

**Report of Community Assessment and Evaluation of
HIV effort on Men who have Sex with Men
in Hong Kong 2006**

**Working Group on
Men who have Sex with Men in Hong Kong
Community Forum on AIDS
Hong Kong Advisory Council on AIDS**

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Under the auspice of the Community Forum on AIDS of the ACA, an exercise named Community Assessment and Evaluation was embarked in the first half of 2006 to draw community input for the formulation of Recommended Hong Kong AIDS Strategies 2007-2011. Working group on seven groups, viz. commercial sex workers and clients, men who have sex with men, injecting drug users, women and children, people living with HIV/AIDS, youth and cross-border travelers were formed to undertake the exercise. Each Working group was convened by a community expert in the field and with members drawn from key agencies, stakeholders and other persons involved. Technical and secretariat support was provided by Special Preventive Programme. A common framework of reviewing epidemiological data, evaluating current response, reviewing overseas guidelines and developing recommendations on prevention and care of local relevance was employed. A report was generated by each Working Group from the exercise.

Membership of Working Group on Community Assessment and Evaluation of HIV effort on Men who have Sex with Men (January – June 2006)

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Foreword and Acknowledgement

The Community Forum on AIDS was convened to enhance communication between community stakeholders and ACA. It provided a platform where the views and expertise of the community can be directly shared and collected, to support policy formulation at the ACA level. The Community Forum's first key task was to mobilize stakeholders to take part in the Community Assessment and Evaluation exercise, an essential and integral component of the process of formulating the Recommended HIV/AIDS Strategies in 2007-2011.

It has been a stimulating and fruitful learning experience for us all to participate in reviewing Hong Kong's past and present AIDS situation and recommending strategies for the coming future. Although the various community groups have very different needs, it was quite clear that they shared common concerns. These were extensively discussed at all levels including the working group, the Community Forum, and ACA. Of particular concern were the effectiveness of existing funding mechanism for community-based projects, issues on the monitoring and evaluation of AIDS prevention programmes, and the prioritization and impact of such programmes on the local AIDS situation.

The recent visit of US expert Dr Tim Brown as an external consultant to review the latest epidemiological situation in Hong Kong laid a convincing scientific basis on which to focus urgent priorities in HIV prevention. The HIV epidemic in Hong Kong has moved from a slow phase to an early phase of fast growth, mainly driven by an increasing number of HIV infections in men who have sex with men (MSM). The key findings from Dr Tim Brown's reports and the Community Assessment and Evaluation exercise will culminate in the evidence-based, action-oriented interventions recommended in the HIV/AIDS Strategies.

The Community Assessment and Evaluation exercise also provided an opportunity for stakeholders to forge stronger ties and partnerships. Moreover, it facilitated capacity building and identification of expertise in the field. The active involvement of non-government organizations and AIDS workers to share their experiences and best practices provided the impetus to launch a local AIDS meeting, the Hong Kong AIDS Dialogue on 16 September 2006. I hope and fully believe that this will be only the start of a concerted movement to engage all relevant parties in the fight against HIV/AIDS in Hong Kong.

I would like to thank Professor CN Chen for providing visionary leadership, guidance and continuous support as ACA Chairman. He has spared no effort to improve communication among Government, policymakers, funding agencies, AIDS service organizations, frontline workers and vulnerable communities. The Community Assessment and Evaluation exercise would not have been possible without the leadership of the Conveners of the 7 Working Groups and the whole-hearted participation of the members. I would also like to record a vote of thanks to the hard-working Secretaries of the Working Group and the staff of the Special Preventive Programme for providing technical support. Finally I would like to express my gratitude to all those agencies, volunteers, interviewers, interviewees and participants who have given their time to support this initiative for the betterment of HIV prevention and care in Hong Kong.

Dr Susan Fan
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Report of Community Assessment and Evaluation of HIV effort on Men who have Sex with Men in Hong Kong

Introduction

1. Men who have sex with men (MSM) is one of the important issues in HIV prevention in Hong Kong since the first cases reported in 1984. Committee on Education & Publicity on AIDS (CEPAIDS) and AIDS Prevention and Care Committee (APCC) prepared two strategy documents on HIV prevention in MSM in 1998 and 2001 respectively. The Working Group on Men who have sex with men was formed under the Community Forum on AIDS, Advisory Council on AIDS (ACA) as one of the seven groups to conduct a community assessment and evaluation of HIV efforts in MSM and recommend strategies for consideration of ACA to be incorporated in the next HIV/AIDS strategy document for Year 2007-2011.

2. The members of working group were recruited from the gay community through internet and egroups and suitable individuals were approached. The group consisted of AIDS non-governmental organisations (NGO) working on MSM, members from gay organisations and groups, task force member who were involved in previous strategy paper, volunteers involving in HIV prevention and individuals who are concerned about the HIV situation in MSM and policy development.

Situation Assessment

Population size estimation

3. A benchmark population based behavioural study in 2001, which sampled about 15000 men aged 18-60 using computer assisted telephone interview, provided an estimation of the size of MSM population at risk for HIV infection.¹ The study showed that 4.5% of the men sampled ever had sex with another men. Two percent (95% CI 1.7-2.2%) had sex with another men in the last 6 months (active MSM), 22.3% of them had anal sex (i.e., 0.45% of the subjects). Applying the mid-year population age structure of 2004, it is estimated about there are 34000 active MSM (sex with men in last 6 months) in Hong Kong, and about 13000 of them practiced anal sex in last 6 months. Forty percent of the active MSM were married, and 63%

¹ JTF Lau. Kin JK. Lau M. et al. HIV related behaviours and attitudes among Chinese men who have sex with men in Hong Kong : A population-based study. Report submitted to the Hong Kong Council for the AIDS Trust Fund. 2002.

had sex with a female in the last 6 months.

