A supplement on the process of formulating the Recommended HIV/AIDS Strategies for Hong Kong (2017-2021)

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Acronyms

ACA	Hong Kong Advisory Council on AIDS
AIDS	Acquired Immunodeficiency Syndrome
aOR	adjusted Odds Ratio
CFA	Community Forum on AIDS
C.I.	Confidence Interval
CMAB	Constitutional and Mainland Affairs Bureau
DH	Department of Health
DDO	Disability Discrimination Ordinance
EM	Ethnic minorities
EOC	Equal Opportunities Commission
FSW	Female sex workers
HARiS	HIV and AIDS Response Indicator Survey
HIV	Human Immunodeficiency Virus
IDU	Injecting drug users
ILGA	International Lesbian, Gay, Bisexual, Trans and Intersex Association
KLA	Key Learning Areas
LDSS	Low dead-space syringes
LGBT	Lesbian, gay, bisexual and transgender
LSBE	Life skills-based education
MWMSP	Male with multiple sex partners
MSM	Men who have sex with men
MSW	Male sex workers
NGO(s)	Non-Governmental Organisation(s)
NSP	Needle and Syringe Programme
OR	Odds Ratio
PLHIV	People living with HIV
PWID	People who inject drugs

SIF	Supervised injection facilities
SSM	Same-sex marriage
STD/STI	Sexually Transmitted Diseases/Infections
SW	Sex workers
SWC	Male clients of female sex worker
TG	Male-to-female transgender
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
WHO	World Health Organization

Chapter 1. Background

1. Since 1994, the Advisory Council on AIDS (ACA) has produced five sets of recommended HIV/AIDS strategies for Hong Kong (the Strategies), the most recent of which covered 2012 - 2016[1]. Formulation of a new set of Strategies for 2017 - 2021 began in mid-2015[2].

2. In the 37th meeting of the Community Forum on AIDS (CFA), the request was made that ACA provide the reasoning for not adopting suggestions (if any) raised by stakeholders during the strategy formulation. In the 92nd ACA meeting, members agreed to address those suggestions that were most controversial, with a view to helping stakeholders and relevant communities understand the rationales behind the new set of Strategies, and also draw support from society at large.

3. Accordingly, this document lays out the rationales during the process of formulating the Strategies for 2017-2021, including the key factors considered, the guiding principles, the views collected during stakeholder and public consultation, and the deliberations involved in some specific issues.

Chapter 2. Basis and guiding principles

4. To draw up the blueprint for a coordinated and consolidated response to the growing HIV epidemic in the next five years, objective, integrative and consultative processes with a public health oriented approach were adopted. Six inter-related factors were considered during the formulation of the Strategies, namely:

   (i). Global and local HIV situation and future projection;

   (ii). Current HIV responses in Hong Kong;

   (iii). Evidence of scientific developments;

   (iv). Recommendations of the World Health Organization (WHO), Joint United Nations Programme on HIV/AIDS (UNAIDS) and other international health agencies;

   (v). Opinions of community stakeholders, and

   (vi). Opinions from the public consultation.

5. According to WHO, the impact of existing or proposed strategies to control the HIV epidemic can be assessed by two indicators - AIDS deaths and new infections[3]. Notwithstanding, scientific evidence may vary among countries and recommendations by international health authorities may not be locally applicable or feasible. Furthermore, opinions from community stakeholders and the general public may be diverse and even contradictory. Hence ACA further applied the following principles to guide its deliberations:

   (a) Adopting an evidence-based approach;

   (b) Facilitating community participation;

   (c) Taking into consideration the acceptability, accessibility and affordability of the strategies to the relevant communities and society at large;

(d) Cultivating a supportive and enabling environment; and

(e) Prioritising resources.

6. Generally, proposals should meet the guiding principles and their effectiveness in decreasing deaths and/or new infections should be ascertained by evidence before they are included in the Strategies. Cognizant of the fact that information will be updated and new evidence will emerge in the future, ACA will continue to monitor the trends and developments relating to HIV/AIDS in accordance with its Terms of Reference.

Chapter 3. Consultation and comments received

A. The consultation process

7. The process of formulation spanned nearly two years from July 2015 to end of April 2017. During this period, three consultations were held – two for community stakeholders and one for the general public.

8. The first session of consultation was held from 16 October to 4 December 2015 to kick off the groundwork for drafting the Strategies. During this eight-week period, stakeholders were invited to input their opinions and suggestions either online or through attending consultation meetings. These opinions have been compiled and are available online[4].

9. The first draft of the Strategies was then prepared and submitted for another three weeks' of consultation with stakeholders from 26 August to 15 September 2016. The third session of consultation, spanning 8 weeks from 7 November to 31 December 2016, was open to the general public. All the opinions collected were deliberated in ACA meetings, and the finalised Strategies were issued in May 2017[2].

B. The comments and suggestions collected

10. Opinions generated from the consultation can be categorised into nine areas, namely:

    (i). Enhance accessibility and availability of prevention tools;

    (ii). Deliver appropriate prevention and control measures;

    (iii). Expand HIV prevention and testing services to sub-populations;

    (iv). Scale up HIV testing;

    (v). Strengthen linkage to care and improve treatment services;

    (vi). Address stigma and discrimination of PLHIV and the priority populations;

(vii). Enhance public sex education;

(viii). Revision and formulation of laws and policies; and

(ix). Mobilization and cooperation of government and civil society.

Chapter 4. Considerations in setting the vision, objectives, targets and key populations

11. During the consultations, ACA received queries about how the vision, objectives and targets were set. These are explained in the paragraphs, followed by an outline of ACA's deliberations.

A. Vision

12. The vision of the Strategies echoes that of the Joint United Nations Programme on HIV/AIDS (UNAIDS) for 2016-2021[5] – Zero new HIV infections; zero discrimination and zero AIDS-related deaths.

B. Objectives

13. The objectives of the Strategies tie in with UNAIDS' "90-90-90 treatment targets"[5] which call for 90 per cent of HIV-infected persons to know their status, 90 per cent of the HIV-diagnosed to access treatment and 90 per cent of those on treatment to have suppressed viral loads by the end of 2020. Another target set by UNAIDS, "90% of key populations to have access to HIV combination prevention services", is also incorporated, resulting in four clear and quantifiable "90" objectives to be achieved by the end of 2020.

C. Targets

14. WHO has suggested a number of indicators to monitor risk-taking and health-seeking behaviours that are directly associated with HIV transmission and treatment effect[3]. These were included in the Strategies as nine "quantifiable targets", drawing reference from levels that had been achieved in the past where the data was available[2] (Table 1).

Table 1. The nine targets

Indicators suggested by WHO	Achieved levels in Hong Kong (as at end 2015)	Targets in the Recommended HIV/AIDS Strategies for Hong Kong (2017-2021) (to be attained by the end of 2020)
1. Condom use MSM : - % of men reporting condom use at last anal sex with a male partner Sex workers : - % of sex workers reporting condom use with most recent clients	MSM : Last anal sex with : - casual partners : 81% - emotional / regular partners: 66-74% Consistent condom use with: - Casual partners: 48.4% - Regular partners :43.5% Female sex workers : Last vaginal sex with : - regular clients : 97% - casual clients: 99.1%	MSM : (a) ≧85% and 70% of MSM used condoms in the last anal sex with casual and regular partners respectively (b) ≧70% of MSM consistently used condoms in anal sex with both regular and casual partners
2. Needle sharing - WHO has no indicator on this	People who inject drugs (PWID) : - Shared needles: 13.9% - Shared needles outside their usual injection partners: 3.7%	PWID : - < 10% of PWID shared needles with other people in past 1 month - < 5% of PWID shared needles with people outside their usual injection partners in past 1 month
3. Access to HIV prevention service 90% of key populations, including sex workers, MSM, PWID, transgender people and prisoners, as well as migrants, have access to HIV combination prevention services	Received HIV prevention message or free condoms in HK in last 1 year: - MSM: 85.6% - TG: 78.8% - SWC: 64.9% - FSW: 92.9% - Opioid dependent persons: 99%	- ≧90% of MSM, Male-to-Female Transgender (TG), Female Sex Workers (FSW) and PWID have accessed at least one item of HIV combination prevention services in the last 1 year (such service may include free condoms, HIV testing, free new syringes, HIV prevention messages, or PrEP as appropriate)

Indicators suggested by WHO	Achieved levels in Hong Kong (as at end 2015)	Targets in the Recommended HIV/AIDS Strategies for Hong Kong (2017-2021) (to be attained by the end of 2020)
4. Availability of free condoms WHO has no indicator on this	Received free condoms in HK in last 1 year: - MSM: 57.8% - TG: 59.1% - SWC: 40.0% - FSW: 86.0% - PWID: 84.4%	- At least 60% of MSM - At least 60% of TG - At least 90% of FSW - At least 90% of PWID received free condoms in the last 1 year
5. HIV testing behavior Number of people who have been tested for HIV and received their results within past 12 months	Received HIV test in the last year and know the results : - MSM: 59.4% - Male clients of FSW: 32.6% - FSW: 65.2% - PWID: 63.0%	80% MSM, TG, FSW and PWID received HIV test in the last 1 year and know the result
6. Diagnosis 90% of all people living with HIV (PLHIV) will have been diagnosed by 2020	73.8% PLHIV diagnosed in 2014	90% PLHIV are diagnosed
7. HIV treatment 90% of all people with diagnosed HIV infection will receive antiretroviral therapy	82.9% received treatment in 2014	90% who know they are HIV positive are receiving treatment
8. Viral suppression 90% of all people on retroviral therapy will have viral suppression	86.9% of those received treatment achieved viral suppression in 2014	90% who are on HIV treatment have suppressed viral load
9. Mother-to-child transmission < 50 new child HIV infections per 100,000 births among HIV-exposed infants	On average less than 1 infection per year	Zero new infection among locally born children

D. Key populations

15. In the previous HIV/AIDS Strategies (2012-2016) for Hong Kong, five priority populations were identified, namely men who have sex with men (MSM), injecting drug users (IDU), sex workers (SW), male clients of female sex workers (SWC), and people living with HIV (PLHIV)[1].

