Construction of the First Set of Core Indicators (2003) for Monitoring Hong Kong's AIDS Programmes

Hong Kong Advisory Council on AIDS

November 2004

Terms of Reference

Advisory Council on AIDS (ACA)

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

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

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

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Background

1. At the *United Nations General Assembly Special Session on HIV/AIDS* (UNGASS) held in June 2001, governments from 189 countries committed to a comprehensive programme of action. Hong Kong joined the Chinese delegation through the participation of the Director of Health and the Consultant (Special Preventive Programme). The Session, in conclusion, issued a *Declaration of Commitment on HIV/AIDS* to reflect the global consensus on a comprehensive framework with specific targets to monitor the progress of international and national responses to curb and reverse the epidemic.

2. In August 2002, the Joint United Nations Programme on HIV/AIDS (UNAIDS) published a set of guidelines to assist national authorities in their construction of indicators for monitoring the Declaration of Commitment.[1] The Guidelines proposed the establishment of two sets of indicators, one at global level and the other at national level. While the UN system would be responsible for calculating the global indicators, national authorities are asked to report, through the respective national AIDS Council (or equivalent) national indicators divided under three categories: (a) indicators of national commitment and action, (b) indicators of national programme and behaviour, and (c) indicators of national-level programme impact. There are a total of 5 indicators at global level, and 13 indicators at national level. For the latter, 2 belonged to National Commitment and Action, 9 to National Programme and Behaviour, and 2 on Impacts. (Appendix I) A variety of methods is recommended to collect data pursuant to the indicators.

3. In September 2003, the UNAIDS published a Progress Report on the Global Response to the HIV/AIDS Epidemic, 2003, as a follow-up to the 2001 UNGASS. Information on the core indicators was compiled from 109 member States (including China)

[1] UNAIDS. Monitoring the Declaration of Commitment on HIV/AIDS – guidelines on construction of core indicators. 2002

which had submitted their national reports.

The Responses in Hong Kong

4. The Hong Kong Advisory Council on AIDS (ACA), at its 42nd Meeting in January 2003, deliberated the issue of UNAIDS core indicators for implementation of the Declaration of Commitment. It was considered that while Hong Kong does not qualify as a national jurisdiction, commitment to Declaration should also be anticipated, common to other national authorities. The national indicators could be valid instruments to help monitor Hong Kong's response to HIV/AIDS, a strategy recommended by the ACA.[2] After discussion, it was resolved that the ACA, through the support of the Secretariat, would coordinate the collection of data for constructing a set of core indicators (CI) for monitoring Hong Kong's AIDS programme.

5. In defining the CI for Hong Kong, the UNAIDS framework was thoroughly examined at the 44th Meeting of the ACA in September 2003. After discussion of the UNAIDS core indicators in the local context, the ACA came up with a set of CI for Hong Kong. Indicators at global level did not appear to apply to Hong Kong. All UNAIDS national indicators were adopted in principle for Hong Kong, except two which were found locally irrelevant - (a) funding on HIV/AIDS impact mitigation within the amount of national fund under National Commitment and Action, and (b) school attendance ratio of orphans to non-orphans under National Programme and Behaviour. The core indicators used by Hong Kong are listed in Appendix II.

6. Several principles are derived by the ACA for the development of CI for Hong Kong; they are: (a) to use existing data as far as possible, (b) to modify UNAIDS indicators as

[2] Hong Kong Advisory Council on AIDS. Recommended HIV/AIDS strategies for Hong Kong - 2002 to 2006. May 2002

appropriate, and (c) to use same methodology for data collection. These principles are recommended in view of the availability of useful data that can be applied, and the need to have serial measurements to monitor changes with time. Hence, a majority of the local CI could be determined by making use of available data, while additional data collection processes, e.g. questionnaire survey, are still required for completing the whole exercise. The owners of the primary data, their methods of collection and frequency of data availability vary across the indicators. These characteristics are depicted in Appendix II.

7. The first set of core indicators refers to the situation centering the year 2003. However, due to the nature of individual indicator and data availability, some of the indicators were collected before 2003. After months of efforts in communicating with stakeholders and collecting relevant data, the ACA Secretariat, staffed by the Special Preventive Programme[3], has collated, analysed and compiled the findings for computation into this Report.

