

**Report of
Community Stakeholders Consultation Meeting for
Development of Recommended HIV/AIDS Strategies
for Hong Kong 2012-2016**

23 March 2011

Community Forum on AIDS (CFA)

and

Hong Kong Coalition of AIDS Service Organizations (HKCASO)

The Community Forum on AIDS (CFA) and the Hong Kong Coalition of AIDS Service Organizations (HKCASO) jointly organized a Community Stakeholders Consultation Meeting from 26 January to 1 February 2011. This pivotal Meeting has drawn extensive community discussions and inputs towards the formulation of the Recommended Hong Kong HIV/AIDS Strategies 2012-2016 by the Advisory Council on AIDS. With the assistance of the Rapporteur and Facilitator, the Secretariat has compiled this Meeting Report. The views and information contained in the Report are as collected and gathered from the Meeting and do not necessarily represent those of CFA and HKCASO.

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Acknowledgement

The Community Forum on AIDS and the Hong Kong Coalition of AIDS Service Organizations has taken a partnership approach to tap into the collective wisdom of the civil society through this multi-day Community Stakeholders' Consultation Meeting. Much has been done to plan how this should be conducted, mobilize community members and organizations to take part, prepare them for informed and meaningful discussions, and facilitate the documentation of the whole process as well as prioritized recommendations from the Meeting. All these could not have been accomplished without the coordinated efforts of the Working Group, facilitator, meeting rapporteur, resource persons and table hosts for each session, as well as the secretariat support of the Department of Health.

On the whole, the meeting was successful in drawing the active participation of community members and generating insights that are owned by them. We believe everyone taking part in the process is proud of being involved and the resulting recommendations would be useful in contributing towards the fight against HIV / AIDS in Hong Kong.

Acronyms and abbreviations

AC	AIDS Concern
ACA	Hong Kong Advisory Council on AIDS
AF	Hong Kong AIDS Foundation
AIDS	Acquired Immunodeficiency Syndrome
APIs	Announcement of Public Interests
ATF	AIDS Trust Fund
BGCA	The Boys' and Girls' Clubs Association Hong Kong
CDC	Center for Disease Control
CFA	Community Forum on AIDS
CRiSP	Community-based Risk behavioural and Seroprevalence Survey for Female Sex Workers in Hong Kong
CSCM	Community Stakeholders Consultation Meeting
DH	Department of Health
EDB	Education Bureau
EM	Ethnic minorities
EOC	Equal Opportunity Commission
FSW	Female sex workers
FSWC	Clients of female sex worker
GO	Governmental Organizations
HA	Hospital Authority
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
HKCASO	Hong Kong Coalition of AIDS Service Organizations

HTH	Heart to Heart
IDU	Injecting drug users
IT	Information Technology
ITC	Integrated Treatment Centre
LGBT	Lesbian, Gay, Bisexual and Transgender persons
M&E	Monitoring and Evaluation
MSM	Men who have sex with men
MSW	Male sex workers
NEP	Non-eligible Persons
NGO	Non-Governmental Organizations
PEP	Post-exposure Prophylaxis
PLHIV	People living with HIV
PRiSM	HIV Prevalence and Risk behavioural Survey of Men who have sex with men in Hong Kong
SAC	The Society for AIDS Care
SARDA	Society for the Aid and Rehabilitation of Drug Abusers
SHC	Social Hygiene Clinics
SHS	Social Hygiene Service
SJHIV	St. John's Cathedral HIV Education Centre
SPF	Special Project Fund
SRACP	The Society of Rehabilitation and Crime Prevention, Hong Kong
STI	Sexually Transmittable Infections
SW	Sex workers
SWC	Sex worker's clients
SWD	Social Welfare Department

TG	Transgender persons
VCT	Voluntary Counseling and Testing service

Executive Summary

The Hong Kong Advisory Council on AIDS has adopted a broad-based, participatory and integrated approach to formulate the Recommended HIV/AIDS Strategies (2012–2016) for Hong Kong. The Community Forum on AIDS (CFA) and the Hong Kong Coalition of AIDS Service Organizations (HKCASO) jointly organized a Community Stakeholders Consultation Meeting from 26 January to 1 February 2011, seeking to engage stakeholders as well as the wider community in informed discussion to shape the formulation of the Strategies.

