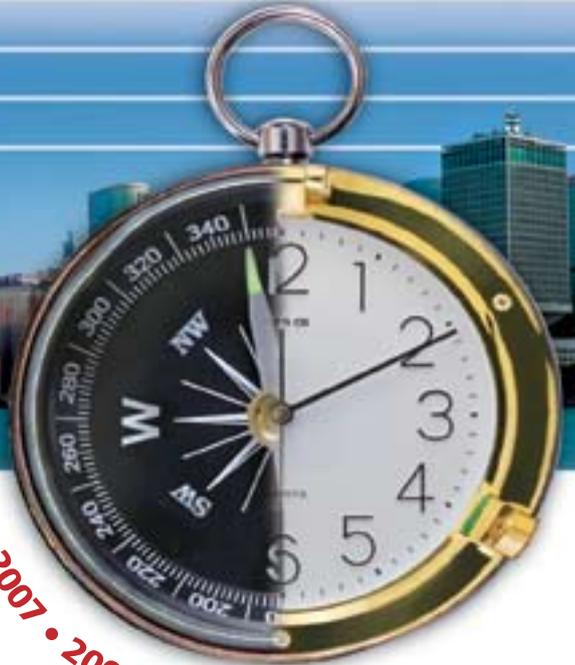


RECOMMENDED HIV/AIDS STRATEGIES FOR HONG KONG

2007 TO 2011



1999 • 2000 • 2001 • 2002 • 2003 • 2004 • 2005 • 2006

• 2007 • 2008 • 2009 • 2010 • 2011 • 2012 • 2013



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Preamble

The Hong Kong Advisory Council on AIDS, in its mandate to advise the Government on policies relating to the prevention, care and control of HIV infection and AIDS in Hong Kong, developed this new Strategies for year 2007-2011. The document serves as the blueprint for the collective AIDS effort in the next five years, in response to the changing local epidemic.

This recommended Strategies is divided into 3 parts. The first part comprises a brief overview of the current HIV/AIDS situation and programme response. The second part depicts the Strategies framework and identifies current priority areas. The third part delineates targets and indicators, and describes the stakeholders and players pivotal to achieving the tasks. Specific targeted action plans are not the intention of this document.

This document is to be used by all people and organizations which are involved in the fight against AIDS in Hong Kong. A partnership approach is taken. We recommend that the Hong Kong government will adopt it as the blueprint document for providing policy and funding support. The Department of Health shall use it to guide its programme and resource planning, service delivery and facilitation of community response. The AIDS non-governmental organizations shall base on the document for aligning and augmenting their prevention and care efforts, largely through the involvement and serving of affected communities and advocacy. Other non-governmental organizations and academic institutions shall use it as a guide in their participation in AIDS services and researches. The Council for the AIDS Trust Fund and the Advisory Council on AIDS shall also base on the document in serving their roles in the AIDS response.

The HIV epidemic in Hong Kong has entered a dynamic and volatile phase. While striving to lay down the overall programme direction with focus on priority areas in this Strategies for the moment, the ACA acknowledges the difficulties to fully and accurately predict the coming situation and needs. Hence, continual monitoring of the epidemic and programme priorities will be necessary for our AIDS response.

Preface

A quarter century creeping into the history of mankind, HIV/AIDS have been most challenging to people around the world. In its sixth term, the Advisory Council on AIDS started in late 2005 to prepare the new AIDS Strategies 2007-2011 for Hong Kong. As the newly appointed ACA Chairman for this term of office, I have mixed feelings in the formulation of these recommended Strategies.

Whilst Hong Kong has remained a place of low HIV prevalence, the turning of the epidemic with its upsurge of infections has forced us to identify and re-focus the new priority areas for action. Without doubt, men who have sex with men have now become the top priority for intervention in our AIDS response. Other at-risk populations, notably sex workers, their clients and injecting drug users also need to be focused in the coming years. Concurrently, we also need to address the factors and settings, either local or external, which are conducive to the generation of new HIV infections in Hong Kong. While we deliberate to formulate these targeted strategies in our fight against HIV/AIDS, it is of utmost importance to have a supportive policy and social environment for their realization.

At the completion of the ACA's new HIV/AIDS Strategies for Hong Kong in 2007-2011, I would like to take this opportunity to thank all those who have helped to make it possible. I very much appreciate the participation of, and contributions from, all ACA members, particularly Dr. Susan Fan, Prof. Lam Tai Hing, Ms Chan Yu and Dr. Lee Man Po, who, as the core group members, laid the foundation in the development of this document. I am also grateful for the staunch support and contributions from the government bureaux/departments, community organizations/partners and other stakeholders. Last but not the least is the unflinching support and hard work of the Secretariat, for which I am grateful.

Lastly, I wish to urge the continual commitment and action from everyone who works on HIV/AIDS, and better still, from every citizen in Hong Kong; concerted efforts are now more needed than ever before.



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2007

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EXECUTIVE SUMMARY

This document is the fourth set of strategies developed by the Hong Kong Advisory Council on AIDS (ACA) since 1994. In its formulation processes, a wide-based approach to involve different stakeholders is adopted, including the separate and distinct exercises of Community Assessment and Evaluation embarked by the Community Forum on AIDS of ACA and Estimation and Projection of HIV/AIDS in Hong Kong commissioned by Centre for Health Protection of the Department of Health.

Hong Kong has been enjoying a low and quiet HIV epidemic for 2 decades since report of its first cases in 1984. Nevertheless, a transition to fast-growing phase is witnessed lately due to a rapid surging epidemic among men who have sex with men (MSM). All along, the government, the non-governmental organizations, the community and other stakeholders have worked collectively for the AIDS programme, in areas of surveillance, health promotion and HIV prevention, care, treatment and support, and programme funding.

Based on a multitude of cross-cutting guiding principles, the goals laid down in the recommended Strategies are to reduce HIV spread, maintain low prevalence and minimize HIV morbidities through early diagnosis and effective treatment. To provide a common direction for a coordinated response to the unprecedented HIV epidemic, five priority areas for action are identified: scaling up targeted HIV prevention in risk populations with MSM being the most pressing priority; mobilising an effective community-based response with prioritization of resources to the areas of need and the provision of adequate technical support; enhancing HIV surveillance and testing; sustaining access to quality treatment and care for people living with HIV/AIDS; and interfacing with Mainland China and nearby regions for an effective response.

In working towards the common goals, ACA recommends that Hong Kong adopts the UNAIDS core indicators framework, incorporation of monitoring and evaluation for individual project and eight specific targets. The specific targets are:

One	Increase condom use of MSM, sex workers and clients to $\geq 80\%$
Two	Incorporate rapid HIV testing for late presenting mothers to close gap of MTCT
Three	Develop one or more resource allocation plan to guide programme funding
Four	Review ATF funding mechanism to improve effective funding of community-based response
Five	Regularize community surveillance of risk populations at 1-2 year intervals
Six	Improve HIV testing coverage among risk populations
Seven	Sustain quality HIV care of international standards to people living with HIV/AIDS
Eight	Enhance collaboration with Mainland China through regular or ad-hoc programmes/projects

Hong Kong is now at a critical point in its history of HIV epidemic. This Strategies provides a framework for the various key players to act for the same cause of HIV/AIDS prevention, care and control.



Previous HIV/AIDS Strategies

When HIV first hit Hong Kong in 1984, prevention and control activities were coordinated by the then Medical and Health Department under the guidance of an Expert Committee on AIDS. Policy development focused on the formulation of technical guidelines on infection control, counselling, HIV antibody testing and the supervision of surveillance activities. It was not until 1990 that a comprehensive approach was adopted in addressing AIDS by the newly appointed Advisory Council on AIDS (ACA). Since 1994, ACA has been producing recommended HIV/AIDS strategies for Hong Kong. Thus far 3 sets of documents were developed (Box 1). Appendix II shows the progress of achieving the targets laid down in the 2002-2006 strategies.

**Box 1. Formulation of HIV/AIDS Strategies by
the Hong Kong Advisory Council on AIDS in the past:**

1994	The first document was named "Strategies for AIDS Prevention, Care and Control in Hong Kong".
1999	The second document was named "AIDS Strategies for Hong Kong, 1999-2001" after the conduct of an internal assessment and external consultancy to review the latest HIV situation and the local AIDS programme.
2002	The third document was named "Recommended HIV/AIDS Strategies in Hong Kong 2002-2006", which was based on the activities and evaluation of ACA and its three committees, the advice of the Community Planning Committee and the input of the Secretariat in researching overseas policy development.

Formulating Strategies for the five years from 2007 to 2011

There were several key processes which contributed to the formulation of the five-year Strategies from 2007 to 2011:

A) Community Assessment and Evaluation

The Community Forum on AIDS (CFA), established in 2005 by ACA in its sixth term, embarked on an exercise of community assessment and evaluation. In response to inputs from CFA members, seven groups were formed, namely men who have sex with men (MSM), injecting drug users (IDU), sex workers and clients, cross-border travellers, people living with HIV/AIDS, women and children, and youth. Convened by a community expert, each Working Group invited members from relevant agencies and stakeholders to provide their expert views. Technical and secretariat support was provided by the Department of Health (DH)'s Special Preventive Programme (SPP). A common assessment framework was adopted, including a review of epidemiological data, an evaluation

of current response, a review of overseas guidelines and the drafting of recommendations for the next 5 years. The exercise spanned from January to July 2006 and the reports generated from the Working Groups were released in September 2006.

