2019 March Vol. 21 No. 1

The Node ... where a leaf arises from a stem

The Node is a bilingual publication dedicated to global HIV/AIDS issues by Red Ribbon Centre, the UNAIDS Collaborating Centre for Technical Support

PRESS RELEASE

New UNAIDS report shows that 75% of all people living with HIV know their HIV status

Report also calls for increased efforts to reach the 9.4 million people living with HIV who are not aware that they are living with the virus and the estimated 19.4 million people living with HIV who do not have a suppressed viral load

ABIDJAN/GENEVA, 22 November 2018— A new report from UNAIDS shows that intensified HIV testing and treatment efforts are reaching more people living with HIV. In 2017, three quarters of people living with HIV (75%) knew their HIV status, compared to just two thirds (67%) in 2015, and 21.7 million people living with HIV (59%) had access to antiretroviral therapy, up from 17.2 million in 2015. The report shows, however, that 9.4 million people living with HIV do not know they are living with the virus and urgently need to be linked to HIV testing and treatment services.

The report, *Knowledge is power*, reveals that although the number of people living with HIV who are virally suppressed has risen by around 10 percentage points in the past three years, reaching 47% in 2017, 19.4 million people living with HIV still do not have a suppressed viral load. To remain healthy and to prevent transmission, the virus needs to be suppressed to undetectable or very low levels through sustained antiretroviral therapy. And to effectively monitor viral load, people living with HIV need access to viral load testing every 12 months.

"Viral load testing is the gold standard in HIV treatment monitoring," said Michel Sidibé, Executive Director of UNAIDS. "It shows that treatment is working, keeping people alive and well and keeping the virus firmly under control."

The report outlines that access to viral load testing is mixed. In some parts of the world, getting a viral load test is easy and is fully integrated into a person's HIV treatment regime, but in other places there may be only one viral load machine for the entire country.

"Viral load monitoring needs to be as available in Lilongwe as it is in London," said Mr Sidibé. "HIV testing and viral load testing should be equal and accessible to all people living with HIV, without exception."

In Côte d'Ivoire, the United States President's Emergency Plan for AIDS Relief is supporting a national scale-up plan for viral load testing. In just

three years, as the number of people on treatment doubled, 10 additional laboratories began viral load testing. Subsequently, viral load testing coverage increased from 14% in 2015 to 66% in 2017 and is projected to reach 75% by the end of 2018.

"This year's UNAIDS theme for World AIDS Day (Live life positively—know your HIV status) reiterates the fact that HIV testing remains the only way to know your status and to adopt a healthy life plan," said Eugène Aka Aouele, Minister of Health and Public Hygiene, Côte d'Ivoire.

Children and HIV and viral load testing

Viral load testing is particularly important for newborns, as HIV progresses much faster in children—peak mortality for children born with HIV is within two or three months of life. Standard rapid diagnostic testing is ineffective up until 18 months of age, so the only viable test for HIV for very young children is a virological test, which they need to receive within the first four to six weeks of life. However, in 2017, only half (52%) of children exposed to HIV in high- burden countries received a test within the first two months of life.

Important advances are being made. New point-of-care testing technologies—testing that takes place in an environment as close to the person as possible—have been shown to shorten the time it takes to return children's test results from months to minutes, which is saving lives.

The persistent barriers to knowing one's status

The report shows that one of the biggest barriers to HIV testing is stigma and discrimination. Studies among women, men, young people and key populations have revealed that fear of being seen accessing HIV services, and if the person is diagnosed, fear that this information will be shared with family, friends, sexual partners or the wider community, was preventing them from accessing HIV services, including HIV testing.

For key populations—gay men and other men who have sex with men, transgender people, sex workers, people who use drugs, people in prisons and other closed settings and migrants— these barriers can affect access to an even greater extent. Stigma and discrimination, from society and health services, can deter members of key populations from accessing health care, while criminal laws can compound that discrimination, increase rates of violence and create additional barriers, including fear of arrest and harassment.

