

Recommended HIV/AIDS Strategies for Hong Kong 2012-2016

on firmer ground, strengthening the Hong Kong Response



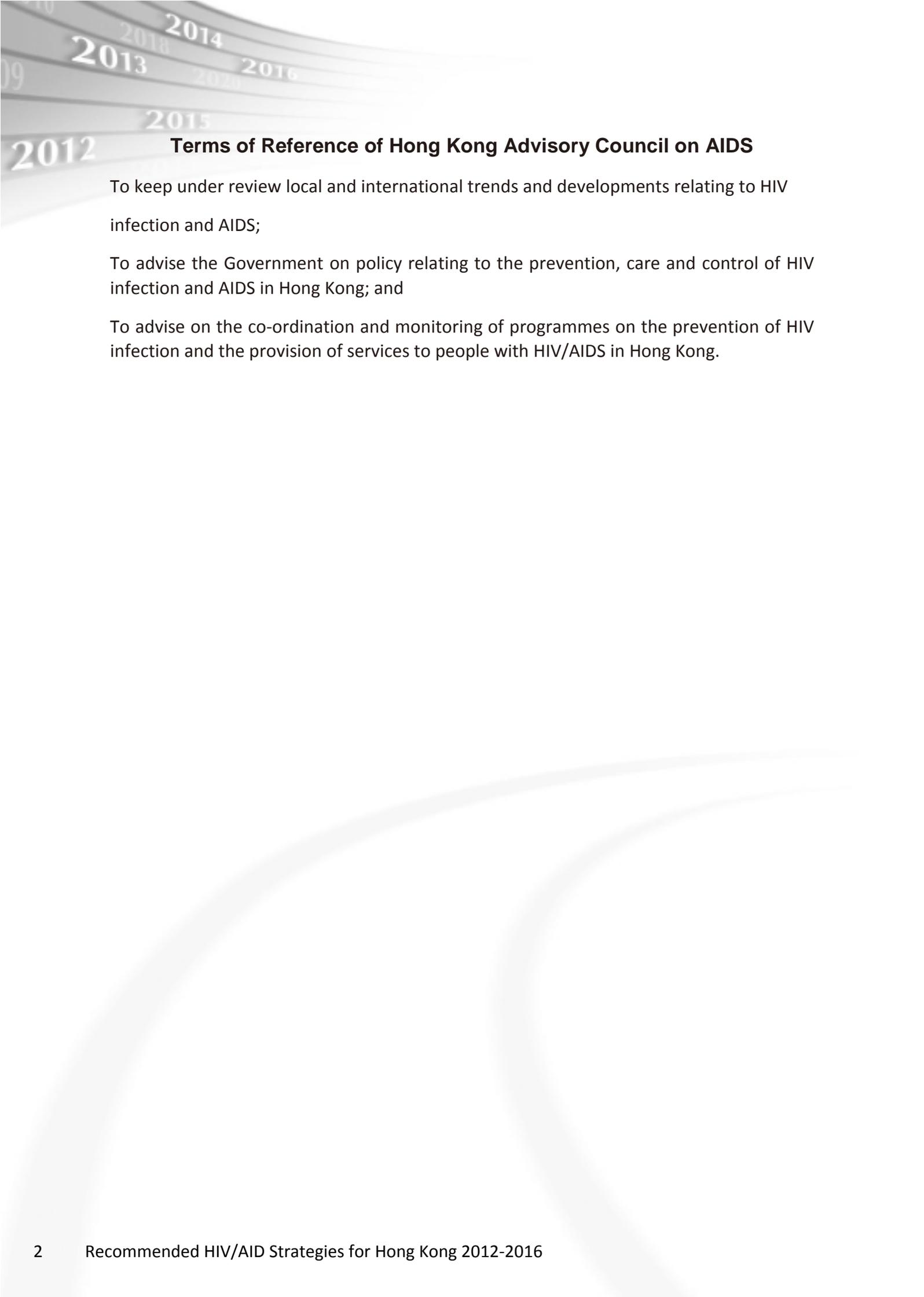
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Terms of Reference of Hong Kong Advisory Council on AIDS

To keep under review local and international trends and developments relating to HIV infection and AIDS;

To advise the Government on policy relating to the prevention, care and control of HIV infection and AIDS in Hong Kong; and

To advise on the co-ordination and monitoring of programmes on the prevention of HIV infection and the provision of services to people with HIV/AIDS in Hong Kong.

Acronyms

ACA	Hong Kong Advisory Council on AIDS
AIDS	Acquired Immunodeficiency Syndrome
ATF	AIDS Trust Fund
CFA	Community Forum on AIDS
CRiSP	Community-based Risk behavioural and Seroprevalence Survey for Female Sex Workers in Hong Kong
CSCM	Community Stakeholders Consultation Meeting
DH	Department of Health
HA	Hospital Authority
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
HKCASO	Hong Kong Coalition of AIDS Service Organizations
IDU	Injecting drug users
M&E	Monitoring and Evaluation
MSM	Men who have sex with men, regardless of whether or not they have sex with women or have a personal or social identity associated with that behaviour, such as being “gay” or “bisexual”
NEP	Non-eligible Persons under Gazette G.N. (E) 13 of 2003 refers to other persons not classified as eligible persons who are (i) holders of Hong Kong Identity Card issued under the Registration of Persons Ordinance; (ii) children who are Hong Kong residents and under 11 years of age; and (iii) other persons approved by the Director of Health.
NGO	Non-Governmental Organisations
PEPFAR	The United State President’s Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PMTCT	Preventing Mother-to-child Transmission of HIV
PRiSM	HIV Prevalence and Risk behavioural Survey of Men who have sex with men in Hong Kong
SPP	Special Preventive Programme in Department of Health
STI	Sexually Transmitted Infections

SW	Sex workers, who are female, male or transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally, and who may or may not consciously define those activities as income-generating.
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary counselling and testing on HIV
WHO	World Health Organization

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Foreword

The HIV/AIDS pandemic continues to be a major public health threat both locally and globally. Despite scientific advances in recent years, a cure for AIDS has yet to be developed and AIDS-related illnesses remain one of the leading causes of death around the World.

Hong Kong is a dynamic society with high population mobility, constantly influenced by the socioeconomic, cultural and health situation in nearby areas and beyond. The rise in HIV infections among local men who have sex with men in the mid-2000s, paralleling a rapid rise among men who have sex with men in other parts of Asia, alerts us that constant vigilance is imperative for the control of communicable diseases. The successes of prompt, resolute and concerted prevention efforts in the last few years among injecting drug users, sex workers and their clients, and men who have sex with men demonstrated that our community can respond effectively to a crisis and slow the growth of the epidemic.

Hong Kong has established a comprehensive framework for curtailing the spread of HIV infection and supporting those living with HIV – a framework in which the Government, its advisory bodies, the medical, nursing and related professions, service organizations and civil society all play a part. To move to the next stage, however, of reversing the epidemic's growth will require sustained policy and resource commitment, improved technical competencies, innovations in prevention, and broad-based support from all sectors of Hong Kong society. The specific actions taken to lower HIV incidence, enhance access to care, optimize health outcomes for people living with HIV, and reduce HIV-related health disparities require continual adaptation guided by changes in the epidemiological and behavioural situation and ongoing assessment of the effectiveness of different responses. Priority-setting in determining strategies and resources should reflect the genuine need of affected communities, as well as the impact and acceptability of programmes and services.

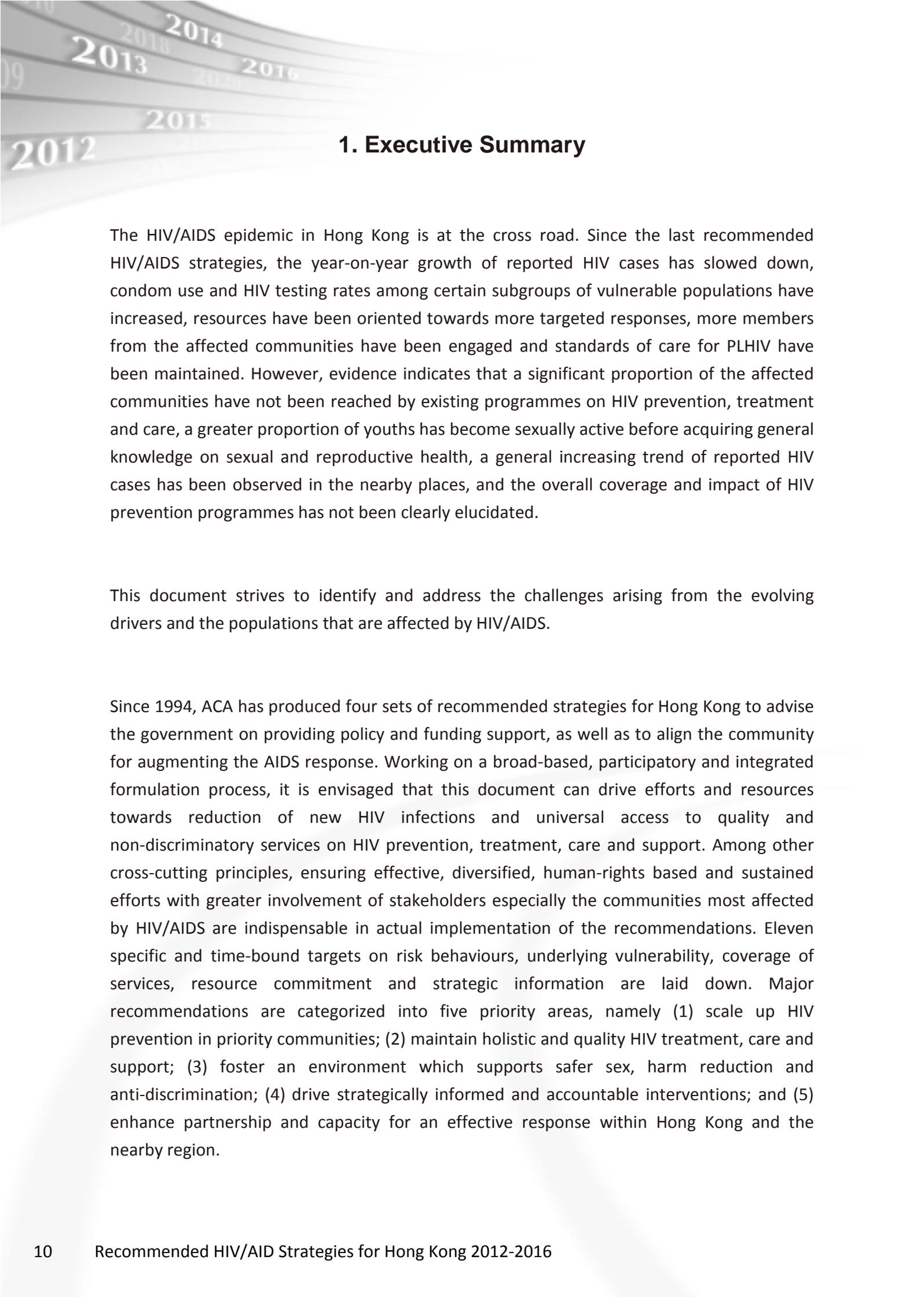
Fostering a supportive environment in the wider community on one hand, and actively engaging members of specific sectors on the other hand, are both complementary and indispensable to the services offered by the Government. This document represents a general consensus on priorities and strategic approaches which are tied to measurable outcomes. It is distilled from extensive consultation and discussion with stakeholders and key players, laying down the blueprint that will address the challenge in the next five years.



Admittedly, no strategic plan can claim to fully cover every eventuality and scenario, and there will always be gaps that test our resilience and solidarity. But in the process of coming together to hammer out the key issues and solutions, I am moved by the selfless commitment of all those who have been involved in the long combat against HIV/AIDS. I am also confident that we have the maturity, tolerance and foresight to work through any differences, and to bring to fruition specific targeted action plans based on our knowledge of the communities we serve, our capacities, and the resources available to us. Let us each contribute our effort to this most challenging but meaningful endeavour.

Dr Susan Fan
Chairperson,
Hong Kong Advisory Council on AIDS
2012





1. Executive Summary

The HIV/AIDS epidemic in Hong Kong is at the cross road. Since the last recommended HIV/AIDS strategies, the year-on-year growth of reported HIV cases has slowed down, condom use and HIV testing rates among certain subgroups of vulnerable populations have increased, resources have been oriented towards more targeted responses, more members from the affected communities have been engaged and standards of care for PLHIV have been maintained. However, evidence indicates that a significant proportion of the affected communities have not been reached by existing programmes on HIV prevention, treatment and care, a greater proportion of youths has become sexually active before acquiring general knowledge on sexual and reproductive health, a general increasing trend of reported HIV cases has been observed in the nearby places, and the overall coverage and impact of HIV prevention programmes has not been clearly elucidated.

