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EAT SMART AND PLAY HARD - PATHWAY TO LONGEVITY AND QUALITY LIVING

Dr Raymond W M LEUNG ¹ Dr Regina CHING ²

Background

Non-communicable diseases (NCD) are major causes of ill-health, disability and deaths, both globally and locally. It is estimated that 80% of NCD deaths occur in low and middle income countries, equally among men and women. NCD often run a protracted course causing significant disability and suffering to those affected and the people around them. Common risk factors are obesity, hypertension, diabetes and abnormal lipid profile. These often coexist and share common preventable lifestyle-related risk factors such as unhealthy eating habits and physical inactivity.¹

Paradoxically, the scientific knowledge based on which to develop effective preventive actions already exists. World Health Organization (WHO) estimates that by adopting healthy lifestyles, i.e. staying clear of tobacco, consuming a healthy diet and engaging in adequate levels of physical activity, we can prevent at least 80% of heart diseases, stroke and type 2 diabetes as well as 40% of cancers.² The World Cancer Research Fund/American Institute for Cancer Research also reaffirmed the protective effect of regular, sustained physical activity against colon cancer and female hormone-related cancers.³

¹ Senior Medical Officer ² Assistant Director (Health Promotion)

Part of this societal inaction has to do with common misconceptions that NCD mainly affect people who are rich or old, NCD are not preventable and people eventually have to die of something. It is not surprising to find the local population sedentary and not consuming a healthy diet. For instance, 22.7% of adult population had very low levels of physical activity and 78.0% did not meet the recommended daily intake of five or more servings of fruit and vegetables.⁴

There is often a tendency to put all the blame on individuals for adopting ‘unhealthy lifestyles’. One should, however, note that unhealthy lifestyles are not solely the responsibility of individuals when the environment is not supportive of their making healthy choices. This is especially true for marginalised groups such as children and the poor who have limited access to healthy food, decent living and working conditions, education and health care.

Seeing health as a resource for everyday life rather than the objective of living, health professionals have a role in enabling people to increase control over health determinants, thereby improving their health. To be effective, this health promotion process calls for actions to build healthy public policy, create supportive environments, strengthen community action, develop personal skills and re-orient health services.⁵ Health promotion is not the responsibility of the health sector alone, but goes beyond to include actions directed at changing social, environmental and economic conditions, strengthening skills and capabilities of individuals and causing healthy choices easier for people. With globalisation at play, there has never been a greater need to apply established health promotion strategies fully, systematically and in a coordinated manner.⁶

Building on contemporary health promotion strategies and principles, the Department of Health (DH)’s Central Health Education Unit (CHEU) adopts a health promotion approach in health communication and improvement, taking into account people’s social and economic circumstances. Below are a few recent efforts which promote healthy diet and physical activity at the population level.

