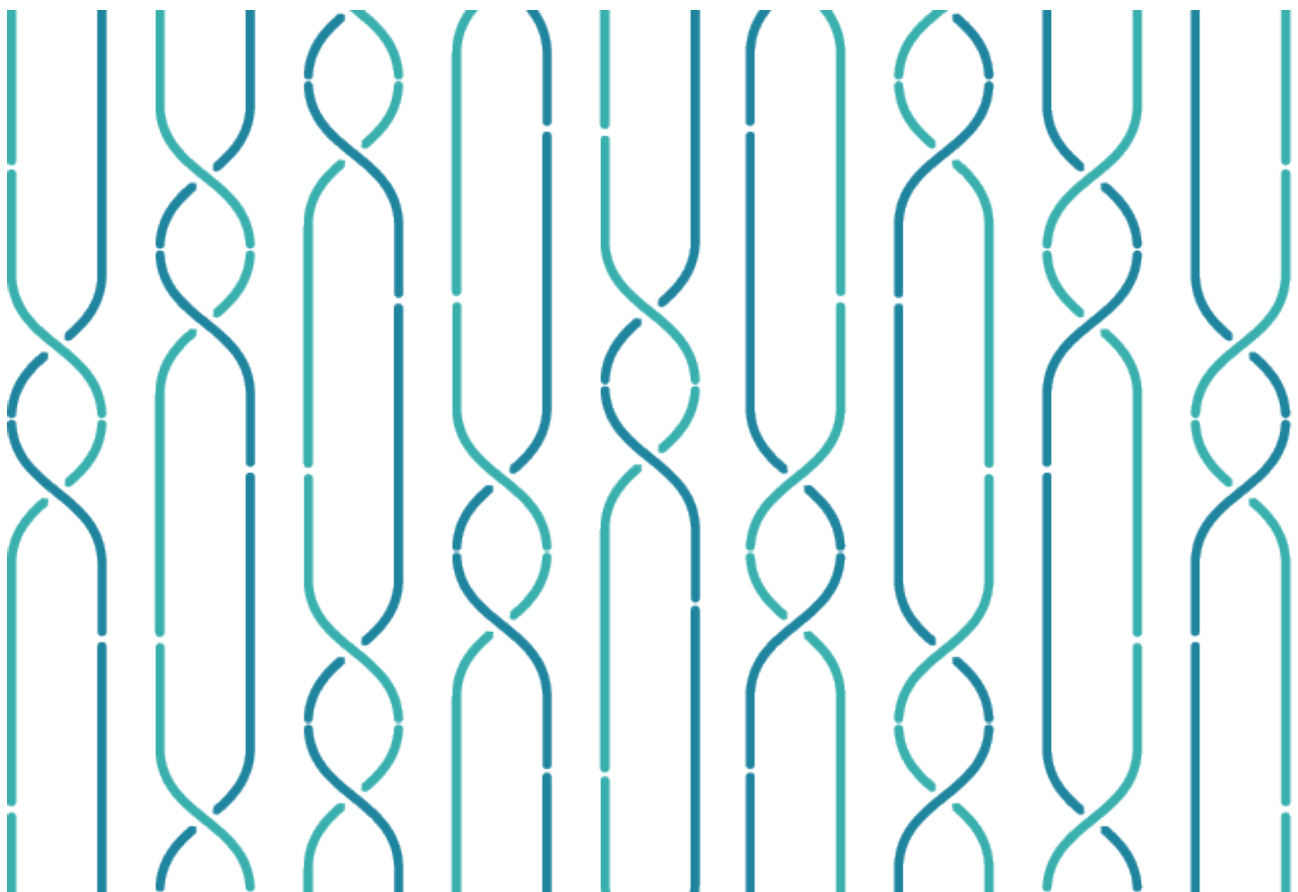




# NGĀ POKENGA PAIPAI ME NGĀ POKENGA HUAKETO MĀ TE TOTO: TE RAUTAKI O AOTEAROA **2023–2030**

## Aotearoa New Zealand Sexually Transmitted and Blood Borne Infection Strategy 2023–2030

*An Aotearoa New Zealand where sexually transmitted and blood borne infections (STBBI) are prevented and where all people living with STBBI live long and healthy lives free from stigma and discrimination*



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# Mihi

Pērā rawa i te awa haehae i te whenua, ko te mamae e haehae nei i te ngākau mō rātou kua riro ki tua i te ārai. Nā te mata kanehu rātou i tanu, tēnei te mata o te pene te hahu ake anō hei whakamahu i te ngākau marū. Me te kī atu ki a rātou, hoatu koutou ki ō koutou tūpuna e tatari mai ana ki a koutou i te pō, haere, haere, oki atu e. Ko rātou te hunga mate ki a rātou, ko tātou te hunga ora ki a tātou.

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# Foreword from Minister of Health

Sexually transmitted and blood borne infections (STBBI) are preventable and treatable. Yet, for many of these STBBI, infection rates are steady or increasing and their health and wellbeing outcomes are inequitable in Aotearoa New Zealand.

As the Minister of Health, I am determined to see a reduction in infection rates, better outcomes for people living with these infections, and elimination of hepatitis C, congenital syphilis and human immunodeficiency virus (HIV) transmission.

We are already in a strong position to achieve these goals. Community organisations, primary care and specialist services are undertaking prevention work, as well as providing screening, testing and treatment. Access to vaccines for human papillomavirus (HPV), hepatitis B and hepatitis A is funded for key population groups and the recently developed cure for hepatitis C is highly tolerable and fully funded. We also have preventative HIV medication and treatment that stops the sexual transmission of HIV.

This Aotearoa New Zealand Sexually Transmitted and Blood Borne Infection Strategy provides a framework to help us reach our elimination and prevention goals and set the direction for action plans for hepatitis C, syphilis and HIV. The strategy responds to new opportunities to detect, prevent, treat and manage STBBI and builds on our response to COVID-19. In particular, it focuses on investing in disease prevention, early testing and treatment; strengthening public health surveillance systems; building contact tracing capacity; and improving the capability of the health system to manage these infections.

The strategy is guided by our obligations to Te Tiriti o Waitangi and achieving equity for population groups disproportionately affected by or most at risk of acquiring STBBI. We can achieve this by prioritising Māori, Pacific and Rainbow communities, people who inject drugs, sex workers and migrants from high prevalence countries in the STBBI strategy. Including people living with or affected by STBBIs will also be critical to delivering an effective public health response and supporting initiatives to challenge stigma and discrimination.

Achieving these ambitious goals will only be possible by building on the sustained efforts from the health sector, researchers and communities that have brought us to where we are today. I want to thank everyone who has been involved in developing this strategy as well as those who will now deliver it.

**Hon Dr Ayesha Verrall**  
Minister of Health



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# Introduction

The scope of the *Aotearoa New Zealand Sexually Transmitted and Blood Borne Infection Strategy* (the strategy) includes common and significant sexually transmitted infections (STIs) and blood borne infections (BBIs). These infections include syphilis, chlamydia, gonorrhoea, human papillomavirus (HPV),<sup>1</sup> human immunodeficiency virus (HIV) and viral hepatitis.<sup>2</sup>

Sexually transmitted and blood borne infections (STBBI) have similar modes of transmission, risk factors, stigma, and priority groups who may be at greater risk of infection and inequitable health outcomes. Co-infection with some STIs increases the risk of HIV infection, and mortality and morbidity of liver disease are increased for those co-infected with HIV and either hepatitis B or C (NCHSTP 2020).

STBBI can have profound and long-term impacts on health and wellbeing for individuals and socioeconomic impacts for communities.<sup>3</sup> In Aotearoa New Zealand, these impacts are characterised by marked inequities and, for some STBBI, rates of disease or complications are increasing. All STBBI are preventable and can be treated or managed, but many are asymptomatic and can remain undiagnosed until complications arise.

## Impacts of Sexually Transmitted and Blood Borne Infections

**Syphilis** can cause serious illness if untreated. It can be transmitted from mother to child during pregnancy, leading to stillbirth or congenital syphilis.

**Chlamydia and gonorrhoea** can cause pelvic inflammatory disease, which is associated with infertility, chronic pelvic pain and poor pregnancy outcomes. Escalating gonorrhoea antimicrobial resistance (AMR) is an important public health issue worldwide.

**Human papillomavirus (HPV)** is implicated in a high proportion of some types of cancer, including cervical, anal and head and neck cancers.

**HIV** impairs the body's ability to combat infections and cancers. Without treatment, it results in acquired immunodeficiency syndrome (AIDS). Like syphilis and hepatitis B, HIV can be transmitted from mother to child.

Without treatment, **viral hepatitis** can cause liver damage and liver cancer. Hepatitis B and C are the leading causes of liver cancer in Aotearoa New Zealand.