B) Estimation and projection exercise on HIV/AIDS in Hong Kong

The previous comprehensive exercise on the estimation and projection of HIV/AIDS in Hong Kong was carried out in 1993. To better understand the current epidemiologic situation and its future trend, an external consultant was engaged for the study. Commissioned by the Centre for Health Protection (CHP), DH, Dr. Tim Brown of East West Center, Hawaii, visited Hong Kong in April and July 2006. Besides reviewing data pertaining to the local situation, Dr. Brown met with the Secretary for Health, Welfare and Food, Director of Health, Controller of CHP, Chairman and members of ACA, Council for the AIDS Trust Fund (ATF), Scientific Committee on AIDS and STI (SCAS), NGO workers and community stakeholders. He also visited community programmes and conducted training. His consultancy report titled "HIV/AIDS in Hong Kong 2006 – Living on the Edge" contained a detailed analysis of the latest local epidemiological HIV situation and his recommendations on the way forward.

C) Opinion survey on AIDS programme and AIDS strategies

ACA issued a questionnaire survey from January to March 2006, both on-line and by post, to collect opinions and feedback from stakeholders and members of the public on the current AIDS programme and the implementation of the 2002-2006 AIDS Strategies. A total of 40 responses were received.

D) Work and deliberations of ACA and its committees

ACA itself systematically reviewed the 2002-2006 AIDS Strategies. Starting from the previous term of ACA in 2002-2005, its 3 committees (Scientific Committee on AIDS, Committee on Promoting Acceptance of People Living with HIV/AIDS and AIDS Prevention and Care Committee) discussed various subjects of local and international relevance within their respective spheres of expertise. They put forward strategy recommendations, guidelines, consensus statements and reports. The Community Forum on AIDS serves to draw input from the community on the needs, gaps and response to support strategy development. While the new SCAS was streamlined under the scientific advisory structure of CHP, effective communication is maintained between ACA and SCAS.



E) Analysis by the Secretariat on non-local development

The ACA Secretariat operated by the SPP kept track of international developments on HIV prevention and control. Relevant papers and documents were obtained and made available whenever possible to Council members to facilitate their efforts in strategy development in the Hong Kong context.

The broad-based approach of involving stakeholders (government and non-governmental organizations and the affected community) in the formulation process allows all key parties to participate and take ownership of the strategy recommendations. This approach facilitates the mapping of strategies pertinent to the local context but with an international perspective. The first draft of this strategy document was deliberated by the ACA in October 2006. The revised document was released for consultation through various channels including forums, internet and direct invitation to the stakeholders and community at large. ACA gratefully acknowledges all the organizations and individuals who have contributed their views and suggestions towards the final document.

REVIEW OF THE HIV SITUATION AND RESPONSES

Setting the scene of global and regional HIV epidemiology

Since the recognition of AIDS as a new disease entity in 1981, HIV epidemic has developed into one of the most devastating pandemics in history. The estimated number of people living with HIV worldwide went up from 10 million in 1993 to about 40 million in 2005, with over 8 million in Asia.¹ In 2005 alone, 5 million new infections have occurred and 3 million lives were lost due to the infection. Cumulatively, some 25 million people have died from the disease.

The global pandemic consists of many diverse epidemics occurring at different pace and locations, affecting heterogeneous and often marginalised populations (Box 2).

Box 2. HIV epidemics around the world

- World Health Organization (WHO) classification:
 - *Generalized epidemics* with over 1% HIV prevalence in the general population are mainly found in African countries.
 - *Concentrated epidemics* with HIV prevalence consistently over 5% in at least one defined sub-population occurred in many parts of the world, mainly in IDU, MSM, clients of female sex workers and female sex workers.
 - *Low level epidemics* with HIV prevalence not consistently exceeded 5% in any defined population.
- Pockets of concentrated epidemics among MSM were first observed in North America and Western Europe and are still continuing. Infections in Asia were due to IDU followed by heterosexual transmission and recently increasing among MSM.² Prevalence in MSM is reported to be as high as 15% to 30% in Cambodia, India and Bangkok, 8% in Taipei, and 3% in one Beijing study.
- The epidemic in Mainland China is mostly IDU-driven, with a rising trend of sexual transmission especially in cities with booming economy such as Guangdong and its Pearl River Delta region. As of 2005, the official estimate is that 650,000 people are living with the virus in Mainland China.

Evolving HIV epidemics in Hong Kong

Hong Kong has remained a low HIV prevalence area but is constantly challenged by the concentrated epidemics in the nearby regions. The most plausible reasons for the past success are believed to be the generally low level of risk behaviours coupled with the maintenance of a low HIV prevalence beneath escalation threshold. Under the voluntary and anonymous HIV/AIDS reporting system, the Department

¹ UNAIDS. 2006 Report on the global AIDS epidemic: Executive summary. 2006

² TreatAsia. MSM and HIV/AIDS in Asia: What is fueling the epidemic among MSM and how can it be stopped? 2006.



of Health has recorded a total of 3004 reports of HIV infection at the end of June 2006. Apart from 38 perinatally transmitted or transfusion related cases, others were adults. Since 1996, the number of AIDS reports was stable at around 60 cases each year. At present, *Pneumocystis* pneumonia and tuberculosis are the commonest primary AIDS defining illnesses in Hong Kong. Identification of HIV-1 subtypes at molecular level is useful for understanding the epidemiologic pattern and important in finding clusters. Locally, the commonest subtypes identified from 2002 to 2005 are CRF_01AE (49%) and B (35%). Subtype C, CRF07_BC and CRF08_BC each occurred in 5%, 3% and 2% of the total cases respectively.

The evolution of HIV epidemic in Hong Kong can be roughly divided into three phases. *The first phase* lasting till the early 1990s was characterized by haemophilic and then MSM infections. It was followed by the *second phase* when heterosexual transmission became prominent. Male infections predominated but as more females became infected, the 5-year averaged male to female ratio gradually dropped from 7:1 in 1990, 3.6:1 in 1995, and 2.4:1 in 2000 to 2.0:1 in 2005. About 80% of infected men were ethnic Chinese. However, a significant proportion of female infections came from non-Chinese Asians. Paediatric infection from mother-to-child transmission has been uncommon.

In the past few years, the HIV situation has quietly left its slow steady state and entered into a *new third phase*. There is a striking increase in infections among local MSM, against a stable heterosexual transmission. The surging MSM epidemic is supported by several observations (Box 3).

Box 3. Evidence pointing to a rising MSM epidemic in Hong Kong

<ul style="list-style-type: none">• About four fold increase in HIV reports among Chinese MSM, from 21 reports in 2000 to 76 in 2005.
<ul style="list-style-type: none">• Increase in proportion of MSM tested positive (by one NGO) from <1% in 2002 to 2.5% in 2005.
<ul style="list-style-type: none">• Identification for the first time of 2 separate clusters of HIV-1 subtype B infection involving at least 34 and 12 men respectively in 2006.

The HIV situation in IDU population, although is still relatively low, has also become more apparent in last 1-2 years. This is largely because of the improved access to HIV testing, mainly through the universal screening programme in methadone clinics where a HIV prevalence of 0.2-0.3% is found among drug user attendees. Of the reported cases, it was observed that there was an increasing trend of non-Chinese cases and new diagnoses made from treatment/rehabilitation services.

According to Dr. Brown's HIV/AIDS estimation and projection report, 3240 people were living with HIV in Hong Kong as of 2005, with about 3700 infected cumulatively. In 2005, there were 340 new

infections. Of the people living with HIV/AIDS (PLHA), MSM and clients of female sex workers each accounted for almost 40% of the infections.

Programmes on HIV/AIDS

Over the years, Hong Kong has established a comprehensive range of programmes and activities by various sectors of the community to address HIV/AIDS. The term programme denotes this unique set of collaborative efforts. This section serves to provide an outline as well as the highlights of the latest development.

Hong Kong's HIV/AIDS Programme are executed by a variety of agencies. Within the Government, the Department of Health's SPP is the designated unit working on AIDS. With the formation of CHP under Department of Health in 2004, SPP was put under its Public Health Services Branch. The Government-appointed *Advisory Council on AIDS* provides policy advice on all aspects of the infection. In 2004, the ACA released its report on the study of HIV-infected haemophiliacs "*The Forgotten tragedy, the Unforgettable trauma*", the recommendations of which were adopted by the Government. The new *Community Forum on AIDS* was set up by the Council in its sixth term of 2005-2008. A number of AIDS non-governmental organizations (NGO)³ provide prevention and care services in community-based settings. Formed in February 1998, the *Hong Kong Coalition of AIDS Service Organizations* (HKCASO) aims to facilitate communication between its member agencies and to advocate on policy issues relating to HIV/AIDS in Hong Kong. The efforts of designated organizations/units are supplemented by other government services, public bodies, mainstream NGOs and the academia.

HIV/AIDS surveillance is a regular programme under the purview of the Department of Health. It is comprised of 4 inter-relating components: (i) voluntary reporting, (ii) seroprevalence studies, (iii) behavioural surveillance, and (iv) sexually transmitted infection (STI) surveillance. Quarterly statistics and annual surveillance reports are published on a regular basis. Updated statistics are released and disseminated to stakeholders through the website (www.aids.gov.hk) and quarterly press meetings. The DH2293 report form on HIV/AIDS was revised in late 2005 to collect more useful information. Based on several years of gainful experience from the pilot molecular epidemiology project, HIV-1 subtyping has been recently incorporated as a surveillance tool in Hong Kong.