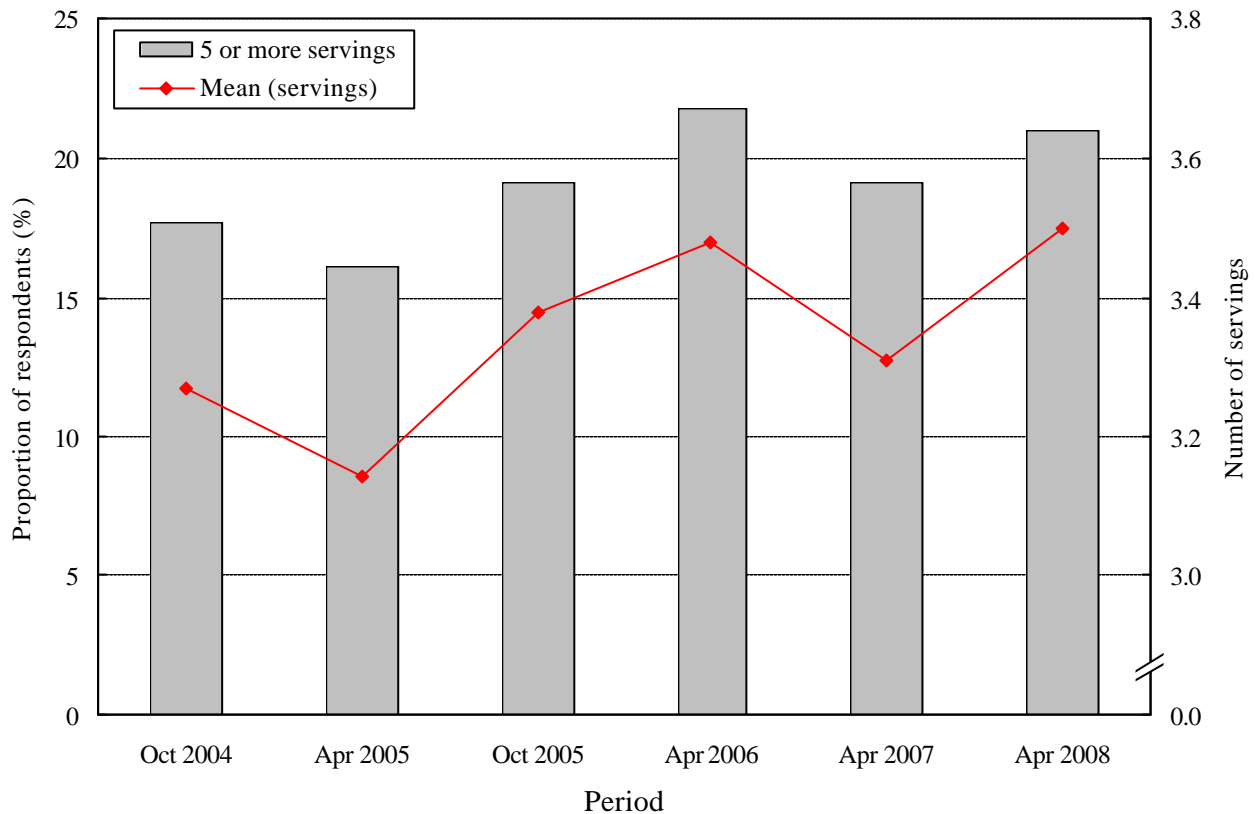
Promotion of Healthy Diet

“2 Plus 3 A Day” Campaign

Taking reference from WHO’s Global Strategy on Diet, Physical Activity and Health, overseas experience and the local situation, a “2 Plus 3 A Day” Campaign was launched from June to November 2005 to promote a balanced diet with at least two servings of fruits and three servings of vegetables a day for adults. The Campaign began with a number of focus group studies that identified commonly perceived barriers to eating fruits and vegetables. Main perceived barriers included long working hours, eating outside frequently and snack (other than fruits) consumption. Actions addressing these barriers were introduced and messages targeting the needs of the population were disseminated through a spectrum of mass communication means. The Behavioural Risk Factor Surveillance System of the DH detected a campaign recall rate of 77.3% and an increase in the proportion of adult population achieving the recommended intake of fruit and vegetables after the launch of the Campaign in October 2005. (Figure 1)

Since information giving is essential but not sufficient to cause behavioural change, CHEU further embarked on two healthy eating campaigns that made use of comprehensive strategies comprising alliance building, publicity and advocacy,

Figure 1 **Daily Average of Fruit and Vegetables Consumed by Respondents of Behavioural Risk Factor Surveys, 2004 to 2008**



education and empowerment, creation of a supportive environment, as well as research and evaluation.

EatSmart@school.hk Campaign

The Student Health Service of DH recorded a rising trend of obesity among primary school students, from 16.2% in the 1995-96 school year to 21.3% in the 2007-08 school year. There is strong evidence that obese children tend to remain obese in adulthood, which is associated with increased risk of metabolic syndrome, atherosclerosis and common NCD.^{7,8} To combat childhood obesity and reduce children’s risk of developing NCD, DH partnered with 12 agencies to launch the EatSmart@school.hk campaign commencing in the 2006-07 school year. The campaign aims to raise public awareness on healthy eating among

children and create an environment that is conducive to healthy eating in schools and the community. The campaign identifies school personnel, parents and food traders as key players.

To engage stakeholders fully, an inter-sectoral Steering Committee and a number of Working Groups and Task Forces were set up to oversee various aspects of execution. Numerous visits to schools and lunch suppliers were arranged to reinforce and encourage good practices. Briefing sessions were held for nutritionists, dietitians, principals’ associations, members of the Federation of Parent-Teacher Associations, organisations operating schools, District Councils and their committees to familiarise themselves with the initiatives and solicit their support. Presentations at local and international conferences were made to share lessons

learned. Mass media communication was extensively used to arouse and sustain community interest in healthy eating.

To create an environment that supports healthy eating practices, a set of nutritional guidelines on school lunch and snacks was promulgated, which was supplemented by training and reference materials for caterers. A train-the-trainer support programme for parents and teachers was implemented. A rich array of multi-media educational resources was produced and a thematic website at <http://www.eatsmart.gov.hk> was launched.

Schools were empowered to develop policy and activities that promote healthy eating among students. Lunch suppliers were supported to comply with the nutritional guidelines and recommendations. Stakeholders' awareness and health literacy were heightened through a basket of school-based activities.