<sup>1</sup> The HPV vaccination programme and the National Screening Unit's strategies and action plans also deal with HPV and its consequences.

<sup>2</sup> This strategy was developed before Mpox emerged internationally as an infection transmitted via intimate contact. For this reason, a response to Mpox has been developed separately. However, the priority groups, directions and priority areas outlined in this strategy support the prevention and management of Mpox and other relevant emergent infections in Aotearoa New Zealand.

<sup>3</sup> WHO. Sexually transmitted infections (STIs). URL: [who.int/news-room/fact-sheets/detail/sexually-transmitted-infections-\(stis\)](https://www.who.int/news-room/fact-sheets/detail/sexually-transmitted-infections-(stis)) (accessed 3 February 2023).



Stigma and discrimination<sup>4</sup> are significant barriers to preventing and managing STBBI. They can impact both people living with or affected by STBBI and people participating in behaviours that can increase their risk of infection (such as injecting drug use). These experiences of stigma intersect and are compounded by other forms of stigma and discrimination such as racism, homophobia, and transphobia. Stigma and discrimination prevent or delay people from accessing and engaging with prevention and health services.

Effective prevention and treatment have been available for many STIs for many years. In addition, we now have pharmaceuticals that can cure hepatitis C<sup>5</sup> and deliver effective treatment for HIV and hepatitis B. We also have many tools for prevention include immunisation for hepatitis B and HPV, pre-exposure prophylaxis (PrEP) for HIV, and treatment as prevention (TasP) for hepatitis C and HIV. It is important that effective prevention and treatment reach those who need them. Making this happen includes ensuring that people are both aware of and able to access appropriate STBBI prevention, testing and treatment.

Aotearoa New Zealand has not previously had a combined STBBI strategy. The purpose of this shared strategy for STIs and blood borne viruses is to improve collaboration, support collective action and set a unified strategic direction for the health agencies — Manatū Hauora (the Ministry of Health — the Ministry), Te Aka Whai Ora (Māori Health Authority) and Te Whatu Ora (Health New Zealand) — and the health and disability sector.

The strategy provides an opportunity to progress prioritised actions in a coordinated way to achieve the vision of 'An Aotearoa New Zealand where STBBI are prevented and where all people living with STBBI live long and healthy lives free from stigma and discrimination'.

The strategy outlines high-level outcomes (goals and objectives), strategic directions and priority areas for action. It has been guided and informed by the international and local strategic context (see Appendix 2), along with the epidemiology of STBBI in Aotearoa New Zealand, including inequities in health outcomes. It further confirms the centrality of Te Tiriti o Waitangi (Te Tiriti) and the commitment to achieving equity for all.

The strategy also sets the scene and direction for current and future action plans that will come under its umbrella. Two action plans have already been developed for STBBI that have significant adverse impacts on public health: the National Syphilis Action Plan (Ministry of Health 2019a), and the National Hepatitis C Action Plan for Aotearoa New Zealand — Māhere Mahi mō te Ate Kakā C (Ministry of Health 2021a). The development of an action plan for HIV is under way. All of these action plans fall under the strategic direction of the STBBI strategy, which will guide their ongoing

<sup>4</sup> Stigma refers to the devalued status attached to certain behaviours or conditions. Stigma can be internalised where people experience negative attitudes leading to feelings of shame, embarrassment, and fear of isolation as well as structural where these perspectives are perpetuated by inadequate legislation, institutions and health services. Discrimination is the unfair or less favourable treatment of people based on their real or perceived health status.

<sup>5</sup> Direct-acting antiviral (DAA) treatment.





implementation. The action plans contain specific actions for relevant health agencies and the sector to deliver and — along with supporting implementation plans — set out the time frames and accountabilities for delivering on these actions.

Further action plans may be developed under this strategy as required, based on assessment of need and prioritisation processes. These will have Te Tiriti and equity at their centre and be designed using priority group expertise and models of wellbeing. While they are not directly under the umbrella of the strategy, policies, strategies, action plans and initiatives related to reproductive health and rights and maternity care will also link to the strategy.

The Public Health Agency (Manatū Hauora) has led the development of this strategy, working in partnership with Māori sexual health and mainstream sexual health technical experts and in consultation with a sector working group (see Appendix 1 for a list of members). Later action plans will be developed in collaboration with the sector and relevant priority groups.

The audience for this strategy includes planners, funders and providers of health and disability services. It also includes communities affected by STBBI, people living with HIV and people living with chronic viral hepatitis.



# Overarching framework of the strategy

## Vision

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An Aotearoa New Zealand where STBBI are prevented and where all people living with STBBI live long and healthy lives free from stigma and discrimination

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## Goals

The overarching goals of the strategy are to:

1. reduce incidence of STBBI in Aotearoa New Zealand and eliminate<sup>6</sup> congenital syphilis, hepatitis C and transmission of HIV
2. decrease mortality and the negative health and wellbeing outcomes of STBBI, including stigma and discrimination
3. improve Māori health and wellbeing in relation to STBBI through delivery on Te Tiriti o Waitangi obligations
4. increase equity in relation to all STBBI goals and objectives.

## Strategic directions

The strategic directions provide a framework for delivering effective action on STBBI are:

1. Surveillance, information and knowledge systems to drive action
2. Results-focused health promotion and comprehensive prevention
3. Equitable access to culturally safe, quality health care for testing and management

<sup>6</sup> WHO has defined the elimination of viral hepatitis as a public health threat as achieving a 90% reduction in new chronic infections and a 65% reduction in mortality (WHO 2016a). For congenital syphilis, elimination is defined as less than 50 per 100,000 live births are affected (WHO 2017), but Aotearoa New Zealand should aim for zero congenital syphilis, which it has previously achieved. UNAIDS (2014) has stated that for HIV to be ended as a global health threat by 2030, 'the number of new HIV infections and AIDS-related deaths will need to decline by 90% compared to 2010' (p 6).



#### 4. Leading for an integrated, supported, consumer-focused system

Each strategic direction contains both opportunities and challenges that need to be addressed to achieve the overall goals of the strategy.

## Priority groups

The current<sup>7</sup> priority groups for the STBBI strategy are:

- Māori
- Pacific peoples
- young people — people under 29 years of age
- gay and bisexual men and other men who have sex with men (GBM)
- people who inject drugs
- people living with HIV and chronic viral hepatitis
- sex workers<sup>8</sup>
- migrants from areas with a high prevalence of STBBI.<sup>9</sup>

Identifying priority groups helps focus the priority area actions and will contribute to achieving the outcomes of the strategy.

The decisions about who are priority groups for the STBBI strategy have been based on the aim of giving effect to Te Tiriti o Waitangi and on local and international epidemiology. This work included identifying groups experiencing inequities and who require extra resources and funding to eliminate STBBI-related inequities (see the section **STBBI in Aotearoa New Zealand**).

We also need more epidemiological information on certain priority groups and key populations in Aotearoa New Zealand. These groups include transgender and non-binary people, those in or recently released from prison, people who are experiencing homelessness or are not in safe or secure accommodation, people who interact with mental health and addiction services, women experiencing violence and others. Most of our actions will focus on the identified priority groups. However, we acknowledge there are other population groups such as pregnant people that are also important. The STBBI strategy will also contain specific actions for these other groups.

<sup>7</sup> Priority groups are not fixed over the time of the strategy and may change based on the latest epidemiology.

<sup>8</sup> This includes migrant sex workers

<sup>9</sup> Some of these migrants may not be eligible for funded health care.