Specific objectives of the Consultation Meeting include –

- (a) envisioning the HIV situation in Hong Kong after 5 years;
- (b) articulating the gaps of current response among the key populations;
- (c) identifying multi-sectoral collaborations, human capacity and other resources which need to be sustained, strengthened or mobilized; and
- (d) devising strategies which need to be continued and added.

Prior to the Consultation Meeting, participants were briefed on the meeting format and background information was provided to them. During the Meeting, group-specific as well as cross-cutting issues were raised by imposing generic questions through a unified discussion framework. Nine sessions on key populations and resource issues were held with a total of 248 participants comprising individuals and community stakeholders from diverse backgrounds.

A total of 114 recommendations were generated and prioritized into three groups by voting of participants in each of the nine sessions. A wide range of issues / concerns were raised, including but not limited to those related to enhancement of sex education for the

public, cross-border higher risk sex behaviours, supportive legal and social environment, tackling stigma and discrimination, the impact of digital communication media such as internet.

The recommendations can be categorized into seven areas, namely -

- (1) scaling up HIV prevention;
- (2) providing comprehensive and integrated treatment, care and support;
- (3) fostering an enabling environment;
- (4) strengthening leadership by government and other stakeholders;
- (5) promoting supportive legal framework and public policy;
- (6) enhancing strategic information; and
- (7) mobilizing resources.

Some key principles underpinning policy, strategy, programmes and services were shared across all communities -

- Being client-centred and protecting the human rights of PLHIV and specific communities;
- Sensitivity to culture (languages and religions) and gender;
- Adopt comprehensive, universal, diversified, targeted and flexible approaches;
- Community participation; and
- Coordinated and collaborated efforts.

Feedback from participants through the evaluation form generally indicated that they were satisfied with the process of registration, information provided for discussion, performance of the facilitator, the significance of their involvement and strategic recommendations generated from each session, but less so with the size of participants group

(except the MSM session), the venue (for sessions held in the Public Health Laboratory), amount of time for discussion and duration of prior notice before the meeting. The Joint CFA and HKCASO Working Group will conclude and evaluate the whole process.

This report, which summarizes the preparatory process, the diverse and constructive views generated in each session, and synthesis of discussion in the whole Meeting, will be revised and submitted to the Hong Kong Advisory Council on AIDS for discussion in its meeting on 8 April 2011 after receiving comments from the meeting participants.

Section 1 – Outline of the Community Stakeholders Consultation Meeting Initiative

1. This section serves to outline the rationale and key steps on the Community Stakeholders Consultation Meeting (CSCM) for providing community input towards the development of HIV/AIDS Strategies in Hong Kong from year 2012 to 2016 by Hong Kong Advisory Council on AIDS (ACA).

Background and Rationale

2. The formulation process of the Recommended HIV/AIDS Strategies for Hong Kong 2007 - 2011 was started in 2005 and has taken nearly two years to complete. The lengthy preparation is due to the comprehensive nature of the processes adopted by ACA, which consisted of community assessment and evaluation, estimation and projection exercise on HIV/AIDS in Hong Kong, opinion survey on AIDS programmes and AIDS strategies, work and deliberations of ACA and the Community Forum on AIDS (CFA) and analysis of international development by the secretariat. Integral to the Strategies, ACA recommended eight specific targets and adoption of UNAIDS core indicators framework for monitoring and evaluation. The 2007-2011 Strategies have been formulated through a broad-based, participatory and integrated approach. Given its success, a similar approach was proposed for the planning of the next 5-year Strategies with some modifications to streamline and expedite the process.