HIV situation in MSM

4. MSM has been playing a significant role in HIV epidemic in Hong Kong. In the reporting system, 690 of 2825 cumulative reported cases (24.4%) acquired the infection through homosexual or bisexual contact, as of the end of 2005. The proportion of MSM among newly reported HIV cases has remained at 20% in the 2000-2004 but surged to 30.5% in 2005. (Fig. 1) Moreover the absolute number rose gradually from 30 in 1995 to 65 in 2004 and then 96 in 2005. (Fig. 2) The number of cases with history of exposure to HIV through homosexual or bisexual contact reported in 2005 increased nearly 50% as compared with 2004.

5. Most of the HIV infected MSM were young adult. The median age at reporting was stable at 36 over the years. The age group 25-34 and 35-44 accounted 43% and 33% of reported cases. MSM aged 15-24 also accounted for 8%, a small but significant proportion. The major rise in number of new cases was also from the age group of 25-34 and 35-44. (Fig. 3) Most of the infected MSM were Chinese (72%) whereas Caucasian also accounted for 21%. The proportion of Chinese MSM was further increasing in recent years. The number of new Chinese MSM cases increased 4 folds in this decade. The number of cases reported in other ethnicity remains stable. (Fig. 4)

6. Among the HIV infected male cases, the proportion of heterosexual contact was predominant in 90's but a trend of more MSM cases was observed in 2000 era. The ratio reversed in 2005, which meant more MSM cases were reported than heterosexual man. (Fig. 5, 6) Actually, the proportion of MSM may be underestimated because some may not want to expose their sexual orientation under the reporting system. The route of exposure could not be determined in 16% of reported cases.

7. There was no systematic prevalence study for MSM in Hong Kong. A local NGO has been offering voluntary counselling and testing (VCT) service specifically for MSM since 2001. The positive rates obtained showed an increasing trend up from <1% in 2001-2003 to 1.8% and 2.3% in 2004 and 2005 respectively. (Fig. 7) Although the recruited sample may be a higher risk group in MSM community, the percentage of positive is much higher than in other vulnerable groups locally, and a rising trend, which correlated with the reporting system, is observed.

8. In the Kowloon Bay Integrated Treatment Centre (KBITC), which is taking care of about 60% of HIV cases in Hong Kong, the proportion of MSM also raised from about 30% in late 1999 to 42% in 2005. The common suspected source of HIV infection among MSM attending KBITC was non-regular, non-commercial sex partner (67%). (Fig. 8) About one fifth of them suspected that they acquired the virus from their regular partner. Most of the HIV infection was suspected to be acquired locally (80%) and some in Southeast Asia (12%). (Fig. 9)

9. A cluster of 20 cases HIV-1 Subtype B infections was detected in a molecular study in 2005. The reported routes of transmission in 15 cases were unprotected homosexual/bisexual contact. The route of transmission for some cases could not be determined according to information given by reporting doctors. The further epidemiological investigation of 10 contactable cases revealed that unsafe sex, known partner through internet, having sex with non-regular, non-commercial partners and using soft drug during sexual activity were risk factors.²

Sexual behaviour pattern

10. Although data from VCT service is a biased sample and difficult to extrapolate to the community group as a whole, the trend of behavioural data obtained from VCT service served a surrogate of the trend in the community. In those MSM attending government AIDS Counselling and Testing Service (ACTS), the median numbers of regular sex partners, commercial sex partners and non-commercial, non-regular sex partners for adult MSM in 2004 were 1, 2 and 4 respectively. These numbers have not fluctuated much since 1998. No significant difference was observed across different age groups. Commercial sex is not common in MSM. The median age of sexual debut in MSM aged 15-24 was 18.5.

11. Concerning the habit of condom use, 44.9% and 55.4% adult MSM used condom regularly* with regular sex partners and casual sex partners in 2004 respectively. A lower percentage of regular condom use in young MSM, aged 15-24, was observed, especially with casual sex partners. The decreasing trend of condom use in MSM was observed but whether it is real or artefact is unclear. The behavioural data collected during the VCT service for MSM revealed that similar picture. 58% of MSM used condom every time during anal sex in past 3 months whereas 73% used

² Surveillance Office, Special Preventive Programme. A cluster of HIV infections in Hong Kong [February 2006] - FACT SHEET. 2006.

* On assessment, there are 4 levels on the regularity of condom use: “always” (100%), “often” (>50%), “sometimes” (<50%), and “never” (0%). Regular use means “always” or “often”.

condom at latest episode of anal sex. However, condom use in oral sex is not common in MSM. Seventy-six percent MSM did not use condom during oral sex in the past 3 months, 95% did not use condom at latest episode of oral sex.

12. Description of pattern of their behaviour related to HIV risk has been fragmented. It is regarded that MSM take varied forms of relationships from strict monogamy to open relationships. In the population study, though, one third of active MSM surveyed believed that their sexual partners have other sex partners. Public sex environments (PSE) play a significant role for MSM in Hong Kong because social and cultural norms often expect most single men live at home with their parents.³ Public toilets have been an important PSE but sexual activity in toilets has become less common. Saunas have been one of the most common places for MSM activity. Twenty saunas, distributed in six districts, were identified. The saunas were stratified by different types of clients e.g. age groups, body figures, economic classes. Internet becomes an important tool for them to meet sexual partners in recent few years. Some private group sex parties were organised. Some may involve the use of soft drugs. The size, frequency and characteristics of participants were unknown.