National Commitment and Action Indicators

Indicator 1.1 Funds spent by government – STD control activities, HIV prevention, HIV/AIDS clinical care and treatment

8. Categorical expenditures as defined by the UNAIDS are not available in Hong Kong, in short of a comprehensive costing exercise. The figures from the Department of Health could, in a way, reflect the resource allocation in the three areas, for the fiscal year of 2002/2003:

(a) STD control: an expenditure of 78.8M was recorded for running the STD service by the Social Hygiene Clinics, which was estimated to have provided STD treatment to

[3] Effective from 1 June 2004, Special Preventive Programme has been functioning as one of the three service units that make up the Public Health Services Branch of the Centre for Health Protection, Department of Health. There are altogether six branches.

about 20% of all cases in Hong Kong

(b) HIV prevention: community-level health promotion and HIV testing activities conducted by Special Preventive Programme through the Red Ribbon Centre and the AIDS counselling and voluntary testing service consumed 13.63M.

(c) HIV/AIDS clinical care and treatment: the drug expenditure of Integrated Treatment Centre was 27.27M, a majority of which was on highly active antiretroviral therapy (HAART).

9. It must be noted that the expenditures quoted in the last paragraph must be interpreted with care and in perspective. HIV prevention, for example, comprises a collection of activities the expenditure of which cannot be easily dissected from the intermingled efforts in laboratory testing, donor screening, harm reduction for drug users and media publicity. Community projects introduced by non-governmental organizations are partly funded by the Government but have not been accounted for[4]. Similarly, expenditures in clinical HIV management should include also staff costs and that of expertise development. Comparability with similar data collected elsewhere is impossible. The figures quoted in the last paragraph, nevertheless, are robust enough for serial monitoring to be undertaken in the coming years.

Indicator 1.2 National Composite Policy Index

10. The "Index" refers to a set of questions which is shown in Appendix III. Responses to the questions were collected by the Secretariat of the Advisory Council on AIDS before its deliberation. The answers are largely positive in areas of strategic plan, prevention, human rights, and care and support.

[4] AIDS Trust Fund (ATF) is a major funding source of community projects organised by non-governmental organizations (NGO). As of December 2004, 381 projects have been supported involving a total of 73.628 millions.

Indicators of National Programme and Behaviour

Indicator 2.1 Percentage of schools with teachers attending in-service education programmes on life-skills, AIDS or sex education

11. During the academic year 2002-2003, 23% of primary schools and 35% of secondary schools had nominated teachers to attend in-service teacher education programmes on life-skills training, AIDS education and sex education organized by the Education and Manpower Bureau.

Lead agency of data	Education and Manpower Bureau
Definition	Denominator = number of primary and secondary schools in Hong Kong. Numerator = number which had nominated teachers to attend in-service teacher education programmes on life-skills training, AIDS education and sex education
Description of data collection methodology	The data was contributed by the Education and Manpower Bureau (EMB) of the Hong Kong SAR Government. The EMB has been organising in-service teacher education programmes separately on life-skills training, AIDS education and sex education for the past years. As the training programmes were conducted in Chinese, all participants came from local schools and not international schools.
Period of data collection (from mo/yr to mo/yr)	Academic year of 2002 to 2003, i.e. September 2002 to July 2003
Results	Denominator = 758 primary schools and 475 secondary schools Numerator = 174 primary schools and 165 secondary schools Score = 27.5% overall, 23% for primary schools and 35% for secondary schools
Remarks	Most participants attended all three types of training programmes and most schools nominated more than one teacher to attend these programmes.

Indicator 2.2 Percentage of large companies/employers that have HIV/AIDS workplace policies and programmes

12. From a specially designed survey on the biggest companies in Hong Kong, 33.33% of public and 0% of private companies achieved all policies and programme criteria in 2003. Most "non-compliance" was attributed to the lack of condom distribution in the workplace.

Lead agency of data	Department of Health
Definition	Denominator = number of companies/employers surveyed. Numerator = number satisfying ALL policies and programmes criteria.
Description of data collection methodology	Ten out of 72 largest private companies and 3 out of 4 largest public employers were interviewed in a specially designed project conducted by a University Social Studies Department. They were asked on (a) existence of non-discriminatory AIDS policy, and (b) workplace HIV/AIDS prevention, control and care programmes, viz. HIV/AIDS education, work-related hazards and safeguards, condom distribution, voluntary counselling and testing, STI services, and provision of HIV/AIDS drugs. Employer is only counted in the numerator if they satisfied all criteria.
Period of data collection (from mo/yr to mo/yr)	1 Dec 2003 to 31 Dec 2003
Results	Denominator = 3 for public, 10 for private, 13 for all Numerator = 1 for public, 0 for private, 1 for all Score = 33.33% for public, 0% for private and 7.69% for all
Remarks	All private and public employers had non-discriminatory policies in place through the application of the Disability Discrimination Ordinance and others. Only one public employer and none of the private sector provided condom distribution; this being the lowest item attained under the programmes criteria. The UNGASS programmes criteria in the workplace, necessitating condom distribution, may not be fully applicable for all workplace settings.