"In Côte d'Ivoire, HIV prevalence among sex workers is 11% and 13% for men who have sex with men and 9.2% for people who inject drugs," said Pélagie Kouamé, President of the Network of Key Populations in Côte d'Ivoire. "We cannot leave key populations behind. Things must change and evolve so that we can come out from the shadows and no longer live in fear."

Other barriers include violence or the threat of violence, especially among young women and girls. Parental consent laws and policies are also a barrier, since in some countries young people under the age of 18 years need parental consent to take an HIV test. In addition, services are often too far away and difficult to access or too expensive. There can also be delays or failures in returning HIV test results and delays in treatment initiation. In some countries, people do not seek HIV testing as they feel they are not at risk—in Malawi, one study found that among adolescent girls and young women (aged between 15 years and 24 years), considered to be at higher risk of HIV, more than half (52%) did not consider themselves at risk of HIV and so were unlikely to seek HIV testing services.

Next generation of testing options

The report highlights how providing a variety of testing options and services, such as community-based testing and home-based testing, can help mitigate many of the logistical, structural and social barriers to HIV testing. They offer testing options for people who live far away from health services, do not have the constraints of inconvenient opening hours, which is particularly important for men and people from key populations, and do not come with the stigma and discrimination often perceived in traditional health and HIV services.

"We cannot not wait for people to become sick," said Imam Harouna Koné, President of the Platform of Networks in the Fight Against AIDS. "We must go

out to our communities and offer HIV testing and treatment services."

The report outlines the importance of taking a five Cs approach: consent, confidentiality, counselling, correct test results and connection/linkage to prevention, care and treatment. "There isn't a one size fits all approach to HIV testing," said Mr Sidibé. "There are a number of different strategies needed to reach people at risk of HIV, including innovative approaches such as self-testing, where people may feel more comfortable that their privacy is respected."

Another important step to take is to integrate HIV testing services within other health services, including maternal and child health services, services for tuberculosis and services for sexually transmitted infections and viral hepatitis. Tuberculosis is the leading cause of death of people living with HIV, accounting for one in three AIDS-related deaths; however, it is estimated that 49% of people living with HIV and tuberculosis are unaware of their coinfection and are therefore not receiving care.

Access to HIV testing is a basic human right, and UNAIDS is calling for a global commitment to remove the barriers preventing people from testing for HIV, which include eliminating HIV- related stigma and discrimination, ensuring confidentiality in HIV testing and treatment services, deploying an optimal mix of HIV testing strategies to reach the populations most in need, integration with other health services, removing policy and legal barriers hindering access to HIV testing and treatment, expanding access to viral load monitoring in low- and middle-income countries and ensuring access to early infant diagnosis for newborns.

The report demonstrates that implementing these measures will hugely advance progress towards ensuring that all people living with and affected by HIV have access to the life-saving services they need.

In 2017 an estimated:

36.9 million [31.1 million–43.9 million] people globally were living with HIV

21.7 million [19.1 million–22.6 million] people were accessing treatment

1.8 million [1.4 million–2.4 million] people became newly infected with HIV

940 000 [670 000–1.3 million] people died from AIDS-related illnesses

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UNAIDS

The Joint United Nations Programme on HIV/AIDS (UNAIDS) leads and inspires the world to achieve its shared vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths. UNAIDS unites the efforts of 11 UN organizations—UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, UN Women, ILO, UNESCO, WHO and the World Bank—and works closely with global and national partners towards ending the AIDS epidemic by 2030 as part of the Sustainable Development Goals. Learn more at unaids.org and connect with us on Facebook, Twitter, Instagram and YouTube.

PRiSM - HIV Prevalence and Risk behavioural Survey of Men who have sex with men in Hong Kong 2017

Background

Men having sex with men (MSM) have continued or emerged to account for a significant proportion of newly acquired HIV infection in many areas around the world, including Hong Kong. The first PRiSM (HIV prevention and risk behavioural survey of men who have sex with men in Hong Kong) study was conducted in 2006. It was the first community-based MSM and HIV study of its kind in Hong Kong. Designed also as a regular public health surveillance programme to track the epidemic and inform intervention, the survey was repeated in 2008 and 2011. Special Preventive Programme of the Department of Health (DH) conducted this fourth round of PRiSM from April to September 2017. The study aims to update on the HIV prevalence among MSM in Hong Kong, and inform on HIV/STIs preventive interventions and the profile of risk behaviours of local MSM.

