Community Stakeholders Consultation Meeting

for

Development of Recommended HIV/AIDS Strategies for Hong Kong 2012-2016

Summary for the Session on Injecting Drug Users

July 2011

Community Forum on AIDS, Hong Kong Advisory Council on AIDS and Hong Kong Coalition of AIDS Service Organizations

The Community Forum on AIDS (CFA) and the Hong Kong Coalition of AIDS Service Organizations (HKCASO) jointly organized a Community Stakeholders Consultation Meeting comprising eight sessions on key populations and a session on resources for local AIDS response from 26 January to 1 February 2011. The Meeting, steered by a working group formed by CFA and HKCASO, sought to engage stakeholders in informed discussion to shape the formulation of the local strategies on HIV/AIDS. A generic framework of discussion and prioritization was adopted in all sessions. This summary contains information on the latest epidemiology and current response presented in the session on injecting drug users (IDU), and suggestions generated by the participants. The views and information contained in this summary are as collected and gathered from the Meeting and do not necessarily represent those of CFA and HKCASO. Summaries of other sessions and a full report of the Meeting can be downloaded from the Virtual AIDS Office (www.aids.gov.hk).

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Review of epidemiology

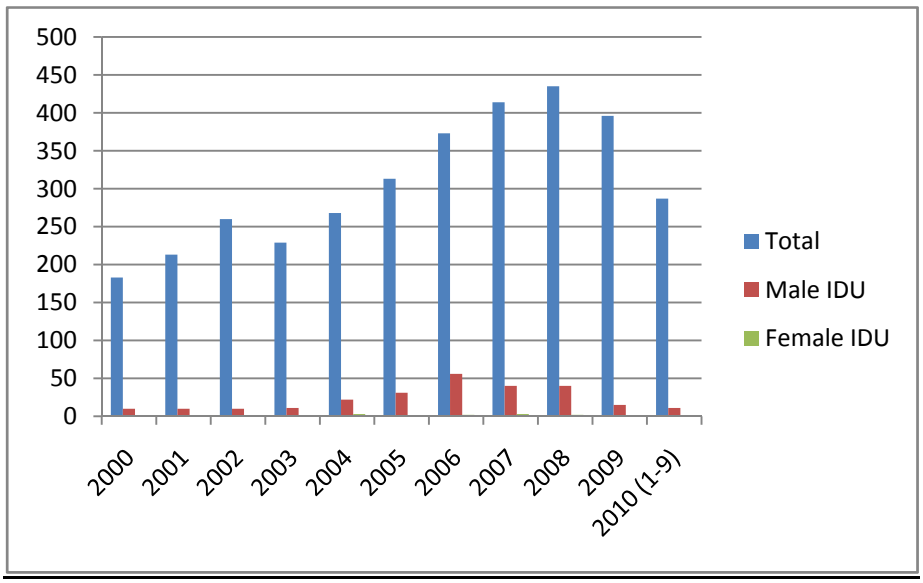
[draft for discussion only]

Population size estimation

- Estimation for the injecting / heroin drug users has taken reference from three major data sources: Central Registry of Drug Abuse (CRDA), Methadone Treatment Programme (MTP) and Street Addict Survey (SAS). Defining IDU has been a difficult topic as movement in and out of injecting behaviour can be very frequent, that the population size for IDU can be changed accordingly depending on the time point one is measuring.
- Based on CRDA, there were about 13,600 and 14,200 of drug users in 2007 and 2008 respectively, of which about 57% and 52% were taking heroin by injection, corresponding to about 7,700 and 7,400 IDU in Hong Kong.
- Based on MTP, a total of 11,117 attendees were recorded in 2009, in which approximately 4,600 attendees were newly admitted or readmitted, suggesting possible drug injecting behaviour prior to the point of care at MTP (though only 25-35% newly admitted attendees admitted drug injecting upon attendance in year 2002-2009). The rest in the MTP were either on maintenance or detoxification therapy and strictly speaking not drug abusers. However, among these individuals it is worth-noting that 20%-40% of opiate test were positive among MTP attendees (although opiate test data is not very reliable), thus, suggesting another 1,300 to 2,600 might need to be added to those newly or readmitted cases, corresponding to very rough estimates of about 6,000-7,000 injecting drug users in Hong Kong, based on the MTP estimates.
- Based on SAS, between 67%-88% of the sample reported drug injecting in past month in year 2005 onward. Given over 94% of the SAS sample attended MTP, the survey findings might provide possible projection to MTP finding, giving about 11,800 population of MTP attendee plus street addicts, in which an overall of 7,900-10,400 reported drug injecting behaviour in past month in Hong Kong.
- The general trend of decreasing heroin use has also been observed from the CRDA data.