3. In contributing towards the formulation of the Strategies, the community plays an important role in mapping out the needs of key populations and identifying solutions to address them. Previous discussions at the CFA have favored adopting a several-day technical consultation meeting to serve the purpose. Such approach allows broader

participation by the community and ownership of the resulting recommendations, as opposed to the work group approach adopted for the 2007-2011 Strategies. It was proposed that the Technical Consultation Meeting (later dubbed as the Community Stakeholders Consultation Meeting) to be organized by CFA and Hong Kong Coalition of AIDS Service Organizations (HKCASO). The aim of the CSCM is to generate informed discussion and insights that are useful for formulating the next ACA Recommended Strategies. Specific objectives include –

- (a) envisioning the HIV situation in Hong Kong after 5 years;
- (b) articulating the gaps of current response among the key populations;
- (c) identifying multi-sectoral collaborations, human capacity and other resources which need to be sustained, strengthened or mobilized; and
- (d) devising strategies which need to be continued and added.

Key Steps in Formulation of the Meeting

4. Further to the resolution of the 19th Meeting of CFA, a Working Group for the CSCM has been formed jointly by CFA and HKCASO to advise on the planning, organizing and summarizing the CSCM for the Development of Recommended HIV/AIDS Strategies for Hong Kong 2012 – 2016. Members of the Working Group were chosen from CFA and HKCASO based on their knowledge and experience on key populations and community consultation. Membership of the Working Group can be found in Annex 1. While the CFA Secretariat was responsible for the overall coordination, planning and logistic support of the CSCM, members or representatives of HKCASO provided technical support and community liaison. Apart from holding two meetings which were held on 8 November 2010 and 5 January 2011, members of the Working Group also communicated with each other through phone and email. After much deliberation upon considering preliminary data on the HIV

epidemiology, views and convenience of community members, mix and group dynamics among potential participants, availability of venue and other practical arrangement, a finalized schedule with nine sessions focusing on various populations and resource issues running from 26 January to 1 February 2011 had been worked out as in Annex 2. Issues surrounding key populations including Men who have sex with men (MSM) and Transgender persons (TG), Injecting drug users (IDU), Female sex workers (FSW) and their clients, People living with HIV (PLHIV), Youth at risk, Ethnic minorities and Male sex workers (MSW) were the focus of discussions for the Meeting.

5. To allow room for generating diverse views and suggestions, three general questions were set for all sessions related to various populations and another three for the session on resource issues. The questions were set in logical progression manner, and were disseminated to participants prior to the meetings for preparation. The last question of the three was specifically designed as a direct feed-in to the recommended strategies, while the first two questions were designed to stimulate ideas and insights, and to allow participants to share their valuable experiences. In this way, group specific as well as cross-cutting themes such as those associated with the wider environment could be brought out as deemed appropriate by the participants. To maximize the participation of and insights generated from the participants, parallel small group discussion using the World Café conversation process¹ was employed for all but one of the sessions. Since it was expected that number of participants for the MSW session would be small and they came mainly from the only NGO which provided service to the MSW community, the World Café process was considered unsuitable and hence a conventional small group discussion format was applied for this particular session. The generic discussion guideline and the discussion guideline for the

¹ More details on the World Café conversation process can be found at www.theworldcafe.com.

special MSW session can be found in Annex 3.

6. All sessions were run by the same facilitator recruited specifically for the CSCM to ensure consistency of following the generic framework of discussion, and supported by a resource person identified by HKCASO who is familiar with the community or issues corresponding to each session. Moreover, table hosts and note takers involved in World Café were clearly briefed about the objective, format, and their roles and responsibilities so that discussion could be conducted in an unbiased, guided, and fair manner. The brief and note taking template that were used are in Annex 4 and Annex 5 respectively. To avoid potential dominance by a particular organization, NGOs were advised not to send more than two representatives to take part in each session. Members from ACA and the ATF registered to participate the CSCM only as observers in order not to influence the outcome of the discussions. The list of duty persons during the CSCM is included in Annex 6.

