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Publication of the Hong Kong Advisory Council on AIDS

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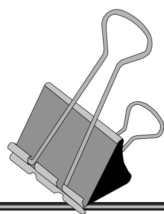
.Calendar.

***XXXXII Meeting of the Advisory Council on AIDS* (ACA)**
2:30pm 3 January 2003



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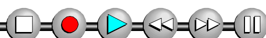

III rd Pearl Workshop

THE Third ***Workshop on HIV Surveillance and Epidemiology in the Pearl River Delta Region*** would be held in Shenzhen on 7 to 9 November 2002.

Members may remember that the first workshop was held in 1998 in Macao and the second in Hong Kong in 2000. The Workshop initially began as a technical forum for professionals working on HIV surveillance in Hong Kong, Macao and the neighbouring cities of Guangdong. The Advisory Council on AIDS had played an active role in the last two workshops, in participation in the programmes, and in networking with others working on the subject. Such networking is considered an important component of Hong Kong's AIDS programme, as reflected in the strategies developed for 2002 to 2006.

The Guangdong Province Centre for Disease Control and Prevention is the organiser of the third workshop, to be held in the Special Economic Zone of Shenzhen. The Workshop would provide an opportunity for the sharing of information on the epidemiological situations in the region, and would also touch upon new subjects such as: mother-to-child infection, opportunistic infections, TB/HIV co-infection, molecular epidemiology etc. The Council is pleased to learn that the Workshop seems to be evolving to become a regular meeting in the Pearl River Delta Region.

Interested members are requested to register to join the workshop. Pre-registration is required, while payment (RMB300 per head) shall be made on arrival. Participants are expected to be responsible for their own accommodation and transport arrangement. Other details can be downloaded from the Virtual AIDS Office VAO: **www.aids.gov.hk**

❑ Dr Homer Tso, ACA Chairman, with three Lions Red Ribbon Fellows who recently visited Hong Kong [from left to right: Ms Victoria Kwong of Red Ribbon Centre, Dr LI Hong, Dr Homer Tso, Dr Hu Feiyue, Dr Krystal Li (Red Ribbon Centre), Ms SONG Jingling and Dr Kelvin Low of the Council Secretariat].

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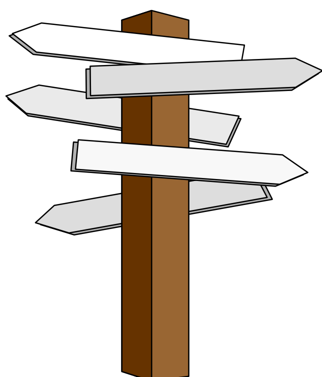
IMPORTANT: on the Third Workshop

The venue for the Workshop has been changed to South China International Hotel 中南國際大酒店 at 2002 Shennan East Road, Shenzhen深圳市深南東路2002號. The hotel is near Wenjindu Customs Control and 5 minutes away from Railway Station.



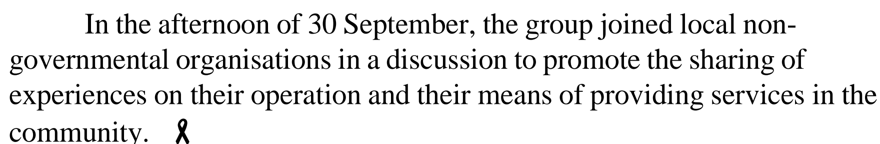
Taking Reference

IN & AROUND HONG KONG

ON 30 September, Dr Homer Tso, chairman of the Council, met for lunch with a group of three technical experts from Beijing on their fact-finding mission in preparation of their establishment of a resource centre on HIV/AIDS, a project of China's Centre for Disease Control and Prevention. The lunch meeting was joined by, among others, two other ACA members. They were: Dr Richard Tan, an active member Lions Clubs International District 303 Hong Kong and Macau, and Rev Chu Yiu Ming, chairman of the Management Advisory Committee of the Red Ribbon Centre.

The national group was taking reference from the model of Hong Kong's Red Ribbon Centre, and seeking means of future collaboration. The three-day visit provided an opportunity for the national experts to understand the history of the Red Ribbon Centre, its modes of operation and the status as a UNAIDS Collaborating Centre, management of the resource collection, the networking through internet and the conduction of other centre-based activities.

In the afternoon of 30 September, the group joined local non-governmental organisations in a discussion to promote the sharing of experiences on their operation and their means of providing services in the community.