# Summary of overarching framework of the strategy

VALUES AND TE TIRITI O WAITANGI STBBI STRATEGY	International and Aotearoa New Zealand strategic context	Te Tiriti o Waitangi										
		United Nations Sustainable Development Goal 3		World Health Organization strategies for HIV, viral hepatitis and STIs		United Nations Declaration on the Rights of Indigenous Peoples		Convention on the Elimination of All Forms of Discrimination against Women		United Nations Convention on the Rights of the Child		
		New Zealand Health Strategy: Future direction				Wai 2575						
		He Korowai Oranga, Māori Health Strategy		Whakamaua: Māori Health Action Plan		Ola Manuia: Pacific Health and Wellbeing Action Plan		Aotearoa Statement on Closing the Gap on STIs and BBVs among Indigenous Peoples of Australasia		The Aotearoa New Zealand comprehensive HIV consensus statement		
	Vision	An Aotearoa New Zealand where STBBI are prevented and where all people living with STBBI live long and healthy lives free from stigma and discrimination										
	Goals	Improve Māori health and wellbeing in relation to STBBI through delivery on Te Tiriti o Waitangi obligations			Reduce incidence of all STBBI and eliminate congenital syphilis, hepatitis C and transmission of HIV			Decrease mortality and the negative health and wellbeing outcomes of STBBI, including stigma and discrimination			Increase equity in relation to all STBBI goals and objectives	
	Objectives	<ul style="list-style-type: none"> <li>Improved information from surveillance systems</li> <li>Increased information about epidemiology including by ethnicity and for priority groups</li> <li>Improved evidence base through research and evaluation</li> <li>Increased dissemination of evidence to the whole STBBI sector and communities</li> <li>Increased community awareness and understanding of STBBI, particularly among priority groups</li> <li>Increased access to and uptake of comprehensive prevention</li> <li>Reduced experience of stigma and discrimination</li> <li>Increase in equitable access to services in the community, primary care and specialist services</li> <li>Increase in culturally safe and acceptable high-quality health care</li> <li>Increase in evidence-based testing and treatment approaches, including contact tracing</li> <li>Improved workforce capacity and capability across the spectrum of services</li> <li>Improved national and regional leadership and governance of STBBI issues across the health sector, and whole of government</li> <li>Improved integration across the prevention and health system</li> <li>Improved workforce capacity and capability planning</li> <li>Improved implementation and monitoring of outcomes of the strategy and action plans</li> </ul>										
	Strategic directions	Surveillance, information and knowledge systems to drive action			Results-focused health promotion and comprehensive prevention			Equitable access to culturally safe, quality health care for testing and management			Leading for an integrated, supported, consumer-focused system	
	Priority groups	Māori	Pacific peoples	Young people	Gay and bisexual men and other men who have sex with men	People who inject drugs	People living with HIV and chronic viral hepatitis	Sex workers	Migrants from high-prevalence areas			
	Action plans	Hepatitis C elimination			Syphilis			HIV				

Evaluation and monitoring



# Te Tiriti o Waitangi

The strategy gives effect to the Ministry of Health's obligations to Māori under Te Tiriti o Waitangi (Waitangi Tribunal 2019) as a responsible Te Tiriti partner and steward of the health and disability system. As outlined in Whakamaua: Māori Health Action Plan 2020–2025, the health and disability system is committed to giving effect to Te Tiriti o Waitangi through the relationship between Māori and the Crown (Ministry of Health 2020a).

The principles of Te Tiriti — as stated by the courts and the Waitangi Tribunal<sup>10</sup> — underpin the Ministry of Health's commitment to Te Tiriti and its related responsibility to ensure the STBBI sector gives effect to the principles (Ministry of Health 2020a). The Waitangi Tribunal concluded in Hauora: Stage One Report on the Health Service and Outcomes Inquiry (Waitangi Tribunal 2019) that persistent health inequities that Māori experience across every disease state were the consequence of the failure to apply the principles of Te Tiriti o Waitangi at the structural, organisational and service delivery levels of the health and disability system. Māori have poorer STBBI outcomes than the rest of Aotearoa New Zealand's population, which are not only persistent but, for many conditions, have worsened.

As with previous health sector reforms, the recent New Zealand Health and Disability System Review recommended system-level changes to bring about more equitable outcomes in Aotearoa New Zealand (Health and Disability System Review 2020). To achieve the urgent change required, this strategy adopts the principles of Te Tiriti as set out below, applying them to the STBBI sector.

## Tino rangatiratanga

The principle of tino rangatiratanga guarantees Māori the right to self-determination, and to live according to Māori philosophies, values and tikanga Māori. This principle encompasses effective and appropriate kaitiakitanga and stewardship over the health and disability system. This includes decision-making over the planning and designing of policies, plans and services for STBBI. The right to operationalise the principle of tino rangatiratanga is present for Māori regardless of where they access STBBI prevention and treatment services.

## Partnership

Working in partnership with Māori in the governance, design, delivery and monitoring (including through data collection and research) of health and disability services is essential to ensure

<sup>10</sup> *New Zealand Maori Council v Attorney-General* [1987] 1 NZLR 641; *New Zealand Maori Council v Attorney-General* [1989] 2 NZLR 142; *New Zealand Maori Council v Attorney-General* [1991] WL 12012744; *New Zealand Maori Council v Attorney-General* [1992] 2 NZLR 576; *New Zealand Maori Council v Attorney-General* [2013] NZSC 6; *The Ngai Tahu Report 1991* (Waitangi Tribunal 1991); *Report of the Waitangi Tribunal on the Orakei Claim* (Waitangi Tribunal 1987); *Report of the Waitangi Tribunal on the Muriwhenua Fishing Claim* (Waitangi Tribunal 1988).



prevention and treatment services are effective and achieve positive health outcomes for Māori (Waitangi Tribunal 2019, pp 27–30).

## Active protection

Active protection refers to the Ministry of Health’s responsibility to actively protect the tino rangatiratanga (self-determination) and mana motuhake (autonomy) of Māori to manage their health — including addressing STBBI — in accordance with tikanga Māori and mātauranga Māori. Until STBBI inequities are resolved, Manatū Hauora and the sector have an obligation under Te Tiriti to prioritise Māori health outcomes explicitly and set goals to achieve these (Waitangi Tribunal 2019, pp 30–33).

## Equity

Te Tiriti confirms that Māori have all the rights and privileges of other New Zealanders, including freedom from all forms of discrimination — racism, homophobia, transphobia and misogyny — and STBBI-related stigma and discrimination. The principle of equity recognises that Māori require different approaches and resources to achieve equitable health outcomes. Applying the principle of equity means collecting data that supports activities to monitor and report inequities and to evaluate actions taken to address these. It means services must treat Māori fairly and equitably; services must be equitably funded and accessible, address barriers that lead to inequities and address inequities as a priority (Waitangi Tribunal 2019, pp 33–35).

## Options

Te Tiriti guarantees Māori the right, as citizens, to live as Māori and in accordance with their knowledges, practices and models of hauora, and to participate as citizens of wider Aotearoa New Zealand. In the context of STBBI, Te Tiriti gives Manatū Hauora the obligation to foster and protect kaupapa Māori STBBI prevention and treatment service options. In addition, it requires all other (ie, mainstream) STBBI services to provide culturally safe and effective services so that Māori are not disadvantaged by their choice of service (Waitangi Tribunal 2019, pp 35–36).

# Strategic approaches to meeting Te Tiriti o Waitangi obligations

The strategy has strategic directions and priority areas that are co-designed<sup>11</sup> with Māori sexual health providers<sup>12</sup> to specifically work towards giving effect to our Te Tiriti obligations. However, while strategic direction statements set a tone and a direction for the sector, we will not achieve

<sup>11</sup> In this context, we interpret the term co-design as meaning working in collaboration with key non-governmental organisation, those with lived experience and those with expertise in Māori sexual health.

<sup>12</sup> Te Whāriki Takapou, Te Kaha o te Rangatahi and Te Ahurei A Rangatahi.



change until actions are delivered. That delivery will occur with the implementation of co-designed action plans.

The strategy sets out expectations for action plans regarding these principles, including that action plans will be planned, co-designed and implemented in genuine partnership with Māori (Waitangi Tribunal 2019, p 28). Action plans will have outcomes frameworks and performance measures that state actions and outcomes specifically about improving Māori health and wellbeing in relation to STBBI. This approach is critical to address any STBBI inequities.



# Values guiding the strategy

The values below have guided the development of this strategy. We expect that these values will likewise inform strategy implementation and development of further action plans.

Te Tiriti o Waitangi and improving equity are central to this strategy, as the sections **Te Tiriti o Waitangi** and **Equity** describe in more detail. It is important to note that while commitment to improving equity is a value, giving effect to the principles of Te Tiriti o Waitangi is a requirement rather than a value and so we have not included it in this section. However, the values intersect with Te Tiriti principles (eg, equity) and support meeting Te Tiriti o Waitangi obligations for example through being accountable for achieving equitable outcomes, and through meaningful involvement of priority groups.

Values	
Equity <sup>13</sup>	We commit to working to improve equity across all STBBI
Whakapono <sup>14</sup>	We have trust and faith in each other to do the right thing
Manaakitanga <sup>14</sup>	We show care, inclusion, respect, support, trust and kindness to each other
Kōkiri ngātahi <sup>14</sup>	We commit and work together collectively towards a common purpose
Accountability	We accept accountability for strategy and action plan development, implementation and achieving stated outcomes <sup>15</sup>
Evidence and knowledge	We have a commitment to evidence-based policy and programmes recognising different forms of knowledge including mātauranga Māori and knowledge of those with lived experience
Meaningful involvement of priority groups	We recognise that Māori — as Te Tiriti o Waitangi partners — and other priority groups, particularly people living with HIV and people living with chronic viral hepatitis, are central in developing an effective and ongoing response

<sup>13</sup> The Ministry of Health’s official working definition of equity is: ‘In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.’ See [health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity](https://health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity) for the Ministry’s full equity statement.