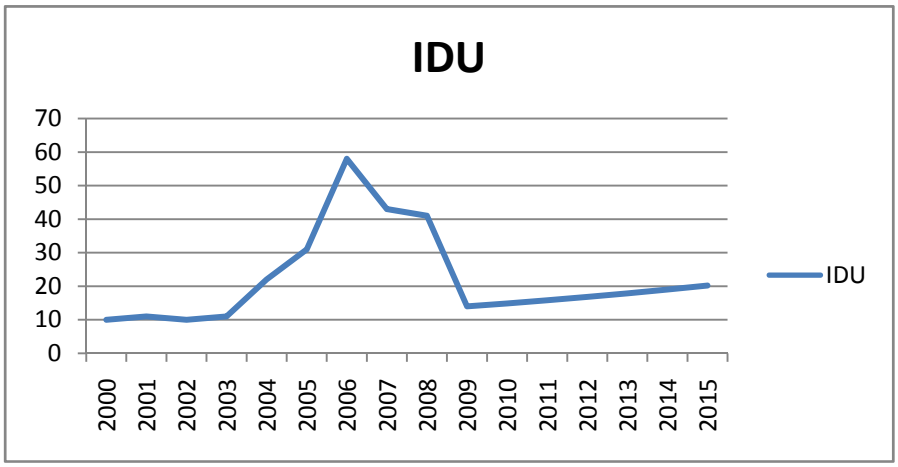
HIV/AIDS reporting system

Trend



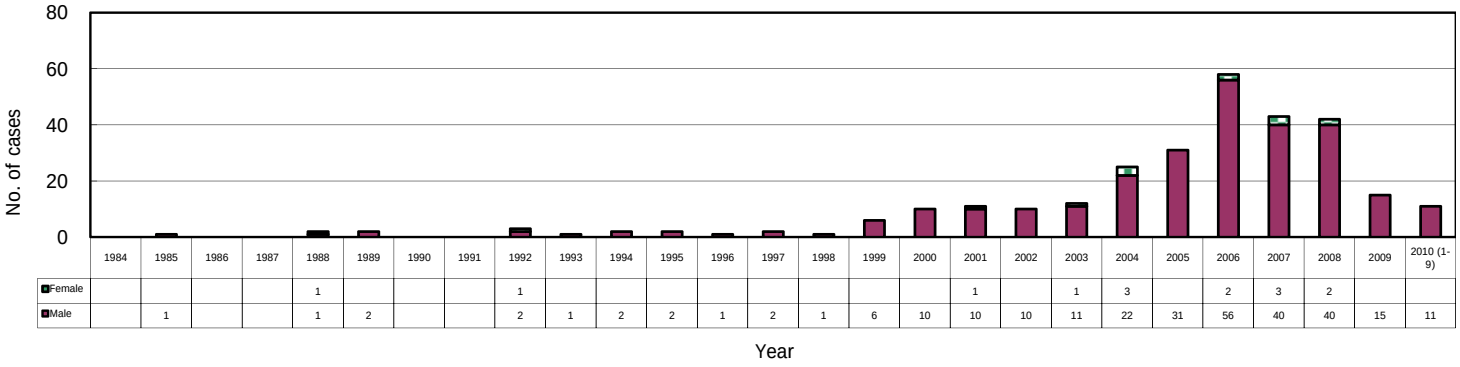
- Number of HIV reported cases contributed by IDU remained on low level after its peak in year 2006-08.
- Male predomated in IDU's contribution by taking over 90% of cases since 2005.

Projection



- Based on past data in year 2005-2009, an average modest increment of 6.3% in HIV cases among IDU will be expected in 2010-2015, which translates into not more than 20 HIV cases annually until 2015.

Gender



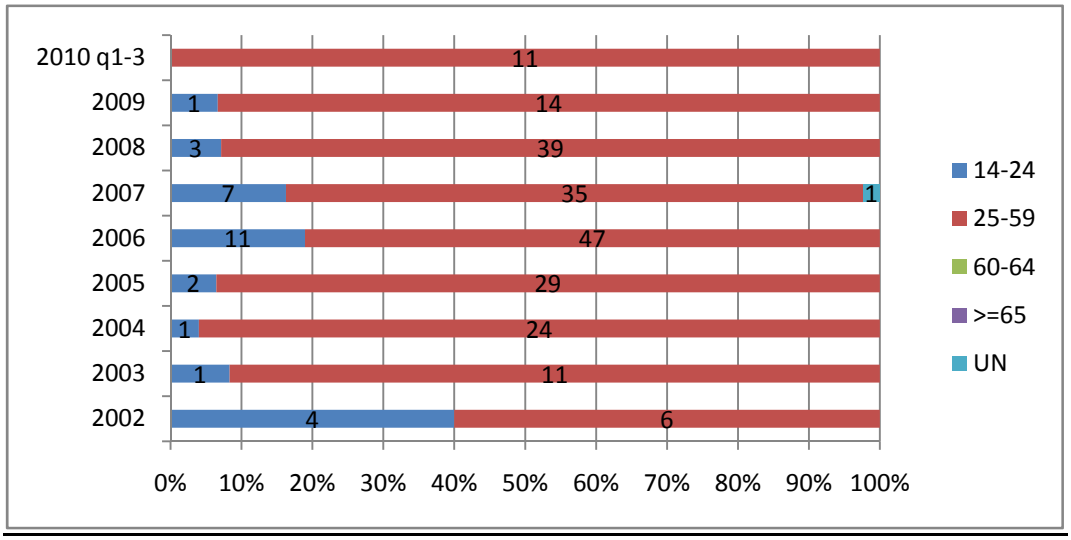
- Male overwhelmingly predominated, with male to female ratio close to 10:1.