7. HKCASO and its members have played a key role to mobilize participation of community stakeholders by publicizing the whole consultation process actively and widely. Actions including phone calls, emails, face-to-face contact, pre-Meeting focus groups, distribution of publicity materials through outreach, facilitation in enrollment etc, were carried out. In addition, CFA secretariat has publicized the consultation as below:

Stakeholders	Publicity channel
ACA, CFA, Scientific Committee on AIDS and Sexually Transmitted Infections, Council for the AIDS Trust Fund, Management Advisory Committee of Red Ribbon Centre	Email communication
PLHIV	Poster and distribution of information card in public HIV Clinics

MSM and MSW	Advertisements in gay websites and gay magazines; MSM Workgroup of ; Gender Identity and Sexual Orientation Unit of Constitutional and Mainland Affairs Bureau
FSW and their clients	Distribution of information card via outreach of HKCASO members
IDU	Poster in Methadone Clinics
Ethnic minorities	Race Relations Unit of Constitutional and Mainland Affairs Bureau

8. Although prior registration is required for the CSCM, a more accommodating approach was taken for late or even on-site registration as long as the necessary supports were in place. HKCASO also deployed a representative for each session to provide financial incentive to attending community members and deal with ad hoc matters. Connection transport to nearby MTR stations and light refreshments was provided to participants. The meetings were audio-recorded for report writing purpose, and photography and video recording were strictly prohibited, except for official photography by the CFA secretariat for documentation purpose.

9. To prepare the participants for an informed and efficient discussion, several thematic webpages were newly created in ACA's website, with information on background of the community consultation process, details of the CSCM including the generic framework of discussion, the three discussion questions, mid-term review on the progress of implementing the current Strategies, updated HIV surveillance report, report on the third set of core indicators for monitoring Hong Kong's AIDS Programme, bilingual (Chinese and English) summaries of latest epidemiology and current responses for various populations under discussion, an updated summary of ATF, development of overseas strategies, and an online opinion survey. The abovementioned summaries of the latest epidemiology, current responses and ATF updates are included in Annex 7, 8 and 9 respectively. Throughout the

registration process, the facilitator communicated actively with stakeholders regarding objectives of the CSCM, the framework adopted, expectations on the CSCM, necessary preparation and identification of table hosts. Besides, NGOs were invited in advance to collect input from and prepare community members for the CSCM based on the general questions in the discussion guidelines. Different activities were conducted by HKCASO members in such process, and a summary of the activities can be found in Annex 10. All sessions, except the session for Ethnic minorities which was conducted in English, were conducted in Cantonese. Bilingual summaries of epidemiological trend and current responses were also distributed and presented at the beginning of each session.

10. A transparent documentation process was adopted, and the participants had ownership for the prioritization process. Upon finishing small group discussion, table hosts took turn to report views and suggestions verbally in each group, which were shown instantaneously through projection and flip chart papers written by the analysis team comprising the facilitator, the meeting rapporteur and CFA secretariat. The information was distilled into strategic recommendations for further clarification, discussion and prioritization by the participants. Participants were also led to discuss whether they would like the recommendations to be prioritized and the criteria for prioritization if they would like to do so. Three methods of prioritizations, that are commonly used in similar contexts, were suggested by the facilitator, and participants are also encouraged to come up with their own suggestions. All nine groups agreed to prioritize the recommendations and agreed to use the voting method to rank the recommendations into “High,” “Medium” and “Lower” priorities. Discussions were also facilitated for participants to voice out their rationales and criteria before the voting to give others a broader perspective during the prioritization. The table hosts and the note takers assisted the counting of ballots, and the results were announced immediately. However, it is to be noted that the recommendations as well as their prioritizations only reflect or brought

forward by the opinions of those who attended the meetings.