Methods

A pilot survey of the pattern of social networking was done in Gay Pride Parade 2016 to identify popular online channels and venues frequented by MSM; a mapping exercise was subsequently done based on the findings; the target sample size was then estimated for each online and venue channel in Hong Kong, adjusted by age distribution of the male population from 2016 Census data. In early April 2017, another pilot study was conducted to evaluate and refine the survey questionnaire, together with a trial run of urine sample collection procedures. The study period was from 26 April to 30 September 2017, during which time participants were invited to access a designated website and self-administer an online bilingual questionnaire. Concurrently, the website was publicised in various platforms such as gay apps and local gay/transgender websites. Posters were also sent to lesbian, gay, bisexual, and transgender (LGBT) venues and NGOs to enhance publicity. An eligible participant would receive a unique code upon completion of the survey, with which he could submit a urine sample to one of 48 Community Collection Points in different districts of Hong Kong. They included 24 private clinics, 14 government clinics, 8 community organizations, the DH AIDS Counselling and Testing Service and the Red Ribbon Centre. Collected urine specimens were sent to DH's Public Health Laboratory Services Branch for HIV antibody testing. The participants would be informed of the test result when they called a designated hotline. Those who tested positive would be referred to DH HIV clinic for further management.

Results

During the captioned period, a total of 4,133 MSM respondents participated in the survey, of whom 2,140 were recruited from internet, 981 from LGBT venues, 564 from NGOs, 317 from friends and 131 from other channels. 93.8% of the respondents identified themselves as Chinese. The median age was 31 years (range 12 to 80). In terms of age distribution, about 5.1% were below the age of 20, 39.2% aged 20-29, 29.9% aged 30-39 and 25.7% aged 40 or above.

HIV prevalence

Overall, 60.8% of subjects submitted urine specimens and 2,427 urine specimens were successfully tested for HIV antibody. There were 161 subjects who self-reported as HIV-positive prior to testing, of whom 136 (84.5%) subjects were sexually active (i.e. having had anal sex with men in the past 6 months). After excluding subjects who were reported to be HIV-

positive, 2.1% of the urine samples of sexually active MSM showed a positive result. Computing the HIV prevalence by adding the self-reported HIV-positive and those with urine tested positive for HIV among other subjects, the overall HIV prevalence for sexually active MSM was estimated to be **6.54%**. Among the respondents who reported themselves as non-HIV positive, the HIV positive rate of urine samples collected from those aged 50 or above was 5.0%, which was the highest among all age groups. The age group with lowest rate was 20 to 29 (1.3%)

Among the respondents who reported themselves as HIV-positive (n=161), all reported to have been followed up for HIV care and more than 95% of them were followed up in one of the 3 public HIV clinics. Overall, 91.9% of them had received highly active antiretroviral therapy (HAART, cocktail therapy).

Sexual behaviour

Overall, 71.8% of the respondents were sexually active. 70.1%, 5.8% and 1.6% of the respondents had sex with men, women and transgender women (TGW) in the past 6 months respectively. Condom use rate in last anal sex with men was 74.3%, condom use rate in last anal/vaginal sex with women and TGW were 63.3% and 66.1% respectively.

Consistent condom use with men (defined as always using a condom for anal sex in the preceding 6 months) reported by respondents were 52.1% for receptive sex and 52.2% for insertive sex. For different types of male sex partners, the percentage of condom use in last sex were as follows –

- Emotional sex partner – 62.3%
- Regular sex partner – 75.6%
- Non-regular sex partner – 85.5%
- Commercial sex worker – 81.6%
- Commercial sex client – 79.7%

Recreational drug/substance use

Recreational drug/substance use during or before sex ("chemsex") was reported in 16.2% of the respondents. The commonest used drug was Poppers (70.0%), followed by erectile dysfunction medications (42.8%), methamphetamine (38.3%), GHB (33.9%) and marijuana (16.4%). Among those having taken drug(s) during/before sex in the past 6 months, 4.2% reported taking the drug by injection. 44.0% of them reported needle sharing in the past 6 months. The commonest drug taken by injection among injectors was methamphetamine (60%), followed by ketamine (28%) and ecstasy (12%). Consistent condom use rate was low (15.5%) among methamphetamine or GHB user under effect of the substances.