Indicator 2.3 Percentage of patients attending STD clinics who had underwent a standardised care process of registration, assessment, counselling, investigations and treatment

13. One hundred percent of new clients attending the government STD clinics in 2003 had received all steps of standard care.

Lead agency of data	Department of Health
Definition	Denominator = number of new STD clinic patients. Numerator = number of patients who have all 11 ticks in their standard care process checklist.
Description of data collection methodology	The data was collected from the Social Hygiene Clinics of the Department of Health. It was performed by health care worker checking against a checklist for new cases attending the clinic, in an effort to ensure delivery of minimal standard of care to the clients. There were 11 steps in the checklist to define a standardised care process to be delivered to each and every new clinic client. The scope of the steps comprised client registration, health assessment, counselling, relevant investigations and treatment. The system was piloted in late 2003 and rolled out fully in 2004.
Period of data collection (from mo/yr to mo/yr)	Sep 2003 to Dec 2003
Results	Denominator = 251 Numerator = 251 Indicator = 100%
Remarks	Data was collected from one clinic from Sep to Dec 2003 and two other clinics in Dec 2003.

Indicator 2.4 Percentage of HIV-infected pregnant women receiving a complete course of MTCT antiretroviral prophylaxis

14. Based on data obtained from the universal antenatal HIV screening programme, 83.3% of HIV-infected women who delivered in 2002 had received a full course of antiretroviral prophylaxis.

Lead agency of data	Department of Health
Definition	Denominator = number of HIV-infected pregnant women detected in the universal antenatal HIV screening programme, leading to delivery in the concerned time period. Numerator = number of women and babies in the denominator who received full (3-part) antiretroviral regimen.
Description of data collection methodology	Data was extracted from the databases of universal antenatal HIV screening programme. The antenatal HIV screening programme was started in Sep 2001 in the public services. Standardised statistical returns were submitted by relevant stakeholders on a regular basis, the data of which contributed to the programme databases maintained by the Department of Health. Data on the situation in 2002 was used in this report.
Period of data collection (from mo/yr to mo/yr)	January 2002 to December 2002
Results	Denominator = 6 Numerator = 5 Score = 83.3%
Remarks	Deliveries in 2002 were chosen for the following reasons: (a) there was substantial lag time for data return and (b) year 2003 data was incomplete

Indicator 2.5 Percentage of advanced HIV disease patients receiving combination antiretroviral therapy

15. About 90% of advanced disease patients followed up in the public service were receiving highly active antiretroviral therapy as of the end of 2003. The figure refers to that of a specific time-point. Patients in the process of evaluation may not be included in the numerator, so are those who might have opted not to receive treatment.

Lead agency of data	Hospital Authority & Department of Health
Definition	Denominator = number of advanced disease patient (excluding dead or left). Numerator = number on highly active antiretroviral therapy (3 or more antivirals).
Description of data collection methodology	Advanced disease is defined as AIDS and/or CD4 <200/ul. The date of 31 Dec 2003 was chosen as the reference time point. Patients who were on HAART at that time point became the numerator while the active advanced disease patients who had attended follow-up at least once in the 1 year on or before that time point was the denominator.
Period of data collection (from mo/yr to mo/yr)	The reference time point was 31 Dec 2003
Results	Denominator = 431 (DH), 358 (HA) Numerator = 361 (DH), 344 (HA) Overall 89.4%, 83.8% (DH), 96.1% (HA)
Remarks	The Integrated Treatment Centre of Department of Health and Special Medical service of Queen Elizabeth Hospital are the two major HIV specialist services providing the data for this report.

Indicator 2.6 Percentage of IDUs who both avoided sharing needles and used condom

16. Based on the methadone clinic behavioural assessment of new and readmitted drug users, 37.4% reported no needle-sharing in the recent 4 weeks as well as having always or usually used condom in past 1 year.

Lead agency of data	Department of Health
Definition	Denominator = number of respondents who were current drug injectors and had sex once or more in the preceding one year. Numerator = number from denominator who reported no sharing of needles in the past 4 weeks and had always or usually used condom for sex in the preceding one year.
Description of data collection methodology	Data was extracted from the behavioural surveillance programme on clients newly or readmitted to the Methadone Treatment Programme at the Methadone Clinics of Department of Health.
Period of data collection (from mo/yr to mo/yr)	The period was Jan 2003 to Sept 2003
Results	Denominator = 1013 Numerator = 379 Indicator = 37.4%
Remarks	Newly admitted clients are those who have never joined the methadone treatment programme in Methadone Clinics, Department of Health before. Readmitted clients are those who have joined the methadone treatment programme before but have defaulted for 28 or more days consecutively. During the first attendance (new admission and readmission) at methadone clinics, all newly admitted and readmitted clients are required to complete a physician administered questionnaire on drug use pattern and other risk behaviours, the data of which constitutes the behavioural surveillance of methadone clinic clients.