This document strives to identify and address the challenges arising from the evolving drivers and the populations that are affected by HIV/AIDS.

Since 1994, ACA has produced four sets of recommended strategies for Hong Kong to advise the government on providing policy and funding support, as well as to align the community for augmenting the AIDS response. Working on a broad-based, participatory and integrated formulation process, it is envisaged that this document can drive efforts and resources towards reduction of new HIV infections and universal access to quality and non-discriminatory services on HIV prevention, treatment, care and support. Among other cross-cutting principles, ensuring effective, diversified, human-rights based and sustained efforts with greater involvement of stakeholders especially the communities most affected by HIV/AIDS are indispensable in actual implementation of the recommendations. Eleven specific and time-bound targets on risk behaviours, underlying vulnerability, coverage of services, resource commitment and strategic information are laid down. Major recommendations are categorized into five priority areas, namely (1) scale up HIV prevention in priority communities; (2) maintain holistic and quality HIV treatment, care and support; (3) foster an environment which supports safer sex, harm reduction and anti-discrimination; (4) drive strategically informed and accountable interventions; and (5) enhance partnership and capacity for an effective response within Hong Kong and the nearby region.

2. Basis of Current Strategies

Development of HIV/AIDS Strategies in Hong Kong

The former Medical and Health Department, under the guidance of an Expert Committee on AIDS, was mainly responsible for the fight against HIV/AIDS when the first case of HIV was diagnosed in Hong Kong in 1984. In the early days of the HIV epidemic, policy development was limited largely to the formulation of technical guidelines on infection control, HIV antibody testing, and the supervision of surveillance activities.

2. In 1990 a comprehensive approach was adopted in addressing AIDS by the establishment of the newly appointed body by the Government named Advisory Council on AIDS (ACA). Since 1994, the ACA has produced four sets of recommended strategies for Hong Kong:

1994 - "Strategies for AIDS Prevention, Care and Control in Hong Kong"

1999 - "AIDS Strategies for Hong Kong, 1999 – 2001"

2002 - "Recommended HIV/AIDS Strategies in Hong Kong, 2002 – 2006"

2007 - "Recommended HIV/AIDS Strategies in Hong Kong, 2007 – 2011"

Formulating Strategies for the five years from 2012 to 2016

3. Building on the experience of previous exercises in strategy development, the current Strategies have been formulated through a broad-based, participatory and integrated approach. Several key factors were taken into account when formulating the current Strategies, including (a) regional and international developments, (b) local HIV/AIDS epidemiological patterns and trends, (c) lessons learnt from implementation of the 2007-2011 Recommended Strategies, and (d) community stakeholders' views on programmes and policy directions.



Analysis by the Secretariat on regional and international developments

4. The ACA secretariat operated by SPP kept track of updated developments on HIV prevention and control. Relevant papers and documents, including synthesis of the latest international and national strategies, were made available to Council members to facilitate their efforts in strategy development in the Hong Kong context. The latest strategies proposed by UNAIDS, WHO and Mainland China are summarized in Appendix I.

Epidemiological patterns and trends of HIV/AIDS in Hong Kong

5. Dr Tim Brown, Senior Fellow of East West Center, Hawaii, was commissioned by DH again to advise on the review of latest HIV/AIDS epidemiological data, estimate size of PLHIV and project HIV incidence.

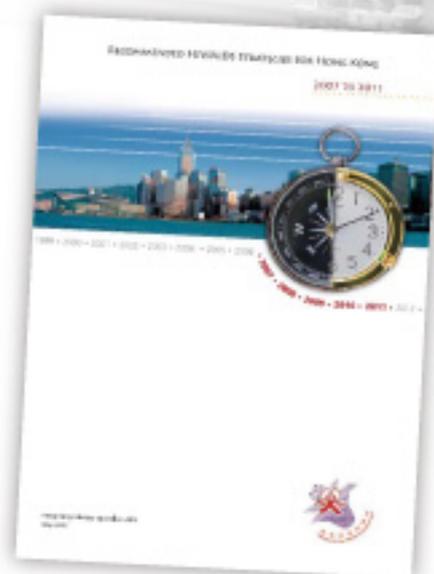
Implementation of 2007 – 2011 Recommended HIV/AIDS Strategies

6. Ongoing reviews on implementation of the last Strategies were conducted with input sought from the public sector, civil society and other stakeholders. An interim review and an end-of period review of the Eight Targets of the 2007 – 2011 Recommended HIV/AIDS Strategies was carried out in 2009 and 2011 respectively (Appendix II). A third set of core indicators for monitoring Hong Kong’s AIDS Programme was published by the Council using the framework of the United Nations General Assembly Special Session on HIV/AIDS Reporting System for year 2010 (Appendix III). The reviews and core indicators were extensively discussed in ACA and CFA, and clarified with stakeholders before they were made available for public access.



Community stakeholders' views on programmes and policy directions

7. The CFA and HKCASO has taken a partnership approach to tap into the collective wisdom of the civil society through a multi-day Community Stakeholders Consultation Meeting (CSCM) for the development of HIV/AIDS Strategies in Hong Kong from year 2012 to 2016. Nine sessions on vulnerable communities and resource mobilisation were held from 26 January to 1 February 2011, with 248 attendances comprising community members and representatives of organisations. A total of 114 recommendations in seven action areas were generated and prioritized by participants in each session. The process, results and associated information were documented in the meeting report and made available for comments by participants of the meeting, relevant



government bureaux and departments and other stakeholders especially on areas under their purview before drafting of the current Strategies [1]. Stakeholders and the public were also invited to express their views through an online opinion survey on local AIDS programme conducted from January to March 2011. Further comments and suggestions have been received from major stakeholders in the public sector, professional bodies, civil society, the universities, overseas experts and members of ACA after a wider dissemination of the report on CSCM and draft Strategies in a series of consultation conducted between May and August 2011, and the public consultation conducted from November to December 2011.





3. Review of the HIV Situation and Response

Global and regional developments – local relevance

8. Thirty years into the AIDS epidemic and 10 years since the landmark United Nations General Assembly Special Session on HIV/AIDS, the HIV/AIDS epidemic continues to be a major global health priority. According to UNAIDS, an estimated 34 million people are living with HIV worldwide at the end of 2010, with Asia (South, South-east and East) accounting for about 4.8 million people[2]. Overall, the annual number of new HIV infections has been steadily declining since late 1990s and there are fewer AIDS related deaths. This trend reflects a combination of factors, including the impact of HIV prevention efforts and the natural course of HIV epidemics. UNAIDS describes the current situation as making promising but fragile progress as new infections continue to outpace the number of people starting treatment[3].

9. In the last few years, trials on various new prevention technologies have been actively conducted, including the use of pre-/post-exposure prophylaxis among vulnerable communities and the use of HAART as a means of prevention in discordant couples. The former approach was met with conflicting results in MSM and heterosexuals while there was promising findings for the latter. But trials are not operational programmes; further researches and efforts are needed before these prevention modalities could be turned into regular programmes, if substantiated by further evidences.

10. Furthermore, there are growing calls at the international level for better focusing our available resources on programmes with maximum impact on the epidemic[4]. These are being heard from UNAIDS, from donors such as the Global Fund and PEPFAR, and from those concerned by recent slowdowns in international funding. Similar concerns have been heard in Hong Kong, as prevention programmes seek to expand coverage among affected populations and ART costs rise.

11. The HIV epidemic among MSM and transgender populations is escalating globally and represents a major source of new infections in our region including Mainland China. MSM in Asia are 19 times more likely to be infected with HIV than the general population[5]. The Asian Epidemic Model predicts that by 2020 around half (46%) of new cases of HIV in Asia will be among MSM and transgender persons. Serial surveys in Bangkok recorded increasing HIV prevalence of 17%, 28%, 31% and 25% respectively among MSM in 2003, 2005, 2007 and

2009. Other Asian countries also witnessed a high HIV prevalence among MSM. In 2008, a survey among MSM in 61 cities in Mainland China revealed a median HIV prevalence of 4.9%, ranging from 0% to 18%[6].

12. In China, a joint survey conducted by the Ministry of Health with WHO and UNAIDS estimated that there were 780,000 HIV infected people including about 154,000 AIDS patients as at the end of 2011[7]. Similar to the estimated number of new HIV infections in 2009, the figure in 2011 was 48,000, with 52.2% being heterosexual, 29.4% being drug injection, 18% being MSM and 0.4% being mother to child transmission. While the overall national HIV prevalence was still low, there were concentrated epidemics among certain vulnerable populations and in specific locations, with Yunnan, Guangxi, Henan, Sichuan, Xinjiang and Guangdong accounting for 75.8% of all cumulated cases. Analysis by Ministry of Health indicated that heterosexual transmissions were most common in provinces which are more affected by the HIV epidemic, and homosexual transmissions were more often found in big and middle-sized cities as well as areas where mobile populations are concentrated.

13. HIV spread in the Pearl River Delta Region of Southern China poses a big public health challenge to Hong Kong given its vast economic growth, geographical vicinity and intense population mobility. Reported HIV cases among 12 major cities participating in a regional surveillance network showed a general increasing trend over the past few years[8]. During the last few years, more cities identified rising epidemics among MSM, while infections among drug users remained common albeit with a general decreasing trend of HIV prevalence. The HIV prevalence among female SW and STI clinic attendees remained relatively stable.

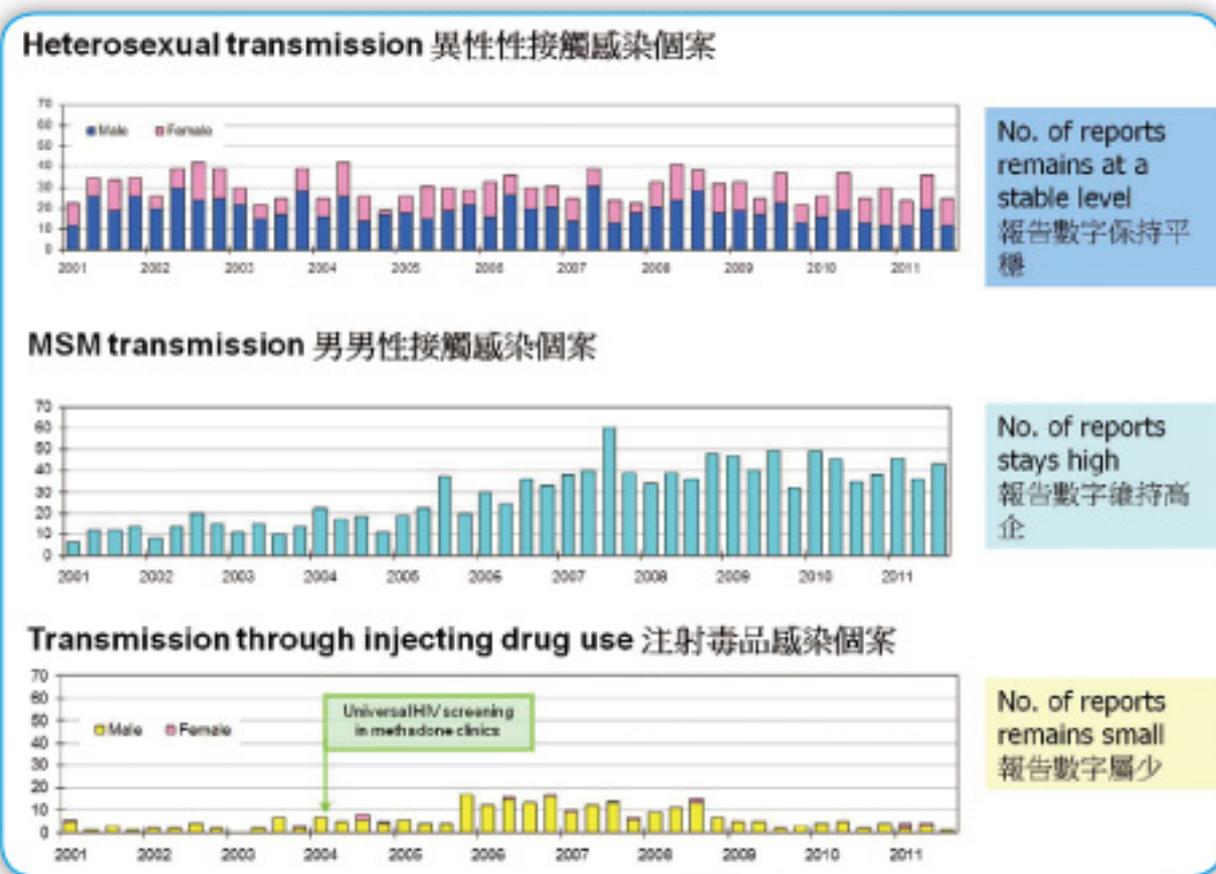
14. In 2010, Hong Kong received a record-high of 36 million visitors from around the world, a remarkable increase of 22% over 2009[9]. Most of them were coming from the Mainland China (22.7 million, of which 14.2 million came under the Individual Visit Scheme), Taiwan (2.2 million) and North, South and Southeast part of Asia (5.7 million). Among a total of 84 million Hong Kong resident departures, a majority of them (68.6 million) went through border control points leading to Shenzhen, followed by ferry terminals going to Macau and Mainland China (8.1 million). During the period between year 2006 and 2010, non-local infections constituted nearly 25% of all reported HIV cases



in Hong Kong. Less than half of heterosexual males who reported a suspected location of HIV infection said it occurred in Hong Kong. Community-based surveys indicated that MSM who had anal sex outside of Hong Kong had a higher overall HIV prevalence. These figures highlight the strong external influences on our HIV epidemic.