<sup>14</sup> From Ngā Uaratanga Our Ministry Values: [health.govt.nz/about-ministry/careers/our-ministry-values-nga-uaratanga](https://health.govt.nz/about-ministry/careers/our-ministry-values-nga-uaratanga)

<sup>15</sup> It is also important to have resourcing for all strategic directions for STBBI so that the sector can deliver on priority areas to achieve outcomes.





# Equity

In Aotearoa New Zealand, people have differences in health outcomes that are not only avoidable but unfair and unjust.<sup>16</sup> The section **STBBI in Aotearoa New Zealand** outlines the epidemiology of STBBI in this country, including inequities.

The structural determinants of health and wellbeing include income, employment, education, housing and many forms of discrimination. They have a substantial influence on people's health but people vary in their level of control over these determinants.

Māori health inequities are the result of unjust and discriminatory structural determinants that operate in Aotearoa New Zealand.<sup>17</sup> For example, congenital syphilis that disproportionately affects Māori is associated with service-level barriers leading to inequity in access to antenatal care. However, when STBBI organisations, practitioners and funders of these services understand the principles of Te Tiriti and the structures that drive inequitable health outcomes for Māori, they can use Te Tiriti-informed contracting arrangements, models and resources (Waitangi Tribunal 2021, Sapere report, pp 14–19) to achieve equitable STBBI health outcomes.

Other population groups in Aotearoa New Zealand also experience STBBI inequities that are unfair and unjust. For example, HIV affects GBM more than other groups, and chronic hepatitis affects Asian and Pacific peoples disproportionately. Equity approaches recognise that different groups have different levels of advantage and disadvantage and that each group needs different strategies if we are to achieve outcomes that are equitable across populations.<sup>18</sup> Achieving equitable STBBI outcomes for population groups can happen when STBBI service providers and health practitioners understand the structures that create advantage and disadvantage and are resourced to implement rights-based approaches.

## Strategic approaches to improving equity

This strategy explicitly addresses equity in its goals, objectives, strategic directions and priority areas. In developing each priority area, we considered how to design it in the best possible way to improve equity and used a prioritisation process based on Te Tiriti.<sup>19</sup> Equity will be used to determine which priority areas should be delivered first.

<sup>16</sup> Ministry of Health. Achieving equity. URL: [health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity](https://health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity) (accessed 3 February 2023).

<sup>17</sup> Toi Te Ora Public Health. 2021. Determinants of health & health equity. URL: [toiteora.govt.nz/public/determinants-of-health-and-health-equity](https://toiteora.govt.nz/public/determinants-of-health-and-health-equity) (accessed 3 February 2023).

<sup>18</sup> From the Ministry of Health's official working definition of equity. See [health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity](https://health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity) for the Ministry's full equity statement

<sup>19</sup> It is important to remember that Te Tiriti does not equate to equity. Te Tiriti includes equity and Māori aspirations.



Outlining recommended approaches and actions that will help action plans to improve equity is essential, so that funders and providers are able to work to improve STBBI outcomes in Aotearoa New Zealand. Considering service-level barriers such as transport, cost, and clinic location and times will contribute to improving equity of health and wellbeing outcomes for STBBI.

Addressing socioeconomic determinants is a key approach to addressing inequities in health outcomes. Where possible, action plans need to be designed so that some actions will influence the social and economic determinants of STBBI health and wellbeing outcomes. Other features essential to the success of an action plan are to:

- design it in collaboration with communities who are affected most by the health issue
- use Te Tiriti and equity first prioritisation approaches to prioritise its actions and initiatives
- include outcome evaluation in monitoring the success of its implementation, with a focus on whether it has achieved equitable outcomes.



# STBBI in Aotearoa New Zealand

Aotearoa New Zealand's rates of STIs remain high. Across all STBBI, there are inequities in health outcomes particularly for Māori, Pacific peoples, young people, men who have sex with men (MSM),<sup>20</sup> migrants and people who inject drugs. Our understanding of STBBI epidemiology is incomplete for other key populations including sex workers, transgender and non-binary people and people in prisons.

Other factors also limit what we know about STBBI in Aotearoa New Zealand. Many STBBI are asymptomatic so to receive a diagnosis, people also need access to health care for testing. Because syphilis reporting relies on clinician-completed notification forms, reported numbers are likely to underestimate the true burden of disease. Behaviour and health care access, including testing, changed during the COVID-19 pandemic, which in turn influenced reported infection numbers in 2020 and 2021. Acute hepatitis B and C are notifiable, but chronic infection with them is not<sup>21</sup> and there have been no large-scale seroprevalence studies of hepatitis C.

This section outlines the epidemiology for key infections in Aotearoa New Zealand.

## Syphilis

Reported syphilis cases began to rise steadily and substantially from 2013, from fewer than 100 cases per year to a peak of 723 cases in 2019.<sup>22</sup> After declining over 2020 and 2021,<sup>23</sup> cases began to rise again in the second half of 2022.<sup>24</sup>

MSM continue to be the group most affected by syphilis in Aotearoa New Zealand. Cases among MSM declined from 455 cases in 2019 to 229 cases in 2021, and then to 222 in 2022. Among women, cases increased more slowly than among MSM from 2013, then cases fluctuated slightly over 2019–2022, ranging from 96 to 118 cases per year. Rates of syphilis per 100,000 people among MSM in 2021 were 458 per 100,000, compared with 5 per 100,000 in men who have sex with women, and in women. Rates of syphilis by ethnicity also demonstrate clear inequities. Rates among Māori and Pacific peoples (16 per 100,000) were more than twice those of New Zealand Europeans (6 per 100,000) in 2021.

<sup>20</sup> This section uses the term MSM rather than GBM because surveillance data captures sexual behaviour rather than sexual orientation.

<sup>21</sup> Under section 74 of the Health Act 1956, health practitioners must notify certain diseases to a medical officer of health and/or local authority. Notifiable diseases are mostly infectious diseases, including some STBBIs.

<sup>22</sup> All syphilis data after November 2018 comes from clinical notifications to the Institute of Environmental Science and Research (ESR). Before November 2018, it comes from enhanced syphilis surveillance from sexual health and family planning clinics coordinated by ESR.

<sup>23</sup> ESR STI surveillance dashboard 2021. <https://www.esr.cri.nz/our-services/consultancy/public-health/sti/>

<sup>24</sup> ESR provisional data for quarters 3-4 2022, extracted January 2023.



In 2022, case numbers were twice as high among Māori women (64 cases) compared with European/Other women (29 cases). From 2016 to 2022, a total of 31 cases of congenital syphilis were reported (2022 data provisional). Of these, 21 babies were Māori (68%), 7 were Pacific (23%) and 3 were European (10%). Ten cases were stillbirths or perinatal deaths.

## Gonorrhoea and chlamydia

Gonorrhoea case numbers and rates increased from 70 per 100,000 people in 2014 to 151 per 100,000 people (7,665 cases) in 2020. However, rates then decreased to 127 per 100,000 people in 2021<sup>25</sup> and into the first half of 2022.

Chlamydia is the most common bacterial STI in Aotearoa New Zealand. Rates for chlamydia remained stable between 2014 (629 per 100,000 people) and 2019 (650 per 100,000 people) before decreasing in 2020 and 2021 (to 492 per 100,000 people, 25,012 cases)<sup>26</sup> and early 2022.

Information on testing numbers shows marked decreases in tests taken for chlamydia and gonorrhoea at times during the COVID-19 pandemic alert level changes, which likely influenced case numbers.

Chlamydia and gonorrhoea rates are over 3 times higher among Māori and Pacific peoples than European people and young people aged 15–29 years are particularly at risk.<sup>27</sup> In 2021, rates of gonorrhoea among MSM were 5,322 per 100,000 people compared to 97 per 100,000 for men who have sex with women and 108 per 100,000 for women who have sex with men.<sup>28</sup>

## HIV and AIDS

Currently in Aotearoa New Zealand, 2,828 adults (2,381 men and 447 women) and 11 children are receiving treatment for HIV (University of Otago 2022). There were 112 people notified with HIV in 2021, of whom 67 were first diagnosed in Aotearoa New Zealand, the lowest number of notifications since 2001. Almost all locally acquired HIV is sexually transmitted. In 2021, 16 people were diagnosed with AIDS and no deaths from AIDS were reported (University of Otago 2022).

Although HIV infections have declined from a peak in 2016, MSM are still the group most affected in Aotearoa New Zealand. MSM account for 62% of all locally acquired HIV in 2020 (University of Otago 2022). Based on 2019 HIV notifications, MSM were 348 times more likely to be diagnosed with HIV (158.3 per 100,000) compared to heterosexual men and women (0.5 per 100,000) (Saxton et al 2021). A 2011 study found an estimated HIV positive population prevalence of 6.5% for MSM, among whom one-fifth were undiagnosed (Saxton et al 2012).