Reported HIV/AIDS Statistics *(updated 30 June 2002)*

		HIV		AIDS	
		total	**Q2 2002**	**total**	**Q2 2002**
Gender	male	1524	55	*510*	*11*
	female	339	10	*75*	*4*
Ethnicity	Chinese	1298	50	*459*	*13*
	non-Chinese	565	15	*126*	*2*
Transmission	heterosexual	1067	39	*388*	*12*
	homosexual	351	11	*101*	*3*
	bisexual	88	1	*29*	*0*
	injecting drug use	48	2	*9*	*0*
	blood/bl products	68	0	*19*	*0*
	perinatal	14	0	*6*	*0*
	undetermined	227	12	*33*	*0*
TOTAL		**1863**	**65**	***585***	***15***

NOTE:
The "total" refers to the cumulative total number reported since 1984, under the voluntary HIV/AIDS Reporting System. "Q2" refers to the period March to June 2002. The "AIDS" number is a subset of the "HIV numbers" and the two should not be added.

SOURCE:
Special Preventive Programmes, Department of Health, Hong Kong SAR Government

[continued from page 46...
Meeting Notes on the 41st ACA Council Meeting]

The Committee Chairmen

The chairman of the three committee for 1999 to 2002 were nominated to serve another term, that is, from 2002 to 2005. They are: Mrs Diana Wong of the APCC, Professor YL Lau of SCA and Professor CN Chen of CPA. The three chairmen kindly accepted the invitation and would be working closely with the Secretariat on the formation of the new committees in the coming weeks.

HIV Situations

The latest HIV/AIDS situations of Hong Kong were discussed, on the basis of a report modified and updated from a chapter from the ***HIV Manual 2001*** published by the Department of Health about a year ago. The paper is reprinted in this issue of ACA Newsfile for the reference of all who are interested.

[*The Advisory Council on AIDS meets on a regular basis every three months to discuss and advice on strategies relating to the prevention, care and control of HIV infection in Hong Kong. The new term of office was appointed on 1 August 2002*]

Reduce Harm

THE 14th International Conference on the Reduction of Drug Related Harm is scheduled for 6 to 10 of April 2003 in Chiang Mai, Thailand.

The conference theme, ***Strengthening Partnerships For A Safer Future***, aims to *bring to the fore the many challenges of reducing drug-related harms in a context of rapid social change and competition for scarce resources*.

Harm reduction encompasses the important components of needle access, substitution treatment (methadone) and outreaching.

Further information about the Conference can be accessed on internet **www.ihrc2003.net**

Global Responses

Preparing for the World AIDS Day

WORLD AIDS Day falls on the first of December each year. To expand the global responses to this day of focus, the UNAIDS (Joint United Nations Programme on HIV/AIDS) launches a two-year World AIDS Campaign to tie in with the activities around World AIDS Days and beyond.

Live and let live is the slogan of the World AIDS Campaign 2002-2003, which will be addressing the elimination of **stigma and discrimination**. In Hong Kong, the Red Ribbon Centre has combined the Campaign slogan and theme to form the key message for activities coordinated by the Centre **標籤無意義　讓我活下去**:

The following message is taken from UNAIDS's designated webpage on World AIDS Campaign 2002-2003:

Stigma and discrimination are the major obstacles to effective HIV/AIDS prevention and care. Fear of discrimination may prevent people from seeking treatment for AIDS or from acknowledging their HIV status publicly. People with, or suspected of having, HIV may be turned away from health care services, denied housing and employment, shunned by their friends and colleagues, turned down for insurance coverage or refused entry into foreign countries. In some cases, they may be evicted from home by their families, divorced by their spouses, and suffer physical violence or even murder. The stigma attached to HIV/AIDS may extend into the next generation, placing an emotional burden on children who may also be trying to cope with the death of their parents from AIDS.

With its focus on stigma and discrimination, the Campaign will encourage people to break the silence and the barriers to effective HIV/AIDS prevention and care. Only by confronting stigma and discrimination will the fight against HIV/AIDS be won.

For further information, Members may wish to visit the the following website:http://www.unaids.org/wac/2002/index.html

Meeting Notes

THE 41st Meeting of the Advisory Council on AIDS was held in the afternoon of 27 September at the Conference Room of the Department of Health Headquarters. This was the first meeting of the new (fifth) term of office of the Council. There were six new members in the Council.