The Government's **HIV prevention and health promotion** activities are implemented by both designated AIDS services and other departments/units. *The Red Ribbon Centre* is the resource centre that houses the Department of Health's HIV Prevention and Health Promotion Team. The Centre organizes three major categories of activities – communication and information projects on awareness

³ Examples of AIDS NGOs in Hong Kong are: Hong Kong AIDS Foundation, AIDS Concern, Society for AIDS Care, TeenAIDS, St John's Cathedral HIV Education Centre



and acceptance, targeted prevention, and capacity building. Its designation as the Joint United Nations Programme on HIV/AIDS (UNAIDS) Collaborating Centre for Technical Support was granted in 1998 and recently extended to mid-2008. A new wing of the Centre was opened in June 2006 to enhance its role in capacity building and training. The Department's *Social Hygiene Service* and *Methadone Treatment Programme* are outlets for STI treatment and harm reduction respectively. Territory-wide social marketing campaigns on harm reduction and safer sex were carried out in 2002 and 2005 respectively. In 2004, a universal yearly urine HIV testing programme was rolled out in all methadone clinics, to improve care, surveillance and control of HIV among drug users. In mid-2006, in partnership with the community, a HIV awareness campaign targeting MSM was launched. The *Hong Kong Red Cross Blood Transfusion Service* is on the forefront in safeguarding blood supply in Hong Kong. Nucleic acid amplification test for HIV and HCV was introduced in July 2002 to further shorten the window period of missing acute infections in blood donors.

On the community level, the AIDS NGOs have continued to consolidate their expertise in HIV prevention and care. *AIDS Concern* is a pioneer in the development of prevention activities targeting MSM, travellers and sex workers. The *CHOICE, Action for Reach Out* and *Ziteng* worked on female sex workers and clients. The *Society for AIDS Care* provides centre-based and home care services to people living with HIV/AIDS. The *St John's Cathedral HIV Education Centre* works on prevention among youth, women, Asian migrant workers and church congregations. *TeenAIDS* focused on HIV awareness and young people. The *Hong Kong AIDS Foundation* targets a range of populations and is notable for its collaboration with Mainland. Over the past few years, there was an increasing number of main stream organizations commencing work in the field of HIV/AIDS. The *Society for the Aid and Rehabilitation of Drug Abusers* works on drug users in outreach and treatment settings, the *Society of Rehabilitation and Crime Prevention* targets sex workers and ex-offenders, the *Caritas – Hong Kong* and the *Boys and Girls' Club Association of Hong Kong* focus on youth. The *Hong Kong Federation of Women's Centres* serves women.

HIV testing, diagnosis and care constitute another broad category of programme on AIDS. The Government's *Public Health Laboratory Centre* is the largest diagnostic laboratory on HIV in Hong Kong, supporting a variety of testing and patient monitoring services/programmes organized by the Department of Health, Hospital Authority, NGOs as well as private sectors (on confirmation testing). The advent of highly active antiretroviral therapy (HAART) has significantly changed HIV treatment and care around the world. At the end of year 2005, it was estimated that there were some 3200 PLHA in Hong Kong, with an estimated 1200 people on HAART. Longitudinal care of the vast majority of PLHA is provided by the public sector – *Integrated Treatment Centre (ITC)* of the Department of Health and the Special Medical Service of the Hospital Authority's Queen Elizabeth Hospital. Princess Margaret Hospital is providing in-patient care on HIV/AIDS and collaborates with ITC through the Infectious

Disease Programme on AIDS. Queen Mary Hospital is the largest centre for HIV-infected paediatric patients. The *Scientific Committee on AIDS and STI* under the CHP formulates technical guidance and recommendations on public health and clinical practice. It issued two local recommendations on antiretroviral therapy and HIV care delivery framework respectively in 2005.

Programme funding source comes mainly from the Government, both through regular established mechanisms and the ATF, to Government departments, public bodies and community organizations. The ATF introduced a technical review system and a 3-year programme funding mechanism in 2003. In 2005, the ATF established an additional ex-gratia payment scheme to provide financial assistance to HIV infected haemophiliac patients and their families.

In response to the rising MSM epidemic, the ATF in December 2006 launched a Special Project Fund for HIV prevention in MSM to support community projects for reducing risk behaviours and preventing HIV infections in MSM for the coming two financial years (2007 to 2009). The SPF funds prevention and research projects and, for the first time, predefined objectives and preferred project areas are listed for application. From 2002 to 2006, a total of 79 projects were funded by ATF, amounting to a total of HK\$107 million. These covered patient support and care, HIV prevention and research. Besides, the NGOs have been active in raising funds for their operation and services to support community-based projects over the years.

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FRAMEWORK FOR STRATEGIES 2007-2011



Basic overview

As indicated in the previous chapters, the formulation of this strategy document is based on assessment of the current situation, an evaluation of programmes, a projection of changing trends, and the identification of gaps in the current response. The proposed recommendations aim to guide the overall community-wide AIDS response in the next five years. It is a product of objective, integrated and consultative processes with a public health oriented approach.

Strategies objectives

The objective of this strategy document is to provide a common direction for a coordinated AIDS response in Hong Kong, with the goals of:

- (a) maintaining low HIV prevalence
- (b) reducing HIV spread
- (c) achieving early HIV diagnosis, treatment and care
- (d) optimising health of HIV/AIDS patients

Guiding principles

The widely adopted international principles on HIV prevention, care and control applies to Hong Kong. Solidarity with partners of Mainland China and international community is indispensable. Several cross-cutting issues underpin all aspects of HIV prevention, care and control in the local context. The guiding principles for addressing these issues, after the processes of strategies development and deliberation of ACA, are listed below:

Adopting evidence-based approach. The prevention and care needs should be evidence-based, taking reference of the latest situations on epidemiology, strategic research findings and programme response.

Encouraging community partnership and support. Community and NGOs are key partners in prevention, surveillance and care programmes for hard-to-reach and vulnerable populations. Greater collaboration among organizations as well as affected communities will enhance the overall collective response.

Building supportive and enabling environment. A non-discriminatory environment receptive to human rights is conducive to effective programme intervention.

Prioritizing funding. In order to maximize the impact from limited resources, a relatively greater proportion of funds should be channeled to areas where most infections occur.

Integrating monitoring and evaluation. Monitoring and evaluation (M&E) should be an integral component of local AIDS programme and conducted at various levels during the different phases of planning and implementation.

Cultivating expertise. The small mass of public health, community and clinical expertise is to be expanded and sustained, while strengthening the general capacity of supporting staff and volunteers.

Addressing vulnerability and risk behaviours with intensive coverage. Intervention for behaviour change communication (BCC) should be relevant and acceptable to the target population, so as to encourage active participation, dialogue and empowerment and to achieve a higher coverage. The increasing human mobility associated with risk behaviours within the region should also be tackled with targeted measures.

Enhancing communication and education. The wider public should also be engaged through sustained awareness-raising and public education efforts of AIDS organizations as well as mainstream NGOs.



This chapter sets out the priority areas for action under the following sections:

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- A. Scaling up targeted HIV prevention in risk populations with MSM being the most pressing priority
 - B. Mobilising an effective community-based response with prioritization of resources to the areas of need and the provision of adequate technical support
 - C. Enhancing HIV surveillance and testing
 - D. Sustaining access to quality treatment and care for people living with HIV/AIDS
 - E. Interfacing with Mainland China and nearby regions for an effective response
-
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A. Scaling up targeted HIV prevention in risk populations with MSM being the most pressing priority

Putting brakes on the accelerating MSM epidemic

The HIV situation in Hong Kong has taken on an urgency never seen before, with implications for both prevention and care. Epidemiologic evidence points to MSM as the highest priority risk community to target for at least the next few years. Dr. Tim Brown's study showed that Hong Kong has entered an accelerating phase of epidemic because of MSM infections. The currently far from satisfactory <60% consistent condom use during anal sex in MSM is of urgent concern. Hong Kong can easily move from a low level to a **concentrated HIV epidemic** should the current situation continues. According to Dr. Brown's estimation, the consequence of failure to prevent this epidemic would mean 3000 more MSM needing HAART by 2020. This would be translated into, human morbidities and social costs aside, a cumulative additional treatment cost exceeding one billion Hong Kong dollars by 2020.

All along MSM is among one of the hardest-to-reach populations for preventive interventions. Nevertheless, in face of the impending public health crisis, HIV prevention efforts for MSM must be rapidly scaled up and sustained. **Increasing condom usage** is the single most effective public health measure to reduce a sexually-driven HIV epidemic. The minimum HIV prevention target for increasing condom use at anal sex among MSM should be set at 80%. (Target one, see P.23) It is necessary to achieve a **high coverage** of practising safer sex among MSM. Increasing condom use apart, they should also be advised to avoid risky sexual practices, e.g., having multiple sex partners or having sex with unfamiliar people. To this end, **community-based prevention** programmes are advantageously positioned to reach MSM. The key to success for HIV prevention is to scale up pilot projects, which have been proven effective. This will ensure that the overall AIDS response will achieve a greater impact on the course of the epidemic. New preventive interventions targeting MSM can also be piloted to increase the overall effect.

The MSM community per se plays a crucial role and they should be **informed, mobilized and provided** with sufficient **technical assistance and capacity building training** to play an active part in the coming response.

Contrary to the drug user and heterosexual population, HIV infection among MSM is mostly **locally-acquired** and perpetuated. Yet, the upsurge observed in Hong Kong is also part of a rising regional trend. Human mobility and connectivity contributes to the spread of HIV beyond borders. Unsafe sex with MSM from other Asian countries with serious MSM epidemic predisposes to further risk. **Greater awareness** of the local and regional HIV situation and the high risk behaviours involved helps to reinforce the messages of safer sex in MSM.

More importantly, these preventive interventions must be conducted in a way that does not foster further **stigmatisation and discrimination** of the MSM community. **Innovative strategies** such as providing sexual health service for MSM should also be explored.

Sustaining low prevalence among drug users

Prevention of HIV among drug users has been a success for Hong Kong, attributable to its wide coverage methadone treatment programme, unrestricted access to clean needles and syringes, high HIV awareness among drug users, relatively low sharing rates and most importantly, maintenance of an exceedingly low HIV prevalence. There are, however, emerging challenges to whether and how this low prevalence can be sustained, primarily in the face of ever-increasing human mobility in the **Pearl River Delta** and the rest of the region. Trends in HIV epidemiology and its related factors have to be tracked and monitored through various sources.