<sup>25</sup> Data from gonorrhoea laboratory notifications to ESR.

<sup>26</sup> Data from chlamydia laboratory notifications to ESR.

<sup>27</sup> Data from chlamydia and gonorrhoea laboratory notifications to ESR in 2021.

<sup>28</sup> Clinical notification received for 56% of laboratory notifications, with sexual behaviour information complete for 79%.



# HPV

In Aotearoa New Zealand and internationally, most cases of cervical cancer (88.5%) and pre-cancer (96%) are related to high-risk types of HPV (Simonella et al 2013; Sykes et al 2014). Likewise, a high proportion of other genital, oropharyngeal and anal cancers are related to high-risk HPV (Lucas-Roxburgh et al 2017; Saraiya et al 2015). People living with HIV are at increased risk of developing cervical cancer, and MSM — in particular, MSM living with HIV — are disproportionately affected by anal cancers (Machalek 2012). Cervical cancer cases and deaths in Aotearoa New Zealand have decreased by 60% with the National Cervical Screening Programme (Ministry of Health 2021b). However, screening coverage is lower among Māori and Pacific than other women (Ministry of Health 2021b) and cervical cancer rates remain higher in Māori than non-Māori women (Ministry of Health 2016, 2019b). Many (33%) transgender and non-binary people report delaying cervical screening due to concerns about how they will be treated (Veale et al 2019).

HPV immunisation prevents infection with the types of HPV implicated in these cancers. Coverage<sup>29</sup> varies by year of birth (birth cohort) and gender: an estimated 30% of women born in 1991 have received a full course, compared with 66% of both males and females born in 2007.<sup>30</sup> Immunisation coverage also varies by ethnicity and is lowest for Māori (59.7%), compared to other (65.2%), Pacific (69.3%) and Asian (78.5%) peoples in the 2007 birth cohort.<sup>31</sup>

## Viral hepatitis

Hepatitis B and C viruses cause 80% of liver cancers in Aotearoa New Zealand and globally (Schauer et al 2020). In Aotearoa New Zealand, Hepatitis C is the leading indication for liver transplantation and results in more than 200 deaths per year. Hepatitis B is the leading cause of liver cancer.

### Hepatitis C

Hepatitis C prevalence estimates come from modelling and small studies. In 2014, an estimated 50,000 New Zealanders had active hepatitis C (Gane et al 2014). Since then, over 11,000 people have been cured<sup>32</sup> and the incidence has halved, resulting in an estimated 45,000 people living with hepatitis C in 2019. Of recently acquired infections, 95% are thought to occur in people currently injecting drugs (E Gane, personal communication, September 2021).

The distribution of hepatitis C by ethnicity in Aotearoa New Zealand is not known. Emerging data suggests that Māori may have higher prevalence of hepatitis C and higher rates of long-term complications than other ethnic groups. Laboratory and treatment data suggests around 20% of those with hepatitis C are Māori and 21% of people referred to the New Zealand Liver Transplant

<sup>29</sup> Provisional immunisation coverage provided by the Ministry of Health Immunisation Team, October 2021. Immunisation for females was introduced in 2008 and for males in 2017.

<sup>30</sup> Immunisation coverage provided by the Ministry of Health Immunisation Team, October 2021. Data provisional.

<sup>31</sup> Immunisation coverage provided by the Ministry of Health Immunisation Team, October 2021. Data provisional.

<sup>32</sup> Test of cure was available for most patients in the trial and funded by Pharmac.



Unit between January 2000 and December 2017 with hepatitis C-related liver cancer were Māori (Schauer et al 2019).

## Hepatitis B

Hepatitis B immunisation is highly effective and has almost eliminated childhood hepatitis B infection in Aotearoa New Zealand.

Migration from countries in the Asia and Pacific region with lower immunisation coverage and high prevalence of chronic hepatitis B contributes to adult and childhood prevalence in Aotearoa New Zealand (Mules et al 2018). An estimated 93,600 New Zealanders were living with chronic hepatitis B infection in 2018 but only around 20% are engaged in monitoring (Horsfall et al 2020).

Substantial ethnic inequities in burden of disease and complications exist. The estimated prevalence of chronic hepatitis B infection is 5.6% among Māori, 7.3% among Pacific peoples, 8.9% among Asians and 0.5% among New Zealand Europeans (Horsfall et al 2020). Research shows chronic hepatitis B accounts for over 50% of liver disease mortality among Māori and Pacific peoples and 10% in New Zealand Europeans (Weir et al 2002).



# Strategic directions and priority areas

Strategic directions and priority areas provide a framework for delivering effective action on STBBI and guide action plan development. The strategic directions are:

1. surveillance, information and public health knowledge systems to drive action
2. results-focused health promotion and comprehensive prevention
3. equitable access to culturally safe, quality health care for testing and management
4. leading for an integrated, supported, consumer-focused system.

Under each strategic direction, gaps and challenges are outlined as well as priority areas for action. Priority areas have been identified to help achieve our Te Tiriti o Waitangi obligations and take an equity approach.

# STRATEGIC DIRECTION 1: Surveillance, information and public health knowledge systems to drive action

To take evidence-based action on STBBI, we need to improve our understanding of epidemiology through timely and comprehensive surveillance. This includes understanding rates of infection by age, ethnicity, injecting behaviour, sexuality, diverse gender identity and expression of sex characteristics. Research within services, communities and research institutes — including on behaviour and effective ways to reduce stigma and discrimination — will contribute to our evidence base. Evaluation of interventions, programmes and services is needed for quality improvement and to identify what is working and should be scaled up. This information will improve planning across the sector — including through assessment of disease burden — and guide the development of future action plans and which actions to prioritise.

## Objectives

Implementing high-quality actions in priority areas around **surveillance, information and knowledge systems** will contribute to the following objectives:

- Improved information from surveillance systems
- Increased understanding of epidemiology including by ethnicity and for priority groups
- Improved evidence base through research and evaluation
- Increased dissemination of evidence to the whole STBBI sector and communities

## Opportunities and challenges

It is a legal requirement for health professionals to notify cases of syphilis, gonorrhoea and HIV.<sup>33</sup> For these infections, identifying information such as name and address must be protected, which can make it difficult to integrate surveillance systems and uphold this level of confidentiality. An interim system has been established, but it involves complex, manual processes which reduces the timeliness of reporting, stability and data quality.

Epidemiology of chronic hepatitis B and C is unclear from national surveillance as only acute cases are notifiable. A hepatitis C register enabling monitoring, surveillance and linkage to care and treatment has been identified as a key requirement for eliminating hepatitis C in Aotearoa New Zealand. A high proportion of people living with hepatitis B remain undiagnosed and are not engaged in monitoring.

Other evidence gaps include regular behavioural information, population prevalence and information for important populations including sex workers, transgender and non-binary people and people in prisons. Timely, granular information is needed to identify the best ways to monitor and prioritise action plans and support the sector and communities to implement

<sup>33</sup> These infections are notifiable under Schedule 1, Part 1, Section C of the Health Act 1956. For more information, see Ministry of Health (2017).





changes. Research can provide more detailed and varied evidence, but currently research in STBBI lacks support and funding and no centres are dedicated to STBBI research.

## Priority areas

### Expand and improve the quality and timeliness of the national STI surveillance system to inform public health action

- Consider developing national clinical data repositories for some STBBI, with more interoperable systems.
- Develop approaches to achieve appropriate and adequate Māori data sovereignty in the surveillance system.<sup>34</sup>
- Link the surveillance system to coordinated public health action, including outbreak management.
- Enhance national laboratory STBBI surveillance, including for antimicrobial resistance. Explore opportunities to adopt relevant emerging technologies such as whole genome sequencing.
- Ensure surveillance information planning and outputs are developed and shared with communities and health professionals.

### Explore other ways to improve understanding of STBBI epidemiology, including by ethnicity

- Explore options such as seroprevalence surveys for the general population, sentinel surveillance, and testing in priority settings.

### Develop a stronger evidence base for future STBBI prevention, testing and treatment strategies

- Build sector knowledge, research and statistical information to improve sexual health outcomes for Māori and improve equity.<sup>35</sup>
- Communicate information back to communities to support them in designing and delivering their own solutions.

<sup>34</sup> In response to action 7.4 of Whakamaua, an approach to Māori data sovereignty is under development with the Ministry of Health.

<sup>35</sup> Aotearoa Statement on Closing the Gap on STIs and BBVs among Indigenous Peoples of Australasia. URL: [nzshs.org/events/the-aotearoa-statement](https://nzshs.org/events/the-aotearoa-statement) (accessed 2 February 2023).