13. It has been shown that sauna users and internet users have higher rate of anal sex and more sexual partners. In the benchmark study 18% of active MSM used internet to meet their sexual partners, and the proportion increased to 38% for MSM who has anal sex with other men in last 6 months. Again in the benchmark study 15% of active MSM has had sex with men in China. They may visit gay venues like sauna, massage club and disco for commercial sex. From the working group members' observations, male commercial sex workers from mainland began to establish their business in Hong Kong. In recent years, regional gay parties in other Southeast Asian countries, like Thailand, Taiwan, Singapore and Japan, are getting popular, yet the proportion and frequency of Hong Kong MSM participating and having sexual activity is unknown.

14. Data are suggesting that MSM can be roughly categorized into two relatively distinct groups with different behavioural risk pattern. On the high-risk end, individuals of the subset frequently practise anal sex with higher number of sexual partners. If the condom use level is not high enough, the behavioural risk pattern effectively opens up the window for HIV to spread quickly within the group itself.

³ Smith, G., Lau, C.C., Louey P. A study of the sexual behaviour and attitudes of the Men who use Hong Kong's gay saunas. AIDS Concern. 2002

Their infection could be linked to the lower risk group if condom use in general is lower with social mixing.

Health behaviour pattern

15. MSM may less likely identify themselves as MSM or seek HIV testing in public health care service. The percentage of those diagnosed in public hospital among MSM was much lower than that of heterosexual men. About 10% cases attending government AIDS Counselling and Testing Service reported homosexual or bisexual exposure. The proportion of the HIV infected MSM known to have progressed to AIDS at reporting was also lower than the proportion in heterosexual men (40%). HIV-infected MSM may be more likely to be diagnosed at an earlier stage as compared heterosexual men.⁴

⁴ AIDS Prevention and Care Committee. APCC Occasional Review: HIV Situation in “Men who have Sex with Men” (MSM) in Hong Kong. 2004

Fig. 1 Proportion of MSM in reported HIV infection

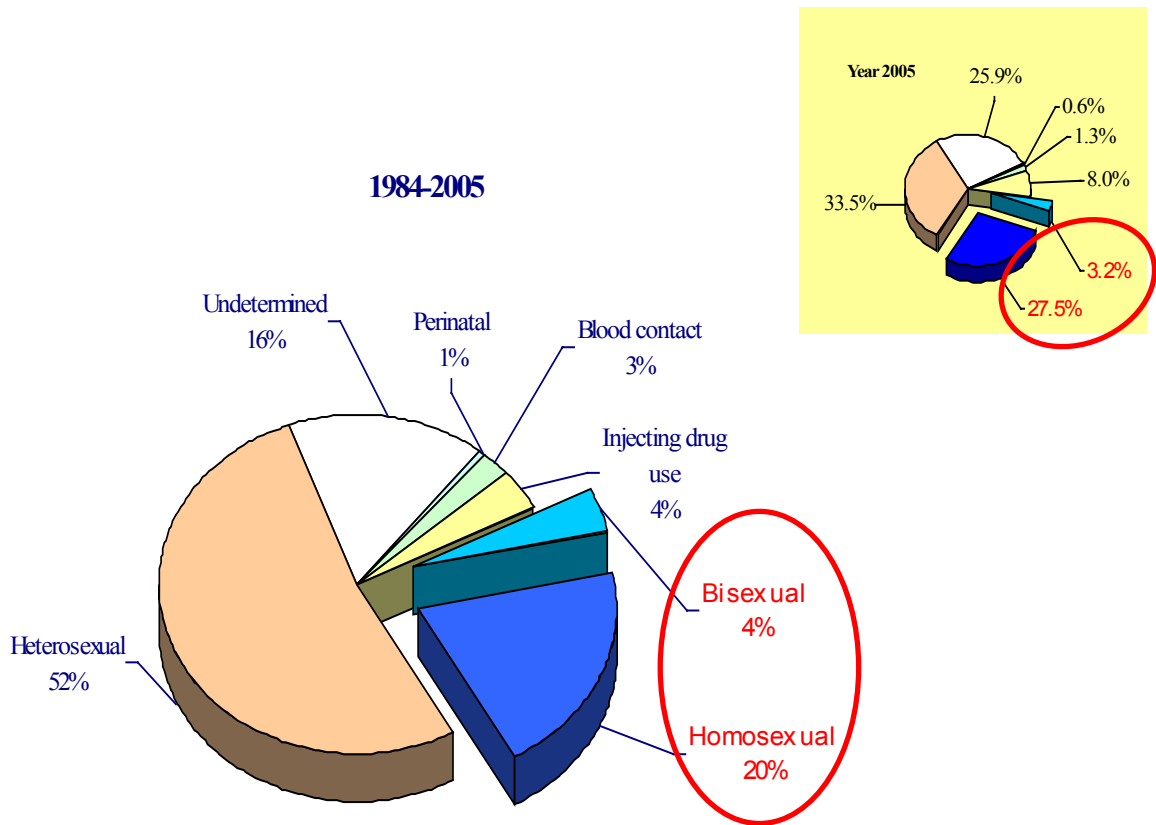


Fig. 2 Reported HIV infection acquired through men having sex with men (1984- 2005)