The campaign met with favourable response from the schools, parents, students and the community. The proportion of local primary schools which participated in at least one activity of the Campaign increased from 67% in 2006-07 school year to 77% in 2007-08 school year. More than 2 600 parents, teachers, social workers, leaders and volunteers from 268 schools and 69 non-government organisations have been trained in nutrition and healthy food choices. Some 437 000 students from 907 pre-primary, primary and secondary schools supported the 'Joyful Fruit Day' event in April 2008. Over 40 million hit counts have been recorded since the launching of the thematic website in 2006.

Comparing data from surveys on dietary patterns of primary school students in 2006 and 2008 revealed that students' attitude and habits of healthy eating have improved.^{9,10} (Table 1)

The campaign has brought about early changes in school environment and students' eating behaviour. Down the road, DH hopes to further strengthen partnership with the education sector, advocate for universal formulation and implementation of healthy eating school policies, empower parents with knowledge and skills in healthy eating and improve compliance of lunch suppliers with nutritional guidelines.

EatSmart@restaurant.hk Campaign

Eating out is commonly practised by the local community. People who ate out wished to be served healthier menus.¹¹ A pilot project of the EatSmart@restaurant.hk Campaign in August 2007 involving 300 catering outlets showed that offering and labelling healthier choices in restaurants' menus was feasible and well received by customers and operators. Based on the pilot experience, DH extended the Campaign to the territory level in 2008.

The Campaign aims to promote healthy eating habit among Hong Kong people by raising their awareness and encouraging restaurants to provide more healthy dishes to customers. Enrolled restaurants undertake to provide at least five EatSmart Dishes* every day during selected business hours, to place the EatSmart Decal at a prominent location in the food premises, to highlight EatSmart Dishes by means of point-of-purchase information (Figure 2),

* EatSmart Dishes are healthier options with more fruit or vegetables, and less oil, salt and sugar according to the "Guidebook for Restaurant Managers and Chefs" of the EatSmart@restaurant.hk campaign.

Table 1 Dietary Habits of P4 to P5 Students Taking Part in the 2006 and 2008 Surveys

Dietary habit	Proportion of students in 2006	Proportion of students in 2008
Had breakfast daily	86.2%	84.7%
Eating fruits \geq 2 times per day	57.4%	57.5%*
Eating vegetables \geq 2 times per day	76.4%	78.7%
Not having food high in fat	13.7%	14.8%
Not having food high in salt	24.6%	27.3%
Not having food high in sugar	10.7%	12.2%
Not having drinks with added sugar	8.8%	10.8%

Note: * No statistically significant change at P=0.05 level.

Figure 2 Point-of-purchase Information of EatSmart Dishes



and to welcome and address customer opinion or feedback.

A multi-pronged strategy similar to that of the EatSmart@school.hk Campaign was deployed. In 2008, about 480 food premises have enrolled in the Campaign. With heightened awareness of healthy eating, we hope to see a growing number

of EatSmart restaurants in town and more people enjoying healthier menus while eating out. An updated list of EatSmart restaurants can be found from the DH's thematic website at <http://www.eatsmart.gov.hk>. Public can also access healthy recipes from the website and make their own healthy dishes.

Physical Activity Promotion

The need for all individuals to engage in active lifestyles and at least 30 minutes of moderate intensity physical activity on most days of the week cannot be emphasised more. The DH has been working closely with the Leisure and Cultural Services Department since 2000 under the “Healthy Exercise for All” Campaign to encourage public participation in all forms of sports and physical activity.

In 2003, a stair climbing project was initiated in partnership with the Housing Department involving eight housing estates with 36 blocks. The project promoted daily use of stairs as a low-cost, accessible and readily achievable form of exercise, using point-of-decision prompt messages. Pilot evaluation showed that overall stair utility increased by 20 per cent. Since then, over 87 housing estates (397 blocks) and 25 organisations have joined the project. Lately, colourful signage was

posted in all MTR stations to encourage commuters to climb the stairs. (Figure 3) We hope that increasingly more corporations and organisations will recognise their powerful role in health promotion and take their little steps to make the community a healthier place for all to live. You will find this web useful <http://stairclimbing.cheu.gov.hk>.

Health care providers, in particular primary care practitioners play a pivotal role in disease prevention. With the support of the Hong Kong Medical Association, Hong Kong Physical Fitness Association, relevant government departments, professional groups and community organisations, the Exercise Prescription Project (Figure 4) has been launched and promulgated among primary care doctors since 2005. Five Certificate Courses were held to build capacity of some 400 doctors in giving relevant, specific, stage-matched and customised advice to their patients on exercise, both for disease prevention and better clinical management.