Dr Homer Tso, the Chairman, began the meeting by thanking old members for their active participation in the last term, and welcoming new members to meet the challenges of AIDS in the coming years. He also requested to put on record his appreciation for the support of the Department of Health in rendering technical and secretarial support to the Council. There were two main agenda items for the meeting - the operative mechanism of the Council for the years 2002 to 2005; and a review of the HIV/AIDS situation in Hong Kong.

Operative Mechanism of the Council

The operative mechanism of the Council was reviewed by members. In order to deliver the objectives of assessing and monitoring the HIV situations in Hong Kong, and to provide strategic direction to the programmes, three standing committees would continue to be formed as in the last term. The three committees are: AIDS Prevention and Care Committee (APCC), Scientific Committee on AIDS (SCA) and Committee on Promoting Acceptance of People living with HIV/AIDS (CPA).

Apart from the scope, the roles of the three committees are distinctly different. While APCC would conveniently function as a coordinating forum, the SCA would be a technical group for advising on guideline formulation and professional development. The CPA, on the other hand, shall be addressing issues relating to stigma and discrimination on HIV/AIDS in Hong Kong. In light of these differences, the membership composition of the three committees would also be handled differently. APCC would be composed of members representing agencies working on HIV/AIDS and people reflecting the needs of the vulnerable communities, as well as people living with HIV/AIDS. Membership of SCA would be drawn from people with technical expertise in a wide range of disciplines relating to HIV prevention, treatment and control. The CPA's members would be a combination of individuals and stakeholders.

The main objectives of each committee were then discussed (see box). These would be translated into more specific terms of references by chairman and members of the three committees when they are formed. Members of the Council were welcomed to join one or more of the three committees. In order that the committees could work effectively and efficiently, it's recommended that standing sub-groups should not be formed under the committees. Should a specific issue require further deliberation by a smaller group of people between meetings, the better options would be the formation of (a) an independent inter-agency group, or (b) a group by a designated organisation.

Similar to the previous years, secretariat support for the Council and the three committees would be provided by the Special Preventive Programme of the Department of Health. Four meetings would be held per year by the Council, and a similar number for the committees. The operative mechanisms of each committee would be determined by the respective chairman in consultation with the members, in accordance with the principles established.

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Box: Objectives of the three committees

THE objectives of the APCC are (a) the networking and capacity-building of agencies working on HIV/AIDS, (b) identification and promulgation of best practices, and (c) addressing the needs of the community and gaps in the programmes.

The SCA shall be involved in (a) the development of principles and professional guidelines on HIV surveillance, prevention, management and control, (b) public health and clinical programme evaluation, and (c) professional development and the agenda for research.

The CPA would be concerned with (a) measures for promoting acceptance of people living with HIV/AIDS, (b) legal and ethical issues and their implications on societal acceptance, and (c) responses to incidents amounting to non-acceptance or discrimination.

AN UPDATE ON THE EPIDEMIOLOGY OF HIV INFECTION IN HONG KONG

(modified from Epidemiology of HIV Infection in Hong Kong in HIV Manual 2001 published by Special Preventive Programme, Department of Health, Hong Kong)

This paper was discussed at the 41st Meeting of the Advisory Council on AIDS on 27 September 2002.

Background

1. There are three major routes for HIV (human immunodeficiency virus) transmission – sexual contacts, exposure to contaminated blood or blood products, and perinatally from an infected mother to the child. The importance of each of these factors varies from one country to another. Other less common routes of transmission, for example, occupational exposure in health care settings, during transplantation, can be included in the category of blood exposure.

2. Globally, sexual transmission is the major mode of HIV spread. The risk of infection varies with the form of sexual activity, being higher with anal intercourse in the passive partner (0.1-0.3%) and lower in the active partner of vaginal sex (0.03-0.09%).[1] More recently, oral sex has also been linked with the transmission of the virus. [2] The exposure of contaminated blood refers largely to the sharing of needles in injecting drug users. Mother-to-child infection has resulted from extensive heterosexual transmission. With the advent of universal antenatal HIV testing and antiretroviral prophylaxis, perinatal infection has declined, particularly in western countries. On a global scale, HIV transmission in health care setting is rare.

3. In Hong Kong, the first cases of HIV infection and AIDS were diagnosed in 1984 and 1985 respectively. This paper outlines the epidemiological situation as revealed by the results of the surveillance program maintained by AIDS Unit, Department of Health.