Ethnicity

Year	Chinese	Asian	Caucasian	African	Unknown		% Chinese	% Asian	% Vietnam
2002	4	6	0	0	0		40%	60%	60%
2003	10	2	0	0	0		83%	17%	8%
2004	18	7	0	0	0		72%	28%	24%
2005	8	23	0	0	0		26%	74%	68%
2006	7	50	0	0	1		12%	86%	72%
2007	10	33	0	0	0		23%	77%	70%
2008	8	34	0	0	0		19%	81%	76%
2009	3	12	0	0	0		20%	80%	67%
2010 (q1-3)	3	8	0	0	0		27%	73%	64%

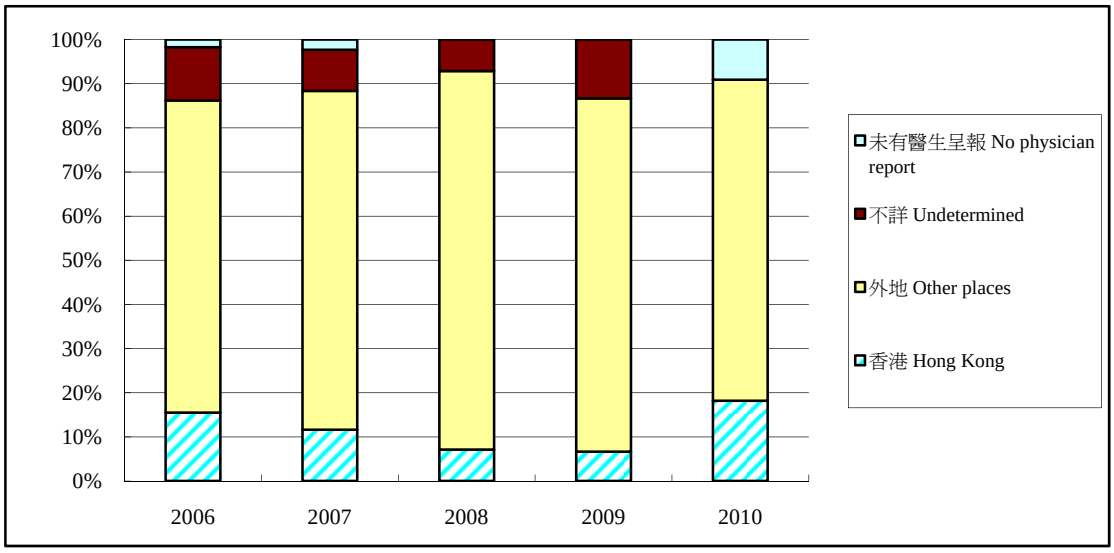
- More than 70% of IDU reported cases are Asians (other than Chinese), of which most were Vietnamese.

Age



- The age group of 14-24 is shrinking in proportion, i.e., < 10% in recent the 3 years.
- There is no reported HIV cases from the above 60 years old age group.

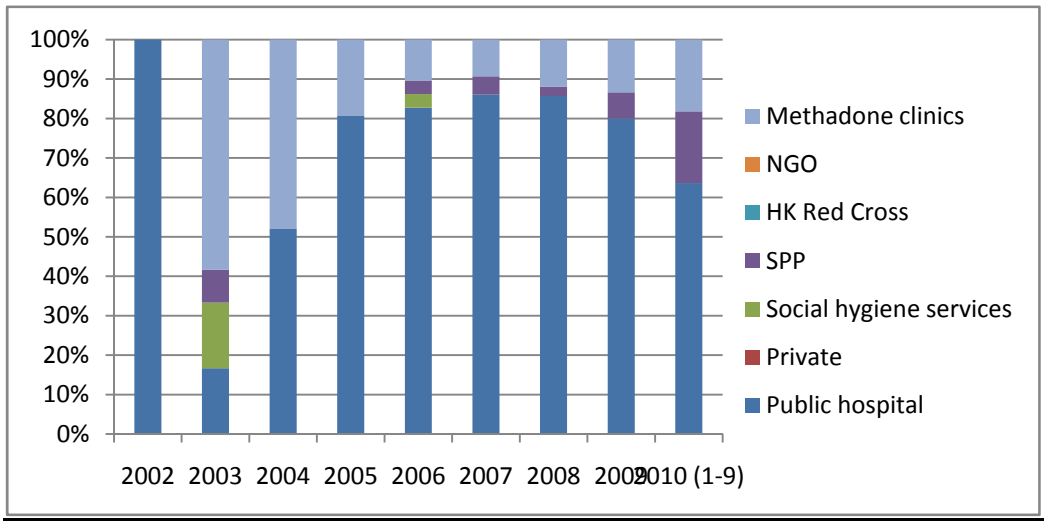
Suspected location



- Less than 20% of the reported cases acquired HIV locally.
- Approximately 70%-80% of IDU acquired HIV outside Hong Kong.
- Among those, acquisition in Vietnam was the most common place.

