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Editorial

The missing pieces in a jigsaw puzzle

Epidemiology is the blood of public health. Through understanding the disease distribution, determinants and trends, epidemiology tells us where diseases are, where they are going, and guides prevention and control efforts. The most important source of epidemiological data is disease surveillance. For sexually transmitted infections (STIs), surveillance activities traditionally take the form of disease notification (e.g. in the US and Australia), case reports at STI clinics (e.g. in the UK) and laboratory surveillance.

Since the 70s, STI epidemiologists have identified the critical role of 'core groups', i.e. individuals with high rates of partners.[1] The extended network with high rates of partner exchange can drive and sustain an epidemic in the core groups and infections may continue to spread to the 'low risk' populations through bridging populations. Sex workers and gay men are commonly identified as the core groups while the clients of sex workers are the bridging population. As such, surveillance and prevention of STI in these core groups is of priority for good control of STI in a community.

In Hong Kong, STIs are not statutory notifiable infections. Data for STI surveillance has been largely contributed by service data collected at the Social Hygiene Service, where diagnosis and treatment are offered freely to local residents. Since 1996, aggregated data on the number of disease diagnoses have been collated regularly and published online quarterly. Distribution by gender and clinics of attendance are also available.

How good are these in reflecting epidemiology about STI in female sex workers (FSWs) and gay men? In fact, the STI surveillance among marginalized groups have been described as 'fragmented'.[2] Until now, STI diagnoses among FSW attending Social Hygiene Clinics in 1999, 2000 and 2004 have been published.[2,3] While it seems convenient to generalize these numbers onto the 'population' of FSWs in Hong Kong, it is actually inappropriate to do so given firstly, the huge heterogeneity and dynamics of the commercial sex industry and secondly, the bias introduced by the health-seeking behaviours of the FSWs. Needless to say, timeliness and accessibility of data is another concern. These have rendered appreciation of STI epidemiology from these data very difficult.

For the epidemiology of STIs in local gay men, it is almost unspoken of apart from HIV infections. It is exciting to learn the innovative interventions, for example like electronic reminders at sexual health clinics to increase screening rates of men who have sex with men (MSM) attending the clinics as described by Chen et al in this issue of the journal. However, Hong Kong is perhaps much backward in this aspect as it is generally reckoned that gay men in fact infrequently attended these STI clinics, and even if they attended them it is uncertain if they would disguise themselves as heterosexuals. Monitoring trends of STI in gay

men locally is by no means possible without additional efforts. Knowing that gay men is the largest population where HIV in Hong Kong are occurring and STI is a well known risk factor for HIV transmission, it is utterly undesirable to see the dearth of STI epidemiological data in them.

What are the barriers to such? Do we not know the existence of the group "FSW"? Do we not know how to reach gay men? Or have we just labeled them "hard-to-reach populations" and ignored them? Researchers elsewhere have raised the concern of STI control programme a 'fractured paradigm' against the background of the emergence of the HIV epidemic.[4] Prevention of infections that are transmitted sexually has slowly become more narrow-based. Locally, there have been significant efforts put into FSWs and gay men for HIV prevention in the past few years. Large-scale community-based studies and surveys on their population characteristics, HIV prevalence and behavioural data have been conducted.[5,6] Community-based efforts are growing. Many of these have been driven by the resources made available through the Government AIDS Trust Fund (ATF) set up in 1993. There are currently at least six community organizations providing outreach services to FSWs and at least eight to gay men for promoting health and well-being of these populations. Some of these organizations have been offering free HIV and STI testing services. In recent few years, close to 5000 HIV tests and some 3000 chlamydia and gonorrhea tests were offered to gay men and FSWs by these community organizations annually.[7,8] The results of one of these testing services for selected subgroups of FSWs have been recently published.[9]

Hong Kong is special in terms of the large proportion of HIV and STI tests in FSWs and gay men being performed not in the STI clinics but in the community. Although lacking the medical expertise, these community organizations are able to reach significant numbers of the target populations and to provide basic testing services. An annual attendance of 30000 FSWs and clients and 66000 gay men were reached by projects supported by ATF.[7,8] A higher degree of collaboration between venereologists, community leaders, community workers and public health workers can improve our understanding of the epidemiology of STI in these two core groups.

Sexually transmitted infections are often a forgotten entity. From the patients' perspectives, few would demand for better services or prevention measures. Many may feel embarrassed or stigmatized and may not seek help from the formal medical system and volunteer history related to homosexual behaviour or sex work. From the health care provider's perspectives, STI diagnosis and treatment are relatively simple and services are already available locally. If we can forget about STI epidemiology, if we can forget about STI in the most vulnerable yet marginalized groups, STI apparently does not deserve more attention. But can we forget?

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