Indicator 2.7 Percentage of young people (20-29) who both correctly identify ways of preventing sexual transmission of HIV and who reject misconceptions about HIV transmission

17. Based on the results of a survey conducted in conjunction with an AIDS publicity project in 2003, 45.9% of respondents aged 20-29 gave correct answers to 5 questions on HIV knowledge and misconceptions.

Lead agency of data	Department of Health
Definition	Denominator = number of respondents (aged 20-29) answering all questions. Numerator = number of respondents (aged 20-29) who gave correct answers to all questions.
Description of data collection methodology	Data was extracted from the web-based evaluation survey of AIDSfile publicity programme of the Department of Health. The survey was conducted from 15 June 2003 to 3 July 2003. The 5 indicator questions (translated into Chinese) were included to assess the AIDS knowledge and misconceptions, embedded in a pre-show (of one of the 7 AIDSfiles) and post-show questionnaire. Data in youth of age 20-29 for the pre-show assessment was used.
Period of data collection (from mo/yr to mo/yr)	The period was June 2003 to July 2003
Results	Denominator = 431 (total), 159 (M), 272 (F) Numerator = 198 (total), 80(M), 118(F) Score = 45.9% (total), 50.3% (M), 43.4% (F)
Remarks	The five prompted questions were: - Can the risk of HIV transmission be reduced by having sex with one faithful uninfected partner? - Can the risk of HIV transmission be reduced by using condoms? - Can a healthy looking person have HIV? - Can a person get HIV from mosquito bites? - Can a person get HIV by sharing a meal with someone who is uninfected?

Indicator 2.8 Percentage of young people (18-24) reporting condom use with pre-marital/pre-cohabitating sexual partner

18. About 36% of the 18-24 years old people interviewed during the 2001 Youth Sexuality Survey by the Family Planning Association reported condom use with their pre-marital/pre-cohabitating sex partners in the first 6 months.

Lead agency of data	Family Planning Association
Definition	Denominator = number of respondents (18-24) who reported ever had pre-marital /pre-cohabiting sex. Numerator = number of respondents (18-24) who reported to have used condom during the first 6 months of sex with the first pre-marital/pre-cohabiting sex partners.
Description of data collection methodology	Data was based on the 2001 survey of a 5-yearly Youth Sexuality Survey conducted by the Family Planning Association. It was a household survey with successful interview of 633 men and 579 women aged between 18 to 27, through systematic random sampling. Data of interviewees aged 18-24 was abstracted for the indicator.
Period of data collection (from mo/yr to mo/yr)	The period was July 2001 to Oct 2001
Results	Denominator = 779 (total), 382 (M), 397 (F) Numerator = 278 (total), 162 (M), 116 (F) Score = 35.7% (total), 42.4% (M), 29.2% (F)
Remarks	The indicator reflects the percentage of people who reported to mainly have used condom as a contraceptive method with their first pre-marital/pre-cohabiting sex partners during the initial six months of sexual relationship.

Impact Indicators

Indicator 3.1 Percentage of young people (15-24) who are HIV-infected

19. Based on the statistics of HIV tests performed by the Department of Health for the universal antenatal HIV screening programme, 0.025% of women aged 15-24 were HIV positive.

Lead agency of data	Department of Health
Definition	Denominator = number of antenatal mothers aged 15-24 who are tested for HIV. Numerator = number whose HIV test results are positive.
Description of data collection methodology	Statistics were collected from the universal antenatal HIV screening programme, the laboratory tests of which were performed at the Virus Unit of the Department of Health.
Period of data collection (from mo/yr to mo/yr)	The period is from Jan 2003 to Dec 2003.
Results	Denominator = 3991 Numerator = 1 Indicator = 0.025%
Remarks	Patients with unknown age have been classified as 25 years old.

Indicator 3.2 Percentage of HIV-infected infants born to HIV-infected mothers

20. None of the babies born to HIV infected mothers in 2002 were found to be HIV positive.

Lead agency of data	Department of Health
Definition	Denominator = number of HIV-infected pregnancies which ended in delivery. Numerator = number of HIV-infected infants born from these

	pregnancies.
Description of data collection methodology	Data was extracted from the databases of the universal antenatal HIV screening programme, which was launched in Sep 2001 in the public services. Standardised statistical returns were submitted by relevant stakeholders on a regular basis, the data of which contributed to the programme databases maintained by the Department of Health.
Period of data collection (from mo/yr to mo/yr)	The period covered deliveries of HIV-infected women from Jan 2002 to Dec 2002
Results	Denominator = 5 Numerator = 0 Indicator = 0
Remarks	There were a total of 6 HIV deliveries from HIV positive mothers in 2002. One of them defaulted after delivery and data regarding outcome of the infant was not available.