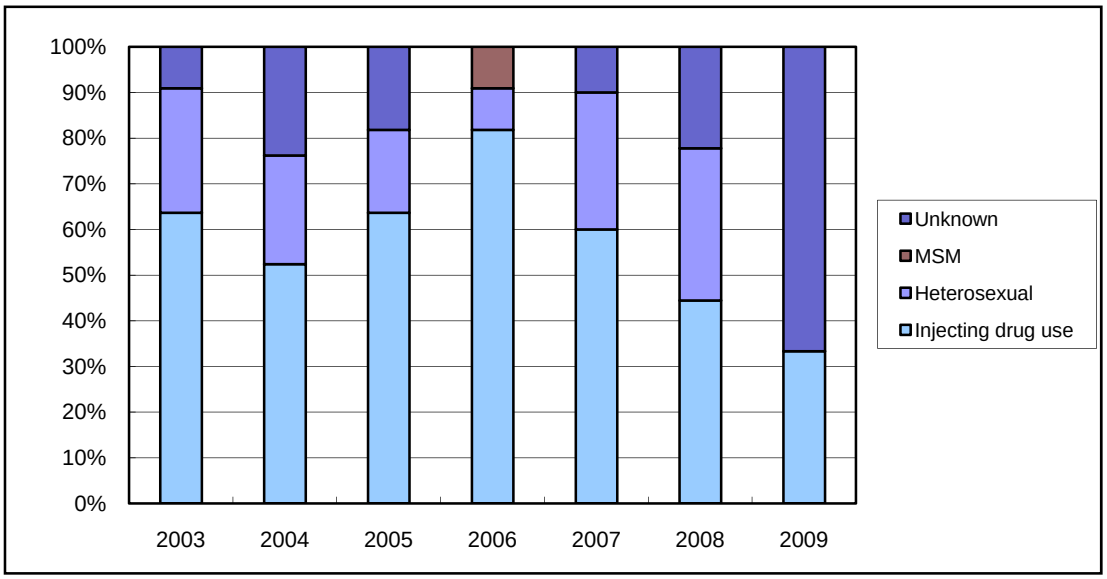
2006	2007	2008	2009	2010
39	27	29	11	6
67%	63%	69%	73%	55%

Reporting source



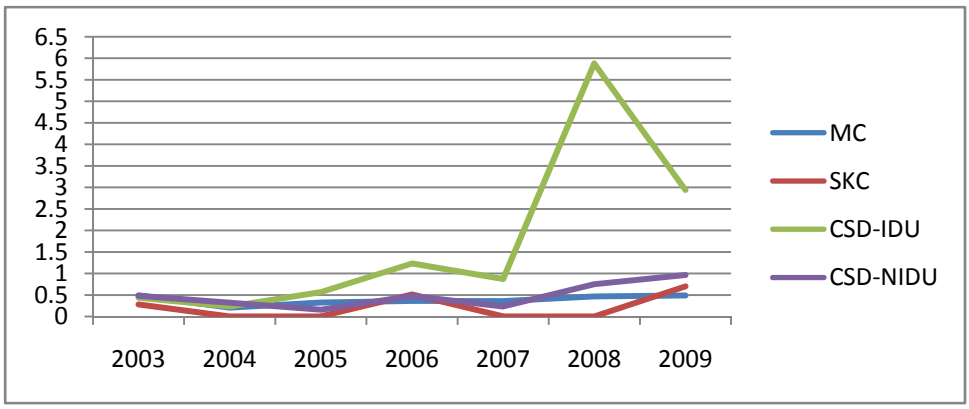
- There was no reported case from NGO in recent years. This does not mean NGO did not provide testing for IDU, but IDU who tested positive for HIV might not be reported to have IDU as their exposure categories.

Exposure risk among HIV positive methadone clinic attendees



- Approximately 30%-60% in 2007 to 2009 of service users under HIV positive methadone user registry was attributable to the injective drug use exposure category.

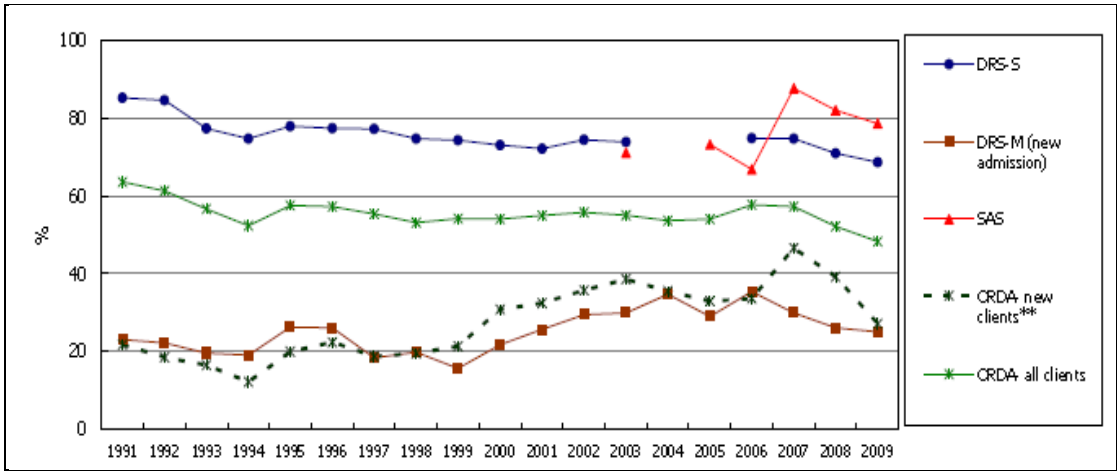
HIV prevalence



- Sentinel surveillance, including Methadone Clinic attendees (MC) and Shek Kwu Chau rehabilitation centre (SKC), generally revealed a low level of HIV prevalence among drug users, consistently below 0.5% over the past years (note that the breakdown into IDU is not available). This prevalence level is comparable to the data in Correctional Services Department (CSD) for the non injecting drug users (CSD-NIDU).
- HIV prevalence, however, was considerably higher among ever injecting users in CSD, in year 2007 to 2009 with a range between 1% and 6%. Most of this was attributed to prisoners with Vietnamese origins (50% in 2007, 58% in 2008 and 100% in 2009).