Figure 3 Signage Promoting Stair-climbing in MTR Stations



Figure 4

Home Page of Exercise Prescription Project



Way Forward

The DH launched the Strategic Framework for Prevention and Control of NCD in October 2008 to facilitate organised community efforts to promote health and reduce risk factors for NCD. By aligning health promotion efforts across sectors and among stakeholders, there is huge potential to maximise the impact of local health promotion work with finite resources. Current health promotion programmes undertaken by the DH will be strengthened and new initiatives which are need-driven, evidence-based, outcome-focused and cost-effective will be introduced to improve population health.

At the individual level, a doctor-patient relationship can do wonders to help modify behaviours, hence reducing patients' risk of ill health. By gaining a better understanding of population based health promotion programmes as well as patient's life circumstances and their stage

of behavioural change, doctors are in a special position to reinforce health messages through a personal touch.

Action speaks louder than words and your patients need a mentor and role model in their journey to practise healthier lifestyle habits. Here are several small yet powerful steps you can take to make a difference:

- Check and help your clients to monitor their body mass index and waist circumference
- Advise on healthy weight management through balanced diet and physical activity
- Be practical and specific when advising how to eat healthily and exercise adequately
- Visit the <http://www.eatsmart.gov.hk> website for healthy eating tips and recipes
- Visit the <http://exerciserx.cheu.gov.hk> website for self-learning materials on exercise prescription

- Visit the <http://stairclimbing.cheu.gov.hk> website for hints on stair-climbing for health
- Recommend EatSmart Restaurants to your clients
- Place orders with the CHEU for posters and pamphlets your clients may find helpful - they are FREE!
- Visit <http://www.cheu.gov.hk>

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MANAGING TOBACCO DEPENDENCE - A COMMUNITY APPROACH

Dr Barry TAM¹ Dr Y H CHONG² Dr Ronald LAM³

Introduction

Tobacco use is a leading cause of preventable disease and premature deaths worldwide.¹ It is responsible for about 100 million deaths in the 20th century. Today over one billion people are current smokers. If current trends continue, tobacco will kill one billion people in the 21st century. In Hong Kong, the top five leading causes of death were attributable to tobacco use.² A local study in 2006 revealed that smoking claimed about 6 900

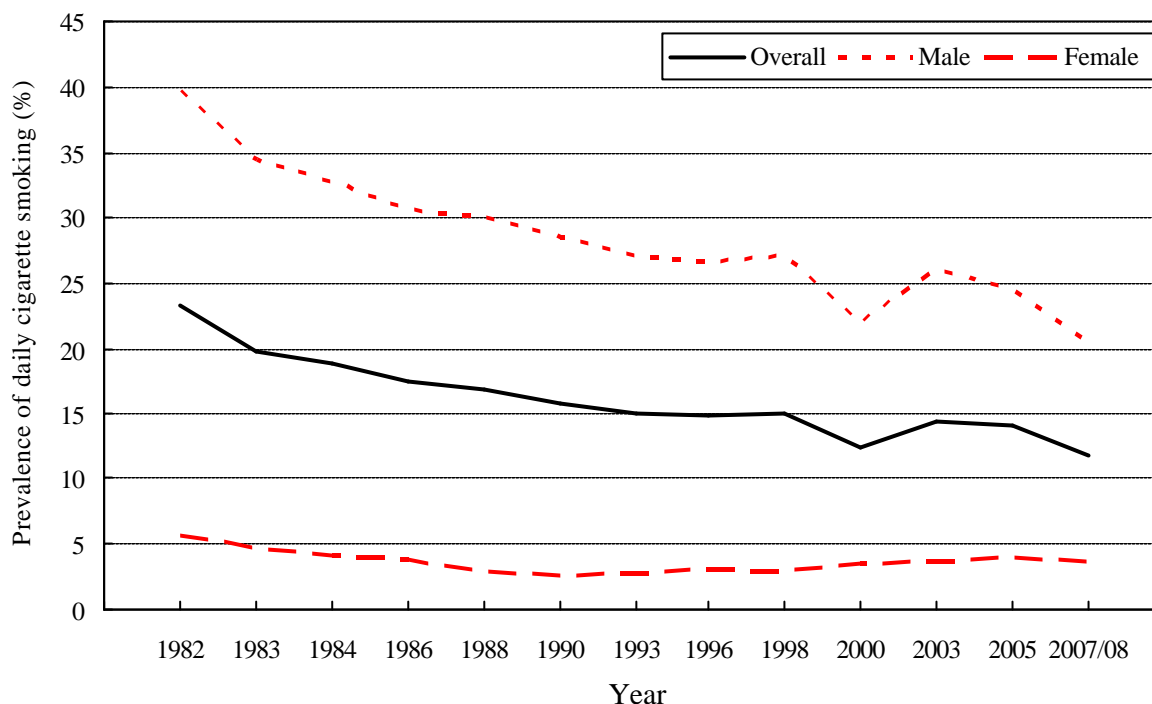
lives a year, and that active and passive smoking together costed Hong Kong \$5.3 billion per year.³ These figures highlight the potential public health gains that can be attained with effective tobacco control measures in place.