11. The process, both prior to and during the CSCM, was facilitated in a manner with sufficient flexibility for stakeholders to voice out their concerns and requests, and to own the decisions of the process. Illustrations of such process include –

- (a) The sessions on FSW and FSWC were both modified to discuss on issues concerning Sex workers and Sex workers' clients at large, including female and male, as requested by participants at both meetings.
- (b) Issues pertaining to transgender persons were included into the MSM session, as requested by a coalition of transgender persons prior to the CSCM, while options had been discussed whether the community would like the consultation to stand alone as a special meeting or to be included to the MSM session.
- (c) The request to distribute leaflet on the discontentment regarding the consultation process by community groups were accommodated during the CSCM.
- (d) The request to stage a short protest regarding stigma against Sex workers' clients during the corresponding session was facilitated.

12. The meeting rapporteur, who was a representative of HKCASO commissioned by CFA secretariat, compiled agreed recommendations and records taken by note takers in a synthesis report. The report would be submitted to ACA for deliberation after incorporating comments from the participants. The timeline of developing the Strategies were presented before the end of each meeting to remind participants on important milestones of the consultation process.

13. Feedback from participants through the evaluation form generally indicated that they were satisfied with the process of registration, information provided for discussion,

performance of the facilitator, the significance of their involvement and strategic recommendations generated from each session, but less so with the size of participants group (except the MSM session), the venue (for sessions held in the Public Health Laboratory), amount of time for discussion and duration of prior notice before the meeting. The summary of participation statistics and feedback of participants on the CSCM can be found in Annex 11 and 12 respectively. Subsequently, feedbacks regarding the CSCM are also collected at the meeting of CFA and HKCASO on 15 and 22 March 2011 respectively. Specific post-meeting feedbacks and remarks submitted by stakeholders are given in Annex 13.

Section 2 – Detailed Sessions Summary

This section reports on the detailed summaries of discussions and prioritized recommendations for each session. The session summaries composed in a manner to adhere and reflect what has been discussed as much as possible to its actual happenings. The rapporteur recorded the discussions on the site, while referring to the audio recording when necessary, and based on the notes being taken by the note takers at the Meeting. For the key populations sessions, each session summary is summarized according to the three pre-set questions, then being grouped into different categories, namely prevention, treatment, clinical care and treatment, care and support, enabling environment, strategic information, and strategy/policy, accordingly. For the financing and resource mobilization for HIV services session, the session summary is summarized according to the three pre-set questions specifically for that session, then being grouped into categories, namely financial and non-financial resources. The prioritized recommendations are reported for all sessions as agreed by the participants. A synthesized analysis report of the sessions can be found in Section 3. The session summaries are presented in the following order (in alphabetical order):

1. Ethnic minorities (EM)
2. Financing and resources for HIV Services
3. Injecting drug users (IDU)
4. Men who have sex with men (MSM) / Transgender persons (TG)
5. Male sex workers (MSW)
6. People living with HIV (PLHIV)
7. Sex workers (SW)
8. Sex worker clients (SWC)
9. Youth at risk

Session Summary for Ethnic minorities (EM)

1. Current needs of the EM community

1.1. Prevention

- 1.1.1. More NGOs and manpower provide service for (hidden) EM groups, especially female sex workers and their EM clients.
- 1.1.2. Mainstream NGOs can provide sex education and knowledge on HIV/STIs, and increase their efforts in raising awareness on safer sex in the EM community.
- 1.1.3. Increase EM access to free (or low cost) condoms since female sex workers find condoms too expensive. For domestic helpers, they worry about bringing condom back home as their bosses may scold them. Educate sex workers' clients who are EM on condom use.
- 1.1.4. Provide 24 hours access to free syringes.
- 1.1.5. Conduct drug and HIV education programme at the street level.
- 1.1.6. Although most Nepalese in Hong Kong know about HIV/AIDS, they have problems in accessing syringes at night time.
- 1.1.7. Vietnamese, both in Hong Kong and in Vietnam, know little about HIV testing and treatment and do not know how to get information. Language is a barrier in accessing local services.
- 1.1.8. Hotline cards are not produced in languages that EM are familiar with.
- 1.1.9. Domestic helpers need more information on sexual health. They worry that their bosses would terminate their contracts if they are infected with STI.