Risk behaviours

Current IDU

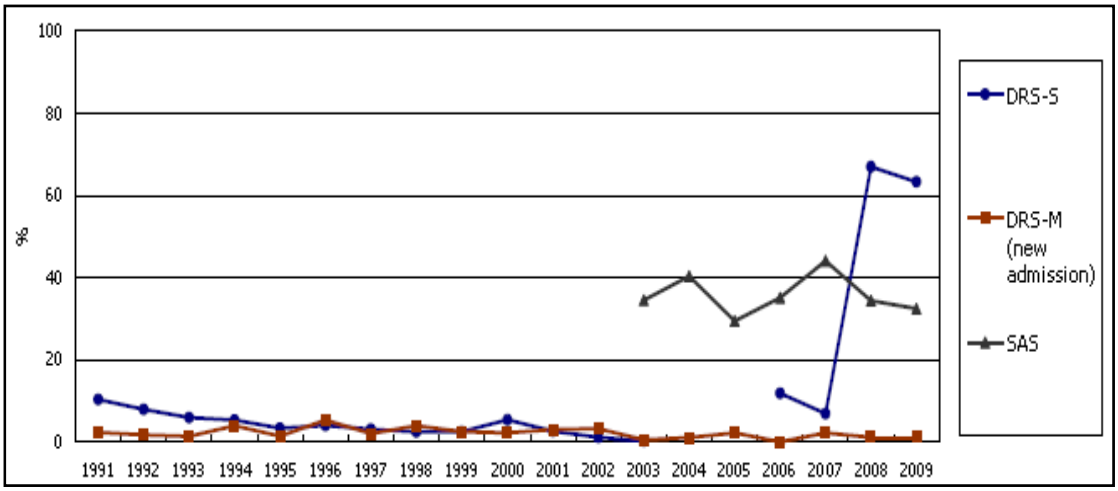


- SKC (or DRS-S) and SAS where peer interviewers were used captured a higher level of drug injecting behavior reported. About 60% and 80% of respondents reported to have injected drugs consistently in past 6 months and 1 month

respectively.

- MC (or DRS-M) where doctors were the interviewers captured a lower level of drug injecting behavior reported at point of care, i.e. 25%-35% among the newly admitted attendees. Although this level is considered to be underreported, however it is still comparable to the newly admitted drug users based on CRDA (which referred to drug injecting behavior in the past 1 month). Thus, new drug users in general appeared to be less likely to engage in drug injecting behavior.
- For all reported drug users in CRDA, between 48%-57% of them were IDU (reporting to have injected drugs in the past 1 month).

Current needle sharing among injector



- Between 30%-44% of IDU reported to have shared needles in the past 1 month based on SAS (2003-2009).
- MC (or DRS-M) again captured a lower level of needle sharing behavior, that way below 3% among the newly admitted drug users reported to have shared needle at the point of care.
- SKC (or DRS-S) fluctuated more widely, that between 7% and 67% of IDU reported to have shared needles in the past 6 months.

<u>Condom usage</u>

- SAS (2007-2009): 13%-30% of all drug users reported to have consistent condom use with RSP in the past 1 year; 82%-91% of all DU reported to have consistent condom use with FSW in the past 3 months; and 77%-93% of DU reported to have consistent condom use with FSW in China in past 3 months.
- SKC (2007-2009): 67%-81% of drug users reported to have had sex in past 6

months. Among them, 2%-21% reported to have condom use with RSP in the last sexual encounter, and 82%-95% reported condom use with FSW in the last sexual encounter.

- MC (2008-2009): 4%-8% of newly admitted drug users reported to have had sex with FSW in the past 1 year. 17%-19% of drug users reported to have consistent condom use in past year for all partner types.
- CSD (2007-2009): 24%-26% of IDU reported to have consistent condom use with RSP in the past 1 year; 54%-71% of male ever IDU reported to have consistent condom use with FSW in past year; 44%-55% of IDU reported to have condom use at the last sexual encounter with RSP; 66%-84% of IDU reported to have condom use with FSW at the last sexual encounter.

<u>HIV testing history</u>

- SAS (2007-2009): 79%-89% of DU reported to have tested for HIV in the past 1 year.
- MC (2008-2009): 76%-78% of all MC attendees reported to have ever tested for HIV; while 76%-81% in from the newly admitted category, and 80% from the readmitted category.
- Methadone Clinic Universal Testing Programme (MUT) (2008-2009): 84%-87% of those entering the MUT reported to have ever tested for HIV, among them, 93% were newly admitted and 90%-92% were readmitted drug users.
- SKC (2007-2009): 12%-80% of drug users reported to have ever tested for HIV.
- CSD (2007-2009): 20%-28% of ever IDU reported to have ever tested for HIV.

Current Response in HIV Prevention

Local responses from 2007 onwards

1. Both the government and non-governmental organizations (NGO) are playing active part in the current response on prevention of HIV infection through injecting drug use in Hong Kong. Both drug prevention and harm reduction approaches are used. The current activities are summarised in the box below.