In October 2005, the People's Republic of China has ratified the "Framework Convention on Tobacco Control" (FCTC) of the World Health Organization (WHO). FCTC is an international public health treaty, which aims at reducing the smoking-

¹Medical and Health Officer ² Senior Medical and Health Officer ³ Head, Tobacco Control Office

Figure 1

**Prevalence of Daily Cigarette Smoking Among
Persons Aged 15 and Above, 1982 to 2007/08**



(DH) rose to over 4 700 within a month, more than the 4 300 calls for the whole year of 2008.

Evidence for Effective Smoking Cessation

The benefits of smoking cessation for reducing disease risk and increasing life expectancy have been extensively documented.^{6,7} However, nicotine dependence makes it difficult for most smokers to quit on their own. A recent review suggested that the long term prolonged abstinence rate for self-quitters with no assistance ranged only from 3% to 5%.⁸ On the other hand, there are many effective interventions for treating nicotine dependence, including brief advice by a physician, pharmacotherapy, as well as individual, group and telephone counselling.⁹

Nicotine Replacement Therapy (NRT) has been shown to increase the likelihood of

long term success in quitting. A systematic review suggested an approximate doubling in the long term success rate with the use of NRT as compared to no therapy during a quit attempt.¹⁰

Bupropion, when prescribed as monotherapy, was found to double the odds of cessation.¹¹ Varenicline is the newest pharmacotherapy which can also increase the chance of successful long-term abstinence two to three-fold as compared to pharmacologically unassisted quit attempts.¹² Counselling and pharmacotherapy are effective when used by themselves for treating tobacco dependence, but their combination is more effective than either alone.⁹

Based on the above evidence, DH has updated a smoking cessation kit on management of clients with tobacco dependence, including the indications and prescriptions of the above pharmacotherapy in 2009. The kit is accessible at

the website of Tobacco Control Office (http://www.tco.gov.hk/english/downloads/files/cess_kit_09.pdf).

Current Smoking Cessation Services

Both DH and the Hospital Authority (HA) are major providers of smoking cessation services in Hong Kong, comprising clinics and hotlines. A client visiting a DH cessation clinic would undergo preliminary assessment and counselling on quitting with or without pharmacotherapy. Techniques of motivational interviewing, behavioural and lifestyle modification, as well as assistance in environmental adjustments may be employed in counselling sessions. Regular post-treatment follow-up for one year will be arranged to provide necessary support for quitters. To evaluate the effectiveness of treatment, the 7-day point prevalence rates of abstinence* at 26 weeks and 52 weeks have been monitored by the DH since September 2003. Both abstinence rates ranged from about 30% to 40% over the past years, which were comparable to overseas standards. In addition, the Smoking Cessation Hotline (1833 183) of DH provides the public with self-help health education and cessation materials, and telephone counselling is handled by trained registered nurses.

HA provides smoking counselling and cessation services at different centres to assist smokers to quit smoking. While the primary target groups of the HA centres are inpatient- and outpatient-smokers, the centres also provide information and advice to smokers' relatives and friends who help the smokers to quit smoking. A Quitline is also run by the HA during office hours.

Apart from the public sector, the academics, non-government organisations (NGOs) and private sector also provide cessation services for the community. The target clients and service delivery models vary under these providers. For instance, some providers address specifically youth and female smokers, some providers place more emphasis on prevention, others utilise channels such as internet as cessation aid in addition to behavioural intervention.

Community-based Smoking Cessation Programme

To meet smoking cessation needs through evidence-based interventions, WHO recommended leveraging community resources and network in order to make cessation services more easily available, accessible and cost-effective.¹³ To enhance the capacity of Hong Kong in this aspect, DH collaborates with the Tung Wah Group of Hospitals (TWGHs) to launch a three-year pilot community-based Smoking Cessation Programme (SCP) from 2009 to 2011. The SCP covers four major areas, namely, clinical treatment and counselling, training of professionals, publicity and health education, and research.