16. In the new Strategies (2017-2021), six key populations were identified, of whom MSM and PLHIV were further emphasized as Primary Target Populations, in whom the greatest effort and resources should be invested. People who inject drug (PWID), ethnic minorities (EM), male-to-female transgender (TG), female sex workers (FSW) and SWC were the Other Key Populations for whom HIV prevention efforts would need to be sustained.

17. In selecting and prioritizing the key populations, ACA took note of UNAIDS' HIV Strategy (2016-2021) which identified a number of key populations including sex workers, men who have sex with men, people who inject drugs, transgender people, as well as migrants as key populations[5]. UNAIDS also advised that "each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context"[5].

18. With regard to the current HIV epidemiology in Hong Kong, the following trends were observed:

    (a) ***MSM:*** MSM dominate the HIV epidemic of Hong Kong, accounting for 60% of newly reported cases in 2015-2016[2]. The growing trend is anticipated to continue in the coming years.

    (b) ***People living with HIV (PLHIV):*** With improved treatment, PLHIV will live longer and more normal lives. Their increasing number has led to a dramatic increase in the demand for treatment services. On the other hand, there was still a 12.3% loss of HIV-infected MSM from diagnosis to receiving treatment in 2015. Therefore, strengthening medical and support services for PLHIV is imperative[2].

(c) ***People who inject drugs (PWID):*** Despite the fact that no more than 15 cases of injecting drug use were reported annually in the past few years, the high needle sharing rate of 13.9%[6], and the recent HIV outbreaks in Greece, Romania and the US among PWID remind us of the need to remain vigilant with this population[7-9].

(d) ***Male-to-female transgender (TG):*** The HIV prevalence of this population was high at 18.6% but their testing rate in the past 12 months was only 60%, as shown in the HARiS studies of 2014 and 2015[10-11].

(e) ***Ethnic minorities (EM):*** The reported HIV infections in EM accounted for 16.6% of all newly reported cases in 2015[12], which was disproportionately higher than their constitution of only 5% among the Hong Kong population[13]. Around 60% were non-Chinese Asians.

(f) ***Female sex workers (FSW) and their male clients (SWC):*** Although the HIV prevalence of FSW remained low at almost 0% (95% CI: 0.0-0.6%)[14-15], their HIV testing rate, as well as that of their clients, has been suboptimal[14-18]. The number of heterosexually transmitted male cases has so far remained steady at around 100 cases per year[12].

E. ACA's deliberations on specific suggestions received

I. About setting target on condom use for FSW

19. As the HIV prevalence of FSW has remained low at almost 0% (95% CI: 0.0-0.6%), and their reported condom usage rate is high at >95%[14-17], their risk of HIV infection and impact on the HIV epidemic in Hong Kong are anticipated to be relatively low. Any specific target for condom use in FSW is unlikely to exceed the current rate and therefore appears redundant. Resources should be focused on sustaining the current prevention efforts for FSW and monitoring their level of condom usage.

II. About setting target on condom use for sex worker clients (SWC) and including male with multiple sex partners (MWMSP) as key population

20. With regard to the suggestion to set target on condom use and HIV testing for male clients of FSW, ACA noted that the number of male HIV cases transmitted through heterosexual contact has remained stable at around 100 reports per year[12], and its epidemiological impact is relatively low. WHO also has not set a target on condom use for SWC[5].

21. Regarding MWMSP, WHO has not identified it as a key population[5]. Nevertheless, ACA considers it important to sustain current efforts on surveillance, prevention and promotion of testing in both the SWC and MWMSP populations.

Chapter 5. Deliberations of specific issues

22. Priority areas for action for the coming five years were framed against the objectives of the Strategies and the current service gaps. They were categorized into:

    A. Areas to be strengthened;

    B. Areas for further examination; and

    C. Current response that should be maintained.

23. The Draft Strategies made specific recommendations in the above areas. The subsequent consultation and exchange with stakeholders found general agreement with the recommendations, while some wording modifications were suggested.

24. On the other hand, some of the community stakeholders called for various legal amendments and policy changes. After careful examination of the issues, ACA decided that they should not be all incorporated into the new Strategies at this moment in time. As these issues would have wide-reaching implications beyond the control of HIV/AIDS, involve the interests of society at large, require substantial and long term effort, and the changes may not be easily reversible, any decision would have to be supported by strong epidemiological and scientific evidence. In this regard, ACA concurs with WHO's use of "AIDS deaths"or "new infections"as the proxy of impact[3]. Overseas experience in HIV control by policy and legal changes would serve as good reference. The following sections expound ACA's deliberations on eight issues of controversy.

Section A. Related to sexual minorities

25. In recent years, some members of the sexual minorities including the gay community have called for legislative reform to be incorporated into the Strategies. They quote that "absence of sexual orientation discrimination ordinance or a specific policy which protects the rights of MSM and transgender people are postulated as factors affecting them to "come out"and their equal opportunities of seeking HIV prevention services"(paragraph 31 of HIV/AIDS Strategies (2012-2016)[1]. They opine that legislating on anti-discrimination on the basis of sexual orientation and ensuring equal rights of sexual minorities would promote acceptance of sexual minorities in society. This could raise their self-esteem and outlook of life, which in turn could enhance their willingness to protect themselves, ultimately helping to control the HIV epidemic.

26. The experience of other countries in legislating on the rights of sexual minorities was studied. Such legislation can be broadly divided into punitive laws and protective laws[19].

27. According to a world survey conducted by the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA) in 2016, many countries still have punitive laws that criminalise sexual activities between men. These include countries in Africa (33 countries), Asia (23 countries), Latin America and Caribbean (11 countries) and Oceania (6 countries). The penalties ranged from imprisonment to the death sentence[19].

28. The move from punitive laws to protective laws generally (might not limited to) takes several stages (Table 2)[19]. Currently, more than 70 countries have at least one protective law, i.e. those at stages 3 to 7.

Table 2. Stages of legislation on the rights of sexual minorities

(1)	Decriminalisation of consensual same-sex acts between adults
(2)	Equalisation of ages of consent for sexual acts
(3)	Prohibition of discrimination based on sexual orientation in employment, and constitutional ban on discrimination
(4)	Hate crimes based on sexual orientation
(5)	Prohibition of incitement of hatred based on sexual orientation
(6)	Marriage and partnership rights for same-sex couple
(7)	Joint adoption by same-sex couples

29. The issues raised by stakeholder communities are essentially the following:

Issue 1 - Legislation to prohibit discrimination on grounds of sexual orientation and gender identity

Issue 2 - Legalisation of same sex marriage

Issue 3 - Equalising laws on unlawful sexual acts between heterosexuals and homosexuals

These are discussed in detail in the following sections.

Issue 1 – Legislation to prohibit discrimination on grounds of sexual orientation and gender identity

30. In Hong Kong, consensual sex between adult men at or above 16 is not illegal. There are, however, no separate protective laws for the other rights of sexual minorities.

31. Scientific evidence on the impact, if any, of protective laws on the HIV epidemic of MSM is lacking. Studies on the association between legal rights of sexual minorities and the risks of HIV infection are scarce. Where available, they were mostly on punitive laws. In general, research showed that criminalisation of same-sex act could create fear for MSM to seek healthcare[20], and that countries with punitive laws, such as those in Latin America and Jamaica, tend to have a high HIV prevalence among MSM[21]. However, these findings are not directly applicable in Hong Kong where consensual sex between adult men has been decriminalised.

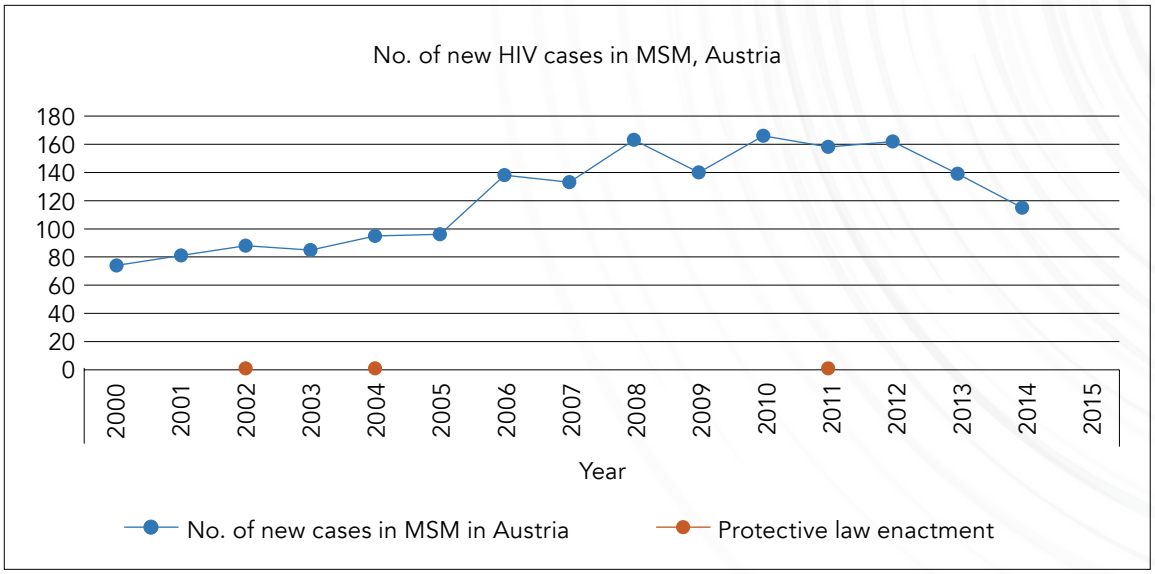
32. On the other hand, there is evidence to support the relationship between experienced or perceived discrimination among sexual minorities, and their risky behaviours or health-seeking behaviours. A study conducted from 2010 to 2013 in New York City, where protective laws against discrimination based on sexual orientation had been in place since 2003[22], showed that MSM who reported experiencing discrimination in home or social neighborhood were 2.5 times more likely to have risky behaviours, i.e. unprotected sex with HIV-positive or unknown status partners[23]. Another similar study showed that those who reported experiencing discrimination in health care settings were only half as likely (54%) to receive HIV testing compared to those who did not experience discrimination[24]. A related study in Hong Kong showed that 58.4% of MSM perceived "noticeable"or "strong"discrimination by the public, and they were 40% less intend to take up HIV testing in the next six months when compared to those MSM who did not report perceived discrimination[25].