Box 1. Summary of current activities for preventing HIV infection among IDU in HK

1. Methadone treatment programme
2. Prevention activities in methadone clinics:
    a. Universal HIV urine testing programme
    b. Individual and group counselling services by social workers
    c. Distribution of condom and HIV prevention materials
    d. Risk assessment and follow up of HIV infected drug users by social workers
    e. DH Working Group on control of HIV infection among drug abusers for coordinating prevention activities
3. Outreach programmes with collection of used needles, distribution of condoms etc. by various NGOs
4. Educational programmes at drug treatment and rehabilitation centres, halfway houses and prisons
5. Public education on harm reduction
6. Voluntary HIV testing and counseling service
7. Treatment of HIV infected drug users in public HIV clinics
8. Surveillance activities:
    a. Behavioural risk assessment at admission/readmission to methadone clinics
    b. Annual street addict survey
    c. Universal testing programme in methadone clinics
    d. Unlinked anonymous testing in prisons and SKC drug treatment centre

2. The methadone treatment programme under the Department of Health (DH) remains the largest drug treatment service for HIV prevention among drug users. Through a network of 20 methadone clinics which open 365 days a year, the methadone treatment programme has a daily attendance of over 6,000. As at December 2010, some 8,400 clients were registered with the programme, 98% of whom were under the maintenance scheme and 2% were under the detoxification scheme. The mean age of the clients was 49 with a male to female ratio of 7 to 1. A local study has reported that consistent use of methadone and a daily dose of

more than 60 mg are associated with lower frequency of injections thus lowering the risk of HIV infection.

3. Other HIV prevention activities in methadone clinics include -

(a) A universal voluntary HIV urine testing programme has been fully implemented since 2004 in view of the increasing amount of HIV positive cases. In the past 4 years, a coverage rate of around 80% has been maintained and more than 7,500 HIV tests were done annually for the methadone users. A total of 61 new HIV infections have been diagnosed since its pilot in July 2003.

(b) Currently about 1,890 cases[1] are receiving care by social workers in methadone clinics. Group and individual counseling services are identified to have positive impact on successful detoxification and acceptance of HIV urine testing.

(c) Condoms are given to all newly admitted patients and are freely distributed in the methadone clinics. Over the last four years, more than 93,000 condoms were distributed annually.

(d) All HIV infected drug users at methadone clinics are regularly followed up and supported by doctors and social workers of the methadone clinics. Regular risk assessments are performed with risk reduction measures continuously reinforced so as to prevent HIV spread from the infected persons. A new programme providing enhanced social support services to HIV infected methadone clinic attendees has been implemented since 2006.

(e) A multi-disciplinary Working Group on Control of HIV Infection among Drug Abusers has been set up by DH to coordinate HIV prevention activities in methadone clinics since March 2005. The group has quarterly meeting to discuss common issues and improve on HIV prevention.

4. Four out of seven substance abuse clinics in the Hospital Authority (HA) also provide services including drug treatment, counselling by social worker, occupational therapy, self help group, religious support to narcotic drug abusers.

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[1] SARDA Annual Report 2009 - 2010

5. Two NGOs and one community group have peer outreach teams for HIV prevention to heroin abusers. During outreach, promotion items such as leaflets, tissue packs, condoms were distributed and people with higher risk behaviours are identified for more intensive intervention and testing for HIV. Some of the sessions also involved picking up used needles and syringes on the streets or parks. For programmes funded by ATF during the period from year 2007 to 2009, the average annual attendances were 21,459 by community outreach, 2,291 by educational groups and 178 by counseling.

6. The Correctional Services Department (CSD) and 17 NGOs provide drug treatment and rehabilitation centres in Hong Kong through compulsory, voluntary, residential or out-patient treatment for heroin abusers. Together they run 43 centres with the total capacity approximating 1,750.[2] A proportion of these residential drug treatment and rehabilitation centres have HIV education programmes for inmates and staff arranged by NGOs or DH. Since 2005, talks, workshops, counseling, training of peer educators and distribution of education materials on HIV prevention have been regularly conducted in more than 12 correctional institutions by one NGO. In collaboration CSD, DH has been distributing close to 10,000 pre-exit kits containing HIV prevention messages to inmates prior to their discharge.

7. Building on the success of a mass media campaign initiated in 2002, DH maintains a website, a hotline and regular educational activities to advocate the harm reduction approach for HIV prevention among drug abusers.

8. Besides Methadone Clinics and the AIDS Counselling and Testing Service operated by DH, IDU may access community-based, voluntary and free HIV counseling and testing service specially provided to them by at least three NGOs.

9. Specialist HIV management is provided by the three major public HIV clinics run by

[2] Fifth Three-year Plan on Drug Treatment and Rehabilitation Services in Hong Kong (2009-2011). Accessible in www.nd.gov.hk

DH and HA for eligible persons[3] (holder of HK Identity Card and children aged below 11 years who are HK residents). Cases diagnosed at methadone clinics of the DH are referred to DH HIV clinic for management. The social workers in methadone clinics play important role in improving adherence to medical treatment among HIV infected drug users and maintain frequent communication with HIV workers through regular case conference and other communications.