Clinical Treatment and Counselling

Since January 2009, four smoking cessation clinics are established over the territory. In tandem with the WHO recommendations, these centres adopt a combination of addiction counselling and evidence-based pharmacotherapy to treat nicotine dependence. Professionals including doctors, nurses, clinical psychologists, addiction specialists and

* A measure of tobacco abstinence based on tobacco use occurrence within seven days prior to a follow up assessment.

social workers work as a team to help smokers to quit smoking. Free medication is provided for clients to ease their quit attempts by relieving their withdrawal symptoms. Opening hours of these centres include evenings and weekends to facilitate visits from the working population.

TWGHs utilise its existing medical clinics, social centres and community centres for client recruitment and organise outreaching programmes to motivate smokers to quit. A hotline is set up to provide professional advice and telephone counselling for smokers, and it uses the same number as the Smoking Cessation Hotline of DH (1833 183).

Training and Capacity Building

A local survey conducted among 4 000 registered doctors in 2002 showed that over half of them did not have adequate knowledge or favourable attitudes towards smoking cessation.¹⁴ More than 40% were not confident in their smoking cessation skills and less than 30% of respondents routinely advised smoking patients to quit. Meta-analyses showed that through the training of frontline professionals, the provision of quality smoking cessation services in the community could be enhanced through the delivery of effective treatments.¹⁵ The SCP will include training for professionals, in particular primary care physicians, dentists, pharmacists, nurses, clinical psychologists and counsellors.

Publicity and Health Education

The 2008 THS revealed that over 60% daily cigarette smokers started smoking cigarette at their age 10 to 19.⁵ Moreover, about 40% daily cigarette smokers were not aware of locally available smoking cessation services, and for those who were

aware, only about 2% had tried the service.⁵ Under the SCP, anti-tobacco educational programmes will be organised in schools to nurture a smoke-free culture in juvenile period. Publicity programmes and a series of community promotional programmes will also be organised to raise the public awareness of smoking cessation.

Research

In collaboration with academics, research projects will be conducted to evaluate the effectiveness of SCP. Their findings will be used to establish standards and validate the best practice of smoking cessation.

Way Forward

The SCP provides a golden opportunity for us to benchmark the best practice in cessation programmes. In parallel, further research need to be conducted to find out the best interventions on quitting for special population groups, such as pregnant women and psychiatric patients. Since the private sector provides approximately 85% of ambulatory care, integration of cessation services into the primary care system is necessary to make them more accessible to smokers.¹⁶ Family doctors, community dentists, pharmacists and other professional disciplines would be our close partners as smoking cessation service providers.

Smoking cessation confers immediate and long term health benefits. Efforts directed at changing the social environment to increase the smokers' desire to quit should be continued. For these reasons, smoking cessation services must be coupled with other tobacco control measures, including increment of tobacco tax, bans on tobacco advertising and promotion, expansion of smoke-free public places, effective enforcement, as well as publicity on harms of tobacco use and benefits of quitting.

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NEWS IN BRIEF

Cumulative HIV Infections Surpassed 4 000 in Hong Kong

The Department of Health (DH), through its voluntary HIV/AIDS reporting system in place since mid-1980s, had received a cumulative total of 4 047 HIV infections as of end 2008. A record-high annual number of 435 cases were reported in 2008, which represented a 5% increase compared to year 2007. Since the introduction of highly active antiretroviral therapy (HAART) as a standard treatment locally in 1997, the number of AIDS report has levelled. Yet, 96 new cases were reported in 2008, again a record number, bringing the total to 1 030. *Pneumocystis pneumonia* and *Mycobacterium tuberculosis* infection are the two commonest diseases when patients progressed to AIDS.

Hong Kong has experienced an increase in HIV infections among men who have sex with men (MSM) since 2004, and the annual number is higher than heterosexual men for consecutive four years as of now. The rising trend is in keeping with a regional and global picture of emerging and reemerging MSM epidemic. Compared to infections via heterosexual contact, more of the MSM infections were suspected to have contracted the virus in Hong Kong (70% vs 35%, 2006 to 2008). The identification of three HIV-1

subtype B clusters affecting mostly MSM also pointed to a rapid local transmission of HIV in the MSM population. In fact, a community-based survey done in 2006/07 revealed a 4% HIV prevalence in MSM, which is substantially higher than other at-risk populations. For instance, one in every 450 and 250 attendees of DH Social Hygiene Clinics and Methadone clinics in 2008 was tested positive. Cumulatively, injecting drug use (IDU) accounted for 6% of all reports. IDU-related infections in 2008 contributed to 9% of all and most were non-Chinese.

It is noteworthy that an increasing proportion of the new cases could not have their HIV exposure category determined due to inadequate information. This is largely because DH did not receive the report form (DH2293, available at <http://www.info.gov.hk/aids/english/surveillance/form.pdf>) from doctors who make the HIV diagnosis. To keep track of the latest pattern and trend of HIV/AIDS situation in Hong Kong for bettering prevention, care and control, it is prudent that all doctors, irrespective in public or private services, report to DH of any new HIV or AIDS case.

