Editorial Board
Executive Editor: Mr WONG Man-kong ACA Secretariat

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Website: http://www.aca-hk.com

We have

Schedule

- *59th ACA Meeting on 6 July 2007*
- *8th CFA Meeting on 11 September 2007*

59th ACA Meeting

The 59th ACA meeting will be held on 6 July 2007 (Friday) at 2:30 pm at the DH Conference Room, 21/F Wu Chung House, Wan Chai. There will be three main items on the agenda:

- **Implementing Rapid HIV Testing in the Labour Ward to Supplement the Universal Antenatal HIV Testing Programme**
- **HIV Prevalence and Risk Behavioural Survey of MSM in Hong Kong (PRISM)**
- **The Community-based Risk Behavioural and Seroprevalence Survey of Female Sex Workers in Hong Kong (CRISP)**

Interested readers may watch for the next issue of the ACA Newsfile for more details.

Report on the Assessment of Recently Acquired HIV Infection in Men Having Sex with Men (MSM) in Hong Kong

The Department of Health commissioned the Stanley Ho Centre for Emerging Infectious Diseases in last August to conduct a study to assess the situation, explore the underlying risk factors and suggest evidence-based recommendations in relation to MSM and HIV infection in response to the rising trend of HIV prevalence and infections among MSM as reported by the Centre for Health Protection.

The **Executive Summary** overleaf *(pages 26 & 27)* is extracted from the report released in April 2007. Readers wish to access the full report can click on *www.info.gov.hk/aids/pdf/g189.pdf* .

Report on the Assessment of Recently Acquired HIV Infection in Men Having Sex with Men (MSM) in Hong Kong

Executive Summary

1. In response to the rising trend of HIV prevalence and reports among men having sex with men (MSM) reported by Centre for Health Protection, Department of Health, Hong Kong, a study was conducted to assess the situation, explore the underlying risk factors and suggest evidence-based recommendations. The study comprises a desktop review of the global and local HIV situation in MSM, a qualitative interview with HIV positive MSM and key stakeholders, and a questionnaire survey administered on HIV positive MSM attending two specialist clinics in the territory.

Global and local HIV infection among MSM

2. Worldwide, there's an emerging epidemic of HIV in MSM populations. About 5 to 10% of people living with HIV were transmitted between men in 2005. In Western Europe and North America, MSM accounted for about half of all HIV cases diagnosed. In Southeast Asia, it is estimated that there are about 10 million MSM. Prevalence of HIV varies from less than 1% in Malaysia to 28% in Bangkok of Thailand. In the past five years, HIV among MSM rose sharply in the United States, Canada, many European and Southeast Asia countries. In Rome, Spain and Australia, for example, the HIV incidence among MSM has doubled or tripled within the past 5 years.

3. Various factors have been suggested to explain the global epidemic. An increasing number of sex partners and the practice of unprotected anal intercourse have been reported. MSM who are online tend to have multiple casual partners and unprotected sex. Party and party drugs (including Viagra) are popular in the MSM community. They are associated with unprotected anal sex and HIV infection. Other contributing factors include lower risk perception associated with improved treatment of HIV, international travel and commercial sex.

4. The situation in Hong Kong is similar to that in other countries. Data from different sources suggested that new infections in MSM have doubled within the past 3 years. The sharp rise among MSM has dominated the overall increase of HIV infection contracted through risk behaviours in Hong Kong. Most of the HIV positive MSM patients are Chinese young or middle aged adults who acquired the infection in Hong Kong through non-regular, non-commercial sex. Epidemiological investigation of two clusters of 46 patients detected in 2006 suggested that there were very active sexual activities among subgroups of MSM. Local studies suggested the condom usage rate among MSM was in the range of 60%. Cross border sex, getting acquaintance with sex partners through internet and having sex in sauna were common practice. A mathematical model predicted a 3-fold increase in the cumulative number of HIV infected MSM within 5 years.

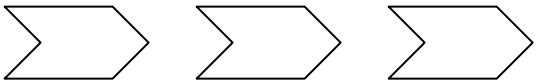
MSM risk network

5. MSM interact in networks which link together individuals as well as through access points called "nodes". Some, like the internet and gay-oriented magazines, are information nodes that link people to physical venues (physical nodes) where sexual activities may occur. The profile and popularity of these nodes have changed over the years. Public toilets are no longer popular and are replaced by saunas, massage houses, bars and parties in the past decade. Internet provides a virtual platform where MSM can meet at any time and place.