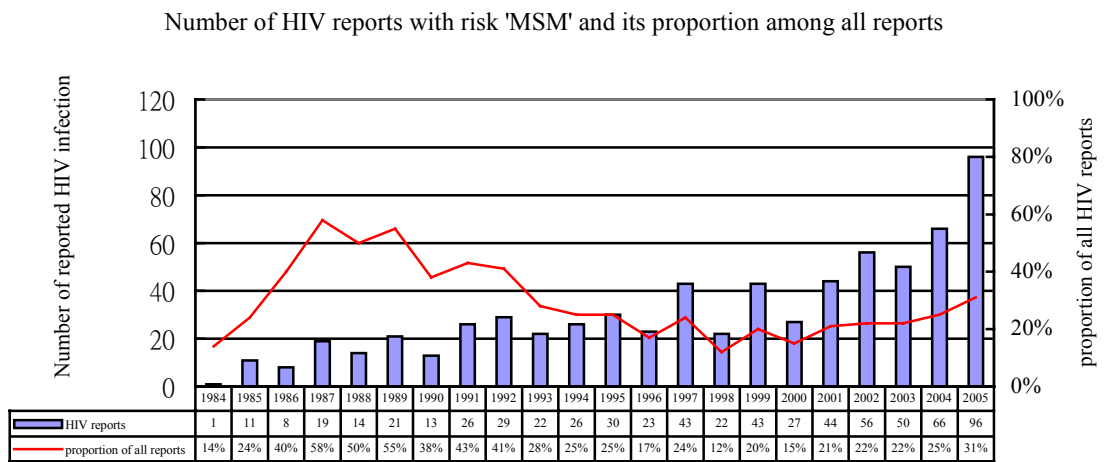


Fig. 3 Age distribution of MSM new cases 1984-2005

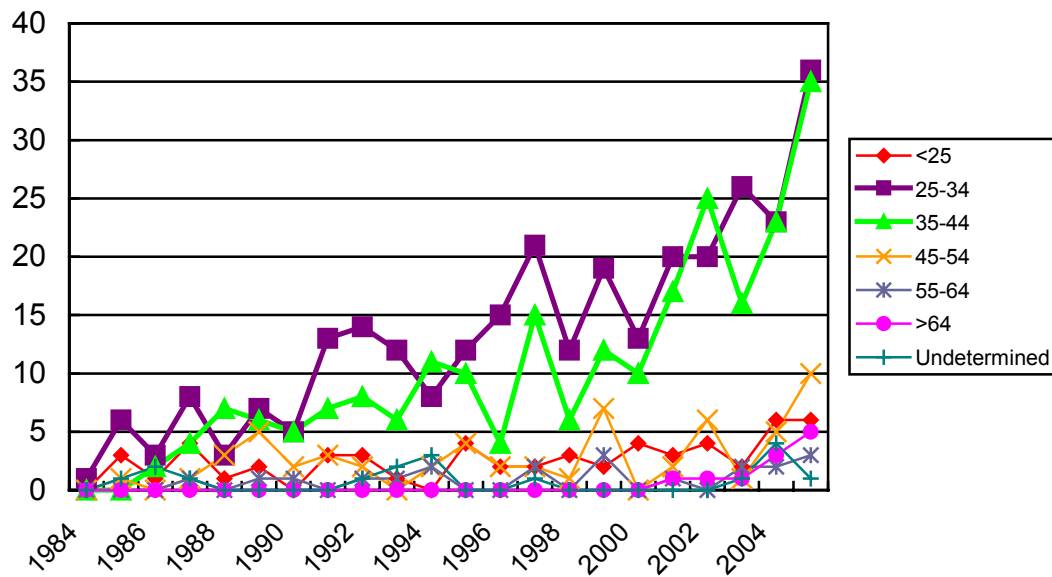


Fig. 4 Ethnicity distribution of MSM new cases 1984-2005

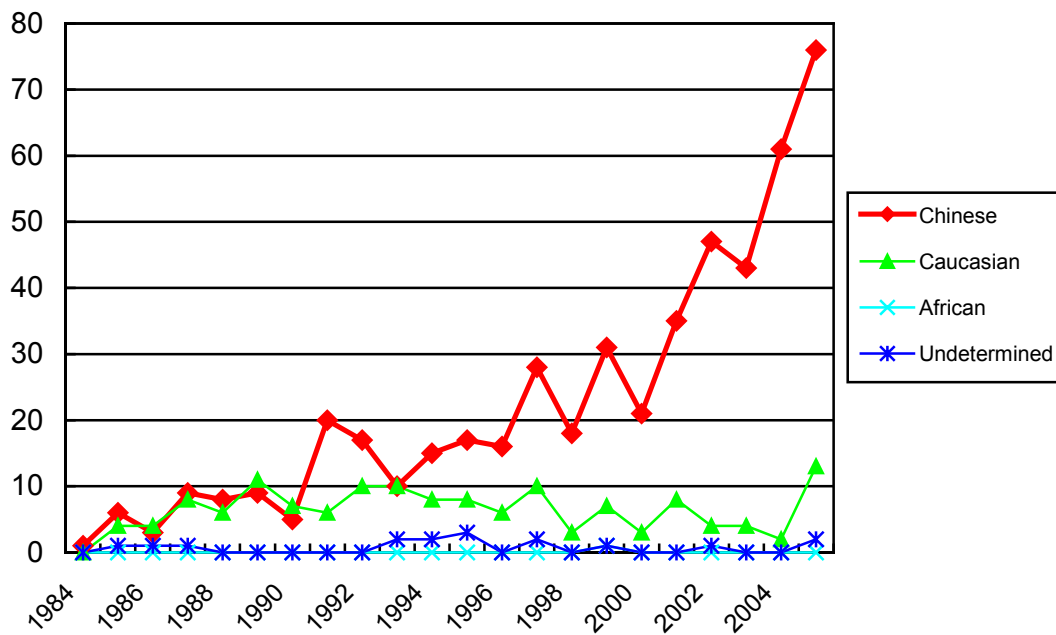


Fig. 5 Ratio of newly HIV reported case in heterosexual men to MSM (by year) 1984-2005