Behavioural Risk Factors, 2004 to 2008

Behavioural risk factors play an important role in the development of non-communicable diseases (NCD) which are the largest health burden in Hong Kong. As monitoring of behavioural risk factors in the population provides important information for planning, implementation and evaluation of disease prevention as well as health promotion activities, the Department of Health established the Behavioural Risk Factor Surveillance System in 2005. It comprises periodic telephone surveys that are designed to measure health-related behaviours among non-institutionalised adult population aged 18 to 64. Table 1 to Table 3 show the prevalence rates of “five” core behavioural risk factors – overweight and obesity, consumption of fruit and vegetables, level of physical activity, smoking and drinking among people aged 18 to 64.

Table 1 Prevalence Rate of Behavioural Risk Factors for Major Non-communicable Diseases, 2004 to 2008

Behavioural Risk Factors	Oct 2004	Apr 2005	Apr 2006	Apr 2007	Apr 2008
Overweight / Obese (BMI≥23)	38.4%	36.0%	41.0%	38.4%	39.4%
Inadequate daily fruit and vegetables intake (<5 servings per day)	82.3%	82.1%	77.6%	81.1%	78.0%
Low level of physical activity (according to the IPAQ classification)	20.4%	18.5%	21.3%	18.9%	22.7%
Daily smoking (smoking at least one cigarette a day)	15.7%	15.9%	15.3%	15.9%	14.4%
Binge drinking (≥5 glasses/cans alcoholic drinks in a row)	10.2%	9.0%	8.3%	8.9%	9.2%

Notes : 1. People aged 18 to 64
 2. BMI (Body Mass Index) is based on WHO classification for weight status of Asian standard.
 3. IPAQ – International Physical Activity Questionnaire (<http://www.ipaq.ki.se/ipaq.htm>)

Source : Behavioural Risk Factor Survey, 2004 to 2008.

Remark : Due to different sampling method and study population, the figures from Behavioural Risk Factor Survey may not be comparable with figures from the Thematic Household Survey conducted by the Census and Statistics Department, which revealed that the prevalence of daily smoker among people aged 15 and above had been decreased from 23.3% in 1982 to 11.8% in 2007/2008.

Table 2 Prevalence Rate of Behavioural Risk Factors for Major Non-communicable Diseases by Sex, 2008

Behavioural Risk Factors	Male	Female	Overall
Overweight / Obese (BMI \geq 23)	54.0%	26.7%	39.4%
Inadequate daily fruit and vegetables intake (<5 servings per day)	82.3%	74.3%	78.0%
Low level of physical activity (according to the IPAQ classification)	22.5%	22.9%	22.7%
Daily smoking (smoking at least one cigarette a day)	24.3%	5.8%	14.4%
Binge drinking (\geq 5 glasses/cans alcoholic drinks in a row)	16.4%	3.0%	9.2%

Notes : 1. People aged 18 to 64
 2. BMI (Body Mass Index) is based on WHO classification for weight status of Asian standard.
 3. IPAQ – International Physical Activity Questionnaire (<http://www.ipaq.ki.se/ipaq.htm>)

Source : Behavioural Risk Factor Survey, April 2008.

Table 3 Prevalence Rate of Behavioural Risk Factors for Major Non-communicable Diseases by Age Group, 2008

Behavioural Risk Factors	18-24	25-34	35-44	45-54	55-64
Overweight / Obese (BMI \geq 23)	13.4%	28.8%	42.4%	53.5%	48.1%
Inadequate daily fruit and vegetables intake (<5 servings per day)	86.8%	78.1%	79.8%	75.1%	72.4%
Low level of physical activity (according to the IPAQ classification)	22.3%	23.7%	20.1%	27.3%	18.2%
Daily smoking (smoking at least one cigarette a day)	8.7%	17.1%	14.8%	17.1%	10.8%
Binge drinking (\geq 5 glasses/cans alcoholic drinks in a row)	9.3%	14.1%	8.8%	9.0%	3.7%

Notes : 1. People aged 18 to 64
 2. BMI (Body Mass Index) is based on WHO classification for weight status of Asian standard.
 3. IPAQ – International Physical Activity Questionnaire (<http://www.ipaq.ki.se/ipaq.htm>)

Source : Behavioural Risk Factor Survey, April 2008.