1.1.10. Provide needle exchange programmes and/or disposal box of used needle, especially in the night time.

1.2. Treatment

1.2.1. Better accessibility to clinical services, e.g. extend opening hours on Sunday/public holidays, have locations near their workplaces, be languages and cultures sensitive, and be user friendly.

1.2.2. Tailor made drug treatment centre to accommodate EM with different languages and religious beliefs.

1.3. Enabling environment

1.3.1. Reduce stigma against PLHIV - many EM face difficulties when it comes to issues such as disclosure of HIV status.

1.3.2. Bridge the language barriers in TV/newspaper. Such barriers prevent people from accessing education and after care services and treatment. Education leaflets, advertisements or hotlines related to HIV should be published in languages that EM are familiar with.

1.3.3. All service centres, including treatment, should have more cultural sensitivity.

1.3.4. Low literacy level and lack of education of EM parents. More information and education especially to mothers, including safer sex, condom use, HIV/AIDS are needed.

1.3.5. Education programmes should be gender and religion sensitive.

- 1.3.6. Lack of translation services. Train more EM to become translators.
- 1.3.7. More support for integration of EM into the society.
- 1.3.8. Increase gender sensitive services by separating services for females and males.
- 1.3.9. Promotion that suits cultural context in reducing taboo related to condom use.
- 1.3.10. More resources for building network between the EM community and NGOs for long term partnership.
- 1.3.11. Sex education targeting young EM with materials and information that are sensitive to their cultures.
- 1.3.12. Provide service for EM who lives in temporary shelters.

1.4. Strategic information

- 1.4.1. Sub-groups in the EM populations are overlooked, e.g. refugees/asylum seekers.
More efforts are needed to assess their needs.

2. Visions in 5 years time

- 2.1. EM youth are more educated on sex education. EM adults are more open to talk about sex and HIV.
- 2.2. Increased education to parents – it is viewed that literacy of EM women is low, which is a barrier for them to access to HIV and STI information.
- 2.3. Racial equality is achieved. Since currently, EM do not see the opportunities for them to further develop in the existing social atmosphere and system. Little hope for good

prospect means not caring for oneself, including sexual health and safer sex. Equal opportunity for all ethnicities to increase access to services and education.

- 2.4. HIV infection will be kept at a low level.
- 2.5. Tailor made treatment, drug treatment centre and after care services for EM drug users, with provision of food and accommodation that suits their cultures, and operated by EM staff.
- 2.6. More EM workers in the field. Sex and equal right educations are provided for EM by EM.
- 2.7. Government promotions on drug and HIV prevention through mass media are in multi-languages. More mass programmes (on HIV and drug use) in schools and communities are conducted in multi-languages. More harm reduction programmes, and the use of diversified approaches.
- 2.8. Employ EM as staff in prison setting for more cultural sensitive services.
- 2.9. Programme on educating on their (patients) rights.
- 2.10. Use mentorship programme to build positive attitude of drug users.
- 2.11. Reduced drug use and less crime. Reduced number of homeless EM.
- 2.12. All programmes and services are cultural and religion sensitive.
- 2.13. Materials/workshops are in one EM specific language. If not, translation is provided in workshops and other activities to EM. More resources to reach out to EM.
- 2.14. A range of services including training, job finding, temporary shelter and integration to society available to rehabilitate EM IDU.

- 2.15. Training for community leaders in different nationalities to become peer educators.
- 2.16. Zero language barriers. Easily accessible translation/interpretation services. Provide language support to NGOs to facilitate their works for EM. Make use of the internet platform for (HIV) related services that are support by multi-languages.
- 2.17. 24/7 services, e.g. social hygiene clinic for EM, and low cost/free services.