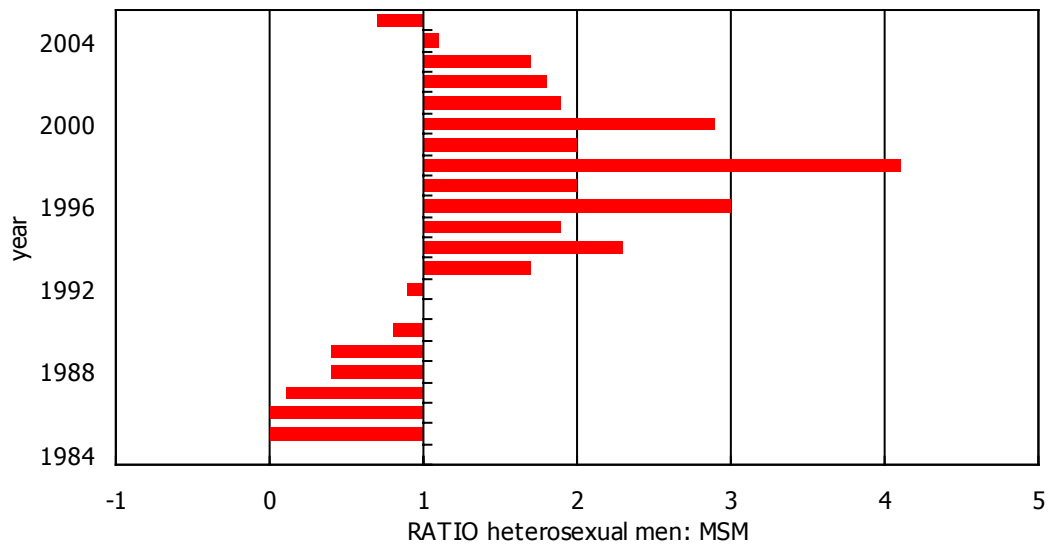


Fig. 6 The ratio of heterosexual men and MSM in reported new cases (by quarter) Q1 1999 – Q4 2005

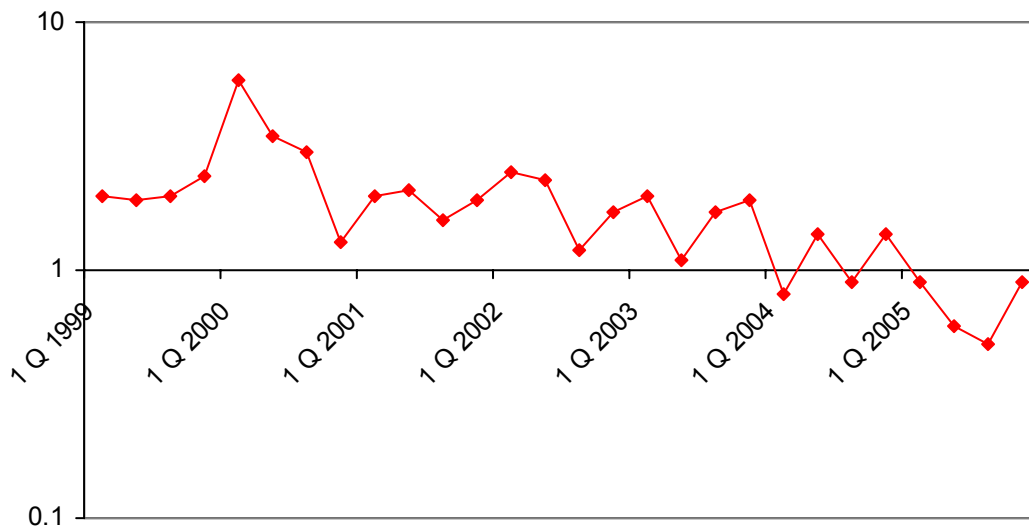


Fig. 7 Positive rate of HIV voluntary testing by AIDS Concern for MSM

	Number of tests	Positive test	% Positive	95% C.I.
2000	38	0	0.00	(0.00 - 0.00)
2001	107	1	0.94	(0.024 - 5.21)
2002	130	1	0.77	(0.019 - 4.29)
2003	223	2	0.90	(0.11 - 3.24)
2004	332	6	1.81	(0.66 - 3.93)
2005	483	11	2.28	(1.14 - 4.08)

Fig. 8 Suspected source of HIV infection from MSM attending KBITC 2000-2004

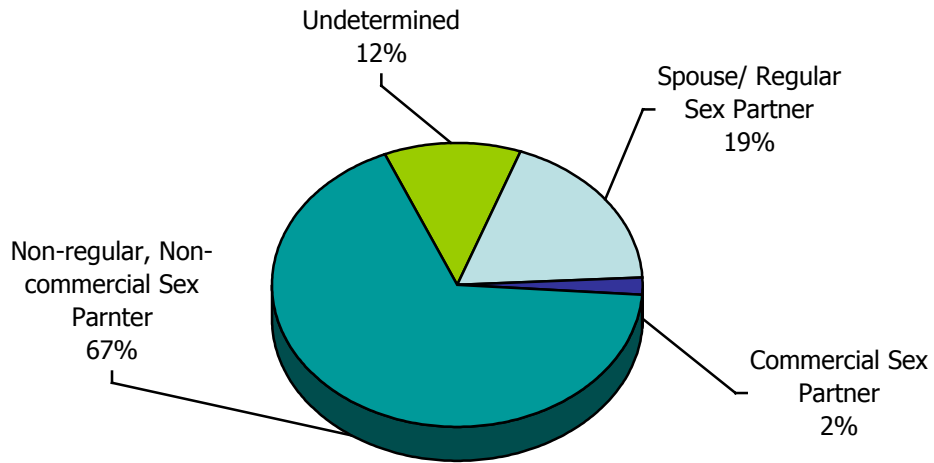
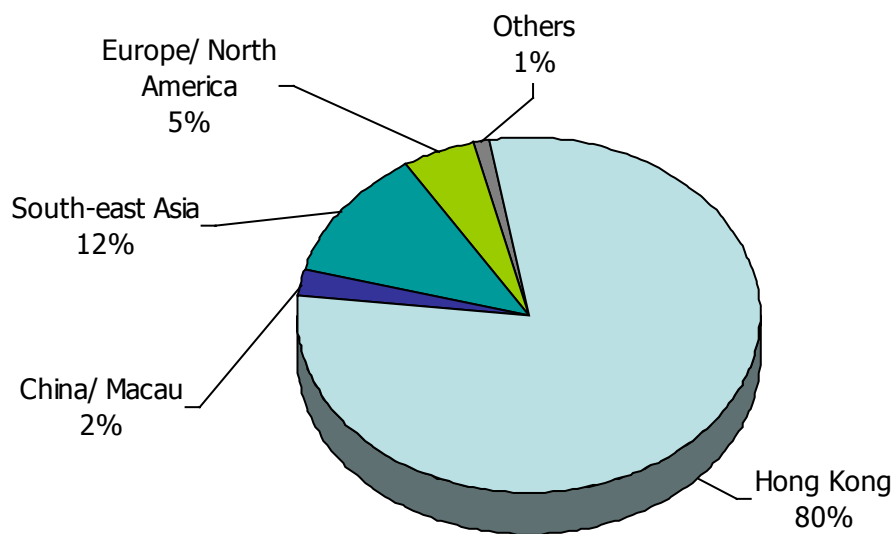