HIV/AIDS Surveillance

	2008 Quarter 4	2008 Quarter 3	2007 Quarter 4	2008 Whole Year	2007 Whole Year	Cumulative total since 1984
HIV	106	119	87	435	414	4 047
AIDS	32	32	17	96	79	1 030

Contact Numbers for Prompt Notification

Infectious Diseases other than Tuberculosis	Fax No. (Form DH1(s))	Tel. No.	Tuberculosis	Fax No. (Form DH1A(s))
Central Notification Office	2477 2770	2477 2772		
Duty Medical Officer (for urgent notification during weekends, public holidays or after office hours)	-	7116 3300 call 9179	Tuberculosis and Chest Service	2834 6627 2574 2439

Number of Notifications of Infectious Diseases

Disease	Nov 2008	Dec 2008	Jan 2009	Feb 2009	Jan-Feb 2008	Jan-Feb 2009
1) Acute Poliomyelitis	-	-	-	-	-	-
2) Amoebic Dysentery	-	-	-	-	3	-
3) Anthrax*	-	-	-	-	-	-
4) Bacillary Dysentery	4	16	8	5	4	13
5) Botulism*	-	-	-	-	-	-
6) Chickenpox	862	968	909	786	2 809	1 695
7) Cholera	-	2	-	-	-	-
8) Community-associated methicillin-resistant <i>Staphylococcus aureus</i> Infection†	31	28	22	29	35	51
9) Creutzfeldt-Jakob disease‡	-	-	-	-	-	-
10) Dengue Fever	4	2	-	3	7	3
11) Diphtheria	-	-	-	-	-	-
12) <i>Escherichia coli</i> O157:H7 Infection*	-	-	-	-	-	-
13) Food Poisoning:						
- Outbreaks	22	35	31	35	67	66
- Persons Affected	62	86	103	152	296	255
14) <i>Haemophilus influenzae</i> type b Infection (invasive)*	-	-	-	-	-	-
15) Hantavirus Infection*	-	-	-	-	-	-
16) Influenza A(H2)*, Influenza A(H5)‡, Influenza A(H7)§ or Influenza A(H9)§	-	1	-	-	-	-
17) Japanese Encephalitis	-	-	-	-	-	-
18) Legionnaires' Disease	-	-	2	2	-	4
19) Leprosy	-	2	-	1	-	1
20) Leptospirosis*	2	-	-	-	-	-
21) Listeriosis*	1	-	3	2	-	5
22) Malaria	2	1	-	1	-	1
23) Measles	1	2	4	7	8	11
24) Meningococcal Infection (invasive)	-	-	1	-	-	1
25) Mumps	4	16	17	13	27	30
26) Paratyphoid Fever	-	-	2	3	2	5
27) Plague	-	-	-	-	-	-
28) Psittacosis*	-	-	-	-	-	-
29) Q Fever*	-	-	-	1	-	1
30) Rabies	-	-	-	-	-	-
31) Relapsing Fever	-	-	-	-	-	-
32) Rubella and Congenital Rubella Syndrome:	2	3	2	8	3	10
- <i>Rubella</i>	2	2	2	8	3	10
- <i>Congenital Rubella Syndrome</i> ‡	-	1	-	-	-	-
33) Scarlet Fever	16	15	29	15	44	44
34) Severe Acute Respiratory Syndrome	-	-	-	-	-	-
35) Smallpox*	-	-	-	-	-	-
36) <i>Streptococcus suis</i> Infection¶	-	1	-	-	1	-
37) Tetanus	-	-	1	-	-	1
38) Tuberculosis	449	477	412	500	846	912
39) Typhoid Fever	1	2	4	3	3	7
40) Typhus and other rickettsial diseases**:	5	1	3	2	2	5
- <i>Scrub Typhus</i>	1	-	-	1	2	1
- <i>Urban Typhus</i>	-	-	1	-	-	1
- <i>Spotted Fever</i> *	4	1	2	1	-	3
41) Viral Haemorrhagic Fever*	-	-	-	-	-	-
42) Viral Hepatitis:	9	9	16	11	40	27
- <i>A</i>	4	-	2	2	11	4
- <i>B</i>	3	8	12	2	10	14
- <i>C</i>	-	-	-	-	-	-
- <i>E</i>	2	1	2	7	19	9
43) West Nile Virus Infection*	-	-	-	-	-	-
44) Whooping Cough	1	1	2	1	10	3
45) Yellow Fever	-	-	-	-	-	-

Notes : * Notifiable since 14 July 2008

† Notifiable since 5 January 2007

‡ Notifiable since 30 January 2004

§ Notifiable since 31 December 2004

|| Notifiable since 16 July 2004

¶ Notifiable since 2 August 2005 and cases prior to this date were voluntarily notified.

** "Typhus" has been revised to "Typhus and other rickettsial diseases" which includes spotted fever since 14 July 2008.