10. Various activities are taking place to track HIV situation among drug users in Hong Kong for improving prevention and control of HIV infection in this population. In addition to the voluntary HIV/AIDS reporting system, there are HIV prevalence studies in methadone clinics (universal testing programme), the largest voluntary residential treatment centre and prisons (unlinked anonymous testing) where an estimated one third of the population are injecting drug users. Sources of information for tracking behavioral trend include Central Registry of Drug Abuse maintained by Security Bureau, admission/ readmission survey at methadone clinics, prisons and drug treatment and rehabilitation centres, and street addict survey. Moreover, all blood specimens diagnosed HIV positive at the public laboratories also undergo HIV-1 subtyping to identify cluster of HIV infection. To better study the HIV epidemiology in Pearl River Delta Region, an electronic platform for systematic collection of HIV surveillance data was established in June 2005 to enhance the exchange and analysis of such information.

[3] Fees and Charges for Public Health Care Services provided by the Department of Health http://www.dh.gov.hk/english/useful/useful_fee/useful_fee_os.html and Fees and charges of medical services provided by Hospital Authority http://www.ha.org.hk/visitor/ha_visitor_index.asp?Parent_ID=10044&Content_ID=10045&Ver=HTML

Discussion Summary

1. Current needs of the IDU community

1.1. Prevention

1.1.1. Provide HIV/AIDS information for IDU who are in rehabilitation services and on the streets.

1.1.2. Reach out to hidden/invisible IDU, e.g. at drug dealing points.

1.1.3. Increase access points (such as convenient stores and installation of vending machines) for sales of clean needles. Access should be 24 hours.

1.1.4. Programme activities should be sensitive to IDU diverse cultures & languages. This includes those providing counseling services in drug rehabilitation centres and correctional institutions.

1.1.5. Ensure a drug free environment in rehabilitation centres and methadone clinics etc., and make certain the surrounding areas are also free of drugs.

1.1.6. Adoption of harm reduction approaches in prevention, e.g. ensure access to clean needles, needle exchange programme, shooting gallery (safety house).

1.1.7. Produce IEC materials in different languages to meet the needs of ethnic minorities.

1.1.8. Provide free condoms and safer sex education.

1.1.9. Put efforts in addressing cross border IDU issues.

1.1.10. Mobile testing service to test the compositions of drugs so that people know what they are taking.

1.2. Treatment

1.2.1. Set up treatment centre specifically for ethnic minorities.

1.2.2. More treatment services which are non-religion affiliated are needed.

1.3. Care and support

1.3.1. After care services should be cultural sensitive e.g. those who are discharged from correction institutions would need access to culturally sensitive social welfare and housing after care services.

1.3.2. Rehabilitation services, testing and counseling should be provided in correctional institutions.

1.3.3. Social worker to provide one-to-one service (case work) for IDU.

1.3.4. Support service to HIV infected IDU and their family members (including children).

1.3.5. More resources allocation to frontline outreach programmes.

1.3.6. Strengthen support and education for IDUs who are not motivated to quit drug.

1.3.7. Educate IDU on first aid skills to handle overdose situation.

1.4. Enabling environment

1.4.1. HIV/AIDS and drug use education in schools for children and their parents.

1.4.2. Make use of TV prime time to educate the general public on condom use. Messages should be in-depth, explicit and to encourage HIV test. Could add information on Hepatitis C in the messages.

1.4.3. Strengthen promotion and education in appropriate places, e.g. public housing estates. Besides, targeted education for new arrivals is needed.

1.4.4. Target on risky behavior but not high risk groups so as to reduce stigma.

1.5. Strategy/policy

1.5.1. Legalize the use of marijuana as part of a harm reduction strategy.

1.5.2. Police needs to strengthen law enforcement around methadone clinics.

2. <u>Visions in 5 years time</u>

2.1. Zero HIV infection in IDU community.

2.2. New development in HAART and a cure of HIV/AIDS is found.

2.3. Government takes the lead in reducing discrimination.

2.4. Tailor made treatment centres for the ethnic monitories, with programmes in English and services not just provided by religious groups.

2.5. More education on the risk of different injection methods in response to the pattern of injecting drug use among young people. Besides, risk of blood borne infections through injecting drug use should be addressed by the government and NGOs.

2.6. Needle exchange/distribution programmes (at least in methadone clinics) or needle vending machines are in place, supported by law reform so that IDUs are not prosecuted by carrying needles.

2.7. IDU and general public are more informed on HIV/AIDS knowledge. Methadone clinics can also provide HIV education.

2.8. Service centre to provide combined efforts including knowledge on safe injection, education, testing and counseling.

2.9. Clean needles can be bought from convenient stores or vending machines. Needle collection boxes are easily available. Access should be universal.

2.10. More HIV and drug use education in schools (starts at early age) and psychiatric hospitals. Besides, such education should be in place and VCT service is available in prisons.

2.11. Service is available to test the composition of illicit drugs so that users know what they are taking.

2.12. Number of Nepalese IDU and their risky behavior will be reduced.

2.13. No more increase in young IDU. If they use drug, they don't use/share needle but use other methods such as inhalation.

2.14. Legalize the use of marijuana.

2.15. Set up safety house for IDU when they need injections, and therefore reduce the chances of disposing used needles in public areas.