Fig. 9 Suspected place of HIV infection from MSM attending KBITC 2000-2004



Current response

16. In Hong Kong, two NGO, AIDS Concern and Hong Kong AIDS Foundation, focused on HIV prevention efforts in MSM. Government and gay organisations and groups augmented the response. Recently, four members of full-time staff from two NGO were actively involved in HIV prevention activities in the gay community. The current responses are summarised as below:

Summary of current response in HIV prevention efforts for MSM

1. Outreach and peer counselling programme for MSM
2. Internet intervention at gay website
3. Condom and lubricant distribution
4. VCT service for MSM
5. Public HIV and STI clinics
6. Scattered awareness activities
7. Regional networking

17. Both NGO run outreach programmes for the gay community. The focus of outreach venues changed from public toilets to bars and saunas. About 5700 contacts were made by the workers and volunteers of two NGO in 2004. Outreach programmes covered 10 bars and discos, about 70% of gay bars and discos in Hong Kong, and about 10 rave parties every year, with the coverage of about 50%. All the saunas were covered by outreach programmes. Moreover, more than 16000 health educational materials were available at 34 gay venues with the coverage of about 70%. In addition, 24 sessions of workshops addressing physical and mental health issues of MSM were conducted with the attendance of about 700.

18. Online interventions are conducted at two Bulletin Board Services on two popular local gay websites and answered enquiries about sex and AIDS. The number of questions raised was about 200 per year and with a total hit rate of 78,087 in 2004. The audiences of the internet interventions were expected to be young MSM.

19. Condoms and lubricants were made available in all 20 saunas. 12,929 condoms and 37,754 sachets of lubricants were distributed by NGO in saunas. Another 14,236 condoms were distributed in other gay venues and outreach programmes. However, the condoms in some saunas were not available at the most visible or accessible sites where sexual behaviours happen. The condom was not

regularly available at bars and clubs.

20. Many gay businesses welcomed the presence of HIV prevention efforts in their capacities. Gay saunas and club/bar owners, and dance party organizers facilitated the outreach of AIDS NGO in their venues. Gay websites and magazines provided free spaces for HIV health promotion and information dissemination. The above efforts were more led by AIDS NGO instead of initiated by the businesses.

21. The two NGO and government run voluntary counselling and testing (VCT) services. Other than the outreach VCT programme specifically for MSM, others served MSM as a member of the public. Outreach VCT service was conducted in 12 gay saunas between 2001 to 2005. Currently, it sustains its coverage to 8 gay saunas, i.e. 40% of existing saunas in Hong Kong. The service later expanded its testing locations to satellite offices by appointment and then reached out to MSM other than sauna-users. It launched as a saliva test in 2001, switched to be urine testing in 2002, and added rapid test in 2005. The number of tests performed was increasing from 223 in 2003 to 483 in 2005. About an extra 20% MSM received counselling but were not tested. In government, MSM contributed to 11.6% (229) of VCT cases in 2004.

22. Specialised HIV management for those infected is provided by two public HIV clinics and hospitals. 42.44% of cases attending Kowloon Bay Integrated Treatment Centre were MSM. No specific sexual health for MSM was available. The percentage of Social Hygiene Clinic attendees who were MSM was unknown. Neither two public clinics nor two AIDS NGO focusing on MSM offered tailor-made support service for HIV infected MSM.

23. Some scattered HIV awareness activities were organized by gay organizations and groups. They either held ad hoc HIV related talks or workshops or devoted parts of their events to HIV related theme, such as in gay and lesbian conference, and film festival. HIV prevention might also have discussed with MSM calling to two main gay hotlines. Instead, the gay organizations tended to focus more on advocacy of gay rights, education of the public on their understanding of gay, social and recreational activities.

24. The collaboration between the government and MSM community was started. Seminars were held to explain the latest HIV situation in MSM and its implications. A working group was formed to plan a population-based HIV prevention

campaign.

25. There were some networks built between organizations targeting MSM from Hong Kong and other regions. Chi Heng Foundation had its funded prevention programmes in 8 Mainland cities. Community workers had been invited for conducting training in the Mainland. Internship programmes were offered for community-based MSM programme officers from the Mainland to build the capacity of their MSM prevention programme. No intervention other than attending conferences or meetings was built with organizations from Asia-Pacific region.