Local epidemiology – threats and projections

15. As at the third quarter of 2011, a total of 5,149 and 1,241 cases of HIV and AIDS respectively have been received by the Department of Health under the voluntary and anonymous HIV/AIDS reporting system since its set up in 1984. The year-on-year growth of reported HIV cases has slowed recently, with growth in 2006, 2007 and 2008 of 19%, 11% and 5% respectively. A year-on-year reduction of 9% for 2009 and 2% for 2010 is noted. While these trends are promising, they should be interpreted cautiously as they can be strongly influenced by the level of testing uptake in different communities.



16. In 2010, the number of newly reported patients was 389. Among them, a majority of the HIV reports belonged to male (72%) and Chinese (64%). A significant proportion of female infections came from non-Chinese Asians. Most (85%) infected people were diagnosed at the age between 20 and 49. Unprotected sexual contact remained the most important risk for HIV transmission. About 74% of MSM infections occurred in Hong Kong, in contrast to a much lower proportion of 39% among heterosexual men. Infections among IDU contributed to 4% of all reports in 2010 and 60% of them were non-Chinese, with most transmission occurring outside Hong Kong.

17. The gap between the number of MSM and heterosexual cases has continued to widen, with the highest ratio of 2.7:1 in 2010 since year 2005. Although MSM cases remained at a stable but high level from 2008 onwards and HIV prevalence between consecutive community-based surveys had no significant rise, more data is needed to assess if the HIV spread among MSM has slowed down. Less HIV cases have been reported as injecting drug users since 2006. Besides, HIV prevalence among methadone clinic attendees remained at a consistently low level of 0.2% - 0.5% from 2004 to 2010. Infection from mother-to-child transmission has been uncommon, and local infection from transfusion of blood or blood products was last reported in 1996. The HIV prevalence of pregnant women in public antenatal clinics has remained low and stable (less than 0.02%).

18. About one-fifth of the reported HIV cases did not have risk factor ascertained due to inadequate information, although sexual transmission was the most probable cause upon analysis as advised by Dr Tim Brown. The analysis concluded that cases without reported risk factor did not significantly affect the overall picture and that the current assessment of the epidemic in Hong Kong presented by the reported cases is reasonably accurate.

19. A slight rise in AIDS cases was observed in recent years but the ratio of HIV to AIDS remained stable. Pneumocystis pneumonia and tuberculosis continued to be the most common primary AIDS defining illnesses.

20. As of 2007, SPP estimated that 3,600 people were living with HIV in Hong Kong based on the UNAIDS Workbook methodology. An updated estimate as of 2011 suggested that the latest figure was 4,030 based on a more sophisticated Asian Epidemic Model. Projection based on statistics of past reported cases showed that the number of MSM HIV reported cases will continue to increase and contribute more to the local epidemic in the years to come. The Asian Epidemic Model, which takes into account the estimated size of vulnerable

populations, new infections, risk behaviours and corresponding intervention programmes, found that the HIV prevalence of MSM would rise steadily if prevention efforts are not escalated in the forthcoming years.

Local response to HIV/AIDS

Strengths of an ever-evolving HIV/AIDS Programme

21. A brief account of the current response can be found in Appendix IV. More details of the latest responses in key populations can be found in Annex 8 of the report on CSCM[1]. An end-of period review of the eight targets set out in the previous Strategies indicated that most of them had been achieved (Appendix II). Considerable advancements were made in enhancing strategic information, increasing access to voluntary HIV testing and counselling services, directing resources to areas most in need, sustaining quality of clinical management and collaborating with Mainland China. In particular, the universal screening of donated blood in a quality assured manner, the broadly participated PMTCT programme, the high coverage of Methadone Treatment Programme, close collaboration between the public sector and civil society, and escalation of community-based responses to the HIV epidemic among MSM have won international acclaim.

Current gaps in the response to be filled

22. There is little doubt that Hong Kong has been largely successful in containing the epidemic. However, the annual reported HIV infections indicate that there are still risk behaviours and issues in sustaining high quality care remain to be addressed. Resolving these will be essential to making further progress to reverse the epidemic.

23. Epidemiological and behavioural evidence suggest that (i) an increasingly greater proportion of youths in successive cohorts report having sexual debut at or below age 15 [10]; (ii) some subgroups within each key populations, such as younger MSM who find sexual partners primarily through the internet, underground sex workers, drug users of ethnic minorities and people who travel overseas for sex, have more risk behaviours but less access to HIV prevention programmes[1, 11, 12]; (iii) the levels of certain protective behaviours in key populations, such as consistent condom use between regular partners among MSM, remain low in serial community-based surveys; (iv) a moderately increasing trend in the cases of early syphilis in MSM treated by Social Hygiene Clinics has been noted; (v) a considerable proportion of reported HIV cases continue to present late or do not receive HIV care in Hong

Kong; and (vi) a substantial proportion of newly reported HIV infections among Hong Kong residents continue to occur while traveling or across the border in China.

24. Insights from some community stakeholders indicate that HIV-related programmes are not reaching all areas and risk settings for priority affected communities, for example, MSM and drug users from ethnic minorities. Support services for significant others of vulnerable individuals such as family members of MSM and those caring for PLHIV remain sparse.

25. And while Hong Kong has had substantial prevention successes among injecting drug users, the threat of a rapid upsurge of HIV cases in this group remains a cause for concern given the very nature of HIV spread among IDU and the prevalent epidemics in IDU populations in surrounding places. The coverage of annual universal HIV testing for attendees of methadone clinics has also decreased over time to less than 80%.

The need for a stronger strategic information base to guide and evaluate responses

26. The coverage, relative effectiveness and costs of prevention programmes in Hong Kong are not well characterized. It is difficult at this point to assess what the actual coverage of programmes is, to identify which programmes have been the most effective, or to assess the overall cost (and therefore cost effectiveness) of different programmes. Addressing these issues is an essential step in moving the Hong Kong response to the next level. This will allow effective programmes to be taken to scale and will permit resources currently dedicated to ineffective programmes to be redirected to more effective ones.

27. Attempts to regularize the community-based surveillance of HIV prevalence and risk behaviours among MSM and FSW with the PRiSM and CRiSP surveys have been successful and have engaged the NGOs and communities as active partners in the collection and dissemination of the findings. However, MSM and FSW are far from homogeneous groups – there are many subgroups of both with widely varying levels of risk and HIV exposure. Considerable gaps exist in understanding the risk and prevention exposure of subgroups which were not captured by such surveys, such as MSM not frequenting gay venues and FSW in entertainment venues other than those covered. Access to these groups for prevention and care remains a major challenge, as many have had limited exposure to the venue-focused programmes undertaken to date.



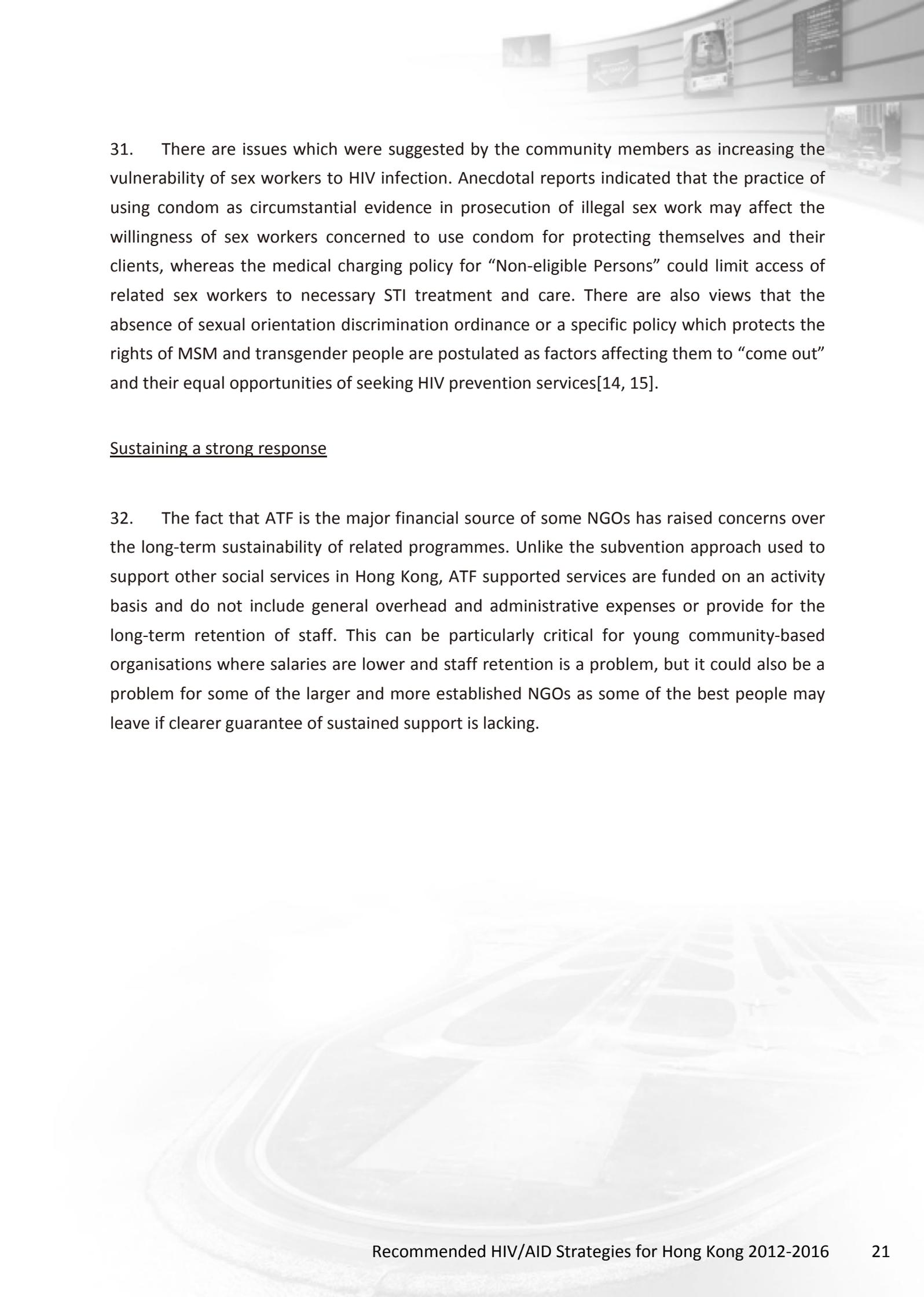
Expanding capacity to increase access

28. Reaching these less accessible populations, while strengthening and expanding the coverage of existing programmes will call for additional capacity building in the communities, the NGOs and other organisations engaged in HIV work. The affected communities need to be engaged, empowered and resourced to carry out prevention activities in an effective and appropriate manner. Building organisations' technical capacity for prevention, monitoring and evaluation and overall management will lead to a more effective overall response.