Social mixing with drug injection when injecting drug users travel across the border in either direction significantly increases the risk of upsurge in local epidemic. This is further complicated by increasing human mobility, migration and foreign travel in the region, where Mainland and some Asian countries have a differentially higher HIV epidemic in IDU than Hong Kong. Of the positive clients diagnosed at methadone clinics in 2005, 44% came from different parts of Mainland China. Surveys showed that 10-20% of Hong Kong IDUs reported purchasing or consuming drugs in Mainland in the past 3 months to 1 year. Non-Chinese cases accounted for about 30%, 75% and over 90% of the reported HIV-infected IDU cases in 2004, 2005 and the first half of 2006 respectively. Furthermore, although the data is limited at present, the phenomenon of recreational psychotropic drug abuse among MSM must not be neglected, as it can potentially fuel a more severe HIV spread in the MSM community through unprotected sex.^{4,5}

⁴ Koblin BA, Husnik MJ, Colfax G, et al. Risk factors for HIV infection among men who have sex with men. *AIDS*. 2006;20:731-9.

⁵ Buchacz K, McFarland W, Kellogg TA, et al. Amphetamine use is associated with increased HIV incidence among men who have sex with men in San Francisco. *AIDS*. 2005;19:1423-4.



HIV transmission among IDU through needle-sharing is well documented for its exponential spread in a short duration. HIV taking root in IDU is often the impetus bridging to an extensive transmission in the heterosexual populations. HIV prevalence in IDU must be kept low. Effective **harm reduction programmes** are already in place and should be continued, notably the existing methadone programme combining with unrestricted access to clean needles/syringes/condoms and outreach programmes. Drug workers taking care of the drug users are in the best position to deliver HIV intervention activities. A supportive policy and societal environment have served as the pillar stones of success and shall continue to be so.

Augmented prevention should specifically target on the **higher risk IDU segments**, including those from Mainland China and ethnic minorities from Asian countries. **Harm reduction programmes for IDU** should be integrated and expanded, including active recruitment of IDU into methadone treatment network, outreach programme to promote HIV awareness, and risk reduction and HIV testing programme. **Barriers** such as culture and language must not be overlooked. These programmes should be provided with adequate and sustainable resource and technical support. HIV-positive IDU should be engaged and maintained in drug and HIV treatment programmes to reduce onward spread of HIV.

The increasing prevalence of midazolam/triazolam use in heroin abusers (about 10% of heroin injectors in 2001 to over 25% in 2005) locally needs to be addressed, as this can be associated with increased **risk-taking behaviours**.^{6,7} IDU visiting Mainland China and other places in the region should be warned about the high HIV prevalence over there. The **prison setting in Hong Kong** provides a good access point for HIV prevention as about one-third of inmates are drug users.

Curbing growth in sex workers and clients

Unprotected sex in commercial sex settings risks HIV infection for both sex workers and their clients. Cross-border factor comes into play in these risk populations. It was found that Hong Kong men are less inclined to use condom when visiting female sex workers (FSW) in Mainland, and so are sex workers who have come from Mainland China, as compared to their practice with local sex workers. The apparently lower condom usage across the border is to be elevated. (Target one, see P.23) However, there is scarcity of information on the characteristics and behaviours relevant to HIV infection and prevention among sex workers from Mainland China and local men. More rigorous research and surveillance initiatives in this area will be required.

⁶ Bleich A, Gelkopf M, Schmidt V, Hayward R, Bodner G, Adelson M. Correlates of benzodiazepine abuse in methadone maintenance treatment. A 1 year prospective study in an Israeli clinic. *Addiction*. 1999;94:1533-40.

⁷ Ross J, Darke S, Hall W. Transitions between routes of benzodiazepine administration among heroin users in Sydney. *Addiction*. 1997;92:697-705.

Prevention programmes targeting risk behaviours in different settings leading to heterosexual HIV transmission need to be implemented and expanded. Sex workers and their clients should be offered good **access to HIV prevention services** including condom distribution and sexually transmitted infections screening and treatment services. The same harm reduction public-health oriented approaches for drug users should be used for sexual transmission prevention, covering sex workers and their clients. In the long term interests of the community, it will be preferable to operate a non-discriminatory and high-coverage health care system for this vulnerable population.

Effective prevention for clients of sex workers would have benefits extended to low risk **women** population, who are mostly infected from their HIV-infected spouse (often sex worker clients) and constitute a large proportion of female living with the infection in Hong Kong. The chain-effect of infections arising from inter-linkages of commercial sex and non-commercial sex has to be acknowledged, and safer sex be promoted as deemed necessary for prevention. Family planning and reproductive health settings are potential sites for enhancing HIV education and prevention for the relatively low risk but big women population.

Prevention of mother-to-child transmission

Universal antenatal HIV testing (UAT) was introduced in Hong Kong in September 2001 with satisfactory results. The current gap in preventing mother-to-child transmission (MTCT) lies in **late presenting mothers** who missed their HIV tests during pregnancy resulting in unknown HIV status at labour. Discerning the HIV status of these mothers in time for prompt prophylaxis to reduce MTCT is critical to narrowing the existing prevention gap. Drawing reference from overseas experiences and recommendations, **rapid testing** should be introduced to supplement the existing UAT programme as a point-of-care tool in these settings to allow timely diagnosis of infected mother and ensuing antiretroviral and obstetrical interventions to reduce MTCT. (Target two, see P.23)

Maintaining high general awareness and enhancing health promotion

Media programmes, publicity campaigns and education activities to increase public awareness have helped cultivating a conducive environment to HIV prevention in Hong Kong. The target audience of these efforts are the public, including youth, women and potentially at-risk people who may otherwise be missed by targeted prevention efforts. HIV prevention is strategically effected through AIDS education and sex education which is integrated into school moral and civic education for youth. Students are provided with ample opportunities to gain knowledge, develop concepts and values in relation to sex education and AIDS education in school curricula in different stages of learning. Promotion of HIV awareness, safer sex practice and avoidance of drug abuse deemed appropriate will help AIDS response, as preventive education should begin early in youth. Discrimination and stigmatization impede effective HIV prevention and care. **Promoting acceptance** of people living with



HIV/AIDS also encourages those people who are at-risk or the infected to access prevention services, HIV testing and early care.

B. Mobilising an effective community-based response with prioritisation of resources to the areas of need and the provision of adequate technical support

A majority of resources on HIV prevention, treatment and care in Hong Kong comes from public funding. In the face of a changing epidemic, particularly among high-risk populations, the distribution of such resources should be **reviewed, re-prioritized and rationalized**. (Target three, see P.23) To be cost-effective, efforts must be directed towards vulnerable groups rather than thinly spread among the low-risk populations. Resources should be allocated to address both **local and non-local factors/settings** fueling the local epidemic.

The Council for the AIDS Trust Fund is the major funder of community-based HIV prevention projects and activities. Its establishment in 1993 was a clear demonstration of the Government's commitment to tackle the AIDS problem. ATF's role remains pivotal to the thriving community-based work of numerous organizations. When the AIDS situation in Hong Kong was "low and slow" as in past years until the present, ATF have provided funds for prevention, treatment and care, and research activities for both high-risk groups and the population at large. With the rapid growth of the HIV epidemic, the ATF and ACA should work together for a coordinated effort. ATF should consider adjusting its funding priorities to ensure that **resources are promptly channeled to the most at-risk and often hard-to-reach populations**. The launch of a Special Project Fund by ATF to enhance HIV prevention among MSM is a move in this direction. In the medium term, a review of ATF funding mechanisms may be considered, with the aim of improving funding in the face of changing epidemic, needs and demands. (Target four, see P.23)

Besides ATF, **other funding sources** in the fields of social welfare, education, research and healthcare should also be opened to application from AIDS projects. These can take the form of on-going core prevention programmes or of innovative pilot projects that can be transformed into continued intervention programmes if shown to be successful. NGOs with proven track record could be commissioned to work on specific at-risk populations. Unnecessary duplication of effort would be avoided, while expertise would be retained and built up. On the other hand, collaboration between different organizations (AIDS, mainstream, community, academia, government) can foster mutual support, enhance cross-fertilization and facilitate widened breadth and depth of HIV projects. In the longer term, more sustainable and predictable operational support would facilitate the work of both NGOs and funders. Overall, umbrella agency like the Hong Kong Council of Social Service can play a pivotal role.

Technical assistance and capacity building are indispensable components besides resource support. Attention should be given to enhance long-term development and retention of expertise in both governmental and community sectors, for a sustained response with continuity. The pool of human expertise has to be expanded through recruitment and training with career development. Institutional and programme management capacity also need to be strengthened in general. For the purposes of accountability and to guide further development, mechanisms for monitoring and evaluation of programmes should be integrated into the funding system with earmarked resources.

C. Enhancing surveillance and HIV testing

In order to target efforts and resources more efficiently and effectively, a science-based, epidemiologically-targeted and regularly evaluated response to HIV/AIDS is needed. Data must be systematically **collected, collated, analysed and interpreted** to cover epidemiologic trends, new infections, risk behaviours and factors driving them, as well as programmatic coverage and gaps. The present surveillance effort within the Department of Health will have to be strengthened with the appropriate epidemiological, behavioural and programmatic expertise. Community surveillance programme would need to be initiated and regularized. (Target five, see P.23)

While surveillance at methadone clinics, data from the Central Registry of Drug Abuse and prison settings provide useful information on the HIV and drug use situation, there are gaps in the understanding and assessment of risks for rapid spread of HIV among **drug users**. Attributes of the non-local factors and the emerging drug-taking behaviours related to HIV are some areas to be explored.