HIV/AIDS in the Workplace

21. The availability of workplace HIV/AIDS policies and programmes in the public and private sectors was examined through the CI 2.2. The total number of employees aged 15-64 of the 13 public and private employers were 220,504, representing 7% of the total employed population in Hong Kong. The public service out-performed the private sector in meeting all policies and programmes criteria. Nevertheless, it is noted that some prevention indicators are related to specific activity, e.g. condom distribution, voluntary counseling and testing, the universal introduction of which in the workplace may not be entirely applicable to all settings. Only one public employer and no private employer had condom distribution for their employees in the workplace.

Knowledge and Sexual Behaviour among Youth

22. Over half and 40% of youth aged 20-29 male and female respectively could accurately answer a standard set of five questions on HIV transmission and misconceptions

laid down by UNAIDS. The data was drawn from the results of an evaluation exercise conducted in conjunction with a publicity project, conducted in a web-based setting that may be more conducive to the youth nowadays. The proportion compared favourably with the 30% reported by the UNAIDS in its *Progress report on the Global Response to the HIV/AIDS epidemic, 2003 – Follow-up to the 2001 United National General Assembly Special Session on HIV/AIDS*.

23. Based on the findings of the 5-yearly sexuality survey conducted by the Hong Kong Family Planning Association in 2001, more than one-third of young people aged 18-24 reported using condoms for sex with pre-marital/pre-cohabitating sexual partners. The survey did not distinguish between regular and non-regular partner. Overall, the proportion using condom was at the lower bound of 30% in the data obtained by the UNAIDS (the upper bound goes as high as 88%). Yet, unexpectedly, more male (42.4%) reported condom use than female (29.2%) in Hong Kong. Linked with condom use among youth, 23% of primary schools and 35% of secondary schools had nominated teachers to attend AIDS, sex and life-skills training programme organised by the Education and Manpower Bureau in 2002/2003. The percentage appears low albeit the possibility that some teachers might have already received training in the past. Moreover, data on assessing specifically if the teachers had taught "life-skills-based HIV/AIDS education" in the last academic year is lacking – the indicator put forth by UNAIDS.

24. HIV prevalence in pregnant females between 15 to 24 years old who had antenatal HIV screening in 2003 was low at 0.025%. The limitations of under-estimate, over-estimate and non-generalisability of the data are noted. Also, there is no best way of obtaining data on HIV prevalence in young men, both for Hong Kong and elsewhere.

Sexual Risk Behaviours and Drug Injection

25. Using data regularly collected at the Methadone Clinics, some 40% of the drug users reported both no needle-sharing in the preceding 4 weeks and "always" or "usually" used condom in last 1 year. It has to be cautioned that the data was derived from a treatment service for new or readmitted drug users. It is possible that drug users not under treatment or any form of rehabilitation may conceivably be more inclined to practise risky behaviours. There is no benchmark data for comparison locally or with overseas.

26. All patients attending the government sexually transmitted infection (STI) clinics in late 2003 had undergone a standard process of care, as recorded against a checklist by the health care provider. Previous studies suggested that government STI clinics provided care to about 20% of patients in the territory.[5] It is noted that the data was taken from 3 clinics (out of a total of 10) only and over a 1-3 month period. The number of STD clients was thus small. Also, the indicator was different from that of the UNAIDS recommendation, which looked at the monitoring of "appropriate diagnosis, treatment and counseling", rather than compliance with regular care.

Mother-to-child HIV Transmission

27. Universal antenatal HIV screening programme was commenced in Hong Kong in September 2001. Five of the six deliveries from HIV positive mothers in 2002 had full course (3-part) antiretroviral prophylaxis. Follow-up information of five babies was available and none of them contracted HIV from the mother. It was assumed that there was no breastfeeding and the babies were thus not at risk of infection at a later stage. Hence, local access to antiretrovirals prophylaxis for mother to child transmission (MTCT) was good and the

[5] Lo KK, Lee SS. Short report on the survey on epidemiology of STD/HIV in Hong Kong. Hong Kong Practitioner 1995;20:245-6.

success of MTCT prevention was evident. Finally, late obstetric presentation of positive mothers, e.g. during labour, precludes the prescription of full course prophylaxis, as in last patient of the six cases.

HIV Treatment for Infected People

28. A high antiretroviral therapy coverage has been achieved for advanced patients attending the HIV clinics of public service. Knowing that very few HIV-infected patients are being taken care of longitudinally in the private sector, the public sector figures should reflect the situation in Hong Kong. This compares favourably with developed countries, while in many other parts of Asia access to treatment is limited. The advent of highly active antiretroviral therapy has been translated into declines in morbidity and mortality of HIV/AIDS patients. It is postulated that reasons such as patient refusal, default and drug side effects explain why some local patients were not on treatment.