29. Challenges exist on the care and treatment side as well. HIV Medicine has expanded its scope considerably with the changing spectrum of disease in the HAART era and with recommendations encouraging early treatment. Many in Hong Kong do not know their HIV status, so they may have limited access to necessary care. For example, only one-third of men who have sex with men, the most rapidly growing component of the epidemic in Hong Kong today, have had a recent HIV test, indicating a need for expanded community access to testing. These factors in combination with the ever increasing number of PLHIV seeking HIV care will raise costs continuously and over-stretch the capacity of health care team to compromise the quality of service.

The need to build a more enabling environment

30. Most targeted prevention programmes to date address risk behaviours directly rather than underlying vulnerabilities of at-risk communities and environmental factors which weaken the efficacy of prevention and care efforts. Despite the fact that a holistic school curriculum of sex education embracing knowledge, skills and values has been developed for students of different developmental stages, resources produced and updated, and professional development programmes for teachers put in place, implementation in schools is variable and far from universal. Open discussion of sex remains a social taboo, and stigmatization of PLHIV and vulnerable groups are still common in Hong Kong[13].



31. There are issues which were suggested by the community members as increasing the vulnerability of sex workers to HIV infection. Anecdotal reports indicated that the practice of using condom as circumstantial evidence in prosecution of illegal sex work may affect the willingness of sex workers concerned to use condom for protecting themselves and their clients, whereas the medical charging policy for “Non-eligible Persons” could limit access of related sex workers to necessary STI treatment and care. There are also views that the absence of sexual orientation discrimination ordinance or a specific policy which protects the rights of MSM and transgender people are postulated as factors affecting them to “come out” and their equal opportunities of seeking HIV prevention services[14, 15].

Sustaining a strong response

32. The fact that ATF is the major financial source of some NGOs has raised concerns over the long-term sustainability of related programmes. Unlike the subvention approach used to support other social services in Hong Kong, ATF supported services are funded on an activity basis and do not include general overhead and administrative expenses or provide for the long-term retention of staff. This can be particularly critical for young community-based organisations where salaries are lower and staff retention is a problem, but it could also be a problem for some of the larger and more established NGOs as some of the best people may leave if clearer guarantee of sustained support is lacking.

2012
2013
2014
2015
2016
2017
2018
2019
2020



4. Framework for Strategies

33. As indicated in the foregoing chapters, the formulation of this document is grounded on a composite assessment of the current situation, projection of future trends, identification of gaps, review of strategies suggested elsewhere and assessment by stakeholders. The recommendations so developed aim to guide the overall community-wide AIDS response. It is a product of objective, integrative and consultative processes with a public health oriented approach.

Vision

34. The latest UNAIDS Strategic Plan 2011-2015 “Getting to Zero” was developed through wide consultation, informed by best evidence and driven by a moral imperative to achieve universal access to HIV-related services and Millennium Development Goals[16]. Its three-pillared vision: zero new HIV infections, zero discrimination, and zero AIDS-related deaths guides the overall direction of the local AIDS response.

Guiding Principles

35. Most of the international and national principles on HIV prevention, care and control apply to Hong Kong. Shared views on core principles for the local response during the process of strategies development and deliberation of the ACA are listed below –

- I. Diversified approaches are to be combined strategically based on latest evidence with regard to epidemiology, research findings and programme response to actively address the heterogeneous and evolving needs of communities at higher risk of HIV infection.
- II. Available resources are to be targeted to reduce those risk behaviours and underlying vulnerabilities of priority communities which can bring down new HIV infections.
- III. Priority areas for action are widely shared, owned and regularly reviewed by stakeholders.
- IV. Services that reach marginalized communities are sensitive to their human rights.
- V. Effective responses are made sustainable, brought to scale, and are flexible enough to make continuous improvement as the situation evolves.
- VI. Policies and programmes are coordinated among agencies, optimized to engage and empower community members, and guided by strategic information.

- 
- VII. The environment is conducive to universal access of HIV prevention, treatment, care and support, especially by the communities most vulnerable to HIV infection.
- VIII. Monitoring and evaluation forms an integral part of the local AIDS programme.

Goals

- I. Sustain the reduction of new HIV/AIDS patients
- II. Ensure universal access to quality and non-discriminatory prevention, treatment, care and support services

Objectives

- I. Empower communities most affected by HIV to reduce their risk behaviours and underlying vulnerabilities
- II. Ensure sustainable resources and adequate numbers of trained personnel for provision of quality and non-discriminatory services
- III. Move toward an increasingly results-based implementation of prevention, treatment, care and support services

Targets by 2015

36. While the goals and objectives specify the overall directions, the following targets are set to be more specific and achievable towards the end of the Strategy.

Behaviours

- I. Expand testing coverage
Receive HIV test in the last year and know the result
 - (a) At least 50% of MSM
 - (b) At least 25% of male clients of female sex workers
 - (c) At least 50% of female sex workers
 - (d) At least 80% of opioid dependent persons
- II. Ensure regular condom use
 - (a) At least 80% and 70% of MSM use condoms in the last anal intercourse with casual and regular partners respectively
 - (b) At least 80% of heterosexual men use condoms in the last vaginal intercourse with

commercial sex partners

- (c) At least 80% of female sex workers use condoms in the last vaginal intercourse with regular clients

III. Maintain low needle sharing

Not more than 10% of IDU sharing needles with those outside their usual injection partners in the last 6 months

Underlying vulnerability

- IV. Condoms are widely accepted as a norm among vulnerable communities for practice of safer sex in all places where risk behaviours might occur.

Coverage of HIV prevention, treatment, care and support services

V. Achieve high coverage.

Access HIV prevention messages or materials including condom in the last year

- (a) At least 75% of MSM
- (b) At least 50% of male clients of female sex workers
- (c) At least 95% of female sex workers
- (d) At least 95% of opioid dependent persons

VI. Expand early detection

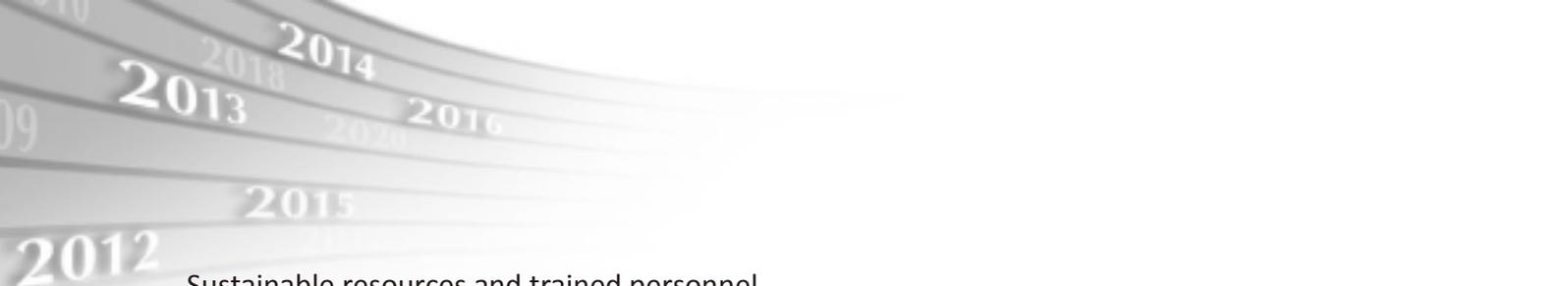
Not more than 15% of newly reported HIV cases progress to AIDS within 3 months of diagnosis

VII. Provide universal ART access

At least 95% of adults and children with advanced HIV infection receive antiretroviral therapy

VIII. Give life skills to youth

At least 50% of students currently studying in senior secondary schools who have in the past received life skills-based HIV education¹ at or before the age of 15



Sustainable resources and trained personnel

IX. Resource effective efforts

Mobilize substantially more financial resources for proven effective interventions implemented by NGO beyond the current levels of provision

X. Build capacity

Regularize sensitization and skill-building training for teachers, social workers, healthcare workers, law enforcement staff, and other NGO workers to ensure equal access to HIV-related services by their service clients.

Realizing results-based implementation

XI. Create results orientation

Develop, implement and act on a common set of indicators for monitoring the local AIDS response for key populations.

Key players in delivering the objectives

37. Hong Kong's AIDS programme is the organized effort of different groups in the society as a whole. They partner with each other, perform different roles, supplement and complement, and serve the same cause. The key players who would be working towards the new goals and objectives, with their anticipated roles are listed below -

Government policy bureaux – The Food and Health Bureau is the lead agency in the development of the government's policy on HIV/AIDS. FHB will continue to provide necessary support and resources as appropriate for carry forward the recommended strategies. In consolidating an integrative approach, other bureau and advisory bodies are also involved, e.g. Education Bureau, Security Bureau.

Advisory Council on AIDS – ACA advises the Government on policy relating to AIDS. It also advises on the co-ordination and monitoring of programmes and services on prevention and care of HIV in the territory.

¹As described in the 2009 guidelines for the construction of core indicators for United Nations General Assembly Special Session, life-skill based HIV education in schools uses participatory exercises to teach behaviours to young people, help them coping with stress and deal with other factors which can lower their vulnerability to HIV. It can include decision-making and problem-solving skills, creative and critical thinking, self-awareness, communication and interpersonal relations, coping skills and practical skills of using a condom.

AIDS Trust Fund – ATF plays a crucial role in supporting community based HIV activities, which is especially critical in responding to today's epidemic. It is proposed that ATF will continue its role as a key player of AIDS response, adequately fund community-based programme/projects, incorporate monitoring and evaluation, and adapt funding support in the face of changed and changing situations and needs.

Department of Health – The Centre for Health Protection, through its Special Preventive Programme, will be regularly monitoring the epidemiology and providing support in building capacity relevant to prevention, care and research efforts. Together with the Hospital Authority and universities, DH will ensure the delivery of quality patient services, development of clinical expertise on HIV care and treatment and strengthening of the existing programmes. The Methadone Treatment Programme plays crucial role in the prevention of HIV by reducing injecting drug use and needle-sharing through easy access and retention to adequate methadone treatment, surveillance, health education and counseling.

NGOs and vulnerable communities – The NGOs are the key players in delivering targeted preventions and surveillance to hard-to-reach populations and in the building of technical capacity in enhancing effectiveness of HIV prevention and care activities. Vulnerable communities are to be mobilized and empowered, in particular the communities of PLHIV and MSM. The leadership and support of the Hong Kong Council of Social Service, HKCASO and Social Welfare Department will be influential in making and facilitating more organisations to participate in AIDS work as well as enhancing those already in the field.

Healthcare sector – healthcare providers especially those in primary care and sexual and reproductive health can play an active role in offering health advice on safer sex and risk reductions, facilitating the HIV test, making HIV reports for surveillance, and linkage of patients to HIV treatment and care.

Academia – academia will contribute by undertaking appropriate studies to improve understanding of the situation and specific risk factors/patterns/interventions.

The wider society – numerous other partners can also play key roles in moving the AIDS programme forward, including but not limited to: media, government consultative bodies, district boards, schools, private sectors, professional bodies and philanthropic sectors.



5. Priority Areas for Action

38. Despite the significant expansion of preventive efforts for the MSM community over the past few years, the epidemic still outpaces the response. Thus, effective efforts should be scaled up with greater involvement of the communities most affected by HIV, with MSM as the most urgent priority, for HIV prevention and early diagnosis of the infected. This is necessary to lessen the upward trajectory of costs for delivering treatment and care, and sustain Hong Kong's current low overall HIV prevalence.

Priority areas for action are –

- Scale up HIV prevention in priority communities
- Maintain holistic and quality HIV treatment, care and support
- Foster an environment which supports safer sex, harm reduction and anti-discrimination
- Drive strategically informed and accountable interventions
- Enhance partnership and capacity for an effective response within Hong Kong and the nearby region

Scale up HIV prevention in priority communities: MSM, male clients of female sex workers, IDU and SW

39. As revealed by the current epidemiology and estimation & projection of new infections in the coming future, MSM remains the highest priority community for prevention. Within the next decade, heterosexual men primarily contracting HIV from SW outside Hong Kong would be the second largest group of new infections. Spouse/regular partner of the infected heterosexual men will also contribute a considerable portion of the new infections. Thus, we need even stronger programmes for these communities. At the same time, the established targeted prevention efforts for IDU and SW, which are traditional most at-risk groups, must be sustained in the next five years to avoid the recurrent global lessons of rapid HIV explosion particularly in IDU.

40. Combination prevention with a strategic mix of structural, biomedical and behavioural interventions that are evidence-informed, human-rights based and owned by affected communities emerges as a central concept in recent prevention thinking [16-20].