Barriers and Gaps in HIV prevention in MSM

26. The working group believed that an effective HIV prevention programme in MSM relied not only on the HIV knowledge of the gay community. It is influenced by the behaviour in the gay community, the gay culture and, also, the attitude and atmosphere of the society at large. The working group identified six unmet needs in the community and barriers of effective HIV prevention in MSM.

Evolving gay culture

27. With the increasing popularity of internet chatroom, public toilet is not a popular public cruising environment anymore. The role of internet in MSM community became much more significant in recent years. Conventional venue-based outreach programmes and condom distribution is not applicable in internet chatroom. The effective tactics of intervention in internet are yet to be identified. Some private sex parties, instead of venue-based activities, were organized. Recreational drug use was sometimes associated with sexual activities. Although some programmes touched on some of these areas, no comprehensive programme was designed to tackle these new fuels for the epidemic.

Too few researches and too many information gaps

28. The strategy paper written in 2001 suggested researching the sexual behaviour patterns of MSM including factors and situations to motivate safer sex practice, diversity of MSM sexual behaviour and the influence of subculture on sexual behaviour. However, in the past 5 years, few local researches related to MSM were published and very few researchers studied the sexual behaviour between men and its relationship with gay culture. The investigation of psychosocial factors on condom use by qualitative study was virtually unavailable. The activities and culture in gay society change rapidly. If the situation was not reviewed periodically, the information

on new initiators, e.g. recreational drug use, private sex party, would be largely unknown and new tactics could not be developed to tackle new challenges.

Limited engagement of gay community in HIV prevention in MSM

29. The gay community groups used to be actively involved in HIV prevention in the nineties but HIV prevention targeting MSM mainly relied on two AIDS NGOs in recent years. The efforts in other gay groups were not coordinated and the impact was not evaluated. Most existing gay groups were lack of the capacity and resource to organise HIV prevention activities, e.g. information of available funding. Moreover, most local gay organizations and groups were run by volunteers in small scale. The existing scale of involvement in the community is not likely to be able to handle the rising epidemic.

Population mobility in the gay community

30. The Hong Kong gay community was not restricted within our geographic boundary. The travel and circus parties linked up the MSM community in the region, e.g. Tokyo, Taipei, Bangkok and Singapore. Sex and drug serve as the cable for the HIV circulation in MSM in the region. MSM in Hong Kong also visit the Pearl River Delta Region frequently. Some gay venues in Shenzhen even placed advertisements in a local gay website, too. The cross border and travel pattern of MSM was a blank area. Neither on the government or community level was there established a good connection with the HIV efforts on MSM in the region. The prevention collaboration between Hong Kong and Shenzhen was yet to explore.

Lack of tailor-made sexual health service

31. The U.S. Preventive Services Task Force suggested the clinician to screen men who have had sex with men after 1975 and at high prevalence setting such as sexually transmitted infections (STI) clinics. MSM friendly sexual health service provides a good and essential portal for HIV prevention and VCT service for MSM. However, the service is virtually unavailable in Hong Kong. Health care workers of sexual health services were not trained to handle MSM cases and were not sensitive to sexual problem of MSM. Lots of MSM pretended to be heterosexual men when attending for STI, which missed a golden chance for appropriate intervention. Moreover, the appropriate treatments for the STI reduce the chance of HIV transmission in the community.

Self acceptance to sexual orientation

32. Local studies suggested that the practice of condom use in MSM is related

to the psychology status, relationship with partners and the attitude towards own sexual orientation. Psychological education reduces the probability of victimization and those with good peer support showed less distress on own sexual orientation. The psychological aspect was not commonly considered in the safer sex promotion.

Lack of accepting environment in the society

33. The discrimination in the society hindered the dissemination of accurate information and discussion in the community. Misleading information disseminated by the conservatives undermined the important HIV prevention messages. The essentialisation of MSM-related HIV information in the public media shifted the focus from health to moral value. The heterosexualistic sex education created an unfavourable environment for those frustrated young MSM to access assistance in sex related issues. Teachers and social workers were not equipped to handle the MSM related cases. The moral-led approach of sex education in secondary school was, in fact, a barrier for young MSM to reach targeted HIV prevention.

Recommended Strategy in HIV prevention in MSM

34. The working group reviewed the current situation and the gaps and barriers of existing services. The aim of the strategy is to slow down the up-rising trend of HIV infection in MSM. In order to achieve this, the existing 60% condom usage rate in MSM have to be increased and this strategy targets at an achievable 80% condom usage in anal sex in MSM.

35. The group recommends that the HIV prevention effort in MSM in Hong Kong should follow 3 guiding principles and 6 strategies in response to the current situation and barriers and gaps identified:

- The HIV prevention programme should be sensitive and specific for the culture of different sub-populations.
- The gay community itself should be empowered and actively engaged in the HIV prevention in MSM
- A non-discriminating and enabling environment in the society is an essential element of a successful HIV prevention programme

Scaling up current targeted prevention efforts

36. The existing HIV targeted prevention model in MSM should be sustained and expanded to other up-coming vulnerable sub-populations. The major objectives of prevention efforts should be to increase the awareness, to promote safer sex practice

and to promote early HIV testing but the activities and culture in gay society change rapidly. The HIV prevention effort should timely respond to the changing situation in the community.

37. The following are some new areas identified by the working group:

- To increase the accessibility of condom and lube in every venue-based public cruising environments, i.e. saunas, bars, and clubs
- To socialize younger MSM and MSM who newly come-out with safer sex practice and positive attitudes on love and sex by establishing a supporting network to them
- To educate the gay community of the impacts of recreational drug for informed decision, and provide skills how to reduce the risk of HIV transmission while using the drugs
- To intensify the intervention on internet for changing it into a safer-sex supporting environment
- To provide support services for HIV-infected MSM and risk reduction behavioural intervention
- To address the tension of condom use in gay relationship and provide techniques on negotiation skill of condom use for gay couples

Researching the HIV epidemiology and behavioural pattern

38. The research agenda of HIV and MSM, as an objective list for the funding body's reference, should aim at studying the risk patterns of subgroups or subculture and the factors contributing to their vulnerabilities to HIV infection. Successful and significant studies also require the involvement and blessing of gay organisations.