Conclusions

29. Construction of a set of CI, for monitoring Hong Kong's AIDS programme, akin to that of UNGASS, has been proven to be feasible. A summary of the findings of the first exercise is in Appendix IV. It should be noted that most of the data contributing to the indicators was drawn from existing services statistics, which might have been collected for other purposes, including research, surveillance, project evaluation, auditing and so on. Given the constraints in CI design and data collection, it is acknowledged that not all indicators are as robust as what one wants to be.

30. The data used in the construction of the first set of CI was, as far as possible, collected in the year 2003 or its closest period, as permitted by the data design and availability.

As such, most of the data could reflect the status in the year 2003, while a few were of year 2002 and 2001. Collection of the required data has largely been smooth. It is expected that the process of data collection from various stakeholders for subsequent CI sets will be even more efficient as much of the data is collected yearly for other purposes. Regularisation of the exercise to obtain longitudinal information on each indicator will allow monitoring and evaluation of the AIDS programmes in Hong Kong. In this regard, it is important that similar methodology will be used. The frequency of reporting schedule of CI set for Hong Kong may follow the recommendations of UNAIDS, which ranges from biennial to every 4-5 years. The promising first exercise sets the foundation for incorporating core indicators development as an integral part of the AIDS programmes in Hong Kong.

Appendix I

National level core indicators for implementation of the Declaration of Commitment

	Indicators	Reporting schedule	Method of data collection
1. National commitment and action			
1.1	Amount of national funds spent by governments on HIV/AIDS • STD control • HIV prevention • HIV/AIDS clinical care and treatment • HIV/AIDS impact mitigation	Biennial	Survey on financial resource flows
1.2	National Composite Policy Index	Biennial	Country assessment questionnaire
2. National Programme and behaviour			
2.1	Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year	Biennial	School-based survey and education programme review
2.2	Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programmes	Biennial	Workplace survey
2.3	Percentage of patients with STIs at health care facilities who are appropriately diagnosed, treated and counselled	Biennial	Health facility survey
2.4	Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT	Biennial	Programme monitoring and estimates
2.5	Percentage of people with advanced HIV infection receiving combination antiretroviral therapy	Biennial	Programme monitoring and estimates
2.6	Percentage of IDUs who have adopted behaviours that reduce transmission of HIV*	Biennial	Special survey
2.7	Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission** (Target:90% by 2005, 95% by 2010)	Every 4-5 years	Population-based survey
2.8	Percentage of young people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner**	Every 4-5 years	Population-based survey
2.9	Percentage of current school attendance among orphans to that among non-orphans, aged 10-14**	Every 4-5 years	Population-based survey
3. Impact			
3.1	Percentage of young people aged 15-24 who are HIV-infected** (Target:25% in most affected countries by 2005 25% reduction, globally, by 2010)	Biennial	HIV sentinel surveillance
3.2	Percentage of HIV-infected infants born to HIV-infected mothers (Target:20% reduction by 2005;50% reduction by 2010)	Biennial	Estimate based on programme coverage

*Applicable to countries where injecting drug use is an established mode of HIV transmission

** Millennium Development Goal indicators

Appendix II

Recommended core indicators for monitoring Hong Kong's AIDS Programme

Indicator	Stakeholder of data*	Method of data collection	Frequency of data	Comparison with UNAIDS indicator
1. National commitment and action				
1.1 Funds spent by government • STD control • HIV prevention • HIV/AIDS clinical care and treatment	DH, HA	Service expenditure recount	On-going, by fiscal year	Same
1.2 National Composite Policy Index	Various	Country assessment questionnaire	Ad-hoc compilation	Same
2. National programme and behaviour				
2.1 Percentage of schools with teachers attending in-service education programmes on life-skills, AIDS or sex education	EMB	Education programme review	On-going statistics keeping	Only attendance for training but not teaching is captured
2.2 Percentage of large companies/employers that have HIV/AIDS workplace policies and programmes	DH	Workplace survey	Ad-hoc	Same
2.3 Percentage of patients attending STD clinics who had underwent a standardised care process of registration, assessment, counselling, investigations and treatment	DH	Health facility survey	On-going statistics keeping	Appropriateness of STD care not captured
2.4 Percentage of HIV-infected pregnant women receiving a complete course of MTCT antiretroviral prophylaxis	DH	Programme monitoring and estimates	On-going statistics keeping	Same
2.5 Percentage of advanced HIV disease patients receiving combination antiretroviral therapy	DH, HA	Programme monitoring and estimates	On-going statistics keeping	Highly active antiretroviral therapy (HAART) counted
2.6 Percentage of IDUs who both avoided sharing needles and used condom	DH	Programme monitoring and estimates	On-going statistics keeping	Sexual intercourse refers to last one year and not last month
2.7 Percentage of young people (20-29) who both correctly identify ways of preventing sexual transmission of HIV and who reject misconceptions about HIV transmission	DH	Population-based survey	Ad-hoc project evaluation	Age 20-29 used and not 15-24
2.8 Percentage of young people (18-24) reporting condom use with pre-marital/pre-cohabitating sexual partner	FPA	Population-based survey	5-yearly Sexuality survey	Age 18-24 used and not 15-24; pre-marital/pre-cohabitating partner and not non-regular partner
3. Impact				
3.1 Percentage of young people (15-24) who are HIV-infected	DH	Programme monitoring and estimates	On-going universal antenatal testing	Same
3.2 Percentage of HIV-infected infants born to HIV-infected mothers	DH	Programme monitoring and estimates	On-going statistics keeping	Same