2012 Comprehensive package is a similar term that has been used to describe programmes and services for HIV prevention among MSM and transgender populations[21]. As current efforts mainly focus on individuals using biomedical and behavioural approaches, there is a general call for more structural interventions to address psychosocial determinants of risk behaviours such as public acceptance of PLHIV and affected communities, life-skill based HIV education, norm on safer sex and social needs of affected communities.

41. As HIV infection becomes a chronic medical problem with long term costs, there is a genuine need to call for more efficient use of resources to deal with the increasing burden and complexity of problems encountered. Resources need to be concentrated on those interventions which have been proven effective in preventing HIV and focused in aforementioned priority communities to maximize their impacts on one hand, and reserved for innovative practices targeting specific sub-groups which are less accessible to conventional interventions.

42. To reduce sexual transmission of HIV and STI, people are advised to avoid risky sexual practices such as having sex at an early age and with multiple or casual sex partners. If this does not meet their needs, proper and consistent use of a condom is the most effective means of protection. Convenient access to quality condoms and lubricants and their consistent use remains the cornerstone for reducing HIV infection among MSM, SW and their clients. Condoms should be continuously made available in venues frequented by priority communities, such as gay saunas, methadone clinics, Social Hygiene Clinics, and commercial sex establishments, and easily obtainable through the internet-based programmes, 24-hour convenience stores, vending machines and in single package.

43. The popularity of providing voluntary testing and counselling service for HIV and STI by NGO has led to an increase in HIV cases reported from this source. Overseas disease modeling suggested that increasing rates of testing and partner notification of MSM who have multiple sex partners or unprotected anal intercourse would have a large epidemiological impact and broadly acceptable to most of them, in comparison to changes in sexual behaviours [22]. The availability of easy-to-use rapid HIV test kits that can be employed in a variety of community settings has effectively increased the coverage of HIV testing among MSM and female SW, and allowed opportunity for more intensive interventions to modify risk behaviours and link clients to relevant services. Regular HIV testing should be promoted among communities with ongoing risk of infection, especially for MSM as epidemiologic

information pointed to their higher incident infections. Feeling safe is a key to whether people will use such services, and this is facilitated by engaging peer providers. Thus, VCT in community settings should be further expanded in scope, made convenient, acceptable and readily accessible to end users, use peer workers as appropriate, and be provided according to concurrent quality assurance guidelines[23].

44. Similarly, sustained efforts are needed to maintain the high coverage of provider-initiated universal HIV testing in clinical settings, including but not limited to methadone clinics, Social Hygiene Clinics and Tuberculosis & Chest Clinics, and pregnant women. As HIV and STI is closely related, routine incorporation of STI screening such as syphilis in HIV testing services should be encouraged[24]. Provision of screening for STI such as Chlamydia and gonorrhoea is viewed as incentive for clients attending community HIV testing services, and should be supported with resources as appropriate.

45. Prevention and treatment are mutually reinforcing and need to be integrated. Positive prevention targeting PLHIV in clinical settings can combine multiple approaches including partner counselling and referral, risk reduction counselling, supervision of adherence to HIV treatment, screening of STI, and prevention of vertical transmission using HAART. In all cases, autonomy and privacy of PLHIV should be fully respected. A more detailed health needs assessment of PLHIV may be useful to develop improvements and modify the interventions for greater effectiveness.

46. Controversy exists with regard to treating PLHIV early with HAART as a public health measure to prevent HIV infection, although treatment initiation at a lower threshold is already the trend of the latest clinical guidelines. With some patients, the added advantage of reducing onward sexual transmission may also be an important factor of treatment consideration[25]. There was evidence among discordant couples that HAART was effective in reducing heterosexual transmission, and overseas studies at population level have suggested that introduction and increased uptake of HAART coincided with decrease in new HIV infections. However, the feasibility of finding early infected cases, especially in low prevalence settings like Hong Kong, achieving high HIV testing coverage, ensuring drug adherence, tracking drug resistance, and measuring effects on risk behaviours resulting from drug treatment are some of the issues that need to be considered. Expanding targeted testing within vulnerable populations may prove an effective way of diagnosing infected individuals earlier and getting them into HIV care.

2012 2013 2014 2015 2016

47. With most reported new cases of infection occurring in people aged between 20 and 39 who are likely to spend much of their time on the internet, some of whom might even have used it as a platform to source sex partners, we must embrace the new channels of communication to reach this population. On the other hand, venue outreach, centre-based service, opportunities in clinical encounters and promotion via mass and mainstream media should be continually employed and broadened as a significant proportion of the priority communities and general public cannot be reached otherwise. There is a need to frame messages in a way that appeals to the broader interests and reflects the life situation of the target audience, rather than simply taking a narrow public health approach[6]. Awareness raising for prevention and treatment of STI other than HIV, which are more common and more often treatable, should be enhanced.

48. New and innovative programmes are needed to reach subgroups of priority communities who are not well covered at present and whose HIV risk has not been extensively studied. These include: (i) MSM who do not attend the bars, discos and saunas, especially younger MSM and those who source sex through new media[26]; (ii) heterosexual men who visit commercial sex workers outside Hong Kong; (iii) older clients of sex workers; (iv) spouses or partners of clients of sex workers; (v) people who cross border for drug injection; (vi) sex workers in less accessible establishments, new to the sex industry or who meet partners through the internet or telephone; (vii) refugees, asylum seekers and new immigrants from places with high HIV prevalence; and (viii) non-injecting drug users. Short of well-established services, pilot projects/programmes would need to be devised and funded to address these areas.

49. Among MSM, increasing condom use in relationships is not easy. Consistent condom use for both non-regular and regular partners should become a norm within MSM community if major impacts on reducing new infections are to be achieved. More comprehensive prevention packages that address relationship issues, self-efficacy of using condoms, partner communication, illicit drug use, health consciousness, and mental health alongside provision of HIV and STI services may be needed to raise condom use further among MSM. Development of comprehensive MSM-friendly sexual health clinics and building a list of MSM-friendly doctors may serve as additional avenues of access and intervention. Studies in other places have shown that the highest proportion of new HIV infections among MSM occurs in the first two to three years after sexual initiation - after that time, many MSM have internalized HIV prevention messages from the community and incidence rates tend to drop substantially. Thus, ways of meeting the prevention needs of

younger MSM are critically needed. Transgender has been shown to be at high risk of HIV overseas. Although the situation is not clear for Hong Kong, this group should not be overlooked in the response.

50. As for IDU who present an ongoing concern about rapid upsurge of HIV, effective intervention measures including primary prevention of drug abuse among young people and harm reduction strategies consistent with international consensus, e.g. the Methadone Treatment Programme, no restriction on purchase of syringes, have to be maintained to reduce the risk of HIV transmission through contaminated needles [27]. Recent epidemiologic data raise concern about the ethnic minorities, and services targeting them should ideally engage people of their own ethnicities to address language and cultural barriers. Disease modelling in overseas studies suggested that high coverage of opioid substitution therapy, needle and syringe programme, and HAART in combination have synergistic effects in reducing HIV incidence among drug users by 50%[28].

Maintain holistic and quality HIV treatment, care and support

51. It is crucial that the successes of HIV care in Hong Kong in the past can be perpetuated. These include accessibility to highly subsidized effective antiretroviral therapy, integrated health care delivery, attention to patients' needs and concerns, commitment on the part of the government and a team of competent and devoted doctors, nurses, social workers and other health professionals.

52. With advancement and universal access of HAART, both the number and the longevity of people with HIV have increased, producing an ageing population of PLHIV over time. With longer life, additional medical needs have arisen with heart conditions, cancers, and negative consequences of long term HAART use becoming more apparent. More medical services have become involved in the management of co-morbidities, treatment complications and side-effects of HAART. Specialists such as cardiologists, haematologists, endocrinologists, oncologists, surgeons, gynaecologists, psychiatrists and dentists who were hitherto uninvolved now need to be engaged. Updated knowledge on HIV-related prevention, investigation, treatment and care should be integrated in the basic and continuous training of healthcare workers. Providers of VCT, primary care practitioners, HIV specialist care, other medical and support services should form a seamless system which link people to continuous and coordinated quality care. Integrative and collaborative work is needed to enhance control and care of TB, STI, and hepatitis co-infections which are inter-related in Hong Kong.

2012 Regularization of laboratory services on drug resistance testing and exploration of clinical studies and trials to fill the gaps of HIV management will add value to sustaining quality care.

53. The local standard of HIV care is benchmarked by peer-reviewed guidelines and clinical effectiveness. It is important that a high level of effectiveness in HIV disease management be maintained through ongoing health needs assessment, clinical governance, with inclusion of indicators on clinical effectiveness, quality of life and mental health of HIV patients as appropriate, and communication of important findings to PLHIV.

54. The initiation of antiretroviral therapy should be a carefully meditated decision following a thorough medical evaluation and informed discussion with the patient. The absolute level of CD4 count is one of the many factors that are considered before starting current life-long HAART. Once started, PLHIV should be supported to achieve good drug adherence, regular follow up and close monitoring, and long term control of disease.

55. Professional training and career development on HIV medicine should be strengthened. The adequacy of treatment, care and support facilities should be reviewed regularly to ensure services to PLHIV are in line with the growing demand.

56. Rehabilitation of PLHIV, which aims at enhancing functional capacity, improving quality of life and promoting self care, should emphasize on management of treatment side effects, promotion of mental health and social integration. PLHIV with concurrent health conditions and those who have challenges meeting their basic social needs should be given with more intensive support and services by professional care providers. Peer groups and networks are encouraged to play a more active role in providing psychosocial support to PLHIV, their families and care takers. Social acceptance of PLHIV is a cornerstone of their integration to the society.

Foster an environment which supports safer sex, harm reduction and anti-discrimination

57. Although formidable, there are social determinants which can be modified to support priority communities in adopting healthy behaviours.

58. Public education on the protections rendered by the Disability Discrimination Ordinance to persons with disability including PLHIV as well as to their associates should be

promoted. It is essential that enquiries and complaints made by PLHIV and their associates related to Disability Discrimination Ordinance are recorded and monitored routinely. Formal investigation should be considered if areas of systemic discrimination are discovered.

59. Social acceptance of PLHIV is closely related to understanding of HIV/AIDS, prevailing values towards PLHIV and key affected groups, and human rights situation in the society. On one hand, people should be educated to dispel myths and misunderstanding related to HIV transmission. On the other hand, it is imperative to recognize that factors outside of an individual's control are powerful forces driving the HIV epidemic. Calls for strengthening advocacy efforts in legal reform have been voiced from the community, particularly in the light of recently issued international declarations which are based on public health and human rights[1, 29-31]. It would be worthwhile to examine the impact of aforementioned laws and policies in paragraph 31 on access to HIV-related services by key affected groups in order to formulate more definitive recommendations. At the same time, promotion of anti-discrimination and equal opportunities using media programmes, publicity campaigns and education activities with active involvement of the relevant sectors and priority communities are to be supported. In particular, condom should be widely promoted as a norm for safer sex in various sexual relationships and young people are empowered to use condom properly whenever needed. Public support, in return, will form an important lever to promote safer sex, harm reduction, HIV testing and other services to the priority communities.

60. Local surveys among youths revealed that increasingly more young people report sexual debut before the age of 15[10], and a majority of local adults opined that sex education in schools is an effective measure in preventing STI and HIV[32]. This speaks eloquently that sex education including condom use should be introduced early and widely enough to protect sexual and reproductive health of youths. Schools should be continuously supported, encouraged and monitored for providing life-skills based HIV education to convey knowledge, skills and values which can lower the risk of HIV transmission at multiple levels and across different subjects. Coordinated efforts are needed to unite stakeholders such as schools, youth services, outreach programmes for school drop outs, vocational institutions,



and medical practitioners who offer STI treatment and contraceptive advice to provide sex education. New media including those in the internet and mobile phones should be fully utilized. Extensive implementation of sex education will avoid labeling certain recipients as “at-risk” youth.

61. To reduce HIV-related health disparities, more comprehensive responses to social needs of priority communities, such as social integration services for IDU, promotion of self acceptance and healthy relationships for MSM, employment, relationship education and legal assistance for sex workers, are recommended. These services are best provided in partnership with schools, family, mainstream NGOs and AIDS prevention efforts.

62. Sensitization training of personnel including peer workers, teachers, healthcare workers, social workers and law enforcement staff will enable them to understand and accept priority communities and PLHIV during daily contact arising from service delivery and law enforcement, thereby minimizing undesirable actions that compromise public health.