2.16. Provide more services to non-Chinese IDU, e.g. Africans or asylum seekers, and encourage community participation.

2.17. Cross departments, including Customs and Police, collaboration in reducing the supply of drugs. Increase penalty to drug dealers.

2.18. A reduced number of drug users and therefore reduced number of clinics.

2.19. PLHIV who are IDU feel comfortable in seeking medical treatment. Support to family members of IDU and/or PLHIV is needed.

2.20. Provide HIV education to female sex workers (particularly to the new arrivals) who are also IDU. Besides, educate them on condom use.

2.21. An overall reduction in stigma and discrimination.

2.22. Free distribution of condoms (in toilets).

2.23. Availability of needle disposal device.

2.24. Increased outreach efforts to reach out to hidden/invisible IDU.

3. <u>Strategies which need to be continued or in place</u>

3.1. Prevention

3.1.1. Increase resources for greater access to HIV testing for IDU, especially those who are hidden or hard to reach.

3.1.2. NGOs outreach programmes and other support services should be continued, and additional resources are needed. Outreach workers to target “invisible” drug dealers for education.

3.1.3. Improve HIV education for ethnic minorities and new immigrants. Besides, more efforts are needed for IDU who may cross the border, share needles and have unprotected sex.

3.1.4. Ensure access to clean needles in late night such as purchase from convenient stores, needle dispensers in methadone clinics, or needle exchange/recycling.

3.1.5. Provide harm reduction services such as access to condoms and methadone in prisons.

3.1.6. More concerns on the co-infection of HIV and Hepatitis C. IDU seems to be more receptive to Hepatitis C because it is less sensitive (than HIV) to the community.

3.1.7. Training for healthcare and NGO workers, and educate them on how to make referrals for Hepatitis C carriers and access to services.

3.1.8. Ethnic minority peer educators are trained to educate their community. Also to enhance peer training in correctional institutions.

3.1.9. Provide comprehensive services for IDU who has lower level of motivation to quit drugs.

3.2. Treatment

3.2.1. Continue methadone clinic services

3.3. Care and support

3.3.1. Care and support is needed to provide to IDU who are PLHIV and their family members. Special attention is needed on those who are ethnic minorities. Service should be cultural sensitive and bridging the language barriers.

3.3.2. Resources to NGO/GO to support helping IDU in areas such as their employment, self-esteem and rebuilding family relationship.

3.3.3. More peer educators are trained.

3.3.4. Provide after care services and support to those, especially ethnic minorities, who are newly discharged from hospitals.

3.3.5. More resources for psychological support to IDU who are rehabilitated, and help them to build a new life to avoid relapse.

3.4. Enabling environment

3.4.1. All programmes and services should address and are sensitive to the needs of the sub-populations including ethnic minorities, new immigrants, illegal workers and refugees due to their cultural/language and other barriers. Support in languages and financial subsidies are needed to encourage them in accessing service and increase their participations.

3.4.2. Anti-discrimination education and promotion for all age groups of the general public.

3.4.3. More promotion/education in methadone clinics, school and mental health institutions.

3.4.4. The use of mass media to educate the public, and provide more in-depth education to reduce misconception on safer sex/HIV.

3.4.5. Target young people who are already taking illicit drugs and educate them proactively, to prevent them from using injecting drug use.

3.5. Strategic information

3.5.1. Sharing of information and collaborating with neighboring countries on serving mobile IDU and addressing their risk behavior.

3.5.2. Government to provide more resources to study on the trend of and changes in drug use.

3.6. Strategy/policy

3.6.1. Police does not use possession of used needles as evidence of prosecution.

3.6.2. Develop policy to facilitate needle disposal.

4. <u>Prioritized recommendations</u>

The following recommendations were compiled based on the above discussions, agreed and prioritized by participants:

High priorities

4.1. Provide comprehensive services, prevention and harm reduction to specific populations such as women, new arrivals, cross border travelers, ethnic minorities, illegal workers, attendees of psychiatric institutions, prison inmates, individuals who have no motivation to quit drugs. Services should be sensitive to their cultures, languages and gender. Also, community participation needs to be increased.

4.2. Increase programme coverage and provide in-depth HIV education to drug users.

4.3. Programmes to increase access to clean needles and disposal of used needles, e.g. needle exchange, vending machines, sales of needles in convenient stores

and needle recycling. Provide comprehensive social services including increased case work, employment, group work and fun activities. These services are not only for IDU but also for their families and partners. Peer education approach is encouraged.

4.4. Prevent young people from using drugs through educating them and their parents.

Medium priorities

4.5. Increase HIV test and safer sex education. Provide one stop service, e.g. venue as shooting gallery (safety house) and access to various services such as methadone, HIV education, drug rehabilitation and referral for Hepatitis C treatment.

4.6. Strengthen after care services and assist IDU to rebuild their life.

4.7. Training to health care workers on Hepatitis C treatment referrals.

4.8. Police to support the implementation of harm reductions.

4.9. Increase work on anti-stigma and anti discrimination against IDU.

Lower priorities

4.10. Strengthen promotion and education in various checkpoints in the Pearl River Delta Region.

4.11. Continue to improve outreach programmes and to maintain methadone treatment.

4.12. Provide harm reductions, education and testing services in correctional institutions.

4.13. Increase efforts in stopping the supply of illicit drugs.

4.14. Research and monitor the changing trend and pattern of illicit drug use.