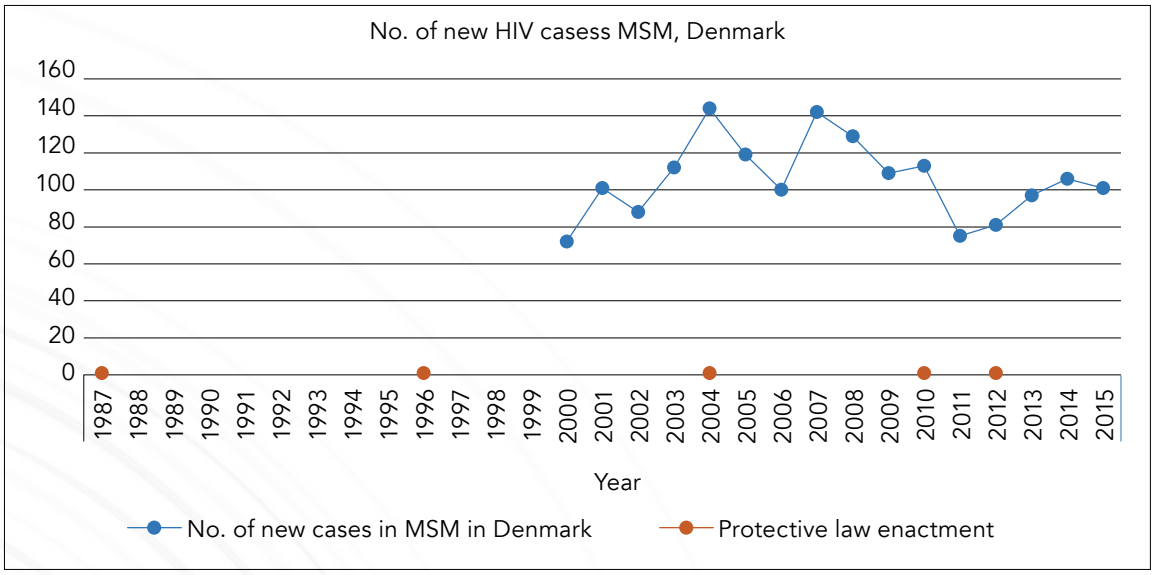
33. Drawing from the experience of New York City, it is not evident that legislation for protective laws beyond the current decriminalisation laws of Hong Kong will remove experienced or perceived discrimination and improve access to HIV services resulting in better control of the HIV epidemic. Systematic studies of a direct impact of protective laws for sexual minorities on control of the HIV epidemic among MSM would be useful but are currently lacking.

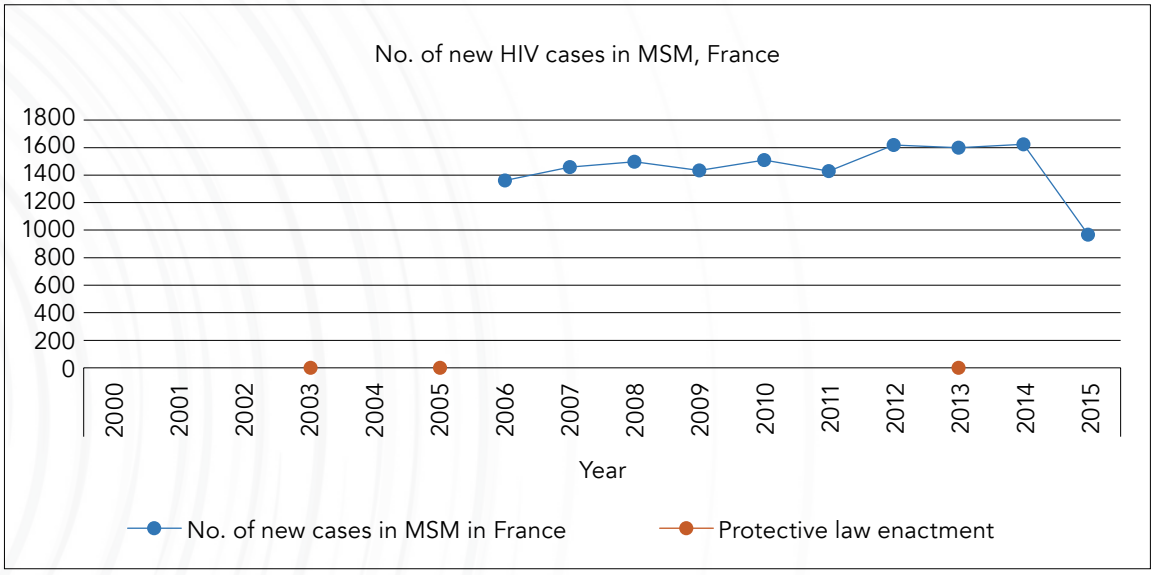
34. Using another approach, the temporal relationship, if any, between law reform and the HIV epidemic of MSM in other countries was examined. The data is shown in Graph 1 and Table 3.

35. It can be seen that the number of new HIV infections among MSM actually rose in Germany, Netherlands, US, UK and Taiwan after the enactment of protective laws. The other countries showed a more fluctuating trend. All in all, a definitive temporal correlation between the enactment of protective laws and an impact on the control of the HIV epidemic among MSM could not be established.

Graph 1. Legislation of protective laws for sexual minorities and the number of newly reported or diagnosed HIV cases in MSM




No. of new HIV casess MSM, Denmark
160
140
120
100
80
60
40
20
0
1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015
Year
No. of new cases in MSM in Denmark
Protective law enactment


No. of new HIV cases in MSM, France
1800
1600
1400
1200
1000
800
600
400
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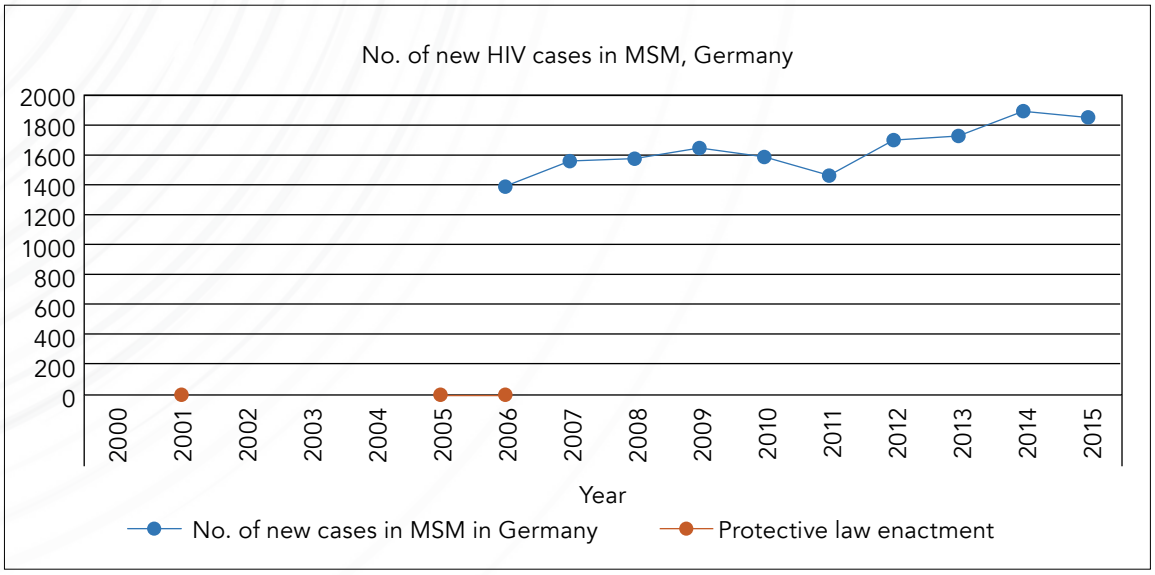
2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015
Year
No. of new cases in MSM in France
Protective law enactment


No. of new HIV cases in MSM, Germany
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600
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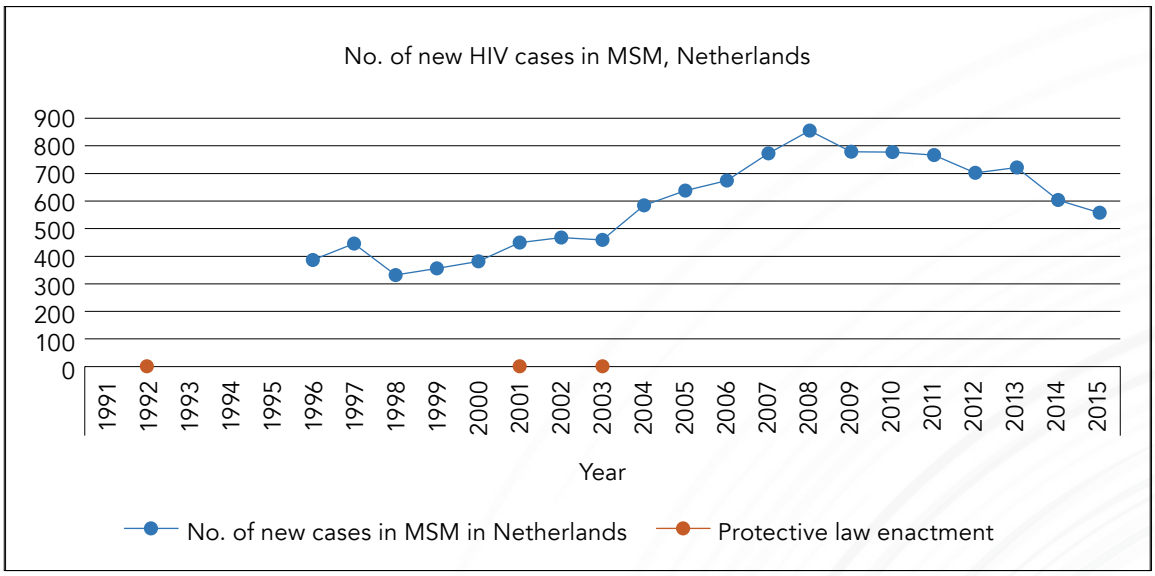
200
0
2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015
Year
No. of new cases in MSM in Germany
Protective law enactment