Drive strategically informed and accountable interventions

63. The WHO has been promulgating the concept of “know your epidemic, know your response” for years[33]. On one hand, we must identify those with continuing risk and direct prevention resources to them. On the other hand, improved mechanisms of evaluation and reporting are commonly used in addressing the cross-cutting issues of effectiveness, efficiency, accountability, engagement of communities and sustainability of investment on HIV-related programmes. It is important that the most strategic information is carefully chosen for monitoring in the local surveillance system so that energy and attention is focused on M&E of the right issues and the right populations.

64. Improving M&E for both prevention and care should be a collaborative process. Multiple partners will need to be engaged, including but not limited to the DH, HA, NGOs, the communities affected along with PLHIV, university researchers, and the key policy and funding bodies, the ACA and the ATF. Emphasis should be put on M&E at multiple levels, from project level up to the Hong Kong-wide level, so that a systematic process of evaluation and continuous improvement of the entire Hong Kong response is put in place.

65. At the programme level, organisations conducting HIV interventions should be encouraged, empowered and adequately funded to monitor their own programmes, especially the measurement of behavioural outcomes or intentions so as to continually improve the effectiveness and outcome. If behaviours are not changing, they should qualitatively assess why not – and this should be a call to action to address their weaknesses and improve their programmes. In addition, they need to be able to estimate the number and types of clients reached. Having their own M&E system will help them to estimate the coverage and costs of their programmes, and use this information to systematically review and improve them over time. While the ATF has already been looking for a concrete, quality and budgeted M&E plan as part of each proposal, it may also want to consider providing training opportunities on M&E especially for smaller organisations through proposal development workshops or a capacity building project. However, the M&E requirements and level of sophistication should be realistic for the size and cost of the planned project and the capacity of the implementing organisation.

66. At the territory-wide level, information on programme exposure should form an integral component in future community-based surveys so that behavioural and epidemiological impacts of prevention efforts on a community basis can be estimated. When the time comes to redesign such surveys, it will be important to engage behavioural and evaluation specialists who can help in designing questions that address both exposure to prevention efforts and intensity of that exposure. A common set of indicators collaboratively defined and used by all organisations to uniformly report levels of behaviour change and size of key populations reached by programmes can be used for triangulation. In this way, effectiveness and coverage of all HIV related programmes, including comparison of costs between alternative programme efforts, can be kept under regular review for better planning and resource allocation.



2012 67. Programmes with proven effectiveness should be widely shared and replicated.

Surveillance results should be systematically disseminated to stakeholders, perhaps through regular M&E meetings involving all partners, reports, fact sheets and targeted meetings with community members and other individuals or groups with a stake in the outcomes.

68. Apart from sustaining the current efforts of monitoring the risk behaviours, STI patterns and HIV prevalence among major priority communities, expansion of data collection is needed to obtain such information among more hidden and less characterized segments of the MSM, transgender people, IDU and FSW and their clients. Any such information collecting activities must go hand-in-hand with expansion of prevention activities where they are most urgently needed, which makes a strong case for collaboration between researchers and AIDS prevention partners in gaining the needed access and gathering the necessary information. Respondent-driven sampling can be one form of means to fill information gaps among MSM and SW and to identify potential avenues for reaching them, but should be regarded more as a research tool rather than a surveillance methodology.

69. There are gaps in our knowledge on prevention that must be filled if we are to build stronger and more effective programmes to address key forms of ongoing risk. A significant proportion of the current HIV transmission among MSM is probably occurring between regular partners. More information is needed to understand relationships among MSM: their duration, discordance in partnerships, behaviour within relationships as a function of HIV status. More studies are also needed for male sex workers and transgender people to understand their specific health needs. Formative research of pilot programme is required to address cross border casual relationship among heterosexual men. Further study is needed to determine the extent to which “compensated dating” is occurring and to ascertain the risk associated with it. Reports of reduced cross-border movement of sex workers must be validated. As the self-reported condom use rates among female sex workers found in previous community-based surveys are too high to be sensitive to changes arising from interventions, and involve considerable desirability bias, other measures such as regular STI monitoring or asking condom use questions from the client-side may be required. Future research should better quantify changes in patterns of drug usage, and explore the HIV risk of non-injecting drug users more comprehensively.

70. To have effective and long-lasting effects on HIV prevention, risk behaviours should not be targeted alone. Yet, evidence about and knowledge of the key pathways leading from different structural interventions to actual behavioural changes is limited at present. As the effect of underlying vulnerabilities on behavioural outcomes, if any, usually has considerable time lag, operational researches using quasi-experimental design or special surveys would be useful to evaluate such interventions.

Enhance partnership and capacity for an effective response within Hong Kong and the nearby region

71. HIV prevention programmes, including those which address health equity, equal opportunities and social needs of priority communities, will only be successful if they can be scaled up to reach significantly greater numbers of people than is currently the case. Achievement of this requires the full and active involvement of the Government, healthcare providers, NGOs and affected communities.

72. Effective communication among service providers, policy makers and funding bodies promote partnership and coordination. It is prudent that the priority areas for action between policy makers and funding bodies are aligned. This is particularly true for ACA and ATF. The existing platforms in ACA, CFA, HKCASO and RRC should be continued with active participation of community members, and exchanges among ATF, ACA and NGOs in resource allocation and funding strategy should be facilitated.

73. Community mobilisation and active involvement of PLHIV has implications for the long-term success of the AIDS response[16, 19, 34]. The response should build on the strengths, resources, competencies, social connections and resiliency that are already present in individuals and communities, while strengthening capacity and technical skills which are missing. Leadership training and other facilitation, such as pairing with a mentor and providing financial incentives, should be provided as appropriate. Peer-led interventions have flourished as an important model for engaging and empowering different priority communities in Hong Kong, but they require that the agencies or communities hiring the peers have the resources needed to keep it sustainable[35].

74. NGO are the key players in delivering targeted prevention and surveillance to the affected communities. While ATF will maintain its resources commitments, efforts should be

made to mobilise other resources. AIDS components can be added or enhanced in existing programmes addressing cross-cutting issues such as prevention of drug abuse, promotion of equal opportunities on the grounds of sexual orientation and gender identity, protection of women and children, and advocacy of health equity, and vice versa.

75. To meet the demand of effective project management and sustainable development, assessment will be required to delineate the scope, sources and funding of support that are required by community organisations to build up their capacity. The Hong Kong Council of Social Service and overseas consultancies on technical support of HIV/AIDS are potential avenues through which additional support may be offered.

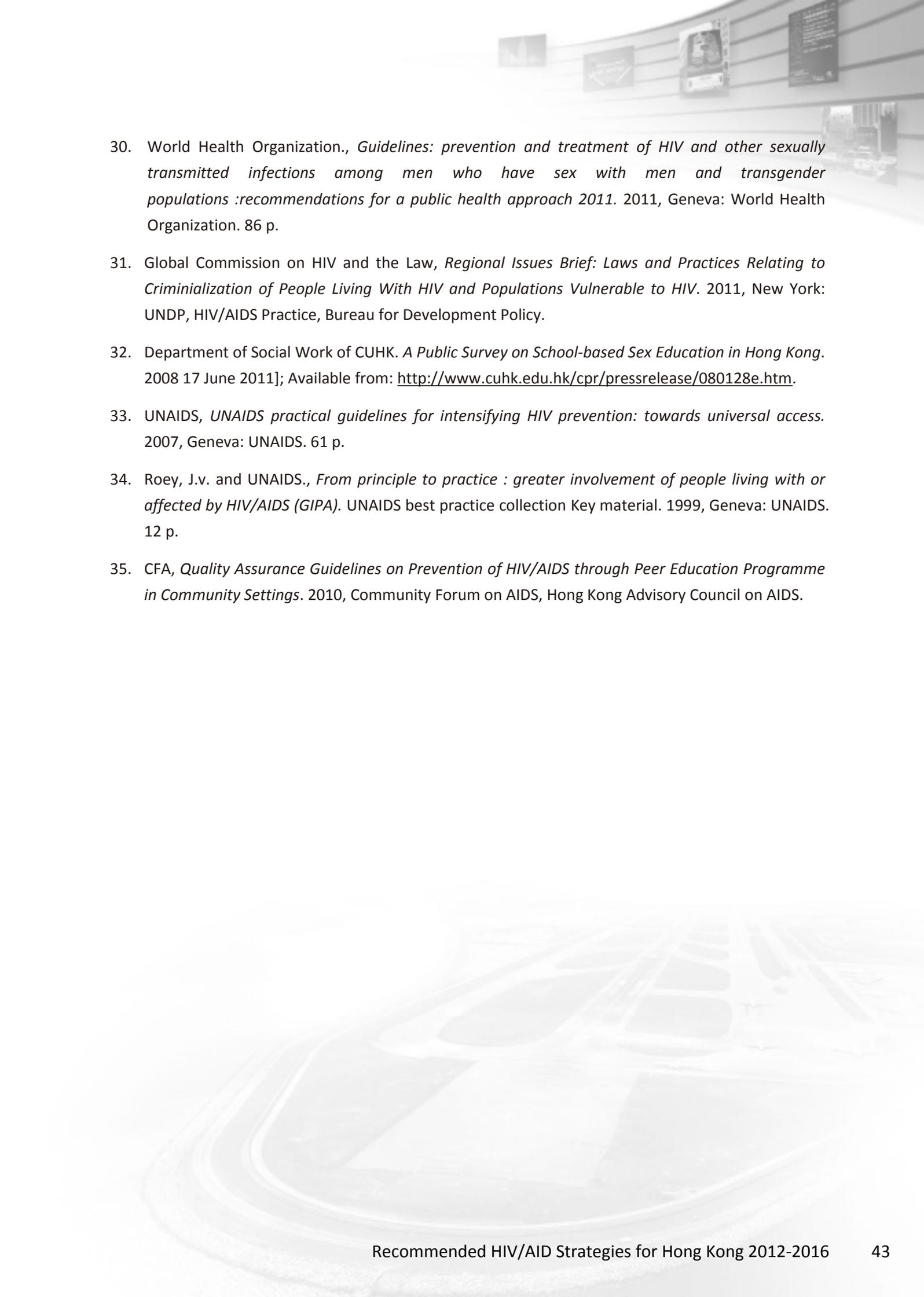
76. Exchange and joint efforts at government and community levels between Hong Kong and the nearby regions especially Mainland China on HIV and related fields has increased over time. Prevention and control of HIV in Hong Kong hinges greatly on the corresponding work in the Mainland. There is ongoing need for mutual enhancement of capacity with Mainland health workers. Closer communication on updated HIV/AIDS situation especially in the Pearl River Delta region keeps us alert on early warning signals. Apart from synergistic publicity, collaboration on HIV prevention and health promotion needs to be actively explored. Other modes of interaction through consultancies, reference services, and reciprocal study tours will also be mutually beneficial.

77. Local residents travelling outside the territory still produce the largest portion of heterosexual male infections. Current efforts are largely insufficient in reaching this mobile population. It is worthwhile to explore augmented efforts to reduce HIV risk of this community.

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**Extract of Key Strategies Documents – UNAIDS,
WHO, Mainland China**

A. *Getting to Zero – UNAIDS Strategy 2011 - 2015* (extracts of vision, goals and key challenges for the global HIV response)

Vision: To get to Zero New Infections

Goals for 2015:

- Sexual transmission of HIV reduced by half, including among young people, men who have sex with men and transmission in the context of sex work
- Vertical transmission of HIV eliminated and AIDS-related maternal mortality reduced by half
- All new HIV infections prevented among people who use drugs

Vision: To get to Zero AIDS-related Deaths

Goals for 2015:

- Universal access to antiretroviral therapy for people living with HIV who are eligible for treatment
- TB deaths among people living with HIV reduced by half
- People living with HIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support

Vision: To get to Zero Discrimination

Goals for 2015:

- Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half
- HIV-related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions
- HIV-specific needs of women and girls are addressed in at least half of all national HIV responses
- Zero tolerance for gender-based violence

Key challenges for the global HIV response

- HIV as a pathfinder and investment opportunity
- Priority-setting, alignment and harmonization
- Access to affordable medicines and commodities
- Strengthening systems
- Social justice

B. Global Health Sector Strategy on HIV/AIDS 2011 – 2015, WHO.

Strategic directions and corresponding core elements

- (i) Optimize HIV prevention, diagnosis, treatment and care outcomes
 - Revolutionize HIV prevention
 - Eliminate new HIV infections in children
 - Catalyse the next phase of treatment, care and support
 - Provide comprehensive and integrated services for key populations
- (ii) Leverage broader health outcomes through HIV responses
 - Strengthen links between HIV programmes and other health programmes, namely TB, maternal, newborn and child health, sexual & reproductive health, non-communicable and chronic diseases, drug dependence & control, blood, surgical and injection safety.
- (iii) Build strong and sustainable systems
 - Strengthen the six building blocks of health systems, namely (1) HIV service delivery models, (2) health system financing, (3) human resources, (4) strategic information, (5) HIV medicines, diagnostics and commodities, and (6) leadership, governance and strategic planning for HIV.
- (iv) Reduce vulnerability and remove structural barriers to accessing services
 - Promote gender equality and remove harmful gender norms
 - Advance human rights and promote health equity
 - Ensure health in all policies, laws and regulations.