6. Apart from a change of the popularity of the nodes, there has been an intensification of connections between different nodes with internet playing a central position.

➲ ➲ ➲ ➲ *to be continued…*

Executive Summary



In a simulation exercise, given the same level of risk behaviours, the increased connection of nodes would predispose to HIV transmission through enhancing the exposure opportunities of individual MSM.

Vulnerability of MSM to HIV infections

7. The partnership pattern of MSM has changed in the recent 5 years, as reflected in the results of a questionnaire survey that explored the behavioural practice before their infections. Public toilets and beaches became less popular while internet was the main avenue for sourcing sex partners. Home has become the most common venue for sex although sauna remains popular in the MSM community. About half of the HIV infected MSM had history of visiting other countries for sex before their contracting the virus. An important observation is that HIV was not perceived as a significant risk by some MSM.

8. Generally speaking, the practice of sexual behaviours (condom usage, oral/anal sex, active or passive role) has remained largely the same in MSM who contracted the virus recently (on or after 2001) in comparison to those infected before 2001. The pattern of safer sex practice with regular and casual partners have also remained the same, while commercial sex was relatively uncommon over the years. However, an increasing use of soft drugs while having sex was observed. This was often associated with parties where MSM might have sex.

9. As regards the process of identity formation, MSM (from the study on HIV infected MSM) identified themselves as homosexual at around 17 years of age. They normally entered the MSM network and had first sex at about 23 years old, and subsequently got infected at an average age of 30s. The popularity of internet means that young MSM can easily come into contact of MSM network during or shortly after the period of identity formation

10. It is encouraging to discover from our study that after diagnosis of HIV, MSM have generally reduced their practice of identifying partners and having sex in various gay venues (physical nodes). Condom usage rate has generally increased. The contexts of such improvement and whether this can be sustained is however not known.

Conclusions and recommendations

11. We conclude that the changing partnership patterns and therefore the evolving configuration of MSM network constituted the major driving force behind the observed increase of HIV infections in MSM in Hong Kong.

12. Six recommendations are made:

(a) strategically promote safer sex targeting young MSM at different time period from identity formation to exposure to HIV risk;
(b) design specific interventions to reach MSM on line, who are prone to have unprotected sex at home;
(c) develop HIV prevention that incorporates sexual health instead of HIV *per se*, so as to circumvent the indifference of some MSM to HIV;
(d) systematize clinic-based HIV prevention;
(e) develop pilot projects and/or studies that integrate programmes on soft drug abuse and HIV prevention, and cross country interventions;
(f) introduce case investigation that characterize partnership for supporting the control of HIV spread.

Reported HIV/AIDS Quarterly Statistics - 1st Quarter, 2007

		This Quarter		Last Quarter		Same Quarter Last Year		Cumulative	
		HIV	AIDS	HIV	AIDS	HIV	AIDS	HIV	AIDS
Sex									
Male		72	17	83	14	70	11	2649	749
Female		19	3	15	0	19	6	640	126
Ethnicity/race									
Chinese		56	15	61	12	60	13	2233	680
Non Chinese		35	5	37	2	29	4	1056	195
	Asian	15	3	22	1	16	4	558	123
	White	5	1	6	1	2	0	247	62
	Black	0	0	1	0	3	0	44	7
	Others	15	1	8	0	8	0	207	3
Age at diagnosis									
Adult		91	20	96	14	89	17	3249	865
Child (age 13 or less)		0	0	2	0	0	0	40	10
Exposure category									
Heterosexual		20	8	30	4	30	8	1630	562
Homosexual		31	4	28	4	24	5	708	157
Bisexual		4	0	3	2	5	0	135	36
Injecting drug use		7	3	17	2	12	3	181	28
Blood/blood product infusion		1	0	0	0	0	0	73	21
Perinatal		0	0	2	0	0	0	19	6
Undetermined		28	5	18	2	18	1	543	65
Source of referral									
AIDS Unit		13	1	8	0	8	1	413	63
Social Hygiene Clinics		11	0	10	0	7	0	474	39
Private hospitals/clinics/laboratories		25	0	20	2	24	3	712	136
Public hospitals/clinics/laboratories		37	19	48	12	46	13	1487	623
Hong Kong Red Cross Blood Transfusion Service		1	0	0	0	1	0	72	8
AIDS service organisations		2	0	9	0	2	0	77	5
Drug rehabilitation services		2	0	3	0	1	0	54	1
Total		91	20	98	14	89	17	3289	875