No. of new HIV cases in MSM, Netherlands
900
800
700
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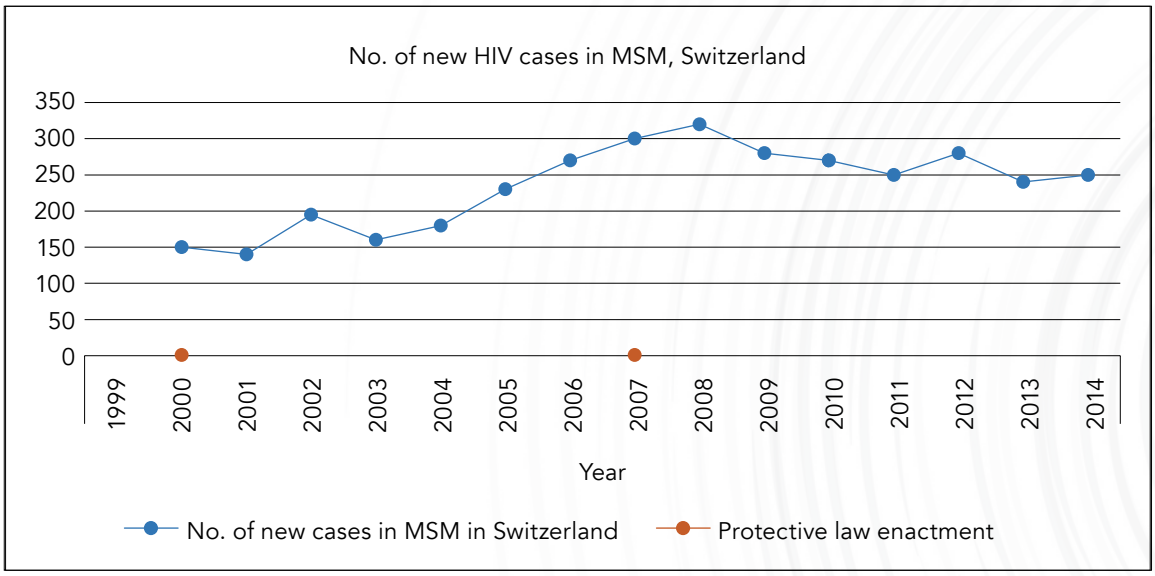
Year
No. of new cases in MSM in Netherlands
Protective law enactment


No. of new HIV cases in MSM, Switzerland
350
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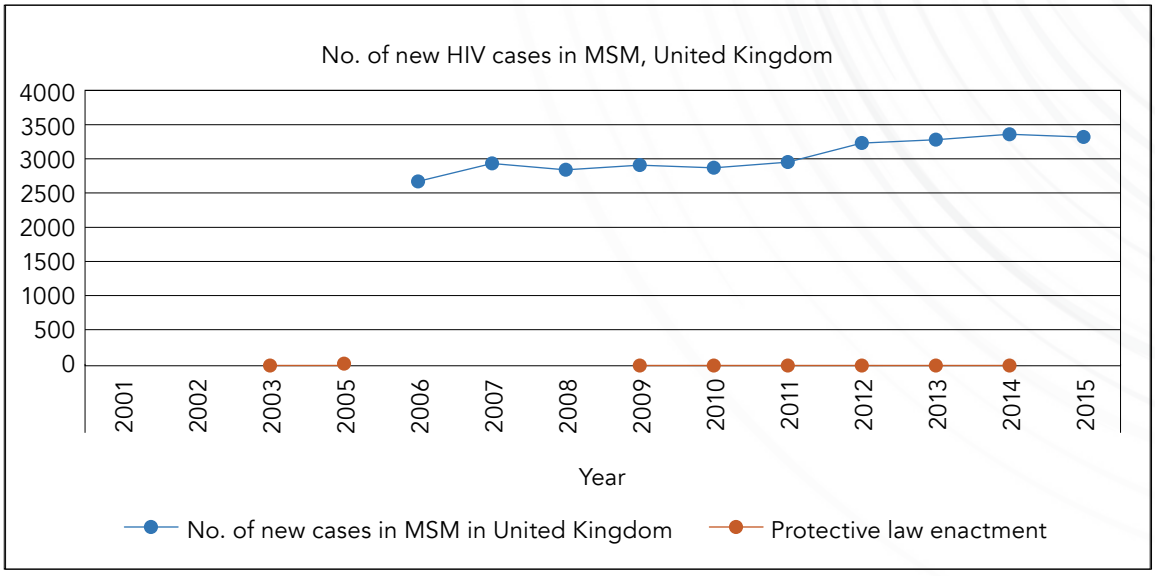
Year
No. of new cases in MSM in Switzerland
Protective law enactment


No. of new HIV cases in MSM, United Kingdom
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3500
3000
2500
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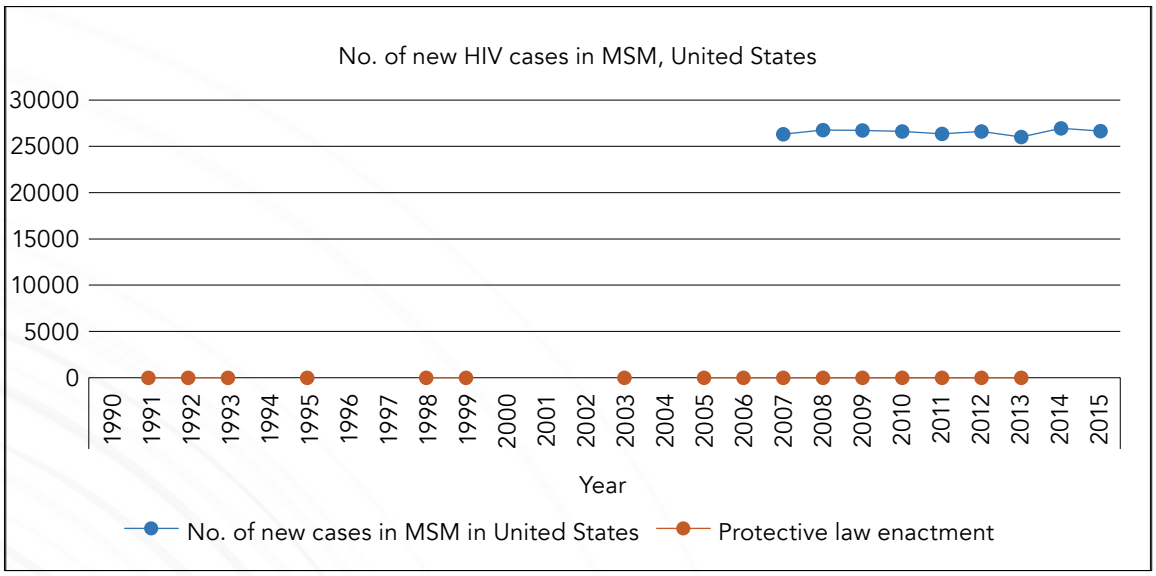
Year
No. of new cases in MSM in United Kingdom
Protective law enactment


No. of new HIV cases in MSM, United States
30000
25000
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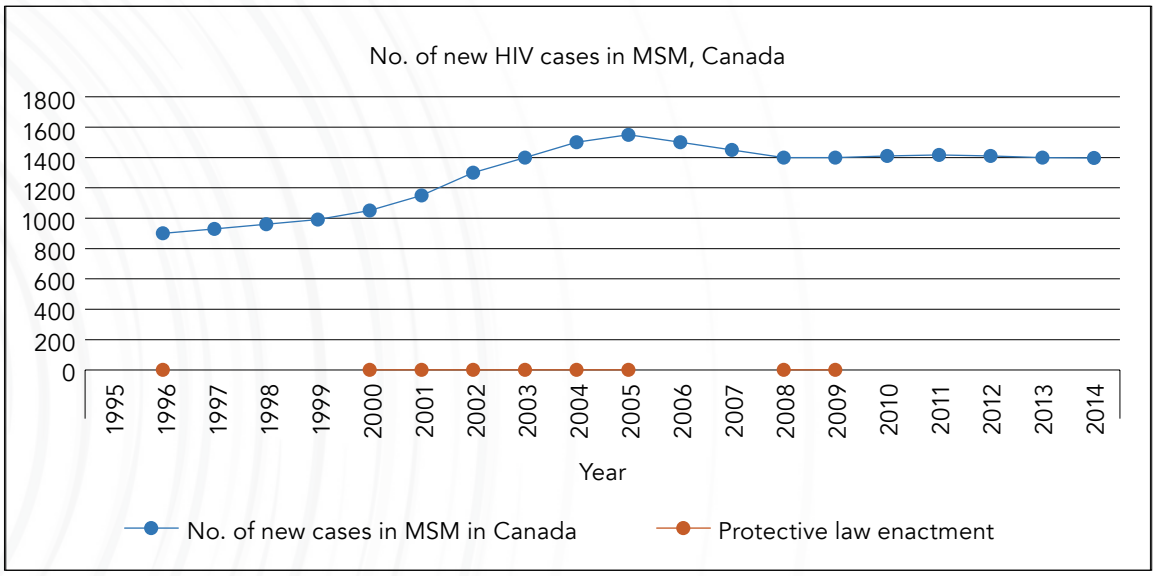
Year
No. of new cases in MSM in United States
Protective law enactment