Assessment and monitoring of HIV prevalence, risk behaviours and prevention needs of **ethnic minorities, new immigrants, and cross-border travellers** are key areas for new or expanded surveillance activities. The scenario among **sex workers** coming from Mainland China and Hong Kong clients patronizing commercial sex establishments across the border is far from clear. Their population size, demographic profile, risk behaviours and pattern, access to prevention service and HIV risk should be studied and tracked over time. For **MSM**, the size, characteristics, risk behaviour, cross border and travel patterns of many subpopulations are also largely unknown and should be examined.

Knowing their HIV status allows infected persons to seek early care and uninfected persons to take precaution and stay uninfected. **HIV testing** should be promoted among vulnerable communities and at-risk populations. (Target six, see P.23) The public health programme of universal testing for drug users implemented at methadone clinics has proved useful for enhancing surveillance, diagnosis and early care of infected persons. Regular screening should be encouraged for people with on-going risk behaviours or exposure. The means of improving access to HIV testing, including **integration into**



non-HIV related health care services or expansion of **voluntary HIV counseling and testing** services in different settings, have to be explored. Understanding the profile of HIV positive people, especially the recently infected, can shed light into prevention and care needs.

D. Sustaining access to quality treatment and care for people living with HIV/AIDS

Since HAART became the standard of care in Hong Kong in 1997, the mortality and morbidity of people living with HIV/AIDS has declined dramatically. This translates into not just health benefits for individuals but also public health impacts at the population level. Globally, scaling up the provision of HAART for the developing countries has been one of the main focus of the work of the World Health Organization in the past few years. Although the WHO's 3 by 5 initiative (i.e. treating 3 million HIV infections by 2005) was not reached, it still contributed to greatly increasing the number of patients being put on treatment. In line with the international trend, Mainland China has pledged to provide free antiretroviral treatment under its "Four Frees and One Care" policy, which was introduced in 2003.⁸

From clinical experience in both overseas and local studies, drug treatment appears to benefit the majority of treated patients for a prolonged period of time. The much extended life span coupled with fewer HIV-related complications emerging over time present new challenges for patients and health care providers. Against this background, the Scientific Committee on AIDS formulated a recommended framework on local HIV care delivery in 2005⁹, with the goal of minimizing HIV morbidity and restoring optimal health (Box 4).

Box 4. Principles of HIV clinical care delivery, SCA 2005

- practice of HIV medicine by specialist physician with necessary facilities and support;
- adoption of multidisciplinary professional team approach;
- integration of care and prevention;
- access to quality care by patients;
- ensurance of community involvement; and
- upholding of confidentiality and privacy.

The past success of HIV care in Hong Kong is probably multi-factorial, including the accessibility of state-of-the-art antiretroviral therapy, systemized health care delivery with expertise and support,

⁸ State Council AIDS Working Committee Office and UN Theme Group on HIV/AIDS in China. *A joint assessment of HIV/AIDS prevention, treatment and care in China (2004)*.

⁹ Scientific Committee on AIDS. *Recommended framework for the delivery of HIV clinical care in Hong Kong. January 2005*.

attention to patient needs and concerns, commitment of the government and low HIV prevalence. The challenge ahead is to sustain the **delivery of quality care** in the face of growing numbers of PLHA. (Target seven, see P.23) Even if HIV prevalence remains low in Hong Kong for the years to come, the **increasing number of cumulative patients** from prolonged survival of existing patients and diagnosis of new patients cannot be ignored.

Virtually all infected patients are under the care of the public health services in Hong Kong, both in the past and for the foreseeable future. The medical and social complexities associated with HIV/AIDS management make it a specialized service in the local context. The Government's commitment for continual provision of quality care integrated with prevention programmes to PLHA is the way forward. Similarly, community involvement in support and care services has to be sustained.

The full benefits of HAART are realized only if there is good drug adherence. Evidence suggested that local patients generally adhere well to their antiretroviral therapy, but it is a life-long commitment to treatment. **Drug adherence programme** should be instituted within the clinical service to facilitate and support adherence to this life-saving therapy. On the other hand, **salvage therapy** is needed in a selected number of patients who failed standard treatment regimens. Newer drugs in the pipeline can provide hope for these patients. Participation in **clinical trials** provides access to novel drugs/regimens. The importance of managing opportunistic complications, e.g. TB/HIV coinfection, and provision of palliative care for patients in-need shall not be neglected. Provision of **up-to-date laboratory diagnosis and monitoring** is also important, as it supports and monitors clinical care and therapy and enhances overall patient management and cost-effectiveness.

Even if effective prevention measures are scaled up promptly, more and more already infected patients will surface in the coming future. Despite the growing number of PLHA, the **critical mass** of medical, nursing and other health care workers conversant with HIV management is relatively small. **Professional training and career development** on HIV medicine should be strengthened. With the changing health needs of long-living patients extending to non-HIV morbidities and mortalities, the need for a greater involvement of medical professionals other than HIV physicians also becomes more apparent. Promotion of acceptance and capacity building among the medical community and other health professionals are needed. Besides ensuring adequate professional human resources development, expansion of treatment, care and support facilities has to be in line with the growing demand. Regular monitoring and evaluation to gauge the standard of care up to international level and locally relevant applied research to improve service would be desirable.

PLHA themselves are crucial partners for both HIV care and prevention. Social services support is an integral part of PLHA management and care. **Targeting positives** for HIV prevention has been



recognized and advocated as a key AIDS strategy overseas.¹⁰ Recruitment and engagement of PLHA into the HIV care network provides a channel for implementing targeted public health interventions, including partner counseling and referral and risk reduction counseling. Hence health and community services organizations for PLHA should **incorporate preventive interventions** in their care provision. It may also be timely for Hong Kong to develop HIV/AIDS self-help groups, so that local PLHAs can take an active part in the prevention and care of their fellow members.

Social rehabilitation recognizes the multiple complex patient and environmental factors that hinder reintegration of PLHA into the society, e.g. difficulties in finding employment. At present, various employment assistance programmes are offered by the government and NGOs. To help this unique group of clients, locally feasible augmentation of rehabilitation services shall be explored, given the changed and changing outlook of PLHA. Promoting acceptance of PLHA and making mainstream services more accessible to them are to be encouraged.

E. Interfacing with Mainland China and nearby regions for an effective response

The voluminous and ever-increasing movement of visitors, workers and migrants between Hong Kong and Mainland China (particularly the neighbouring Pearl River Delta region of Guangdong), (Box 5) coupled with the differential and changing HIV prevalence among various risk populations make China connection the major external determinant of the future epidemic in Hong Kong.

Box 5. Statistics and events in human mobility across the border

- 24-hour clearance service was introduced at Lok Ma Chau Control Point in January 2003.
- The Individual Visitor Scheme was introduced in 2003.
- A survey in 2004 showed that some 235400 Hong Kong residents were working in Mainland.
- Hong Kong residents made 62.8 million person-trips to Mainland China in 2005, with two-thirds being personal trips. Of the 40.1 million personal trips, 52% was to Shenzhen and 42% to other places in Guangdong.
- Over 23 million people visited Hong Kong in 2005, of which about 54% were from Mainland China.

The Mainland has shown greater political commitment and support and made positive moves on HIV prevention and control in recent years. Examples are seen in the enhanced surveillance and information

¹⁰ *Advancing HIV prevention: new strategies for a changing epidemic – United States, 2003. MMWR Weekly 52(15), 18 April 2003.*

systems, substantially uplifted funding at national and local levels, launch of the landmark “Four Frees and One Care” policy, and the rolling out of methadone clinics across the country after a pilot programme.

Exchange and joint efforts at government and community levels between Hong Kong and Mainland China on HIV and related fields has increased in the past few years. Various forms of regional networking, information exchange and collaboration can be further stepped up, (Target eight, see P.23) including experience sharing, visits and attachments, structured capacity building initiatives, setting up and facilitating exchange platforms and joint health promotion/prevention projects. Support from government policy bureaux shall be rendered as necessary and appropriate. There have been many HIV study tours from Mainland China and South East Asia to Hong Kong, notably on the internationally-recognized best practice of methadone programme and HIV prevention. In the last two years, Hong Kong has started providing structured fellowship training programme on clinical HIV medicine and nursing care for Mainland China health professionals. Regularization of information exchange on the latest HIV situation and response, as well as joint cross-border publicity and targeted prevention activities, will benefit both sides. Maintaining dialogue on care will be useful as PLHA move across the border for short or long-term stay. Interfacing with Mainland China and nearby regions would need additional resources support, which should be seen as an investment rather than purely expenditure when HIV observes no border and Hong Kong is heavily affected by the epidemic in neighbouring places.



ACA considers it important to monitor the progress of the collective local AIDS programme. As part of the global community, Hong Kong's AIDS response contributes to the international picture on AIDS. Firstly, ACA recommends that Hong Kong adopts the UNAIDS core indicators framework, which will allow for international comparison with other countries/places. Secondly, eight specific targets are set in this strategy document for moving responses towards common direction and goals. Thirdly, individual programme/project should have its own monitoring and evaluation incorporated.