- Some priority areas and information gaps should be investigated: sauna users, young MSM and newly come out MSM, recreational drug use, regional/cross border sexual activities, internet sex networking.
- Qualitative studies help to understand the determinants of safer sex practice in regular couples and casual sex partners and collect information on the psychosocial barriers of safer sex practice in different local MSM populations.
- A surveillance system on HIV prevalence and behavioural patterns in MSM should be set up. The modified venue based unlinked anonymous surveillance study can be employed in the local MSM setting.

Fostering greater gay community involvement

39. The gay community should be revitalised against the HIV prevention and put it on the agenda of gay community. With greater involvement of gay organisations in HIV prevention, it aims to dissolve and integrate the HIV prevention message into the social functions of gay society.

- The community at-large should be alerted for the urgency of their involvement by constantly disseminate the updates on the infection situation. Specific unorganized subpopulations should also be involved.
- Identified key members of the sub-populations have to be approached and facilitated for their involvement. These members already identified include magazine editors, webmasters, club/bar/sauna owners, dance/sex party organizers.
- The gay organizations are encouraged to set up a post called health advisor/ambassador, who is responsible for integrating health issues in their functions and identify the health needs of their organisation.
- Technical support and capacity building for gay organizations and groups can be built through collaborative projects, seminars and workshop.
- In view of increasing demand for technical support, a full time community liaison officer can serve as a central contact point for different sub-populations and stakeholders and liaise and coordinate the HIV prevention effort in the community.

Establishing regional collaboration

40. With the ease of travel and popularity of internet, the MSM community is no more restricted in this locality. The effort targeting MSM should expand beyond the boundary. Epidemiological data in the region, especially those hot spots, should be monitored. This information can be disseminated and alert to the community about the HIV risk in the region.

- The cross-border MSM sex networking activities of local MSM in the region should be mapped out.
- Collaborative network should be established to communicate with HIV workers in the region to understand the trend of HIV situation in MSM and activities in the region and identify working partners in the region for building their capacities in HIV prevention targeting MSM.
- The capacity of local AIDS workers should be developed and they should attend regional conferences to maintain the connection with other workers in

the region.

- The region-based website owners and party organisers should get involved the HIV prevention effort by understanding the MSM regional sex networking, and taking actions to tackle the rising epidemic across the region.

Expanding current HIV-focused approach into a holistic sexual health approach

41. For MSM, HIV is just one of the sex-related issues. They may have other sexual concerns that may relate to HIV transmission. A holistic sexual health approach should be employed to tackle other issues, including sexually transmitted illness, sexual function, psychosocial issues, gender identity and relationship, that affect safer sexual practice and integrate the HIV prevention in sexual health care.

- Sexual health service may serve as a portal for promoting HIV education and testing. The current community-based HIV VCT service can be developed into a holistic sexual health check-up service.
- The sensitivity and skills of medical personnel in handling MSM cases for their sexual health needs, e.g. Social Hygiene Clinic, Special Preventive Programme, should be enhanced. Skill building workshops and guidebook development with the involvement of MSM community will help the health care personnel to address the specific need of MSM in sexual health services.

Promoting an enabling environment in the society

42. A hostile and discriminating atmosphere in the society is one of the barriers to effective HIV prevention in MSM. It blocks the access of MSM to HIV prevention efforts and drives the at-risk population further unreachable. The lack of an accepting and accommodating environment for same sex relationship affects the self-acceptance of MSM and their sexual behaviour. An enabling environment is an important factor to make the message deliverable to individual MSM, especially those newly coming out.

- Support groups and hotline services on the self-identity, self-acceptance of sexual orientation and gender issues in the gay community should be set up to help individual MSM to remove their felt stigma and guilty feeling.
- The sex education in schools and youth centres should employ a non-judgmental approach and include correct MSM-related HIV prevention knowledge and sexuality issue in their sex education programme. The

teachers and school social workers should be trained to professionally handle MSM cases in schools.

- Myths about homosexuality in the society and the falsified statements promulgated by those pseudo-professional bodies should be clarified. Accurate and correct information on MSM will help the public to understand the real situation in the MSM community.
- The working group considered that an accepting society has to be built by the government. Besides public education, the introduction of sexual orientation discrimination ordinance is also a crucial step to promote the enabling environment in Hong Kong.

Concluding Remarks

43. The success of this strategy will rely on the financial support, the coordination of implementation and the participations of the key players in the field, such as gay community members, academics and the government. The allocation of financial resource for MSM HIV prevention activities is one of key elements to expand the HIV prevention efforts in MSM. Adequate funding with a directive and transparent policy is needed to encourage applications to attain a significant coverage in areas requiring attention. As the trend and behavioural pattern in the community change rapidly and is affected by our neighbouring cities, the funding mechanism should be flexibility to tackle upcoming issues. A successful HIV prevention in MSM community should be led by the gay community itself and with a strong support from the government, in terms of policy, funding and technical resources.

44. The gap between planning, implementation and evaluation was raised in the strategy paper in 2001. Although this paper set the condom usage rate as the outcome indicator for evaluation and 80% condom use in anal sex as the target, the working group agreed that the implementation of the recommendations in this strategy paper has to be regularly monitored. The unmet service gaps can be timely identified and rectified in the monitoring to ensure the 80% condom use in anal sex in MSM occurs in the coming 5 years.