Exposure to HIV prevention message

A majority (84.5%) of the respondents had received HIV prevention information in the previous year. 46.6% had received a free condom in Hong Kong in the previous year. Overall, 3,638 out of 4,133 (88%) of the respondents had received HIV prevention message and/or free condoms in the previous year.

HIV testing behaviour

79.4% of the respondents had ever had HIV testing and 52.6% of respondents had their recent tests performed in the previous year. 10.1% of the ever-testers had tried HIV self-testing before and 59.9% of the ever-testers not known to be HIV-positive would like to perform HIV self-testing in future. Ever testing rate was particular low (47.1%) among age group less than 20.

The factors which favour their HIV testing were also explored: 33.8% of respondents considered "privacy" was the most important, followed by "testing services open at night" (28.6%) and "testing services open on public holidays" (21.3%).

Sexually transmitted illness (STI)

Overall, 9.6% of respondents reported at least once diagnosed STI within past 12 months. 4.0% of the respondents reported syphilis, 2.7% reported gonorrhoea, and 2.7% *Chlamydia*.

HIV Pre-exposure prophylaxis (PrEP) use

Among respondents ever tested HIV and last result was not positive, 3.6% of reported taking or having taken PrEP before. Most people (73.2%) spent HKD$1,000 or below per month on PrEP. Most people (48%) obtained the drugs from overseas clinics (or institutions), followed by local private clinics (26%) and through online purchase (22.8%).

Given the condition that *"Studies have shown that PrEP could offer 86% protection and must be prescribed by a doctor, and regular (at least every 3 months) follow-up and blood tests are required."*, 48.3% of those reported to have never taken PrEP before expressed willingness to use PrEP if offered free.

Discussion

1. The method of calculating the HIV prevalence in this survey was different from previous PRiSM studies. In PRiSM 2017, 3.9% of MSM subjects reported to be HIV-positive, and their urine submission rate was much lower than those who reported HIV-negative (45% vs 66%), nevertheless, a vast majority of them (95%) reported having follow up in one of the public HIV clinics. Hence in PRiSM 2017, we considered it reasonable to count both self-reported HIV-positive and subjects with urine tested positive for HIV as cases (numerator) to calculate the HIV prevalence. The crude HIV prevalence rate for sexually active MSM in PRiSM 2017 was 6.54%, which was higher than the 3.3% in iPRiSM (internet-based survey) conducted by the Chinese University of Hong Kong (CUHK) in 2011 but was closer to the 5.85% prevalence in HARiS 2014 (venue-based) survey. Of note, the rates could not be directly compared because of differences in sampling size and recruitment strategies of the surveys.

2. HIV testing rates in the past 12 months among MSM (52.6%) was higher than in PRiSM 2011 (41%), but was slightly lower than HARiS 2016 results (around 60%). It suggested that MSM subjects not reached by NGOs might have a lower awareness of the need of regular HIV testing. HIV self-testing was not common among ever-testers (10.1%) but more than 50% of ever-testers would like to try HIV self-test in the future. As an additional approach to HIV testing services, HIV self-testing should be promoted.

3. Consistent condom use rate with men among MSM were unsatisfactory, at around 52% for both insertive and receptive sex. Education on safer sex practices, including persistent and proper use of condoms, should be reinforced.

4. The percentage of MSM practising chemsex in the past 6 months was higher in PRiSM 2017 than HARiS 2016 (16.2% vs 10.7%). The increase was likely due to difference in sampling frame (community subjects vs subjects recruited via NGOs). Literature generally showed that chemsex was associated with lower (anti-retroviral) drug compliance and increased unprotected sex, which could increase HIV, hepatitis B and C and STI transmission among MSM. The emergence of chemsex poses additional hazards to both individual and public health. The high rate of needle sharing among those injecting (recreational) drug users (44.0%) should also be closely monitored.