HIV surveillance in Hong Kong

4. The HIV/AIDS surveillance system comprises the following programs: (a) HIV/AIDS reporting, (b) seroprevalence studies, (c) STD surveillance and (d) behavioural surveillance and other research activities. Surveillance activities are undertaken through the Research Office of the AIDS Unit. Results are published in the Hong Kong STD/AIDS Update, a quarterly surveillance report of AIDS Unit and Social Hygiene Service. Both the publication and the summary tables can be viewed and downloaded from the Virtual AIDS Office at www.aids.gov.hk

5. The HIV/AIDS reporting programme is a dual mechanism involving the voluntary reporting of newly diagnosed HIV and AIDS cases by attending physicians using the DH2293 form and by laboratories providing confirmatory tests in the public service. Seroprevalence studies are conducted on selected communities. Methodologies such as unlinked anonymous screening [3] have been applied to enhance our understanding of the HIV situation. STD surveillance is a separate system coordinated in conjunction with the Social Hygiene Service. Finally, behavioural surveillance is a rather new concept in HIV epidemiology. Since 1994, AIDS Unit has been experimenting on a pilot behavioural surveillance mechanism in collaboration with Department of Microbiology, The University of Hong Kong. [4]

Routes of HIV transmission

6. As of the end of June 2002, a cumulative total of 1863 HIV infections have been reported. On a yearly basis, about two hundred cases are notified under the voluntary reporting mechanism to the Department of Health (Box 1). Through an analysis of the available epidemiological information, it was estimated that in 1999, the HIV prevalence in Hong Kong ranged between 2000 and 3000 (Revised projection of HIV infection and AIDS cases in Hong Kong by Dr James Chin, www.aids.gov.hk, a figure supported by results of seroprevalence studies. Sexual transmission has so far been accounting for a majority of the known cases.

The central role of sexual transmission

7. Over the years, sexual transmission has remained the single most important route of HIV spread in Hong Kong. (Box 2) Not

Council paper

surprisingly, the HIV prevalence is highest in the age 25 to 34. From the reported figures, there has been a notable change from a predominantly homosexual to a heterosexual infection. Between 1985 and 1990, less than 30% of the reported sexually-acquired infections were heterosexuals. In 2001, this percentage has risen to 58.2%. These figures must be interpreted with care because of the different denominators involved. The importance of homosexually acquired infection should however not be ignored. Assuming that one-tenth of men in Hong Kong are homosexuals, the HIV prevalence in homosexual men is at least three to five times that of heterosexual men. In parallel there' s been a narrowing of the male-to-female ratio from 8:1 in 1992 to about 3:1 in 1998 and beyond. [5]

8. The Government Social Hygiene Clinic, which looks after a significant fraction of local STD patients, is an important source of HIV reports. Diagnosis of HIV infection in STD patients reflects, to a certain extent, the HIV rate in those who have practised high-risk sexual behaviour. So far, clients of Social Hygiene Clinic have accounted for about 15.6% of all known cases of HIV. However, the prevalence of HIV in STD patients remained at a low level of 0.06% in year 2001. On the other hand, commercial sex is often considered to be another marker of possible high-risk behaviours. There is no reliable figure for the HIV rates in commercial sex workers in Hong Kong. Condom use is one of the behavioural markers regularly monitored in STD patients. The proportion that always or frequently used condom for commercial sex was less than 30% in the last two years. The condom usage rate varies significantly from one community group to another, but has remained relatively stable over years in the same community. [6]

The potential risk of injecting drug use

9. Overseas observations have confirmed the propensity for rapid HIV spread to occur in the drug-taking communities once the virus gets into this very population. Hong Kong has so far been spared of this daunting phenomenon. 5.2% of the reported infections in 2001 were attributable to injecting drug use. Cumulatively it is 2.5%.

10. There are indications that HIV rates in drug users are rising. Unlinked anonymous screening of methadone users revealed a yearly positive rate of less than 0.1% up 1997, rising gradually in the last year to 0.27% in 2000. The number of reported cases has also risen from not more than 3 per year before 1998, 6 in 1999, 10 in 2000 and 11 in 2001.

11. Behavioural surveillance has provided further insights into the potential risk of HIV spread in the drug-taking communities. The injection rates, for example, had varied with the locations of the surveys, being highest at 80% in those before admission to an inpatient drug treatment centre, and lowest at 20% in new registrants of methadone clinics. [6] The average needle-sharing rate was higher in street addicts, followed by methadone users and then those opted for inpatient treatment (20%, 10% and 5% respectively for the last years). There has however not been any significant change in the behaviours of drug users surveyed. One recent study suggested that risk-taking behaviours generally fell after registering for methadone maintenance (data of Special Preventive Programmes, Department of Health).