# STRATEGIC DIRECTION 2: Results

## focused health promotion and comprehensive prevention

Health promotion involves 'enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions'.<sup>36</sup> Māori health promotion has been defined as 'the process of enabling Māori to increase control over the determinants of their health and strengthen their identity as Māori' (Ratima 2010). While this section outlines priority areas using the Ottawa Charter,<sup>37</sup> Aotearoa New Zealand has other established frameworks for health promotion such as Te Whare Tapa Whā (Durie 1984), Te Pae Mahutonga (Durie 1999),<sup>38</sup> Te uruuru mai a hauora (Ratima 2001), Te Wheke (Pere 1991) and Fonofale (Pulotu-Endemann 2001).

Health promotion is one approach to primary prevention.<sup>39</sup> Both health promotion and primary prevention are based on the concept that the conditions in which we live, learn, work and play shape our health.

Comprehensive STBBI prevention<sup>40</sup> requires using evidence alongside Te Tiriti o Waitangi, human rights, and community-based behavioural, biomedical and multi-level approaches together and at scale. This approach involves providing access to and promoting appropriate information, condoms, needle exchange programmes, vaccination, HIV pre-exposure prophylaxis (PrEP), and appropriate testing and prompt treatment, all based on Aotearoa New Zealand evidence from surveillance and research.

Treatment as prevention (TasP) refers to the fact that people living with HIV who are on antiretroviral treatment with a fully suppressed viral load do not transmit HIV to their sexual partners.<sup>41</sup> TasP also applies to hepatitis C prevention.<sup>42</sup> Diagnosis and treatment of all STBBI reduces onward transmission and has a public health impact (strategic direction 3 has a focus on testing and treatment).

<sup>36</sup> WHO. Health promotion. URL: [who.int/westernpacific/about/how-we-work/programmes/health-promotion](https://www.who.int/westernpacific/about/how-we-work/programmes/health-promotion) (accessed 2 February 2023).

<sup>37</sup> The five action areas of the Ottawa Charter for Health Promotion 1986 are: Build healthy public policy; Create supportive environments for health; Strengthen community action for health; Develop personal skills; Re-orient health services. In this strategy, building healthy public policy features in strategic direction 4.

<sup>38</sup> Te Pae Mahutonga includes: mauriora — access to te ao Māori; waiora — environmental protection; toiora — healthy lifestyles; and te ora — participation in society. It also contains two important prerequisites for health promotion: ngā manukura — leadership; and te mana whakahaere — autonomy.

<sup>39</sup> Primary prevention aims to keep us well by promoting population health and preventing disease, as an 'upstream approach' (WHO 2014). Primary prevention should not be confused with primary care. Primary care is a setting for the delivery of health care. It is most commonly referring to GP or PHO services. While primary care can be a setting where primary prevention is delivered it has quite a different meaning.

<sup>40</sup> The concept of comprehensive STBBI prevention we use here draws on the *Consensus Statement on Comprehensive HIV Prevention in Aotearoa/New Zealand* ([hivconsensus.org.nz](https://www.hivconsensus.org.nz)) and combination HIV prevention as defined by UNAIDS.

<sup>41</sup> This is also known as undetectable equals untransmissible (U=U).

<sup>42</sup> In this case, successfully treating a large number of people at higher risk of transmitting hepatitis C (eg, people who inject drugs) reduces transmission and in this way reduces prevalence in this population.



## Objectives

Implementing evidence-based approaches based on the established frameworks for health promotion and comprehensive prevention will contribute to the following objectives.

- Increased community awareness and understanding of STBBI, particularly among priority groups
- Increased access to and uptake of comprehensive prevention
- Reduced experience of stigma and discrimination

## Opportunities and challenges

Aotearoa New Zealand needs sustainable programmes and policies, based on Te Tiriti and equity, that aim to empower people with the knowledge they need to take up existing and emerging opportunities for health promotion and comprehensive prevention.

Relationships and sexuality education (RSE) is an important part of health promotion. Due to the requirements for schools to consult with their community at least every 2 years, schools vary in what they teach in RSE and the way they teach it. In 2018, the Education Review Office found RSE was fragmented and varied in quality throughout Aotearoa and some schools did not cover it in a culturally appropriate way (ERO 2018). RSE is largely unavailable in communities or outside of school settings.

Priority populations face barriers to health promotion and comprehensive prevention in health settings that may not be appropriate or affordable, or where health providers are not aware of risks or prevention approaches available. Hepatitis A and B vaccination is recommended for many key groups, but unfunded for some.<sup>43</sup> Access to comprehensive needle exchange services varies by region, with a current service model which is not best practice.<sup>44</sup> There are likely to be inequities in the current reach of PrEP in Aotearoa New Zealand.<sup>45</sup>

Strategic prevention will be particularly important as we move closer to achieving the strategy's elimination goals. Often when implementation of a prevention initiative begins, uptake is high from people who experience fewer barriers to accessing health care. After that, the initiative needs to take more targeted approaches so that it reaches everyone that would benefit from it. Stigma and discrimination create barriers for people at risk of STBBI or living with HIV or viral hepatitis by delaying help-seeking and preventing engagement with health services (Ludlam et al 2015; UNAIDS 2003). Stigma and discrimination associated with sexuality, sexual and gender identities, intravenous drug use and sex work create barriers to accessing and engaging with

<sup>43</sup> Hepatitis B vaccination is recommended and free for people living with HIV and hepatitis C, and for household and sexual contacts of people with chronic hepatitis B. It is also recommended but unfunded for MSM, sex workers, people who inject drugs, migrants from countries where hepatitis B is endemic, and people in prison. Hepatitis A vaccination is recommended but not funded for people living with chronic hepatitis B and C and MSM (Ministry of Health 2020b).

<sup>44</sup> Equipment is only free when exchanging used equipment for sterile equipment.

<sup>45</sup> **Based on eligibility for PrEP prior to July 2022, an estimated 5,847 individuals would be eligible, of whom 99.5% would be GBM and 0.5% non-GBM (Saxton and McAllister 2019). Pharmac has since expanded their eligibility criteria so people at risk of HIV, so the number of eligible individuals will be higher.** Syphilis notification data indicates a significant proportion of at-risk MSM were not taking PrEP at the time of their syphilis diagnosis.

health services, information and education, and communicating about preventing STBBIs and condom use with sexual partners (Pihama et al 2020; Veale et al 2019).

## Priority areas

### Create supportive environments

- Design and deliver — at scale — evidence-based Māori and priority population-led health promotion initiatives to reduce STBBI. These include initiatives to reduce stigma and discrimination experienced by communities at risk of STBBI or living with HIV or viral hepatitis.

### Strengthen community action

- Support Māori and communities to design and deliver health promotion and harm reduction services, particularly comprehensive prevention services and programmes for GBM who are disproportionately impacted by HIV and STIs.

### Develop personal skills

- Design and deliver community-led comprehensive STBBI prevention, testing and behaviour change initiatives that are evidence-based, culturally safe and targeted to priority populations.
- Initiatives should be designed, planned, implemented and evaluated by Māori for Māori communities.
- Work with Ministry of Education and English- and Māori-medium schools to support the delivery of comprehensive and culturally safe RSE (Ministry of Education 2020b; Te Whāriki Takapou 2020).
- Ensure prevention and needle exchange services for people who inject drugs that are peer-based, accessible, high quality, empower individuals to protect their health and have a focus on improving equity and Te Tiriti o Waitangi obligations.

### Reorient health services

- Resource kaupapa Māori STBBI health promotion providers to partner with STBBI health services to meet the needs of Māori communities.
- Ensure health providers (including primary and secondary care, prison-based services and addiction treatment services) increase their focus on promotion and prevention, especially for young people and other priority populations.
- Improve outbreak management, including facilitating collaboration between public health units,<sup>46</sup> secondary services, primary care, kaupapa Māori providers and communities during outbreaks.
- Increase vaccination coverage for STBBI (HPV, hepatitis B and hepatitis A), particularly for Māori and priority groups.
- Ensure sex workers have access to appropriate prevention measures.

<sup>46</sup> This role is expected to move to the national public health service in the future.



# STRATEGIC DIRECTION 3: Equitable access to culturally safe, quality health care for testing and management

The health sector for STBBI encompasses a wide range of people and services, including specialist services, primary care, Māori and Pacific providers, maternity care providers and peer-led services. Access to primary care (where much of the testing and management of STIs and blood borne viruses takes place) and support from secondary services in communities (including sector leadership and training) is the basis of our health system. Community-based and community-led services can remove significant barriers to health care faced by priority groups. For example, they may help any GBM who may not be comfortable disclosing sexual behaviours in health care settings and may not receive appropriate testing.