*DH=Department of Health, EMB= Education and Manpower Bureau, FPA=Family Planning Association, HA=Hospital Authority

Appendix III

National Composite Policy Index for Hong Kong

Strategic plan

1. Has your country developed multisectoral strategies to combat HIV/AIDS? (Multisectoral strategies should include, but not be limited to, the health, education, labour, and agriculture sectors.)

Yes ✓	**No**	**N/A**
Comments : Multisectoral strategies have been put in place to combat HIV/AIDS. The sectors include health, education, social welfare and correctional services.		

2. Has your country integrated HIV/AIDS into its general development plans (such as its National Development Plans, United Nations Development Assistance Framework, Poverty Reduction Strategy Papers and Common Country Assessments)?

Yes	**No**	**N/A** ✓
Comments : N/A		

3. Does your country have a functional national multisectoral HIV/AIDS management/coordination body? (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months.)

Yes ✓	**No**	**N/A**
Comments : The Hong Kong Advisory Council on AIDS is the HIV/AIDS management/coordination body operationally supported by the Special Preventive Programme of the Department of Health.		

4. Does your country have a functional national HIV/AIDS body that promotes interaction among government, the private sector and civil society? (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months.)

Yes ✓	**No**	**N/A**
Comments : The Hong Kong Advisory Council on AIDS advises the Government on policies relating to prevention, care and control of HIV/AIDS in Hong Kong.		

5. Does your country have functional HIV/AIDS body that assists in the coordination of civil society organizations? (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months.)

Yes ✓	**No**	**N/A**
Comments : The AIDS Prevention and Care Committee of the Hong Kong Advisory Council on AIDS and the Hong Kong Coalition of AIDS Service Organizations are charged with the coordination work.		

6. Has your country evaluated the impact of HIV/AIDS on its socioeconomic status for planning purposes?

Yes ✓	**No**	**N/A**
Comments : It has been incorporated in a study carried out in 1998 by the Hong Kong Advisory Council on AIDS.		

7. Does your country have a strategy that addresses HIV/AIDS issues among its national uniformed services, including armed forces and civil defence forces?

Yes	**No**	**N/A** ✓
Comments : N/A		

Prevention

1. Does your country have general policy or strategy to promote information, education and communication (IEC) on HIV/AIDS?

Yes ✓	**No**	**N/A**
Comments : The Hong Kong Advisory Council on AIDS and its AIDS Prevention and Care Committee are responsible for formulating policy to promote IEC in Hong Kong.		

2. Does your country have a policy or strategy promoting reproductive and sexual health education for young people?

Yes ✓	**No**	**N/A**
Comments : The Education and Manpower Bureau of the HKSAR Government formulates polices in this respect.		

3. Does your country have a policy or strategy that promotes IEC and other health interventions for groups with high or increasing rates of HIV infection? (Such groups include, but are not limited to, IDUs, MSM, sex workers, youth, mobile populations and prison inmates.)

Yes ✓	**No**	**N/A**
If yes, please list the groups : The eight identified groups are : MSM, cross-border travellers, IDU, youth, sex workers and clients, women, people with HIV/AIDS and prison inmates.		
Comments: The first seven groups were proposed by the AIDS Prevention and Care Committee and the last group by the Correctional Services Department.		

4. Does your country have a policy or strategy that promotes IEC and other health interventions for cross-border migrants?

Yes ✓	**No**	**N/A**
Comments : There are polices formulated by the AIDS Prevention and Care Committee to promote IEC and other heath interventions for the cross-border travellers.		

5. Does your country have a policy or strategy to expand access, including among vulnerable groups, to essential preventative commodities? (These commodities include, but are not limited to, condoms, sterile needles and HIV tests.)