C. China Action Plan to Prevent and Control HIV/AIDS (2011-2015) Second Draft – an Extract

Working principles

- (i) Ensure the leadership and organizational role of government, multi-sectoral accountability, and involvement of all social actors.
- (ii) Prioritize prevention, combine prevention and control, respond to HIV/AIDS according to the law, and ensure the scientific soundness of the HIV/AIDS response.
- (iii) Concentrate on the epicenters of the epidemic, provide differentiated guidance according to the different situations, conduct hierarchical management of the HIV/AIDS response at different levels, and ensure accountability.
- (iv) Integrate resources, conduct comprehensive governance, ensure quality, and strengthen monitoring.

Strategies and measures

- (i) Conduct extensive, in-depth and sustainable information, education and communication on HIV/AIDS that leverage the advantages of existing networks, (1) via mass media; (2) in settings and communities including public venues and transportation facilities; (3) in remote and ethnic minority areas; (4) among migrants and other key populations including life skill training in junior high schools and above with annual assessment at the schools.
- (ii) Expand the coverage of effective prevention interventions and enhance the quality of interventions, with (1) priority on containment of HIV transmission via sex; (2) strengthening of comprehensive interventions with drug users to promote community-based drug maintenance treatment; and (3) expanding the coverage of PMTCT of HIV and congenital syphilis
- (iii) Strengthen blood safety management and prevent iatrogenic transmission
- (iv) Improve the laboratory testing network to increase the accessibility of testing services
- (v) Strengthen the management of PLWHA to implement comprehensive care and support measures
- (vi) Increase the accessibility and quality of ART to reduce HIV/AIDS mortality, with relevant systems improved, supply and management of ART strengthened, and full utilization of traditional Chinese medicines as part of the regime for AIDS treatment.
- (vii) Improve the comprehensive surveillance system and strengthen monitoring and evaluation
- (viii) Promote social participation in response to HIV/AIDS, through implementation of preferential taxation policies for enterprises involved in HIV/AIDS work, mobilization of social organizations and purchasing of services provided by them.
- (ix) Strengthen scientific research and international cooperation in HIV/AIDS response

Progress of the Targets of the Recommended HIV/AIDS Strategies for Hong Kong 2007 – 2011

<p>Target One Increase condom use of MSM, sex workers and clients to $\geq 80\%$</p>	<ul style="list-style-type: none"> Community-based surveys among MSM, sex workers and their clients indicated that the level of consistent condom use remained stable; 75% of MSM always used condom for anal sex among non-regular sex partners (54%-60% for internet-recruited MSM); 95% of female sex workers used condom more than half encounters in preceding week during vaginal sex with customers; 67% and 71% of male sex workers used condom every time in vaginal sex and anal sex respectively with their clients; and 73%-81% of male clients of female sex workers always used condom.
<p>Target Two Incorporate rapid HIV testing for late presenting mothers to close gap of MTCT</p>	<ul style="list-style-type: none"> The universal antenatal HIV testing programme was implemented on 1 September 2001. In 2006, one of the main recommendations from the evaluation of the antenatal HIV screening programme (2001-2004) identified that rapid HIV testing should be considered for late presenting women whose HIV status was unknown at the time of attending labour wards. To fill this gap, SCAS recommended the introduction of rapid HIV testing in 2007. After a pilot scheme in 2007, rapid HIV testing has been offered to late presenting pregnant women in all public hospitals since 2008. As a result, the proportion of women who had HIV status known before delivery went up from 90.96% in 2006 to a record 99.96% in 2010.
<p>Target Three Develop one or more resource allocation plans to guide programme funding</p>	<ul style="list-style-type: none"> Based on the success of ATF's Special Project Fund and the resource allocation model of San Francisco, ATF was recommended to move towards an epidemiology based under-driven approach for resource allocation. As a result, a resource allocation plan had been suggested by SPP based on the reported statistics in 2007 and the resource allocation of ATF to various populations and areas between financial year 2005/06 and 2007/08. Funding of programmes supported by ATF has been in line with the resource allocation plan.
<p>Target Four Review ATF funding mechanism to improve effective funding of community-based response</p>	<ul style="list-style-type: none"> At the 61st ACA meeting, ATF presented a paper on how to improve its funding mechanism for a more effective community-based response having taken into account of the changing HIV situation and ACA's latest recommended strategies. High risk groups identified for high priorities included MSM, IDU, sex workers and their clients, cross-border travellers and persons living with HIV. Subsequently, ATF revised its funding guidelines to tie in with the priority areas as identified by ACA and specify important considerations of applications in May 2008 and again in 2009.

<p>Target Five Regularize community surveillance of risk populations at 1-2 year intervals</p>	<ul style="list-style-type: none"> • In 2006/07, a community-based HIV prevalence and risk behavioural survey for MSM frequenting gay saunas, bars and discos (PRISM). The HIV prevalence was 4.1% from a sample of 859 MSM. In 2008/09, this survey was repeated with a sample of 831 MSM which showed a seroprevalence of 4.3%. • In 2006, a community-based risk behavioural and seroprevalence survey on female sex workers from different sex establishments including nightclubs, street, bars and “one- woman brothels” (CRISP). From 996 eligible samples, the HIV prevalence was 0.2%. The survey was repeated in 2009 with a sample of 986 female sex workers which showed an adjusted seroprevalence of less than 0.1%. • Seroprevalence and risk behaviours of community-based heroin drug users can be inferred from the universal HIV antibody urine testing programme in methadone clinics (since 2004) and annual Street Addict Survey (since 1991) respectively. • The above mentioned surveys, which were funded by DH and carried out in collaboration with NGOs and/or academic institutions, would be continued. • A series of behavioural risk surveys targeting male clients of female sex workers in Hong Kong have been conducted every one to two years and funded by ATF since 1999.
<p>Target Six Improve HIV testing coverage among risk populations</p>	<ul style="list-style-type: none"> • The proportion of MSM who had been tested for HIV in the past one year has increased from 24% in 2006/07 to 35% in 2007/08. The proportion of FSW who had been tested for HIV in the past one year has increased from 45% in 2006 to 49% in 2009. • The increase can be attributed partly to an escalation of funding from ATF for HIV testing services in the community settings. As a consequence, a greater proportion of new HIV diagnosis was now made by NGOs. The wide adoption of rapid HIV testing, including the government AIDS Counselling and Testing Service, which has better acceptability over conventional testing, also contributed towards a higher coverage. • With more organizations providing HIV testing and counselling in the community settings, CFA published quality assurance guidelines in 2009 to guard against the standard of service provision. • As for IDU, the coverage of annual universal HIV antibody urine testing programme in methadone clinics has reached 77% - 90%.

<p>Target Seven Sustain quality HIV care of international standards to people living with HIV/AIDS</p>	<ul style="list-style-type: none"> • Over the last few years, about 70% of reported HIV cases had received care at public HIV specialist services in the DH and HA. There was substantial increase in the drug expenditure due to rise in patient load and increasingly more of them receiving HAART as a standard lifelong treatment. As a result, extra funding has been allocated to both DH and HA to procure antiretroviral drugs. • The establishment of an HIV clinic in 2009 at Princess Margaret Hospital has strengthened the clinical capacity. • The local standard of HIV care is benchmarked by peer-reviewed guidelines and clinical effectiveness. All clinics have participated in the promulgation of relevant guidelines and importantly have achieved a high level of effectiveness in HIV disease management, such as low default rate, drug adherence, timely acquisition of new drugs, integrated management of co-infection, and programmes for preventing onward HIV transmission. • Scientific Committee on AIDS and STI continues to be a strong factor in the local standard of care. Since 2007, guidelines and recommendations have been published and updated for areas of prevention and care, including the prevention of perinatal HIV transmission, management of tuberculosis and hepatitis B co-infection, use of BCG vaccine in HIV infected patients and principles of antiretroviral therapies in HIV disease.
<p>Target Eight Enhance collaboration with Mainland China through regular or ad-hoc programmes/projects</p>	<ul style="list-style-type: none"> • There has been enhanced collaboration with Mainland China on three major areas, namely (i) surveillance; (ii) health promotion and publicity; and (iii) capacity building. • Apart from regular meetings and the Pearl River Delta electronic platform which has been used for sharing HIV surveillance data among 12 participating cities in the region since 2005, a collaborative research project on HIV-1 molecular epidemiology between Shenzhen, Guangzhou, Macau and Hong Kong was completed in 2007. • Since 2007, Hong Kong, Shenzhen and Macau from both the government and NGOs have been supporting each other in the publicity activities around World AIDS Day, HIV prevention campaigns for MSM, and sharing of mutual experience in related programmes. • Apart from the ongoing Lions Red Ribbon Fellowship Scheme which has been organized since 1999, a new one-week attachment programme was started in 2007 under the sponsorship of Lions Club for frontline workers in Shenzhen and Guangzhou on HIV prevention among MSM. This provides an opportunity for colleagues from across the border to learn about the outreach and centre-based HIV prevention activities in Hong Kong. • There were numerous exchanges between the Mainland and Hong Kong through regional meetings, forums and consultancy projects. For example, Mainland colleagues were invited as participants and/or observers in two large-scale meetings held in Hong Kong, namely the technical consultation on the health sector response in HIV and MSM in 2009 and the Regional Action Planning Meeting of Multi-city HIV Initiative among MSM and Transgender Populations in 2010. • Regarding training of HIV physicians and clinical staff, DH regularly received clinicians and nurses for clinical attachment programmes from various parts of Mainland China, including Beijing, Gansu, Guangxi, Guangdong, Sichuan and Hunan.

Appendix III

Summary of Third Set of Core Indicators for Monitoring Hong Kong Aids Programmes (Adapted From the Framework of the United Nations General Assembly on HIV/AIDS Reporting System)

	Indicator	Data period	Result
<i>Expenditures</i>			
1.	Fund spent by the Government	Financial Year 2008-09	STI Treatment: \$66 million HIV Prevention: \$21.7 million Drug expenditure on HIV/AIDS clinical care and treatment: \$103 million ATF: \$34.3 million
<i>Policy Development and Implementation Status</i>			
2.	National Composite Policy Index	2008 – 2010	Details can be found in the full report
<i>Programmes</i>			
3.	Percentage of donated blood units screened for HIV in a quality assured manner	2008	100%
4.	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	2008	Adult male = 91.1%; Adult female = 92.4%; Overall Adult = 91.3% Children < 15 = 100%
5.	Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission	2008	50%
6.	Percentage of patients in the TB-HIV Registry managed by DH that received treatment for TB and HIV	2008	Male = 63.6%; Female = 100%; Overall = 68.0%
8.	Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results	2008 – 2009	MSM= 35.7% FSW = 48.8% Heroin drug users (HDU) = 83.4% - 86.3%

9.	Percentage of most-at-risk populations reached with HIV prevention programmes	2008 – 2009	<p>MSM:</p> <ul style="list-style-type: none"> • 90.4% received HIV prevention information; & • 72.4% received free condoms <p>FSW:</p> <ul style="list-style-type: none"> • 99.2% received HIV prevention message; • 52.5% received outreach education; • 58.3% received free condom; & • 68.9% had peer discussion <p>HDU:</p> <ul style="list-style-type: none"> • 97.4% ever registered with methadone clinic(s) in the past 7 years
Knowledge and Behaviour			
13.	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	2006	<p>Aged 15 – 17:</p> <ul style="list-style-type: none"> ■ Male = 57.3% ■ Female = 65.6% ■ Overall = 61.9% <p>Aged 18 – 24:</p> <ul style="list-style-type: none"> ■ Male = 64.0% ■ Female = 71.8% ■ Overall = 67.8%
14.	Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	2008 – 2009	<p>MSM = 90.4%</p> <p>FSW = 99.2%</p> <p>HDU = 100%</p>
15.	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	2006	<p>Aged 15 – 17:</p> <ul style="list-style-type: none"> ■ Male = 8.0% ■ Female = 3.2% ■ Overall = 5.4% <p>Aged 18 – 24:</p> <ul style="list-style-type: none"> ■ Male = 2.3% ■ Female = 2.5% ■ Overall = 2.4%
18.	Percentage of female and male sex workers reporting the use of a condom with their most recent client	2007 – 2009	<p>FSW = 96%</p> <p>MSW:</p> <ul style="list-style-type: none"> ■ 71.4% (every time with anal sex) ■ 66.7% (every time with vaginal sex)