It is essential to plan for and deliver high-quality, appropriate services (including services that are youth friendly and culturally safe) that will meet the needs of priority groups in particular. Increasing access not only to these health services but also to community-based and innovative testing and treatment strategies will improve diagnosis and management of STBBI.

## Objectives

Implementing strategies to equitably increase access to quality health care for testing and treatment will contribute to the following objectives.

- Increase in equitable access to services in the community, primary care and specialist services
- Increase in culturally safe and acceptable high-quality health care
- Increase in evidence-based testing and treatment approaches, including contact tracing
- Improved workforce capacity and capability across the spectrum of services

## Opportunities and challenges

Undiagnosed infections are a barrier to eliminating hepatitis C and transmission of HIV, and to treating HIV and hepatitis B. An estimated 35–40% of New Zealanders living with chronic hepatitis C and over 50% of those living with chronic hepatitis B are undiagnosed. There is a need to more effectively identify those who may be affected by STBBI and better link to diagnosis and management.

Policy and planning at both regional and national levels have not considered sexual health carefully, and services are fragmented and difficult to navigate. For many people, cost is a significant barrier to primary care consultations and prescriptions, and funding and therefore cost to consumers vary by region. For example, in some areas, under 25-year-olds are eligible for free primary care sexual health consultations and in other areas the age of eligibility is under 21 or lower. Most testing, monitoring and care for people with viral hepatitis occurs in primary care and similar cost barriers exist.



Resourcing greatly limits the availability of support from sexual health specialists in the form of training, governance, clinical support or referral. The support available also varies by location, with rural sexual health services extremely limited in some areas. Support has been limited for developing, updating and promoting national guidelines and referral pathways for STBBI.

The emergence of Mpox highlights the need for the specialist sexual health capacity to respond to emerging risks and infections. As an infection that was primarily transmitted through intimate contact, sexual health expertise played a key role in detecting cases early and managing them, and in the outbreak response.

Most STBBI services across primary and secondary care are not equipped to provide culturally safe services, especially for young Māori, which creates further barriers to health care access. Marked inequities in congenital syphilis for Māori and Pacific women demonstrate that they have inadequate access to antenatal care. Engagement with Māori and other priority populations is insufficient when designing, leading and evaluating initiatives and health services for STBBI.

Currently much STI contact tracing is patient-led, with support from sexual health services. Contact tracing is a skilled and resource-intensive activity. Although the requirement for STIs to be notified without name and address supports privacy, it complicates the role of public health units in contact tracing and the overall public health management of STIs. The roles of public health units, the Institute of Environmental Science and Research (ESR) and clinicians in the follow-up of notifiable STBBI are unclear.

## Priority areas

### Planning and design of health services

- Explore the number, range and distribution of services that should be delivered nationally and regionally, considering the needs of different populations, which may include taking different approaches.
- Expand capacity of specialist sexual health services to provide support, leadership and training to primary care.
- Actively involve Māori and priority populations in designing and leading services.
- Fund and support kaupapa Māori STBBI services.

### Increasing access to health services for testing and management

- Expand free, or very-low-cost, testing and management of STBBI in primary health care for Māori and priority populations whilst ensuring the approach addresses stigma and discrimination.
- Explore the cost–benefit of universal free access to STBBI testing and treatment.
- Design multi-pronged, cross-agency measures to address structural barriers to antenatal care and increase the Māori and Pacific midwifery workforce.

### Increasing quality of health services

- Deliver national workforce training on how to provide culturally safe, youth-friendly health care that supports gender and sexual diversity and is free from stigma and discrimination; to



increase understanding of STBBI management; and to increase awareness of the needs of priority groups.

- Explore kaupapa Māori provider-led partnerships with STBBI services in order to equip organisations to provide appropriate services for Māori, particularly young Māori.
- Provide and promote up-to-date, best-practice clinical guidelines and referral pathways to inform screening/testing and contact tracing.
- Increase the capability and capacity to undertake contact tracing, including by using digital tools and learnings from COVID-19 contact tracing successes

## Increasing access to community and innovative testing and treatment approaches

- Increase opportunistic testing for STBBI in health services outside primary care and sexual health services (eg, kaupapa Māori provider-led services at national and regional kapa haka, waka ama etc events, Big Gay Out and Pride events, mental health and addiction services, prisons and emergency departments).
- Increase community-based testing (eg, in the Needle Exchange Programme, women's refuges, peer-support organisations and pharmacies).
- Scale up existing effective community-led and targeted testing, outreach and support initiatives.
- Develop and evaluate additional innovative strategies to increase testing for priority groups, including in remote communities, such as by post, self-testing, peer-testing, rapid testing, venue outreach and point-of-care testing.
- Explore nationally consistent strategies to promote concurrent testing of hepatitis B and C and HIV/STIs for priority groups.
- Investigate the feasibility of large-scale screening programmes such as for hepatitis B targeted to Māori, Pacific and Asian peoples.
- Investigate ways to increase access to pharmaceuticals, including by widening prescribing to nurses and pharmacists, with appropriate monitoring.



# STRATEGIC DIRECTION 4: Leading for an integrated, supported, consumer-focused system

Oversight, leadership and a system thinking approach can create opportunities to better integrate the whole STBBI health and prevention system. In that way, we can improve the system's efficiency and effectiveness. With a better-integrated system, we can also design services to be consumer- and community-focused and meet Te Tiriti o Waitangi obligations. Most determinants of inequitable STBBI health outcomes for Māori and other priority groups are outside the health sector, so addressing these will require a whole-of-government approach. Oversight and monitoring are important to determine if the system is meeting the strategy's objectives and goals.

## Objectives

Implementing system-level strategies to support leading for an integrated, supported, consumer-focused system will contribute to the following objectives.

- Improved national and regional leadership and governance of STBBI across the health sector and whole of government
- Improved integration across the prevention and health system
- Improved workforce capacity and capability planning
- Improved implementation of key actions and initiatives, and monitoring of outcomes

## Opportunities and challenges

Leadership, coordination and integration at a strategic level have been limited across the STBBI sector. Services for STBBI are also poorly integrated between prevention services, primary care, Māori health, maternity and secondary services such as sexual health clinics, infectious diseases, gastroenterology and other hospital-based services. Sometimes the roles and responsibilities of different agencies, including leadership, are unclear. Funding and delivery of sexual health services, needle exchanges and Department of Corrections health services are not nationally consistent.

Little workforce planning occurs across the STBBI sector. Workforce planning would need to aim to develop a workforce that reflects the priority groups and communities it provides services to.

## Priority areas

### Leadership and integration of the system

- Establish central stewardship for STBBI (including partnership approaches between relevant entities such as Te Aka Whai Ora and Manatū Hauora) with shared accountability to achieve strategic goals.





- Take a whole-of-government, cross-sector approach to address determinants of health and wellbeing, including racism.
- Action the right of Māori to co-design culturally responsive policies and strategies that match their sexual health priorities, knowledges and practices.<sup>47</sup>
- Establish an expert group with Māori co-chair or leadership to lead, prioritise and advise on STBBI and improve integration across the STBBI prevention and health system.<sup>48</sup>

## Effective implementation of key actions

- Develop STBBI action plans through meaningful involvement of priority populations.
- Support sustainable community-led and community-based health and wellbeing service provision and initiatives.
- Develop a system for horizon scanning for new outbreaks<sup>49</sup> and for innovative and effective developments in treatment and prevention (eg, condoms or other broad-spectrum barrier prevention methods).
- Develop monitoring plans with indicators for each action plan. Report regularly, particularly to Māori, on reaching indicators and goals (including specifically for equity and Te Tiriti o Waitangi obligations).

## National workforce planning

- Support Māori provider capacity and capability building and ensure the STBBI workforce reflects priority groups.
- Support STBBI provider workforce development to reduce racism along with stigma and discrimination related to STBBI.
- Strengthen workforce training across the sector through strong partnerships between different colleges and organisations.
- Promote and support careers (including peer workers) in STBBI health and prevention services.

## Collaboration

- Develop opportunities for the sector to collaborate and share best practice nationally to support quality improvement. (For example, encourage innovation that is shown to work, including kaupapa Māori approaches and mainstream approaches to working with Māori.)

<sup>47</sup> Aotearoa Statement on Closing the Gap on STIs and BBVs among Indigenous Peoples of Australasia. URL: [nzshs.org/events/the-aotearoa-statement](https://nzshs.org/events/the-aotearoa-statement) (accessed 2 February 2023).

<sup>48</sup> Many of the things that would improve patient-centred management and integration of the system are health system wide and outside the scope of this strategy. They include coordinating IT systems to ensure access to clinical information nationally, and national coordination of laboratory services.