No. of new HIV cases in MSM, Canada
1800
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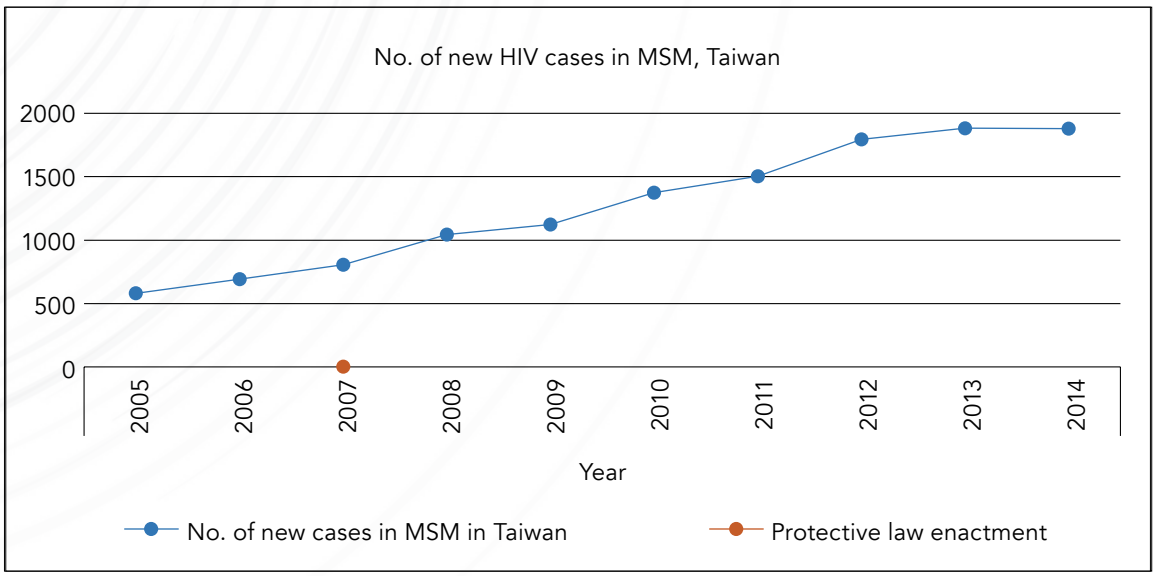
Year
No. of new cases in MSM in Canada
Protective law enactment


No. of new HIV cases in MSM, Taiwan
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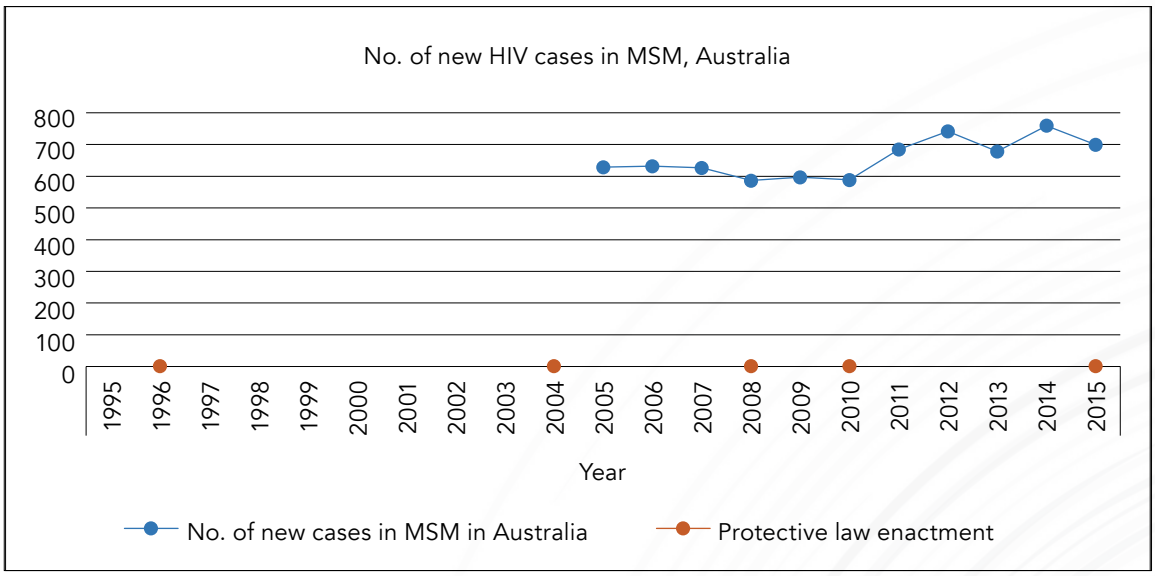
Year
No. of new cases in MSM in Taiwan
Protective law enactment


No. of new HIV cases in MSM, Australia
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2011
2012
2013
2014
2015
Year
No. of new cases in MSM in Australia
Protective law enactment

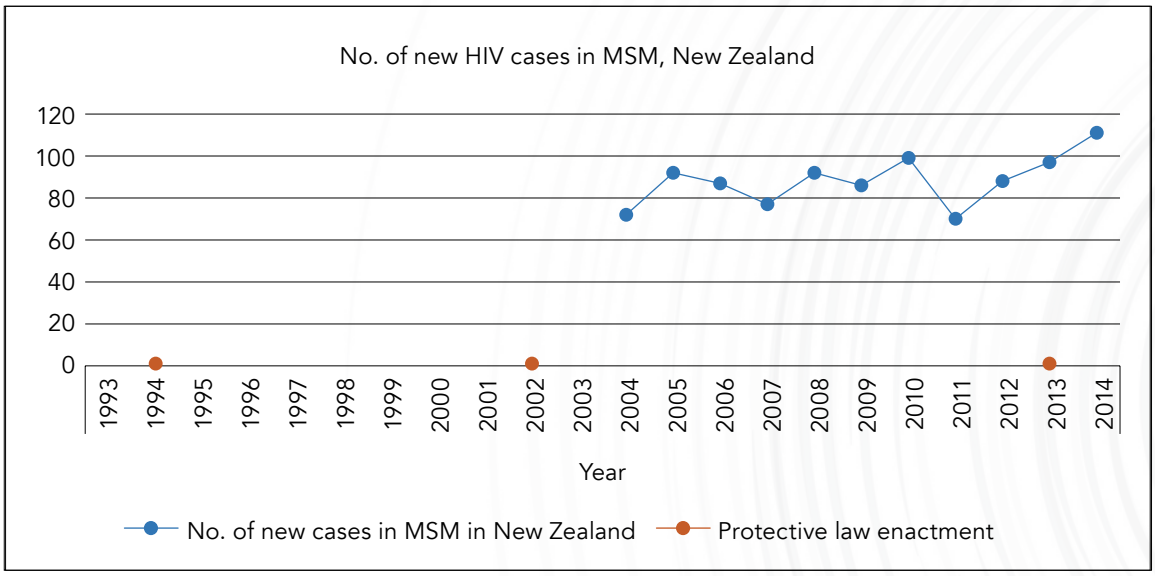
No. of new HIV cases in MSM, New Zealand
120
100
80
60
40
20
0
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
Year
No. of new cases in MSM in New Zealand
Protective law enactment

Table 3. The number of newly reported or diagnosed HIV cases in MSM

Countries	Year when different protective laws came into force[a]	HIV prevalence among MSM	No. of newly reported / diagnosed HIV cases in MSM per year
Europe			
Austria	2002 (equal age of consent) 2004 (employment) 2011 (incitement) 2016 (second parent adoption)	Not available	1999 : 77 [b] 2000 : 74 2001 : 81 2002 : 88 2003 : 85 2004 : 95 2005 : 96 2006 : 138 2007 : 133 2008 : 163 2009 : 140 2010 : 166 2011 : 158 2012 : 162 2013 : 139 2014 : 115
Denmark	1987 (incitement) 1996 (employment) 2004 (hate crime) 2010 (joint adoption) 2012 (marriage)	Not available	1990-1999 : 1055 [c] 2000 : 72 2001 :101 2002 : 88 2003 :112 2004 : 144 2005 : 119 2006 : 100 2007 : 142 2008 : 129 2009 : 109 2010 : 113 2011 : 75 2012 : 81 2013 : 97 2014 : 106 2015 : 101
France	1985 (employment) 2003 (hate crime) 2005 (incitement) 2013 (marriage) 2013 (joint adoption)	2011 : 17.7% [d] 2012 : 17.7% 2013 : 17.7%	2006 : 1,361 [e] 2007 : 1,457 2008 : 1,498 2009 : 1,434 2010 : 1,508 2011 : 1,428 2012 : 1,618 2013 : 1,600 2014 : 1,624 2015 : 967