UNAIDS core indicators for Hong Kong

In August 2002, the UNAIDS published a set of guidelines to help national authorities construct indicators for monitoring the United Nations Declaration of Commitment.¹¹ Using the UNAIDS framework, the ACA constructed the first set of core indicators for Hong Kong in 2004 with modification to be compatible with local conditions.¹² The UNAIDS revised its core indicators guidelines in 2005 to better reflect the need on monitoring for different epidemic levels.¹³ The ACA deliberated the new recommendations, modified per local situations and came up with the recommended list of 9 indicators for Hong Kong as a low/concentrated HIV prevalence epidemic:

- Amount of national funds disbursed by government in low and middle income countries
- National Composite Policy Index
- Percentage of (most-at-risk population (s)) who received HIV testing in the last 12 months and know the results
- Percentage of (most-at-risk population (s)) reached with HIV/AIDS prevention programmes
- Percentage of (most-at-risk population (s)) who both identify correct ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
- Percentage of male clients of female sex workers reporting the use of a condom in last sex with FSW in Hong Kong and in Mainland China
- Percentage of men reporting use of a condom last time they had anal sex with a male partner
- Percentage of injecting drug users who have adopted behaviours that reduced transmission of HIV i.e. who avoid using non-sterile injecting equipment and use condoms in the last month
- Percentage of (most-at-risk population (s)) who are infected.

¹¹ UNAIDS. *Monitoring the Declaration of Commitment on HIV/AIDS – guidelines on construction of core indicators. 2002.*

¹² Hong Kong Advisory Council on AIDS. *Construction of the first set of core indicators (2003) for monitoring Hong Kong's AIDS programme. 2003.*

¹³ UNAIDS. *Monitoring the Declaration of Commitment on HIV/AIDS – guidelines on construction of core indicators. 2005.*

Local data on HIV knowledge, attitude, behaviour and prevalence for four most-at-risk populations, viz. MSM, female sex workers, their clients, and IDU were constructed basing on the currently best available information from regular statistics, community surveys and ad-hoc statistics (Appendix III). The enumeration frequency ranges from annual to 4-5 years per UN recommendation.

The targets

Eight targets in the form of deliverable/desired outcome are proposed:

One	Increase condom use of MSM, sex workers and clients to $\geq 80\%$
Two	Incorporate rapid HIV testing for late presenting mothers to close gap of MTCT
Three	Develop one or more resource allocation plan to guide programme funding
Four	Review ATF funding mechanism to improve effective funding of community-based response
Five	Regularize community surveillance of risk populations at 1-2 year intervals
Six	Improve HIV testing coverage among risk populations
Seven	Sustain quality HIV care of international standards to people living with HIV/AIDS
Eight	Enhance collaboration with Mainland China through regular or ad-hoc programmes/projects

A mid-term and a period-end review of achievement of the targets shall be made.

Key players in delivering the objectives

Hong Kong's AIDS programme is a collective effort of the government, non-governmental organizations and the academia. They partner with each other, perform different roles, supplement and complement, and serve the same cause. The following are the key players who would be working towards the new goals and objectives, with their anticipated roles:

Government policy bureaux – the Health, Welfare and Food Bureau (HWFB) is the lead agency in the development of the government's policy on HIV/AIDS. HWFB will be asked to examine and endorse the recommended strategies. In consolidating an integrative approach, other bureaux and advisory bodies are also involved, e.g. Education and Manpower Bureau and Security Bureau.

AIDS Trust Fund – The Council for the AIDS Trust Fund 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 review funding mechanism in face of changed and changing situation and needs.



Advisory Council on AIDS – The ACA advises the Government on policy relating to AIDS. ACA advises on the co-ordination and monitoring of programmes and services on prevention and care of HIV in the territory. The ACA shall propose a resource allocation plan and keep under review the progress of AIDS response in Hong Kong.

Government operations – The Centre for Health Protection of Department of Health, through its Special Preventive Programme, will be regularly monitoring the epidemic and providing support in building capacity relevant to prevention and care efforts. Together with the Hospital Authority and universities, there will be the delivery of quality patient services, development of clinical expertise on HIV care and treatment and the further prevention of mother-to-child transmission by strengthening the existing programme.

AIDS NGOs – the AIDS 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. They will also be partnering mainstream NGOs in expanding Hong Kong's response to AIDS.

Mainstream NGOs, the community and community organizations – Vulnerable community itself and its organizations are to be mobilized, in particular for MSM. They have to be supported by all other AIDS workers. The leadership and support of Hong Kong Council of Social Service and Social Welfare Department are influential in making and facilitating more mainstream NGOs to participate in AIDS work as well as enhancing the work of AIDS NGOs.

Academia – the academia would be important in undertaking appropriate studies to improve understanding of the situation and specific risk factors/patterns.

The wider society – several 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.

APPENDIX I

Key strategies documents – UNAIDS, WHO and Mainland China

A. Intensifying HIV prevention- UNAIDS Policy Position Paper 2005 (extracts of principles and policy actions)

Principles of Effective HIV Prevention

- All HIV prevention efforts / programmes must have as their fundamental basis the promotion, protection and respect of human rights including gender equality.
- HIV prevention programmes must be differentiated and locally adapted to the relevant epidemiological, economic, social and cultural contexts in which they are implemented.
- HIV prevention actions must be evidently informed based on what is known and proven to be effective and investment to expand the evidence base should be strengthened.
- HIV prevention programmes must be comprehensive in scope, using the full range of policy and programmatic interventions known to be effective.
- HIV prevention is for life ; therefore both delivery of existing interventions as well as research and development of new technologies require a long-term and sustained effort.
- HIV prevention programme must be at a coverage, scale and intensity that is enough to make a critical difference.
- Community participation of those for whom HIV programmes are planned is critical for their impact.

Essential Policy Actions for HIV Prevention

1. Ensure that human rights are promoted, protected and respected and that measures are taken to eliminate discrimination and combat stigma
2. Build and maintain leadership from all sections of society
3. Involve people living with AIDS in the design, implementation and evaluation of HIV preventive strategies, addressing their distinct prevention needs
4. Address cultural norms and beliefs, recognizing the key roles that they have in supporting prevention efforts and the potential they have to fuel HIV transmission
5. Promote gender equality and address gender norms and relations to reduce the vulnerabilities of women and girls, involving men and boys in this effort
6. Promote widespread knowledge and awareness of how HIV is transmitted and how infection can be averted
7. Promote the links between HIV prevention and sexual and reproductive health
8. Support the mobilization of community based responses
9. Promote programmes targeted at HIV prevention needs of key affected groups and populations
10. Mobilize and strengthen financial, human and institution capacity
11. Review and reform legal frameworks to remove barriers to effective, evidence based HIV prevention, combat stigma and discrimination and protect the rights of people living with HIV or vulnerable or at risk to HIV
12. Ensure that sufficient investments are made to research and development and advocacy of new prevention technologies



B. Universal Access for HIV Prevention, Treatment, Care and Support by 2010 - WHO

In its July 2005 Summit in Gleneagles, G8 leaders committed to reducing HIV infections by working with WHO, United Nations Joint Programme on AIDS (UNAIDS) and other international bodies to develop and implement a scaled-up package for HIV prevention, treatment and care. An integral part of this commitment was the aim of assuring Universal Access to HIV/AIDS treatment for all those who need it by 2010. This goal was subsequently endorsed and expanded by heads of state at the High Level Plenary Meeting of the 60th Session of the United Nations General Assembly in September 2005^a.

At the Fifty-ninth World Health Assembly (WHA), the world's health leaders reaffirmed the international commitment to achieving Universal Access^b; and, the Health Assembly took note of the intentions of the WHO Secretariat to develop a five-year, 2006-2010 work plan for an organization-wide contribution to scaling up efforts towards Universal Access, based on the Essential Package of Health Interventions for HIV/AIDS Prevention, Treatment and Care^c. WHO's contribution to this goal of Universal Access was explained to the WHA as a base on investment in five strategic directions: (1) enabling people to know their HIV status through confidential HIV testing and counselling; (2) maximizing the health sector's contribution to HIV prevention; (3) accelerating the scale-up of HIV/AIDS treatment and care; (4) investing in strategic information to guide a more effective response; and (5) strengthening and expanding health systems.

^a *United Nations General Assembly, Sixtieth session, 24 October 2005, A/RES/60/1.*

^b *Fifty-Ninth World Health Assembly, 27 May, 2006, Resolution WHA59.19.*

^c *Fifty-Ninth World Health Assembly, Provisional agenda item 11.3, A59/39, 4 May 2006.*

C. China's Action Plan for Reducing and Preventing the Spread of HIV/AIDS (2006 - 2010) – an Extract

The working principles

- (1) The government takes the leadership and organizational role and every department has its own specific responsibility with whole society participation.
- (2) Comprehensive control should be implemented as the primary strategy in prevention and combined with treatment and care.
- (3) Action according to the law, guided by science, and evaluated by comprehensive indicators.
- (4) Concentrate on the epicenters of the epidemic, provide differentiated guidance according to the different situation, and evaluate the effectiveness by the change in real world.
- (5) Manage the work by different levels, clearly defined responsibility, and enhanced monitoring.

Strategies and Action Measures for HIV/AIDS Prevention and Treatment

- ◆ Carry out comprehensive communication and education activities on HIV prevention and treatment and free blood donation; to build up a supportive social environment for HIV/AIDS prevention and treatment and for caring people living with HIV and AIDS patients. (1) Strengthen mass media communication. (2) Strengthen the education in public locations and communities. (3) Strengthen the education in working places and schools. (4) Strengthen the education and communication for key groups.

- ◆ Scale up the implementing effective intervention measures
(1) Actively to develop preventive interventions for blocking HIV transmission by sex, and promoting condom usage. (2) Increase the coverage of drug-maintaining rate for opium abusers (specifically the heroin-abusers) and needle exchange-sides. (3) Enforce the prevention for HIV mother-child transmission.

- ◆ Strengthen the safe blood management, especially in blood collection and blood transfusion constitutions.

- ◆ Improving the quality of HIV care services. Totally implement the AIDS treatment measures, and develop care and alleviation for HIV positives, AIDS patients and their families.

- ◆ Build up and Improve the HIV test-surveillance system.

- ◆ Strengthen STD prevention and management. Strengthen operational researches and international co-operations in HIV prevention and treatment.