19.	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	2008 – 2009	90.1% (last anal sex with non-regular partner); 74.6% (every time in anal sex with non-regular partner) 44.5% (every time in anal sex with regular partner)
20.	Percentage of injecting drug users who reported regular use of a condom with regular partners in the last year	2008	35.4%
21.	Percentage of injecting drug users who reported using sterile injecting equipment as a current practice	2008	46.3%
Impact			
23.	Percentage of most-at-risk populations who are HIV infected	2008 – 2009	MSM = 4.3% FSW = 0.05% HDU = 0.45%
24.	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	2007	Adult male = 94.6%; Adult female = 96.9%; Overall Adult = 95.0% Children < 15 = 100%
25.	Percentage of infants born to HIV-infected mothers who are infected	2008	0%

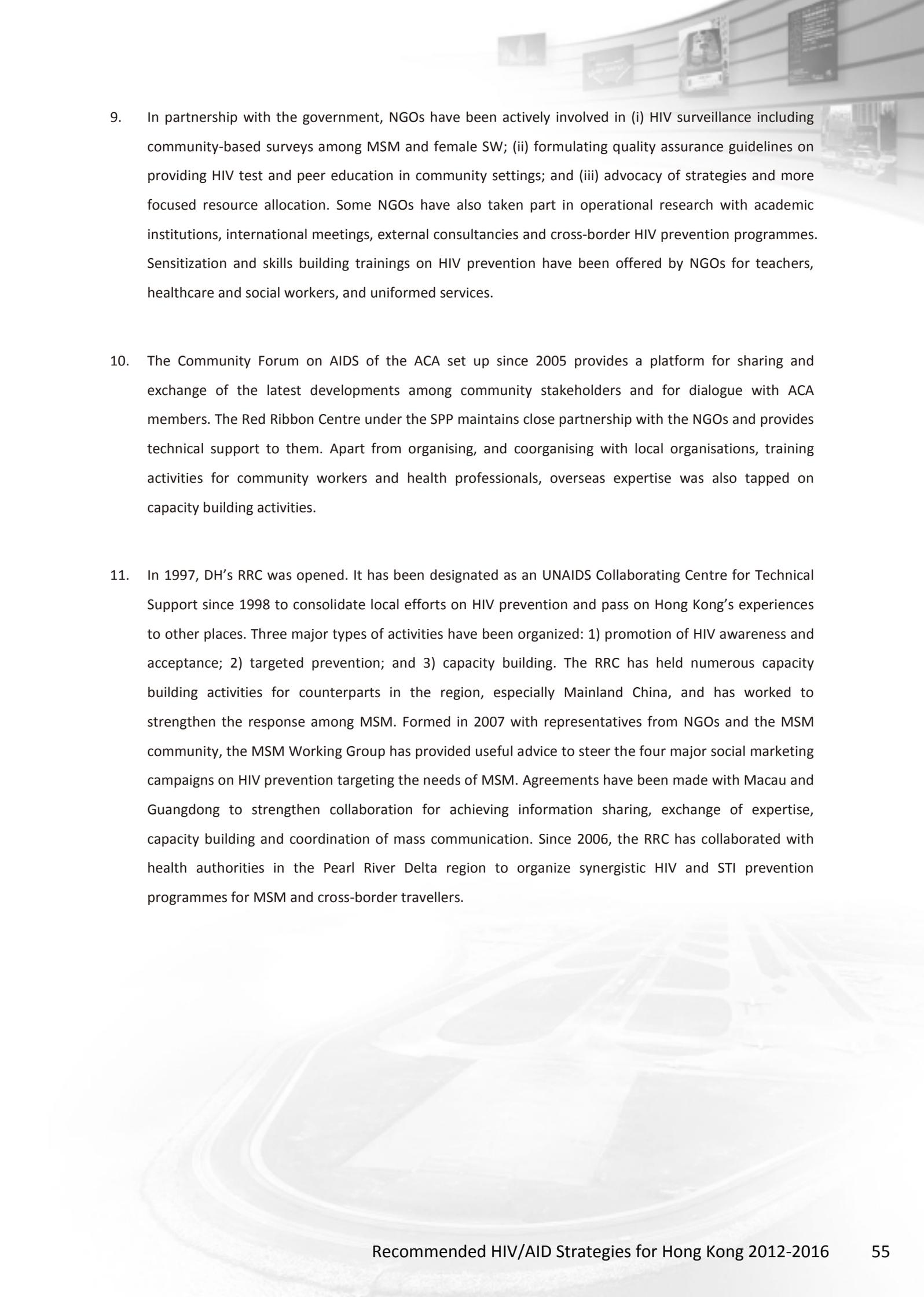
N.B. The above indicators are numbered in accordance to the Guidelines on construction of core indicators for the United Nations General Assembly on HIV/AIDS 2010 reporting cycle. There are UNGASS indicators which are considered less significant and hence not included in the local set. The full report can be accessed via the document cabinet of the Council's website (www.aca.gov.hk).

A Brief Account of Current Response on HIV/AIDS in Hong Kong

1. With early introduction of a fairly comprehensive prevention, treatment, care and support framework, surveillance system, multi-sectoral participation and a supportive environment in Hong Kong, the HIV prevalence among both the general population and at-risk populations has been kept at a low/relatively low level. The local HIV/AIDS programmes are executed by a variety of agencies spanning across sectors including health, social, educational, legal, private, correctional services and other.
2. There are two major Government-appointed advisory bodies. The Advisory Council on AIDS reviews the latest developments and provides policy advice on all aspects of HIV infection. The Scientific Committee on AIDS and STI of CHP, DH formulates technical guidance and recommendations on public health and clinical practice.
3. The Special Preventive Programme is the operational service of the DH specialising in HIV prevention, surveillance, care and support for Strategies development and implementation. Its clinical component offers voluntary HIV testing and counselling service, designated HIV care through its Integrated Treatment Centre, positive prevention programmes, and works closely with local hospitals and universities to sustain quality and seamless care. Its HIV surveillance system collects, analyzes and disseminates information on (i) size, distribution, risk behaviours and HIV prevalence of key populations from studies and sentinel sites; (ii) STI statistics provided by Social Hygiene Service; (iii) HIV/AIDS infection through a voluntary, anonymous reporting system and (iv) HIV-1 subtyping. It also participates in the Pearl River Delta Region HIV Epidemiology Electronic Platform, which was started in 2004 and involves 12 cities including Macau and Hong Kong, with a report published in December 2009.
4. Other related DH services include (i) STI prevention, counselling and treatment by the Social Hygiene Service, which is provided free to the local community; (ii) management of HIV/TB co-infection by the Tuberculosis and Chest Service; (iii) HIV antibody testing, HIV-1 genotyping and subtyping, CD4/CD8 T lymphocyte subset test and plasma HIV-1 load tests by the Public Health Laboratory Centre; (iv) Methadone Treatment Programme and other harm reduction activities for opioid dependent persons by methadone clinics; and (v) sexual and reproductive health services offered by the Family Health Service and the Student Health Service to women of reproductive age and school students respectively.
5. Outside DH, some programmes are integrated in the existing Government structure. Other than DH and Food and Health Bureau, the Government departments / policy bureaux with active involvement in the AIDS programme include the Correctional Services Department (health education and sentinel surveillance), the Education Bureau (holistic sex/AIDS education in school curriculum, resource production and professional development of teachers), the Information Services Department (mass communication on HIV prevention and anti-discrimination), and the Social Welfare Department (subvention of social and rehabilitation services related to HIV prevention of marginalized populations and support of PLHIV). The work of the Government is supplemented by the Hospital Authority

(hospital-based clinical service) and its Hong Kong Red Cross Blood Transfusion Service (safety of blood and blood products). With the introduction of nucleic acid testing in 2006, the window period for the detection of HIV in donated blood and blood products has been significantly shortened. Within the Hospital Authority, adults who are PLHIV receive HIV care from the Special Medical Service in Queen Elizabeth Hospital and Princess Margaret Hospital, while children affected by HIV are managed by the Paediatrics units in Queen Mary Hospital and Queen Elizabeth Hospital.

6. The Government set up a special fund – AIDS Trust Fund - in 1993 to render financial support to those living with HIV infection and haemophilia. The ATF launched an additional ex-gratia payment scheme in July 2005 to provide on-going financial assistance to the haemophilia patients and their families. The fund has effectively served as the main source of financial support for agencies working on HIV/AIDS prevention and patient support and for research activities operating in Hong Kong. It is managed by a Council chaired by a government-appointed community leader and made up mainly of non-officials. Over the years, the Fund has become increasingly focused on supporting programmes with the greatest impact on the epidemic in its funding decisions. For example, faced with the rising HIV epidemic among MSM, the ATF launched a Special Project Fund for a period of 2 years between December 2006 and August 2008. Revision of funding guidelines to tie in with the priority areas as identified by the Advisory Council on AIDS was promulgated in May 2008.
7. The first AIDS NGO was set up in 1990 and the number has grown over the years. The Hong Kong Coalition of AIDS Service Organizations formed in 1998 provides a platform for collaboration and experience sharing among various NGOs working in HIV-related areas. The Coalition has 15 full and associate members in 2011-2012, including non-AIDS specific NGOs which are involved in HIV prevention and health promotion activities. Coordination among NGOs has made it possible for them to complement each other and scale up programme coverage for key subgroups.
8. In recent years, a large proportion of the work carried out by NGOs has been focused on populations which are disproportionately affected by HIV, such as MSM, IDU, SW and their clients, prisoners, and ethnic minorities. In addition to more conventional activities such as venue outreach, hotline, group, educational sessions, community programmes, distribution of promotional material and condom, and media advocacy, more NGOs have been running online interventions, HIV testing and counselling services, and sexual health programmes for their clients. NGOs provide support services to PLHIV and those caring for them mainly through visits, home care, referral, free transport and escort to clinic follow-up, counselling, support groups, social functions and rehabilitation programmes. Increasing community involvement has been evident in the last decade, and training of peer volunteers has become a popular tool to engage and empower community members. On a smaller scale, HIV prevention activities such as workshops, peer education, distribution of promotional materials, drama and community functions have also been organized by NGOs to raise awareness of HIV among school students and general public.

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9. In partnership with the government, NGOs have been actively involved in (i) HIV surveillance including community-based surveys among MSM and female SW; (ii) formulating quality assurance guidelines on providing HIV test and peer education in community settings; and (iii) advocacy of strategies and more focused resource allocation. Some NGOs have also taken part in operational research with academic institutions, international meetings, external consultancies and cross-border HIV prevention programmes. Sensitization and skills building trainings on HIV prevention have been offered by NGOs for teachers, healthcare and social workers, and uniformed services.
 10. The Community Forum on AIDS of the ACA set up since 2005 provides a platform for sharing and exchange of the latest developments among community stakeholders and for dialogue with ACA members. The Red Ribbon Centre under the SPP maintains close partnership with the NGOs and provides technical support to them. Apart from organising, and coorganising with local organisations, training activities for community workers and health professionals, overseas expertise was also tapped on capacity building activities.
 11. In 1997, DH's RRC was opened. It has been designated as an UNAIDS Collaborating Centre for Technical Support since 1998 to consolidate local efforts on HIV prevention and pass on Hong Kong's experiences to other places. Three major types of activities have been organized: 1) promotion of HIV awareness and acceptance; 2) targeted prevention; and 3) capacity building. The RRC has held numerous capacity building activities for counterparts in the region, especially Mainland China, and has worked to strengthen the response among MSM. Formed in 2007 with representatives from NGOs and the MSM community, the MSM Working Group has provided useful advice to steer the four major social marketing campaigns on HIV prevention targeting the needs of MSM. Agreements have been made with Macau and Guangdong to strengthen collaboration for achieving information sharing, exchange of expertise, capacity building and coordination of mass communication. Since 2006, the RRC has collaborated with health authorities in the Pearl River Delta region to organize synergistic HIV and STI prevention programmes for MSM and cross-border travellers.