Countries	Year when different protective laws came into force[a]	HIV prevalence among MSM	No. of newly reported / diagnosed HIV cases in MSM per year
Germany	2001 (civil partnership / unions) 2005 (second parent adoption) 2006 (employment)	2011 : 11.5% [d] 2013 : 12.3% 2014 : 6.7% 2015 : 5.2%	2006 : 1,388 [e] 2007 : 1,558 2008 : 1,575 2009 : 1,646 2010 : 1,585 2011 : 1,461 2012 : 1,698 2013 : 1,728 2014 : 1,894 2015 : 1,851
Netherlands	1992 (employment) 1992 (incitement) 2001 (marriage) 2001 (joint adoption) 2003 (hate crime)	2013 : 5.1% [f]	1996 : 386 [f] 2000 : 381 2001 : 449 2002 : 468 2003 : 459 2004 : 584 2009 : 779 2011 : 766 2013 : 722 2015 : 558
Switzerland	2000 (employment) 2007 (civil partnership / unions) 2015 (Incitement)	2007 : 8.1% [d] 2011 :11.29% 2013 :11.2%	2000 : around 150 [h] 2002 : around 200 2004 : around 180 2007 : around 300 2008 : around 320 2009 : around 285 2011 : around 250 2012 : around 275 2013 : around 225 2014 : around 250 2015 : 247
United Kingdom	2003 (employment) 2004,05,10 (hate crime) 2004,05,10 (incitement) 2014 (marriage) 2005, 2009, 2011-14 (joint adoption)	2014 : 5% [i] (London : 9% Outside London :3.6%)	2006 : 2,670 [j] 2007 : 2,930 2008 : 2,840 2009 : 2,910 2010 : 2,870 2011 : 2,950 2012 : 3,230 2013 : 3,280 2014 : 3,360 2015 : 3,320
Americas			
United States	1982-2013 (employment) 2009 (hate crime) 2015 (marriage) Some states (joint adoption)	2014 : 14.5% [d]	2007 : 26,320 [k] 2008 : 26,750 2009 : 26,739 2010 : 26,629 2011 : 26,367 2012 : 26,612 2013 : 26,013 2014 : 26,954 2015 : 26,646

Countries	Year when different protective laws came into force[a]	HIV prevalence among MSM	No. of newly reported / diagnosed HIV cases in MSM per year
Canada	1996 (hate crime) 2003 (employment) 2004 (incitement) 2005 (constitutional) 2005 (marriage) 1996-2009 (joint adoption)	2009 : 14.7% [d] 2011 : 14.9%	1988 : around 1500 [l] 1996 : around 1,000 1999 : around 1,000 2005 : around 1,550 2008 : around 1,400 2011 : 1,416 2014 : 1,396
Asia			
Taiwan	2007 (employment)	2012: 4.38% [m]	2005 : 580 [h] 2006 : 693 2007 : 807 2008 : 1,044 2009 : 1,124 2010 : 1,375 2011 : 1,504 2012 : 1,795 2013 : 1,883 2014 : 1,878
Oceania			
Australia	1996 (employment) 2004-2008 (civil partnership / unions) Years not specified (joint adoption)	2012 : 14.0% [o] 2013 : 16.5% 2015 : 18.3%	2005 : 628 [o] 2006 : 631 2007 : 626 2008 : 586 2009 : 596 2010 : 588 2011 : 684 2012 : 741 2013 : 678 2014 : 759 2015 : 699
New Zealand	1994 (employment) 2002 (hate crime) 2013 (marriage) 2013 (joint adoption)	2005 : 4.4% [p] 2014 : 6.5%	2004 : 72 [p,q] 2005 : 92 2006 : 87 2007 : 77 2008 : 92 2009 : 86 2010 : 99 2011 : 70 2012 : 88 2013 : 97 2014 : 111

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Issue 2 – Legalisation of same sex marriage

36. Same sex marriage is not recognised in Hong Kong.

37. As with protective laws in general, there are few studies that looked into the relationship between legalisation of same sex marriage and its effect on the local HIV epidemic among MSM.

38. There was a study on HIV ecology modelling which used statewide laws on same-sex marriage (SSM) as a proxy of anti-homosexual stigma. It looked for associations between social determinants and HIV incidence in 80 cities in the US in 1990 and 2000[26]. The findings were complex and not easy to interpret. They showed that cities in low-stigma states (as measured by fully legal SSM) did have a lower HIV incidence in MSM than cities in high-stigma states (banned SSM). However, social determinants like income inequality, poverty and segregation were also found to be significantly associated with HIV incidence, although statistically the strength of association was stronger with heterosexual men than with MSM (2.6 vs 1.5 folds). The authors of the study cautioned that the results did not imply that HIV incidence could be lowered by legalisation of SSM *per se*, but rather that the attitudes underlying social acceptance of SSM were protective against HIV infection.

39. Another study in California found that under the current health insurance policy in the US, partnered gay men were 42% less likely than married heterosexual men to obtain employer-sponsored dependent coverage[27].

40. Therefore evidence is currently lacking on impact of legalisation of same sex marriage on the control of HIV epidemic in MSM. Nevertheless, the California study does draw attention to the likelihood of inequitable access to health care by sexual minorities.

41. Referring back to Graph 1 and Table 3, there is no significant temporal association between legalisation of same sex marriage and HIV infection in MSM.

Issue 3 - Equalising laws on unlawful sexual acts between heterosexuals and homosexuals

42. Under Hong Kong's Crime Ordinance, Chapter 200, Section 118C[28]:

A man who:-

(a) commits buggery with a man under the age of 16; or

(b) being under the age of 16 commits buggery with another man, shall be guilty of an offence and shall be liable on conviction on indictment to imprisonment for life.

However, the penalty for a similar offence in a heterosexual relationship (Section 124) is 5-year imprisonment only.

43. There are other laws regarding sexual acts between men under Sections 118G, H, J, K which state that procuring others to commit homosexual buggery, gross indecency with or by man under 16, gross indecency by man with man otherwise than in private, and procuring gross indecency by man with man are illegal. There is no similar law for heterosexual act.

44. Members of sexual minorities have called for equalising the above laws between heterosexual and homosexual relationships, citing that difference in the penalties might itself constitute a form of discrimination.

45. There is currently no scientific evidence in support of a significant impact of equalising the laws between heterosexual and homosexual relationship on the HIV epidemic in MSM.

ACA's views and conclusions

46. Having considered all the available evidence, ACA concludes that ***there is currently insufficient scientific evidence to show that enactment of protective laws for sexual minorities will impact directly on the HIV epidemic in Hong Kong.*** Epidemiological data in the past 10 years did not demonstrate a temporal relationship between the enactment of protective laws and the control of the MSM HIV epidemic in other parts of the world.

47. On the other hand, perceived discrimination against sexual minorities exists[23-25] and is associated with a higher rate of risky behaviours[23] and lower health seeking behavior such as HIV testing[24-25]. To address this, ACA is of the view that the immediate goal should be towards health care that is discrimination-free and accepting, facilitating people of different sexual orientations to access HIV related services. This is in fact in line with the current recommendations of both WHO and UNAIDS.

Towards discrimination-free health care for sexual minorities

48. One of the visions in WHO's Global Health Sector Strategy on HIV (2016-2021) is "Zero ***HIV-related*** discrimination", especially in health care settings [29-30]. It suggests reform of HIV-related discriminatory laws, regulations and policies that hinder equitable and safe access to HIV-related services for key populations, and training of healthcare workers to this end. It also advocates the use of public health evidence to shape pro-health laws and actions based on medical ethics, human rights and public health principles[29].

49. While the current UNAIDS Strategy (2016-2021) continues to adopt the vision of three zeroes – "Zero new infections, zero discrimination, and zero AIDS-related deaths", the scope now focuses specifically on health care, workplace and educational settings[5], echoing WHO's vision. This contrasts with the previous UNAIDS strategy (2011-2015) in which the recommendations for "zero discrimination"were broader and covered legal reforms for human rights, promotion of social norms of tolerance, removal of policy barriers, and equal access to service and justices[31-32]. In 2015 and 2016, seven other UNAIDS publications also emphasised that

building discrimination-free health care and ensuring equality in health care would be the focus of "zero discrimination"in the coming years[33-39]. Examples of discrimination in health care, such as denied health care, stigmatising treatment, negative attitudes of service providers, and lack of privacy and confidentiality were quoted[33-34,40]. These would obviously undermine access to HIV prevention, treatment and care services and should be addressed in the ACA Strategies.

50. Hong Kong enacted the Disability Discrimination Ordinance (DDO) in 1995. The Ordinance aims to eliminate and prevent discrimination against persons with disabilities. People living with HIV would be protected under this ordinance[41].

51. In recent years, the Government has been addressing discrimination on sexual orientation through (i) setting up the Advisory Group on Eliminating Discrimination against Sexual Minorities (ii) supporting projects by Equal Opportunities (Sexual Orientation) Funding Scheme, (iii) issuing and promoting the Code of Practice against Discrimination in Employment on the Ground of Sexual Orientation[42], and (iv) public education and publicity.

52. The Advisory Group on Eliminating Discrimination against Sexual Minorities has conducted stock-taking and studies from 2013 to 2015, issuing its report on 31 December 2015[43]. The report documents that there have been cases of transgender (TG) persons "being refused provision of medical services", and medical staff "often lacked good knowledge of transgenderism". The Group recommends the provision of sensitivity training to professional groups having more direct interactions with sexual minorities, including medical practitioners, associated professionals and frontline workers in hospitals and clinics; social workers; teachers and human resource professionals, so as to increase their sensitivity towards the sexual minorities. It also recommends the Government conduct an in-depth review of relevant support services in consultation with relevant service providers and sexual minorities to delineate service gaps and improve the effectiveness of the services.

53. The Equal Opportunities Commission conducted a similar survey in 2015, issuing its report in January 2016[44-45]. The report cites some examples of discrimination in health care settings:

    (a) Denial of medical and social services due to sexual orientation or gender identity, e.g. reports that gay men and lesbians had been denied the right to visit their partners in hospital;

    (b) Discriminatory experiences directed at LGBT by providers of medical and social services, e.g. in the form of derogatory comments; and

    (c) Transgenders reporting experience with medical workers who insisted on referring to their biological sex at birth and ignoring their self-identified gender identity.