Assuring measures

- (1) Strengthen the leadership of the government and improve the management mechanism.
- (2) Enforce the legal and policy assurance with relevant management measures and standardized operational procedures.
- (3) Strengthen institution and capacity building.
- (4) Increase financial support with multi-channel fund-raising and systematically integrated management and usage.

Monitoring and Evaluation

APPENDIX II

Progress of the targets of the Recommended HIV/AIDS Strategies for Hong Kong 2002-2006

<p>Target One A set of programme indicators will be established to monitor the effectiveness of Hong Kong's efforts in HIV prevention and care</p>	<ul style="list-style-type: none"> • ACA initiated the construction of the First set of Core Indicators (2003) for monitoring Hong Kong's AIDS programmes and adopted all UNAIDS national indicators except 2 indicators that were not locally applicable. In 2006, the ACA deliberated the new set of UN core indicators for Hong Kong application.
<p>Target Two A second cycle of the community planning process will be implemented and evaluated</p>	<ul style="list-style-type: none"> • The Community Planning Process (CPP) was in operation between 1999 and 2001 when funded by ATF. CPP was a breakthrough in strengthening societal responses to the challenges of HIV/AIDS. A report on prioritized activities was compiled and became a useful reference for ACA and ATF when drawing up strategies and assessing HIV/AIDS community funding applications respectively. Subsequent applications for funding for a second round of CPP were rejected. The ACA established a Community Forum on AIDS to enhance communication between ACA and AIDS NGOs and provide a platform for collaboration in combating HIV/AIDS epidemic, among other things.
<p>Target Three A technical review mechanism will be in place to ensure funding of effective community-based HIV prevention activities</p>	<ul style="list-style-type: none"> • ATF has continuously improved its evaluation mechanism for community projects and taken reference on the prioritized intervention in the priority communities from CPP when assessing applications. At the initial stage, 2 independent reviewers outside ATF will be invited to assess the application and make recommendations per a standard template. There are guidelines for the reviewers on how to review the applications. Members of ATF Council and its subcommittees will then vet and decide on the funding approval of the applications. Applicants may be invited to make presentations of their projects to ATF members. • Since April 2003, programme-based funding has been introduced for activities that would last up to 3 years.
<p>Target Four Harm reduction will be adopted as one of the effective strategy in addressing substance abuse</p>	<ul style="list-style-type: none"> • Harm reduction has been adopted as one key strategy in preventing IDU from contracting HIV. In 2002, DH's Red Ribbon Centre (RRC) together with Narcotics Division of Security Bureau launched a territory wide publicity campaign named "Break the needle habit, methadone does it." The main objective of the campaign was to increase awareness and acceptance of the harm reduction concepts in the general public, as well as drug users, by employing a social marketing framework in health promotion. The harm reduction media campaign was evaluated and received positive feedbacks. • A pilot programme on universal antibody urine testing was introduced in 2003. Subsequently, the universal HIV urine testing programme was rolled out in all methadone clinics in 2004.
<p>Target Five A framework on sex education integrating HIV prevention will be developed</p>	<ul style="list-style-type: none"> • During the academic year 2002-03, 23% of primary schools and 35% of secondary schools had nominated teachers to attend in-service teacher education programmes on life-skills training, AIDS education and sex education organized by Education and Manpower Bureau. • Since December 2003, DH and RTHK collaborated in a joint project to transform "Dr Sex Hotline" into a new interactive internet-based sex education website.



<p>Target Six Participation of mainstream service organization in HIV/AIDS activities will be increased</p>	<ul style="list-style-type: none"> • There has been increasing participation of mainstream service organizations in HIV/AIDS activities with ATF applications. Twelve out of eighteen successful applicants for ATF funding came from mainstream service organizations and academia in 2003. Before 2000s, the successful applicants were almost exclusively AIDS service organizations. Even for the membership of Hong Kong Coalition of AIDS Service Organizations, it was noted that nearly 50% of their members are from mainstream service organizations. • People from mainstream NGOs were invited to introduce their projects at sharing sessions in RRC / ACA committees. They are also invited to become members of the Community Forum on AIDS formed in 2005.
<p>Target Seven Technical assistance will be established to support agencies in the development of HIV/AIDS prevention and care activities</p>	<ul style="list-style-type: none"> • The DH's Red Ribbon Centre is an UNAIDS Collaborating Centre for Technical Support and provides support to local organizations and those of neighbouring regions. There were increased exchange, assistance and collaboration between local workers. RRC continues to support 2-week training opportunities for Mainland China health professionals in HIV prevention, under the Lions Red Ribbon Fellowship programme.
<p>Target Eight A research agenda will be proposed to stimulate a wider participation of the academia in supporting evidence-based programme development</p>	<ul style="list-style-type: none"> • The Scientific Committee on AIDS (SCA) operated from 2002-05 as one of the 3 committees under ACA. During this term, researches pertaining to clinical HIV/AIDS in the last 20 years and an agenda to support research were discussed and reviewed by SCA. After 2005, there is a new Scientific Committee in DH's Centre for Health Protection named Scientific Committee on AIDS and STI taking over the work of the previous SCA.
<p>Target Nine Clinical and public health HIV medicine will be integrated in the training and service portfolio of the health profession</p>	<ul style="list-style-type: none"> • HIV medicine has become a component of the Higher physician training programme of several specialties under the Hong Kong College of Physicians. Training on public health HIV medicine is also accredited towards Fellowship training programme of the Hong Kong College of Community Medicine.
<p>Target Ten A wider access of HIV testing will be promoted</p>	<ul style="list-style-type: none"> • A new Hotline for ethnic minority in Hindi, Indonesian, Nepali and Urdu was developed. • Two mass HIV screening programmes were launched. The universal antenatal HIV testing programme was introduced in September 2001 whereas the universal methadone clinic urine HIV testing was rolled out in January 2004. Community organizations have expanded their testing service for risk populations such as MSM, sex workers and clients. • To assist outreach workers to perform rapid HIV test in Hong Kong, the SCA issued a set of recommended principles on the application of HIV antibody rapid test in Hong Kong for their reference. Since late 2005, pilot rapid testing programmes were implemented by DH and non-governmental organisations.

<p>Target Eleven</p> <p>Forums to network people working on HIV/AIDS in Hong Kong and Mainland China, and the Asia Pacific region will be established</p>	<ul style="list-style-type: none"> • Dr Shen Jie, the then Director of the China CDC Centre for STD/AIDS Prevention and Control was appointed as a special adviser of SCA (2002-2005) and SCAS (2005-2007). • UN Regional Task Force on Drug Use and HIV Vulnerability hosted a methadone treatment workshop in Hong Kong (22-24 October 2003), with the participation of about 100 technical people from neighbouring regions. • Since 2004, a project on setting up an electronic platform of HIV epidemiology in the Pearl River Delta Region was initiated, with 12 participating cities. • The Lions Red Ribbon Fellowship scheme is an ongoing exercise to network Mainland HIV healthcare professionals since 1999. For the past 2 years, Red Ribbon Centre coordinated an annual forum to network NGOs involved in AIDS work in Mainland China and neighbouring regions.
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APPENDIX III



UNAIDS core indicators for concentrated /low-prevalence epidemic - knowledge, behaviour & impact, HKSAR 2005

UNAIDS core indicators for concentrated / low-prevalence epidemics – KNOWLEDGE, BEHAVIOUR & IMPACT

Hong Kong SAR 2005 [SECOND SET]

Table 1. Summary of 2006 indicators

Indicators	MSM		Clients of FSW		FSW		IDU	
3. Percentage received HIV testing in the last 12 months and who know the results	Best est.: 13.9% (2001) ^{M3}	Plan: to regularize survey by DH	Best est.: 12.7% (2004) ^{C3}	Plan: to regularize survey by DH	Best est.: 14.9% (2004) ^{F3}	Plan: to regularize survey by DH	Best est.: 91% (2005) ^{D3}	Plan: to continue
4. Percentage reached by prevention programmes	Best est.: <10% (2005) ^{M4}	Plan: to regularize survey by DH	Best est.: ~16% (2005) ^{C4}	Plan: cont. or to regularize survey by DH	Best est.: ~12% (2005) ^{F4}	Plan: cont. or to regularize survey by DH	Best est.: 93.4% (2005) ^{D4}	Plan: to continue or supp by SAS
5. Percentage both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Best est.: 44.8% (2001) ^{M5}	Plan: to regularize survey by DH	Best est.: 74% (2004) ^{C5}	Plan: to regularize survey by DH	Best est.: 65.8% (2004) ^{F5}	Plan: to regularize survey by DH	Best est.: 99.1% (2005) ^{D5}	Plan: to continue or supp by SAS
6. Percentage of female and male sex workers reporting the use of a condom with her most recent client [MODIFIED*]	Nil for 2005	Plan: not planned	Not applicable		See below		Not applicable	
* Percentage of male clients of female sex workers reporting the use of a condom in last sex with FSW in Hong Kong and Mainland China	Not applicable		Best est.: 79.4% (HK) ^{C6a} , 67.7% (China) (2004) ^{C6b}	Plan: to regularize survey by DH	Not applicable			
7. Percentage of men reporting the use of a condom the last time they had sex with a male partner	Best est.: 66% (2005) ^{M7}	Plan: to regularize survey by DH	Not applicable					
8. Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV i.e., who avoid using non-sterile injecting equipment and use condoms in the last month	Not applicable						Best est.: 36.6% (2005) ^{D8}	Plan: to continue
9. Seroprevalence	2.48% (1.13%-4.07%) (2005) ^{M9}		0.07%(0.05-0.10%) (2005) ^{C9}		N.A (2005) ^{F9}		0.32% (0.21-0.46%) (2005) ^{D9}	

N.B. All, except indicator 8, were NOT required and not collected for 'First set of core indicators (2003) for monitoring Hong Kong's AIDS Programme'.