<sup>49</sup> This strategy was written prior to the emergence of Mpox, however this is an example of an emergent disease which may be transmitted sexually, noting that further research and evidence may be needed to understand the transmission of Mpox.

# Implementation

Relevant actions plans will further develop the priority areas in this STBBI strategy into specific actions, which will be delivered in phases. An implementation plan will then outline each phase.

Implementation plans are shorter-term plans that prioritise work for up to 4 years based on the funding and resources available. They will include specific information on the actions, timeframes and lead agencies responsible for the delivery of actions. The actions included in the implementation plan will be determined using prioritisation criteria such as meeting our obligations under Te Tiriti o Waitangi, equity, burden of disease, evidence of effectiveness and cost-effectiveness.

Performance measures and indicators will be developed to track progress in delivering the key actions and initiatives outlined in the implementation plan and whether outcomes (objectives and goals in this strategy) are being achieved. The development of monitoring and reporting measures and indicators will take place in partnership with Māori STBBI sector leaders. Adjustments will be made as required, particularly where the actions are not meeting our obligations under Te Tiriti o Waitangi or are not achieving equitable outcomes.

To support the implementation of the STBBI strategy, a Manatū Hauora steering group will be established to provide strategic oversight and direction on implementation. We will also need to develop strong partnerships and shared accountabilities with relevant health entities such as Te Aka Whai Ora and Te Whatu Ora. The wider health sector can use the strategy and the associated action plans (for HIV, syphilis and hepatitis C) as a basis for collective actions and working towards shared outcomes across STBBI.

A genuine partnership with Māori must be part of the development of any future action plans, which includes planning, co-design and implementation. Action plans will have outcomes frameworks and performance measures specifically related to improving Māori health and wellbeing in relation to STBBI.



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# Abbreviations

AIDS	acquired immunodeficiency syndrome
BBI	Blood-borne infection
DAA	Direct-acting antiviral
ESR	Institute of Environmental Science and Research
GBM	Gay and bisexual men and other men who have sex with men
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
MSM	Men who have sex with men
PrEP	Pre-exposure prophylaxis
RSE	Relationships and sexuality education
STI	Sexually transmitted infection
STBBI	Sexually transmitted and blood borne infections
TasP	Treatment as prevention
U=U	Undetectable equals untransmissible
WHO	World Health Organization





# Glossary

Blood borne virus (BBV)	A virus that is transmitted primarily by blood or by body fluids that contain blood. BBVs may be transmitted if blood, semen or vaginal fluids pass from a person who is infected with the virus into the bloodstream of another person via a break in the skin or mucous membrane.
Direct-acting antiviral (DAA)	A relatively new class of medication based on a small molecule that can selectively target and inhibit specific steps in the hepatitis C viral life cycle. DAAs are highly effective, well-tolerated treatments designed to shorten the length of therapy, minimise side effects, target the virus itself and improve sustained virologic response rates.
Seroprevalence	The number of people in a population who test positive for a specific disease based on serology (blood serum) specimens. This is often presented as a percentage of the total specimens tested or as a proportion per 100,000 people tested.
Sexually transmitted infection (STI)	An infection that is primarily transmitted through sexual contact via direct contact or bodily fluids. STIs include bacterial, viral and parasitic infections.
Health agencies	With the recent health and disability system reforms, three core agencies were created: the Public Health Agency within Manatū Hauora (the Ministry of Health), Te Whatu Ora (Health New Zealand) and Te Aka Whai Ora (Māori Health Authority).



# Appendix 1: Members of the STBBI working group

The table below lists the members of the STBBI working group who were involved in developing the strategy, together with their respective organisations at the time of development.

Member	Organisation
Dr Julia Scott (Chair)	ESR
Dr Alison Green	Te Whāriki Takapou
Dr Beth Messenger	Family Planning
Dame Catherine Healy	Aotearoa New Zealand Sex Workers' Collective
Dr Catherine Jackson	Northland Public Health Unit
Connie Gilfillan	Pharmac
Professor Ed Gane	Chair of the Hepatitis C Action Plan Oversight
Emma Clarke	Pharmac
Frances Townsend	Royal New Zealand College of General Practitioners
Dr Gerard Sonder	ESR
Dr Heather Young	New Zealand Sexual Health Society
Dr Jacek Kolodziej	Burnett Foundation Aotearoa New Zealand
Jacqui Anderson	New Zealand College of Midwives
Jane Bruning	Positive Women Inc.
Dr Jason Myers	Burnett Foundation Aotearoa Group
Lei Johnson	New Zealand Sexual Health Society
Mark Fisher	Body Positive
Dr Massimo Giola	Royal Australasian College of Physicians, Sexual Health Medicine Chapter
Associate Professor Peter Saxton	University of Auckland
Ricky te Akau	Te Whāriki Takapou
Riki Nofōākifolau	Village Collective
Dr Sue McAllister	University of Otago AIDS Epidemiology Group
Dr Sunita Azariah	Auckland Sexual Health Services
Dr Tim Blackmore	New Zealand Microbiology Network
Clare Possenniskie	Manatū Hauora
Jane Chambers	Manatū Hauora
Karen Beirne	Manatū Hauora
Katherine Reweti-Russell	Manatū Hauora
Nidha Khan	Manatū Hauora
Dr Rebecca O'Connell	Manatū Hauora
Samuel Andrews	Manatū Hauora



# Appendix 2: Strategic context

In Aotearoa New Zealand, Manatū Hauora sets strategy and policy for STBBI in collaboration with the health sector. Here we identify the strategic context of this work: both the overarching global strategies and the national strategies<sup>50</sup> for the unique context of Aotearoa New Zealand.

## Overarching international strategies and agreements

- United Nations Sustainable Development Goals: <https://sustainabledevelopment.un.org/sdg3>
- *Global Health Strategies on, Respectively, HIV, Viral Hepatitis and HIV for the Period 2022–2030* (WHO 2022)<sup>51</sup>
- United Nations Declaration on the Rights of Indigenous Peoples: [un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html](https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html) — in particular Articles 1, 2, 3, 5, 15, 21, 23–24, 31
- United Nations Convention on the Elimination of All Forms of Discrimination against Women: [ohchr.org/en/professionalinterest/pages/cedaw.aspx](https://www.ohchr.org/en/professionalinterest/pages/cedaw.aspx)
- United Nations Convention of the Rights of the Child: [ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child](https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child)

## Aotearoa New Zealand strategic context

- Te Tiriti o Waitangi
- *Hauora: Report on Stage One of Health Services and Outcomes Kaupapa Inquiry (Wai 2575)* (Waitangi Tribunal 2019, 2021)
- *New Zealand Health Strategy: Future direction* (Minister of Health 2016)
- *He Korowai Oranga: Māori Health Strategy* (Ministry of Health 2002)
- *Whakamaua: Māori Health Action Plan 2020–2025* (Ministry of Health 2020a), developed to give practical effect to *He Korowai Oranga* (Ministry of Health 2002)
- *Ola Manuia: Pacific Health and Wellbeing Action Plan 2020–2015* (Ministry of Health 2020c), which builds on the successes of the previous Pacific health action plan, *‘Ala Mo’ui*

<sup>50</sup> Strategies, policies and statements relevant to specific infections will be in relevant action plans.

<sup>51</sup> This WHO publication presents global health sector strategies on HIV, viral hepatitis and sexually transmitted infections for 2022–2030 in one document. It emphasises important synergies to be found in combatting HIV, viral hepatitis and STIs collectively.



- Aotearoa Statement on Closing the Gap on STIs and BBVs among Indigenous Peoples of Australasia: [nzshs.org/events/the-aotearoa-statement](https://nzshs.org/events/the-aotearoa-statement)<sup>52</sup>
- The Aotearoa New Zealand comprehensive HIV consensus statement: [hivconsensus.org.nz](https://hivconsensus.org.nz)<sup>53</sup>

## Other relevant Aotearoa New Zealand strategies and documents

- *Child and Youth Wellbeing Strategy* (Department of the Prime Minister and Cabinet 2019)
- *New Zealand Antimicrobial Resistance Action Plan* (Ministry of Health and Ministry for Primary Industries 2017)

## Other Aotearoa New Zealand relevant documents (led by the Ministry of Education)

- *Relationships and Sexuality Education: A guide for teachers, leaders, and boards of trustees* (Ministry of Education 2020b<sup>54</sup>)
- *Ka Hikitia — Ka Hapaitia: Māori Education Strategy (refreshed)* (Ministry of Education 2020a)

<sup>52</sup> Key stakeholders in the sexual health sector have endorsed this statement.

<sup>53</sup> While this statement relates to HIV, it has approaches and framing that are useful for the STBBI strategy.

<sup>54</sup> The guidelines come in two volumes: one for years 1–8 and the other for years 9–13.