54. The Constitutional and Mainland Affairs Bureau is actively following up on the recommendations of the Advisory Group. Among other things, resources and training for personnel in specific fields (including healthcare, social work, education and human resources) will be provided to enhance their sensitivity towards sexual minorities, and the existing support services will be reviewed and reinforced with a view to better addressing the needs of sexual minorities.

55. Both DH and AIDS NGOs have purposefully been promoting HIV services to the MSM community. The contents are tailor-made to appeal to the target population, often inviting their input as to the detailed messages and designs. Various channels are used to reach the community, e.g. gay websites, gay apps, gay venues, gay events, gay hotline, announcement of public interest (API) and other publicity campaigns.

56. Moreover, education and training have been provided by DH and NGOs to health care service providers to enhance their sensitivity to the special needs of sexual minorities, to improve the quality of service and foster an anti-discrimination and accepting environment.

Section B. Related to sex workers

57. Under the current legal system, selling sex is not illegal in Hong Kong. However, certain other activities related to sex work are illegal, such as those under CAP 200 Crime Ordinance [28]:

    (a) Section 131 : Causing prostitution

    (b) Section 139 : Keeping a vice establishment

    (c) Section 147 : Soliciting for an immoral purpose

    (d) Section 147A : Prohibition of signs advertising prostitution

58. NGOs working with male and female sex workers have expressed concern that the police would seize condoms during law enforcement and use condoms as evidence for prosecution of sex work. Consequently sex workers might be reluctant to store or use condoms for fear of prosecution. The community stakeholders therefore raised the following issues, which are discussed in the following sections:

Issue 4 - Decriminalisation of sex work

Issue 5 - Requesting the Police not to seize condom during law enforcement and not to use condoms as evidence of prosecution for sex work related offences

59. There are studies showing that criminalisation of sex work could be associated with unsafe sex [46-47]. For instance, a systemic review of 137 articles worldwide regarding FSW found that those who had ever been arrested were 1.8 times more likely to have HIV infection (aOR:1.8, 95% CI: 1.1,3.0)[46]. Another systematic review of 3,214 publications found that criminalisation of sex work (including all aspects such as solicitation and living off the avails by third parties) was associated with an unsafe working environment[47], which may take the form of violence from clients, police harassment and abuse, incarceration, and confiscation of condoms. These could result in FSWs to rush transactions with their clients, forgo condoms, and engage in risky sexual behaviour.

60. However, the author of the above systematic review cautioned that quantitative evidence on the impact of ***decriminalisation*** of sex work on decreasing HIV transmission is scarce. Resorting to mathematical modelling to assess such impact[47], the author showed that:

    (a) Decriminalisation of sex work could avert 33%-46% of HIV infections in the next decade among FSW and sex worker clients through its effect on violence, policing, and fostering safer work environments.

    (b) Community interventions (especially sex-worker led outreach) could similarly prevent another 20% of HIV infections in the next decade among FSW.

61. Literature search could not find any similar studies on male sex workers.

HIV situation among male and female sex workers in HK

62. The HIV prevalence of male sex workers in Hong Kong has not been clearly defined. In the 2014 HARiS survey of a small number of MSM recruited from motels, whom AIDS NGOs believed to be male sex workers, HIV prevalence reached 21% (10/46)[48]. In the same survey, the condom use rate in last anal sex among MSM with commercial sex partners was high (94%). The number of condoms DH distributed to male sex workers (MSW) through NGO increased from 24,600 in 2014 to 31,920 in 2015.

63. The HIV prevalence of female sex workers in Hong Kong has been low: 0.19% in 2006, 0.05% in 2009, and 0% (95% CI : 0.0-0.6%) in 2013[15]. The condom use rate in last sex has been consistently high at over 94% in the past few years[15]. DH has been distributing condoms to FSW through NGO, ranging from 108,000 in 2011 to 164,160 in 2015.

Recommendations by international health authorities

64. WHO and UNAIDS recommend that countries ensure universal availability of condom, either free or at low cost[49] because consistent use could reduce HIV transmission by around 85%[50-51]. Law reforms, including removal of punitive laws, are to be considered if there are laws hindering equitable and safe access to HIV-related services[5,29-30]. They also recommend governments to establish laws to protect against discrimination and violence faced by sex workers, in an effort to reduce their vulnerability to HIV infection and guarantee their rights to social, health and financial services[52].

ACA's effort on the issues

65. In recent years, ACA has taken active steps in response to the concerns raised by local NGOs regarding condoms being confiscated and used as prosecution evidence for sex work. In July 2009, ACA wrote to the Commissioner of Police. In its reply, the Police stated that:

- "a liaison mechanism has been in place since May 2008 between police, NGOs and sex workers to discuss on matters of mutual concern";
- the police would "reassure them that sex workers would not be arrested solely because of possession of condoms"; and
- "possession of condoms will form the circumstantial evidence to prove the person's involvement in illegal prostitution activity."

66. NGOs continued to express that many sex workers were still afraid of possessing condoms to avoid charges related to prostitution. In September 2012, a judge was invited to attend a CFA meeting in which NGOs serving sex workers were also present. During the meeting, the judge reiterated that possession of condoms and lubricants alone would not be taken as evidence of prosecution, nor would they be major evidence for prosecution of prostitution-related cases.

67. In June 2013, ACA wrote again to the police, requesting them to consider the latest developments in New York, San Francisco, and Los Angeles where the relevant authorities had issued memorandums to prohibit using condoms as evidence in prostitution-related cases after considering the long-term public health gains. The Metropolitan Police Department of Washington DC even issued a card headed "Know Your Rights"to assure the public and sex workers that police officers cannot conduct a stop or a search based on possession of condoms.

68. The Police gave a similar reply in July 2013, stating that they would "make their judgement on a case-by-case basis as regards condom seizure, and no change to their policy regarding the prosecution of prostitution–related cases will be considered for the time being".

69. ACA further pursued the matter with another letter sent to the Police again on 3 September 2013, requesting the Police to re-consider taking positive steps to stop using condoms as evidence of prostitution, and issue guidelines to frontline officers in this regard. The letter was also copied to the Secretary for Security, the Secretary for Justice, and the Secretary for Food and Health.

70. The reply from the Police in September 2013 reiterated that prostitution itself is not illegal in HK, and their enforcement priority is against those organised prostitution activities that exploit sex workers and prostitution involving underage persons and visitors. They further stated "Please be reassured that only items with absolute evidential value would be seized and law enforcement action has not been and would not be solely based on possession of condoms". They "will continue to address sex workers' concerns and enhance mutual understanding through their established channels by explaining their enforcement priority."

71. The issue was further discussed during the 84th ACA meeting on 4 Oct 2013. It was agreed that NGOs would be informed about the actions that ACA had taken and the response and reassurance from the Police. Should NGOs and other stakeholders or interested parties encounter Police action that contravenes what was stated in the reply from the Police, NGOs were urged to bring the matter up to the ACA Secretariat.

72. To date, no local precedent case has been found in which "possession of condom"was used as the sole or major evidence leading to successful prosecution of illegal prostitution activity.

ACA's views and conclusions

73. ACA is aware that criminalisation of sex work-related activities can intimidate sex workers, which in turn may lower their willingness to access HIV related services, or make it difficult for health workers and NGOs to reach them. Condom seizure by police for possible prosecuting evidence could make the situation worse.

74. In terms of impact on the local HIV epidemic, however, ACA concludes that *there is currently insufficient scientific evidence to show that decriminalisation of sex work will further reduce the already low HIV transmission among sex workers in Hong Kong*.

75. Nevertheless, ACA recognises that condom seizure is being practised by the police during law enforcement. Since there has been no legal precedent of successful prosecution in which "possession of condom"was used as the sole or major evidence, ACA will continue the dialogue and liaison with law enforcement and judiciary bodies for the feasibility of not confiscating condoms at all. Communication between stakeholders and the police through the existing liaison mechanism should be maintained, and the access to health services and condoms among male and female sex workers should continue to be monitored.

Section C. Related to people who inject drugs (PWID)

76. Under Hong Kong Law Chapter 134 Section 36, "possession of any pipe, equipment or apparatus fit and intended for the smoking, inhalation, ingestion or injection of a dangerous drug"is illegal[28]. In Section 27, only registered medical practitioner and other specified person are authorised to possess equipment for injection of dangerous drug.

77. Nowadays, PWID in Hong Kong are usually able to purchase needles from local pharmacies. One AIDS NGO launched a 1.5 year programme in 2015-2016 with free distribution of "health kits"containing new syringes, alcohol swabs, bandage, and cotton balls. Clips and sharp boxes were also provided to cleaners for collecting used needles in places where drug users frequent. In the same period, the needle sharing rate dropped from 24.3% in 2014 to 13.9% in 2015, although the effect of other HIV prevention efforts could not be excluded[6].

78. The number of newly reported HIV infections in Hong Kong transmitted through injecting drug use remained low with 14 to 17 cases per year from 2010-2015, accounting for 1-3% of newly reported cases for the year[12,53]. The overall HIV prevalence of people who inject drugs (PWID) is 1.1%, as estimated from methadone clinic attendees. However, their needle sharing behaviour, which is a major route of HIV transmission, remains high at 13.9% according to HARiS 2015 conducted by DH[6]. Therefore, the potential risk of an HIV outbreak among this population cannot be overlooked.

79. Stakeholders of the PWID community have called for decriminalisation of possession of drug taking equipment. Under the current law (paragraph 76), PWID may be reluctant to carry their own syringes to and from the drug taking venues, for fear that they might be arrested in the street for such possession. As a result, they might resort to sharing used needles with others at the drug taking venue. They further suggest that the Government establish safe house for drug taking, where new needles and sterile kits would be freely provided and used needles properly collected and disposed of. These issues are discussed in the following sections:

Issue 6 - Decriminalisation of possession of drug taking equipment

Issue 7 - Establishment of safe house for drug taking

Issue 6 - Decriminalisation of possession of drug taking equipment

80. In 2008, a study in Mexico followed around 400 PWID to assess their drug injecting behaviours. Results showed that people who had been arrested for possession of drug taking equipment were 2-3 times more likely to have needle sharing behaviour (adjusted odds ratio: 2.05; 95% C.I.: 1.26, 3.35)[54]. Another study of 187 drug users conducted in Los Angeles, USA also showed that anticipation of being arrested for carrying a needle was associated with needle sharing (OR: 2.48; 95% C.I.: 1.34,4.61)[55]. However, studies are lacking on the direct association between decriminalisation of possession of drug taking equipment and its impact on HIV infection rate.