* Modification proposed based on local epidemiological relevance.

Table 2. Details of 2006 indicators

Category of source	Name of source	Location of source	Year of data collection	Method of calculations	Result and remarks
^{M3} Community survey	HIV related behaviours and attitudes among Chinese men who have sex with men in Hong Kong: a population based study.	JTF Lau (CUHK). Sexually Transmitted Infections, Dec 2004; 80(6):459–465	2001	Numerator: numbers from denominator reported having tested for HIV in last 6 months; Denominator: men reported having sex with other men in last 6 months in a telephone survey (n=292)	13.9% (2001)
^{C3} Community survey	Behavioural surveillance surveys of the male clients of female sex workers (CFSW) population in Hong Kong from 2003 to 2005.	JTF Lau (CUHK). Report submitted to Hong Kong Council for the AIDS Trust Fund.	2004	Numerator: numbers from denominator reported having tested for HIV in last 6 months; Denominator: men reported having visited female sex workers in last 6 months in a telephone survey (n=237)	12.7% (2004)
^{F3} Community survey	Behavioural surveillance for female sex workers working in villa (brothels)	JTF Lau (CUHK). Report submitted to Hong Kong Council for the AIDS Trust Fund.	2004	Numerator: number from denominator reported having tested for HIV in last 6 months. Denominator: all FSW sampled in brothels for a face to face interview during study (n=336)	14.9% (2004)
^{D3} Regular statistics	Universal (Urine) HIV Testing Programme in Methadone Clinics (MC).	Department of Health	2005	Numerator: total number of specimens collected for HIV test during testing period in 2005 (n=8749). Denominator: Total number of attendees in MC during testing period in 2005 (n=9619). Remarks: Data from MC is used because of its wide coverage.	91% (2005)
^{M4} Ad hoc statistics	Programme statistics collected for community assessment and evaluation 2006.	Department of Health	2005 and 2006	Numerator: person-times reached by NGOs in outreach (est. 5,700 in 2004), VCT (483 in 2005), internet message boards (200 questions with total 78000 hits). Assumptions : individuals reached is about half of the person times for outreach, half of VCT reached in outreach or internet, individuals reached by internet difficult to be determined and some were not sexually active in the past year; hence approx <5000. Denominator: size estimation 51,000 (as in estimation and projection exercise 2006)	Crude estimate by programme statistics: <10% (2005) <i>COMPARED with indicator M3</i>
^{C4} Ad hoc statistics	Programme statistics collected for community assessment and evaluation 2006.	Department of Health	2005 and 2006	Numerator: (sum of person-times reached by NGOs in outreach (est. 30,000 in 2005) and social hygiene service (28,000 in 2005). Assumptions: limited double counting, about half of 70% of the clients had visited social hygiene clinics in the past one year. Hence total individuals approx. 38,500; Denominator: size estimation 240,000 (as in estimation and projection exercise 2006). Assumptions derived from outreach workers experience.	Crude estimate by programme statistics: 16% (2005) <i>COMPARED with indicator C3, and 12.1% of clients at brothels reported having received STD/ AIDS prevention service in previous 6 months.¹</i>



Category of source	Name of source	Location of source	Year of data collection	Method of calculations	Result and remarks
^{F4} Ad hoc statistics	Programme statistics collected for community assessment and evaluation 2006.	Department of Health	2005 and 2006	Numerator: person-times reached by NGOs in outreach (est. 4,000 in 2005), educational workshops at establishments (est. 750 in 2005), workshops at prisons (est. 500 in 2005), drop-in-centre (est. 2,000 in 2005) and social hygiene service (2,000 in 2005). Assumptions: each sex worker being visited three times in a year, 100% overlap between outreach and workshops, 0% overlap between prisons and others, actual number of sex workers visited drop-in centre approx 200, 20% of those visited social hygiene service have been reached by other forms of service. Hence, total individuals approx. 3633; Denominator: size estimation 30000 (as in estimation and projection exercise 2006). Assumptions derived from outreach workers experience.	Crude estimate by programme statistics: 12% (2005) <i>COMPARED with indicator F3</i>
^{D4} Regular statistics	Methadone Clinic and Central Registry of Drug Abuse.	Department of Health and Central Registry of Drug Abuse	2005	Numerator: effective registration at end of 2005 in Methadone Clinics (n=9,095); Denominator: total reports of heroin abusers by Central Registry of Drug Abuse in 2005 (n=9,734). Attendance at MC is a preventive programme by itself. Effective registration is number of drug abusers who have attended MC at least once in previous 28 days.	93.4% (2005) <i>COMPARED with data from Street Addict Survey 95.7% of respondents reported being currently registered with MC</i>
^{M5} Community Survey	HIV related behaviours and attitudes among Chinese men who have sex with men in Hong Kong: a population based study.	JTF Lau (CUHK) <i>Sexually Transmitted Infections, Dec 2004; 80(6):459-465</i>	2001	Numerator: numbers from denominator who agreed 'a healthy looking person can transmit HIV to others'. Denominator: men (18-60) who reported to have sex with men in last 6 months in a telephone survey (n=292)	44.8% (2001) <i>DIFFERENT questions from those specified by UNAIDS</i>
^{C5} Community Survey	Behavioural surveillance surveys of the male clients of female sex workers (CFSW) population in Hong Kong from 2003 to 2005.	JTF Lau (CUHK) Report submitted to Hong Kong Council for the AIDS Trust Fund. October 2004.	2004	Numerator: numbers from denominator who correctly named at least two correct modes of HIV transmission; Denominator: men (18-60) who reported to have commercial sex in last 6 months in a telephone survey (n=237)	74% (2004) <i>DIFFERENT questions from those specified by UNAIDS</i>
^{F5} Community survey	Behavioural surveillance for female sex workers working in villa (brothels).	JTF Lau (CUHK) Report submitted to Hong Kong Council for the AIDS Trust Fund. October 2004.	2004	Numerator: numbers from denominator who agreed 'a healthy looking person can transmit HIV to others'; Denominator: all respondents during face to face interviews of FSW in brothels (n=336)	65.8% (2004) <i>DIFFERENT questions from those specified by UNAIDS</i>

Category of source	Name of source	Location of source	Year of data collection	Method of calculations	Result and remarks
^{D5} Community survey	Street Addict Survey	Department of Health and SARDA	2005	Numerator: numbers from denominator who agreed that 'sharing needles can transmit HIV' and 'using condoms can reduce risk of getting HIV'; Denominator: heroin abusers reached by ex-drug users for face to face interviews in the survey (n=441)	99.1% (2005)
^{C6a & C6b} Community survey	Behavioural surveillance surveys of the male clients of female sex workers (CFSW) population in Hong Kong from 2003 to 2005	JTF Lau (CUHK) Report submitted to Hong Kong Council for the AIDS Trust Fund. October 2004.	2004	Numerator: numbers from denominator reported always used condoms when visiting female sex workers in last 6 months; Denominator: men (18-60) who reported having visiting female sex workers in the past 6 months in Hong Kong only (13, n=141) and in China and/or other places (14, n=96) in a telephone survey	79.4% (never China) and 67.7% (ever China) <i>MODIFIED to reflect condom use in heterosexual commercial sex; important relevance to local epidemiology.</i>
^{M7} Community survey	Voluntary Counselling and Testing Service targeting for MSM by community organization (AIDS Concern)	Department of Health and AIDS Concern	2005	Numerator: numbers from denominator who reported having used a condom in last sex with other men; Denominator: men attending the VCT service and who reported anal sex with other men in previous 6 months (n=441)	66% (2005)
^{D8} Regular statistics	Survey at methadone clinics for newly admitted or readmitted (previously registered but consecutively defaulted for 28 days) heroin abusers	Department of Health	2005	Numerator: numbers from denominator who reported no sharing of needles in past 4 weeks and had always or usually used condom for sex in past 1 year (n=454); Denominator: newly admitted or readmitted drug abusers at MC reported injecting heroin at the time of survey and had sex in preceding one year (n=1,241)	36.6% (2005) Same method used in previous set of indicators (37.4% in 2003)
^{M9} Community survey	Voluntary Counselling and Testing Service targeting MSM by community organization (AIDS Concern)	Department of Health and AIDS Concern	2005	Numerator: numbers of individuals from denominator tested HIV positive by urine tests (n=12); Denominator: total number of individuals tested for HIV by AIDS Concern in the year (n=483)	2.48% (1.13%-4.07%) (2005)
^{C9} Regular statistics	Voluntary Testing Statistics at Government STI clinics	Department of Health	2005	Numerator: numbers from denominator that are newly HIV tested positive (n=28); Denominator: total number of tests performed for attendees at government STI clinics in the year as reported by Government Public Health Laboratory (n=38,978)	0.07% (0.05-0.1%) (2005) <i>Note: About 10% of the attendees were female</i>
^{F9} An estimate is expected to be available in late 2006 from unlinked anonymous survey at retention centre for female illegal immigrants					
^{D9} Regular statistics	Universal testing programme at methadone clinics	Department of Health	2005	Numerator: Number of individuals tested HIV positive (n=28); Denominator: Number of tests performed for attendees at MC during programme (n=8696)	0.32% (0.21-0.46%) (2005) <i>Note: include all injectors and non-injectors.</i>

Community survey Surveys initiated by community (NGOs or academic institutes). DH obtains the published data or raw data from the researchers or survey coordinators and does not own the data

Regular statistics Statistics that have been regularly collected by DH from government units for monitoring purposes

Ad hoc statistics Statistics that have not been regularly collected but collected and collated for time-limited purposes in the past

¹Behavioural surveillance of male clients of FSW in brothels. J Lau (CUHK). Report submitted to the Council of AIDS Trust Fund. October 2004