of the majority of the STI's as well. Several of the serious STI's that are easily spread through anal sex also directly increase the risk of HIV infection.
8. In the midst of HIV and STI epidemics that are rising sharply once again in MSM around the world, it is essential to recognise that condom use is primarily a "community responsibility" rather than first and foremost an "individual choice". The main lessons from the last 25 years of HIV management still apply. All epidemics of infectious diseases are collective events, and their control must operate effectively at the population level. This means that a population wide frame of reference is critical. Of course every gay and bisexual man can make a significant personal contribution to the successful control of HIV transmission by using condoms each time they engage in anal sex.
9. It is also essential to ensure that HIV prevention programmes for MSM are "by gay men, for gay men" if community influence and effectiveness is to be maintained. A thorough bio-psychosocial understanding of gay male sexuality is a necessary element in effective prevention interventions because the sexual health needs of MSM are unique and specialised. Sexual behaviour, in particular unprotected anal sex, almost completely drives the

spread of HIV in the New Zealand MSM population, with injecting drug use playing only a minor role.

10. HIV prevention and its underlying biological rationale have developed into complex professional fields over the last 25 years. This means that a high level of “knowledge” input into strategic programme design is now fundamental to the success of HIV prevention initiatives. All interventions must be properly engineered to take account of the biological, epidemiological and sexual network realities of HIV transmission. HIV prevention is first and foremost a public health endeavour.
11. It follows that it would be a serious mistake to determine overall HIV prevention strategy solely on the basis of the gay community equivalent of *vox pop* polling. But it is vital also to recognise that grass roots gay community opinion and feedback is a centrally important input into the design, in particular, of effective HIV prevention tactics.
12. To facilitate these multi-level processes of knowledge transfer it is necessary to encourage an organisational and community culture of engagement with the science that underpins HIV prevention. HIV transmission biology determines the basics of epidemic spread. Effective primary prevention is impossible if this is not understood.
13. Targeting specifically tailored HIV prevention messages to the population group that is at greatest risk in New Zealand remains as essential now as it was 25 years ago. There is no hope of continued prevention success here if this approach is not accorded the highest strategic and tactical priority.
14. Most people in New Zealand are not at significant risk of HIV infection because they do not engage in the particular sexual behaviours and multiple partnering configurations that are the main contributors to HIV spread. This means that our effectiveness at promoting condom use for anal sex by MSM will continue in large part to determine the future course of the HIV epidemic in this country.

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