Contaminated blood and blood products – the historical past?

12. A total of 63 haemophilia patients and 4 transfusion recipients had contracted HIV before 1985 as a result of the use of contaminated blood product before blood screening and safer alternatives became available. Over the years about a quarter of the haemophiliacs have been tested positive for HIV. While the risk of transfusion has become a subject of the historical past, we were again reminded of the remote chance of infection from blood collected during the window period, when a patient actually got infected in 1997. There is no absolute safety despite the implementation of donor deferral, donor screening for HIV antibody and the introduction of Nucleic Acid Test (NAT) by the Hong Kong Red Cross Blood Transfusion Service. An infinitesimal residual risk of infection remains.

Mother-to-child transmission: cause for concern

13. A study coordinated by AIDS Unit had identified a total of 41 incidents of HIV positive pregnancies between 1992 and 1999. As of the end of the year 2001 reports of 14 cases of mother-to-child infections have been received, accounting for less than 1% of the cumulative total of

reported HIV cases. A significant proportion of the reported infections were diagnosed only after the birth of the infected children. The Advisory Council on AIDS had proposed the strategy of universal antenatal HIV testing in Hong Kong, [7] a move which may affect the profile of the infections in Hong Kong.

The setting of HIV diagnosis

14. HIV infection may present in one of the following settings: firstly, in the process of receiving voluntary counselling and testing (VCT) because of the perceived HIV risk, while one is still asymptomatic; secondly, undergoing an HIV test when seeking treatment for a condition that shares the same risk factor, for example sexually transmitted disease (STD) or drug addiction; thirdly, in the workup when one presents with a clinical complication.

15. Over the years, a significant proportion of the HIV positive cases presented only after one had progressed to AIDS. Overall, about a third of the HIV infections were detected within three months of the corresponding AIDS diagnosis. [8] Only 15% were reported from an AIDS service where VCT was offered, and another 15% from the Government' s STD service, both considered as the avenues for early diagnosis.

16. *Pneumocystis carinii* pneumonia (PCP) remains the single most important ADI over the years. In the year 2001, PCP accounted for 43.3% of all ADIs, followed by tuberculosis. *Penicillium marneffei* is a unique infection occurring in South East Asia, including Hong Kong. Penicilliosis has been included as one of the ADIs in the definition established by the Scientific Committee on AIDS. [9] Between 1 to 7 cases were reported annually. Box 3 shows the distribution of the major AIDS defining illnesses in Hong Kong. The access to antiretroviral therapy is gradually changing the landscape of AIDS with the number of reported AIDS reaching a plateau since 1997.

Determinants of HIV spread in Hong Kong

17. What would the future patterns of HIV infection in Hong Kong be like? Two questions are proposed to help us predict the future. Firstly, are new infections happening? Secondly, are there societal forces that would affect the practice of risk behaviours in Hong Kong?

18. The determination of incidences is the key to understanding the occurrence of new infections. For HIV infection there is the intrinsic problem in assessing new infections because of (a) the absence of reliable laboratory tests for incidence testing, and (b) the difficulty in characterizing the onset of infection clinically. In evaluating all newly reported HIV cases in the past ten plus years, it is evident however that the age has remained relatively constant at 32 to 36. The absence of age cohort effect testifies to the occurrence of new infections here in Hong Kong.

19. Knowingly, one' s practice of risk behaviours exposes him/her to HIV infection. On the population scale, these behaviours are influenced by societal forces which either predispose individuals to or protect them from the virus. Human mobility is one such driving force. As a city in the Pearl River Delta region, there are ten times more people coming in and out of Hong Kong than the number of residents themselves. The human interaction in Hong Kong and the neighbouring cities is far more complex than can be imagined. Cross-border commercial sex, drug trafficking and the practice of illicit drug are but some of the determinants of possible HIV spread. A quantification of the HIV risk of human mobility is an impossible task. On the other hand, a supportive environment is extremely important in ensuring the consistent practice of safer behaviours. Condom promotion, harm reduction in drug users, favourable legal framework, access to HIV testing and care are the building blocks of a supportive environment. So far, the network of methadone clinics, currently serving some 7000 drug users daily, has been providing a "safety net" to guard against HIV spread in the drug-taking communities. Regular methadone users are less frequent injectors and have a lower tendency to share needles. [10] It must be noted however that the delicate equilibrium in methadone users, now with a low HIV rate, may be tipped once HIV is introduced.

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