Yes ✓	**No**	**N/A**
If yes, please list Groups: IDU; STD patients; Other groups Commodities: Methadone; Condoms and HIV tests; Condoms and HIV tests		
Comments : Vulnerable groups are provided with special services to reduce their risk of contracting HIV/AIDS through the Social Hygiene Service, Special Preventive Programme and Methadone Clinics.		

6. Does your country have a policy or strategy to reduce mother-to-child HIV transmission?

Yes ✓	**No**	**N/A**
Comments : The Universal antenatal HIV testing programme in the public service has been implemented since September 2001.		

Human rights

1. Does your country have laws and regulations that protect against discrimination of people living with HIV/AIDS (such as general non-discrimination provisions and those that focus on schooling, housing, employment, etc.)?

Yes ✓	**No**	**N/A**
Comments : The Disabilities Discrimination Ordinance protects against discrimination of people living with HIV/AIDS.		

2. Does your country have laws and regulations that protect against discrimination groups of people identified as being especially vulnerable to HIV/AIDS (i.e., groups such as IDUs, MSM, sex workers, youth, mobile populations, and prison inmates)?

Yes ✓	**No**	**N/A**
If yes, please list groups: N/A		
Comments: Apart from the Hong Kong Bill of Rights Ordinance, a total of 14 United Nations human rights treaties apply to Hong Kong.		

3. Does your country have a policy to ensure equal access for men and women to prevention and care, with emphasis on vulnerable populations?

Yes ✓	**No**	**N/A**
Comments : The Sex Discrimination Ordinance has already been put in place since December 1996.		

4. Does your country have a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by an ethics committee?

Yes ✓	**No**	**N/A**
Comments : Medical institutions have set up ethics committees to scrutinize research on all fields including HIV/AIDS.		

Care and support

1. Does your country have a policy or strategy to promote comprehensive HIV/AIDS care and support, with emphasis on vulnerable groups? (comprehensive care includes, but is not limited to, VCT, psychosocial care, access to medicines, and home and community-based care.)

Yes ✓	**No**	**N/A**
If yes, please list Groups:	Commodities:	
Comments: The Hong Kong Advisory Council on AIDS and its committees promote comprehensive HIV/AIDS care and support to all people living with HIV/AIDS including vulnerable groups.		

2. Does your country have a policy or strategy to ensure or improve access to HIV/AIDS related medicines with emphasis on vulnerable groups? (HIV/AIDS-related medicines include antiretrovirals and drugs for the prevention and treatment of opportunistic infections and palliative care.)

Yes ✓	**No**	**N/A**
If yes, please list Groups:	Commodities:	
Comments: The policy of the HKSAR Government is that no one is declined health care services because of lack of means. HIV/AIDS patients have access to HIV/AIDS-related medicines when clinically indicated.		

3. Does your country have a policy or strategy to address the additional needs of orphans and other vulnerable children?

Yes ✓	**No**	**N/A**
Comments : The Social Welfare Advisory Committee keeps social welfare services under continuous review. The Social Welfare Department undertakes to look after the interests of all orphans and children in need.		

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WHO (2002) *Indicators for monitoring and evaluation of HIV/AIDS care and support programme* (draft), Geneva: WHO.

www.measuredhs.com/data (a useful indicator database)

Appendix IV

Summary Findings of Hong Kong's First Set of Core Indicators, as of 2003

	Indicator	Data period	Result
1.1	Funds spent by government • STD control • HIV prevention • HIV/AIDS clinical care and treatment	2003	-
1.2	National Composite Policy Index	-	-
2.1	Percentage of schools with teachers attending in-service education programmes on life-skills, AIDS or sex education	Academic year 2002/03	27.5%
2.2	Percentage of large companies/employers that have HIV/AIDS workplace policies and programmes	2003	7.69%
2.3	Percentage of patients attending STD clinics who had underwent a standardised care process of registration, assessment, counselling, investigations and treatment	2003	100%
2.4	Percentage of HIV-infected pregnant women receiving a complete course of MTCT antiretroviral prophylaxis	2002	83.3%
2.5	Percentage of advanced HIV disease patients receiving combination antiretroviral therapy	2003	89.4%
2.6	Percentage of IDUs who both avoided sharing needles and used condom	2003	37.4%
2.7	Percentage of young people (20-29) who both correctly identify ways of preventing sexual transmission of HIV and who reject misconceptions about HIV transmission	2003	45.9%
2.8	Percentage of young people (18-24) reporting condom use with pre-marital/pre-cohabitating sexual partner	2001	35.7%
3.1	Percentage of young people (15-24) who are HIV-infected	2003	0.025%
3.2	Percentage of HIV-infected infants born to HIV-infected mothers	2002	0%