81. Possession of injecting equipment is legal in Canada, Australia, some states of USA and some European countries[56]. In Macau, needle exchange programme is being conducted by NGOs despite the fact that possession of drug taking equipment is illegal there[57].

Recommendations by international health authorities

82. WHO suggests Needle and Syringe Programme (NSP) as one of many measures to control the spread of HIV among PWID[58]. There are several components of NSP as recommended by WHO, with decriminalisation of carrying injection equipment being one of them:

    (a) Provision of needles for free – to reduce number of injection with used needles;

    (b) Provision of low dead-space syringes (LDSS) – to reduce amount of remaining blood;

    (c) Safe disposal for used syringe – by providing puncture-resistant containers (e.g. sharp box);

    (d) Decriminalisation of carrying of needles and syringes – to reduce the resistance for PWID to take used needles for proper disposal; and

    (e) Provision of injecting-related paraphernalia (e.g. alcohol swabs, sterile water, tourniquets) for safe and hygienic injection.

Issue 7 - Establishment of safe house for drug taking

83. Supervised injection facilities (SIF) (also known as "Drug consumption rooms"or "Safe House") are legally sanctioned and medically supervised facilities designed to reduce health and public order problems in relation to illicit drug use[59]. It provides a comprehensive package of harm reduction services, with the core components of: (a) provision of needles; (b) health education; (c) treatment referral for detoxification; (d) condom distribution; and (e) a place where illicit drugs can be consumed under the supervision of trained staff.

84. SIF exists in some European nations including Switzerland, Denmark, Germany, Netherlands, Spain, Norway and Luxembourg, as well as in Canada and Australia[59-60]. Studies have been done to evaluate its effectiveness in the following areas:

(a) ***HIV transmission:*** Insufficient evidence exists for SIF's effectiveness in reducing HIV transmission[61-62].

(b) ***Syringe sharing:*** A meta-analysis showed that SIF could reduce syringe sharing among users by 69% (95% C.I.: 0.17–0.55)[63].

(c) ***Unsafe syringe disposal:*** A study showed that 56% IDU participants reported less unsafe syringe disposal after using SIF[64], but another study in Spain showed inconsistent results[65]. The effectiveness of SIF in reducing unsafe syringe disposal depends very much on other factors, such as police intervention[65], the combination of services available and waiting time[58,65].

(d) ***Detoxification:*** A study showed 56% increase in the uptake of detoxification services within one year in a SIF where methadone provision is available[66].

(e) ***Overdose fatality:*** A report from European Monitoring Centre for Drugs and Drug Addiction showed no overdose fatality despite millions of injections in SIF in Europe in the past 20 years[67].

(f) ***Acceptability:*** A study showed 71% of respondents would have preferred to use SIF for drug injection instead of injecting in public or private[68].

85. Despite the favourable effects of SIF on a number of indicators, no reduction of HIV infection among PWID has been found.

86. WHO has not reviewed the evidence of the effectiveness of SIF[58], nor had it made any recommendation on setting up SIF for HIV prevention and control.

87. There is no designated legalised place for consumption of illicit drugs in Hong Kong. Instead, DH's Methadone Clinics which have been in operation for over 40 years provide opioid substitution therapy, detoxification services, health education and free condoms. These are some of the key components of SIF as mentioned above (see paragraph 83). The Methadone Clinics have a high acceptability among drug users with over 7,000 clients annually. Moreover, the Hospital Authority and NGOs provide drug treatment and rehabilitation services including detoxification.

ACA's views and conclusions

88. Needle sharing is not uncommon among PWID in Hong Kong, posing a potential threat of HIV outbreak in this population. ACA is aware that criminalisation of possession of drug injection equipment may increase needle sharing behaviour while SIF may reduce it. In terms of impact on the local HIV epidemic, however, ACA concludes that *there is currently insufficient scientific evidence to show that decriminalisation of possession of drug injection equipment and establishment of SIF will further reduce the already low HIV transmission among PWID in Hong Kong*.

89. On the one hand, the current methadone treatment programme, as the main strategy of keeping the HIV infection rate low among PWID, should be sustained. On the other hand, community organisations are encouraged to explore ways to ensure stable access to clean syringes by PWID and to enhance proper disposal of used syringes and safe handling by cleaners. Injection behaviours, needle sharing, availability of clean syringe and the situation of HIV infection among PWID should continue to be monitored.

Section D. Others

90. Sexual activity is not uncommon among adolescents in Hong Kong. A study in 2011 by the Family Planning Association of Form 3 to From 7 students found that 7% of girls and 10% of boys had had sexual intercourse, and their mean age of sexual debut was 15.3 and 14.6 respectively[69]. In addition, data from DH showed that the number of newly reported sexually transmitted HIV infections among those aged 19 or below rose from 4 cases in 2010 to 22 cases in 2015. Among them, 88% were infected through homosexual contact, and 12% heterosexual contact.

91. In Hong Kong, elements of sex education are incorporated into various subjects in secondary schools, covering knowledge of HIV and sexually transmitted infections, and respecting people with different sexual orientations. Schools are given flexibility in the design of their own school-based sex education curriculum according to the needs of students and other stakeholders.

92. There are voices from diverse communities criticising that the coverage of sex education and HIV education is inadequate in schools. In particular, they claim that the subject of sexual orientation and discrimination of sexual minorities is rarely taught. They are of the view that such teaching could foster an accepting school environment for students of sexual minorities, so that they would be more willing to seek help regarding their sexual health problems and reach out for HIV preventive service. They therefore call for:

    Compulsory coverage of homosexuality and inclusion of messages against discrimination of sexual minorities in sex and HIV education in all schools.

Issue 8 – Compulsory coverage of homosexuality and inclusion of messages against discrimination of sexual minorities in sex and HIV education in all schools

93. Literature search has been conducted into the impact of including homosexuality and related anti-discrimination messages in changing health behaviours and preventing HIV infection. One study showed strong evidence that curriculum-based sex and HIV education can delay sex among young people, improve HIV knowledge and increase condom use[70]. However, its effectiveness also depends on many factors, including teaching contents, education policies, teaching format and teachers' training[70].

94. Another review found that programmes that focused clearly on reducing one or more risky sexual behaviors to prevent unintended pregnancy or HIV/STD infection could effectively increase condom use. In contrast, those covering an array of sexuality issues, such as gender roles, dating, and parenthood had no significant effects on increasing condom use[71].

95. There are no studies on the association between teaching topics of homosexuality and related anti-discrimination, and reduction of HIV transmission.

Recommendations by international health authorities

96. The Joint United Nations Programme on HIV/AIDS (UNAIDS) and United Nations Educational, Scientific and Cultural Organization (UNESCO) recommend life skills-based HIV education (LSBE) before sexual debut. LSBE refers to HIV education through strengthening the cognitive, self-management and communication skills of the youths, as well as teaching them how to use condom[72-73].

97. They further recommend that HIV education programmes should deliver messages that are sensitive to sexual orientation, and should cover HIV-related discrimination[72]. However, they do not specifically ask for coverage of sexual orientation for HIV prevention.

ACA's effort on the issue

98. In Hong Kong, sex education is an integral part of the school curriculum. Related knowledge, values/attitudes and skills are incorporated into the relevant Key Learning Areas (KLAs) or subjects. As such, elements of sex education are incorporated into various subjects, including Biology, Ethics and Religious Studies, Life and Society curriculum, and Liberal Studies. Knowledge of HIV and sexually transmitted infections is usually covered under Biology while respecting people with different sexual orientations is covered under Moral and Civic Education for the implementation of values education, incorporating knowledge, skills, values and attitudes. Schools generally design their own school-based sex education syllabus according to the needs of their students and stakeholders.

99. In 2013, ACA formed a Task Force to coordinate a territory-wide baseline survey with the participation of the Education Bureau and DH[74]. It aimed to assess HIV education in lower secondary levels. Survey results showed that:

    (a) 91.7% of all the responding schools had covered HIV education through key learning areas/subject (i.e. traditional curriculum), and 80.8% through life skills-based approach;

    (b) Around 70% included the message of "use condom to prevent HIV infection"; and around 20% covered topics of sexual orientations/ minorities;

    (c) 67% had invited NGOs to conduct in-school HIV education; and 46% had invited DH; and

    (d) 66% had had training of their teachers by Education Bureau, NGO or DH.

100. In response to these results, ACA recommended further raising the awareness by the public and schools of LSBE HIV/AIDS education, and involvement of NGOs in providing HIV education in schools.

ACA's views and conclusions

101. Having considered all the available evidence, ACA concludes that *there is currently insufficient scientific evidence to show that compulsory coverage of homosexuality and inclusion of messages against discrimination of sexual minorities in sex and HIV education in all schools will impact directly on the HIV epidemic in Hong Kong.*

102. However ACA is gravely concerned about the rising trend of HIV infection, particularly among young MSM. It recommends that current sex education and HIV education should be intensified through the LSBE approach. Such education should be age-appropriate and focus on avoidance of risky sexual practices such as having sex at an early age, and with multiple or casual sex partners. The practical use of condoms to prevent unintended pregnancy and reduce HIV/STD infection should be taught. Topics on HIV-related discrimination should also be covered. In this regard, the need for providing training to teachers to raise their awareness and respect of different sexual orientations is recognized.

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