3. Strategies which need to be continued or in place

3.1. Prevention

- 3.1.1. Increase outreach efforts and expand to other districts, such as Kowloon City and Wanchai.
- 3.1.2. Set up outreaching team that stations at border checkpoints and provide information on HIV and sexual health.
- 3.1.3. Disposable syringe boxes in places where EM congregate.
- 3.1.4. More education to EM SW and SWC. Promote regular medical check-ups.
- 3.1.5. Promote safer sex through internet/website. Internet outreach programme for HIV/STI education.
- 3.1.6. Increase number of EM peer educators, and their training (in appropriate language and addressing cultural differences).
- 3.1.7. Change the concept of condom use among EM. Improve access to (cheaper) condoms.

3.1.8. Access to new syringes, and they should be available 24 hours. Set up needle exchange programmes. Disposal box for syringes should be available in different locations.

3.1.9. Provide education workshops to refugees.

3.1.10. More VCT and counseling services for EM.

3.2. Treatment

3.2.1. Increase access to free (also for those who are NEP) health care services, extended opening hours on Sunday and night time, and in different locations.

3.2.2. Drug treatment and follow-up services specifically for EM. More cultural and language sensitive services (including after care).

3.2.3. Ensure drug free environment in methadone clinics.

3.3. Care and support

3.3.1. More checkup services and volunteer counseling services for EM. Services should be cultural sensitive.

3.3.2. Service to EM needs to be improved as a whole: both in treatment and after care by providing job opportunities and other support.

3.3.3. Motivate EM to stay away from drug use.

3.4. Enabling environment

- 3.4.1. School for EM should provide sex and HIV education in multi-languages. Increase the number of talks, and the quality has to be good.
- 3.4.2. Access to drug rehabilitation services that are religion free.
- 3.4.3. NGOs and church groups that work with EM should work on mainstreaming HIV issues into their institutions, such as churches.
- 3.4.4. More networking between organizations that serve EM and the EM communities.
- 3.4.5. More long term funding to sustain NGO partnership with EM community. Monitoring should be in place.
- 3.4.6. User friendly translation service should be provided, e.g. in the hospital to increase accessibility.
- 3.4.7. Workshops by NGOS to target different EM groups. Increase education for adults in general.
- 3.4.8. Extensive use of peer educators in EM programmes.
- 3.4.9. Provide support services to EM who are living in the border areas, e.g, domestic helpers who are in-between contracts.
- 3.4.10. Provide service/workshops that are for EM females such as, Indians and Nepalese.
- 3.4.11. Create an EM caring society.
- 3.4.12. Promote anti-discrimination against PLHIV among different ethnicities.

3.4.13. Health information centres provide services in multi-languages. Improve government hotlines service to cater the needs of EM. Existing hotlines are not user-friendly.

3.5. Strategy/policy

3.5.1. EOC should look at the current services and check whether they are free from racial discrimination.

4. Prioritized recommendations

The following recommendations were compiled based on the above discussions, agreed and prioritized by participants:

High priorities

4.1. Provision of education and services for EM communities in general as well as sub-groups, including children/youth, parents, drug users, sex workers and their clients, refugees and asylum seekers, domestic workers, prison inmates, community leaders, cross border, and “in-between contracts” domestic workers. Education and services should be cultural sensitive and prioritized according to the risk of HIV infection.

4.2. Accessible & affordable health care services to EM, e.g. opening hours should accommodate the needs of migrant and domestic workers, construction workers and security guards etc.

- 4.3. Capacity building in the EM community to enable them to become HIV prevention workers, peer educators (in same language) and health care workers. Provide training for them in different languages (languages of their origins).
- 4.4. Multi-faceted approach for EM services: Increase outreaching services to different sub-groups (e.g. drug users, sex workers & clients) and in different locations such as Kowloon City, Wanchai. More street level education and the use of peer education approach in delivery. Increase access to condoms.

Medium priorities

- 4.5. A drug free methadone clinic, cultural sensitive treatment centre and hostels, and provide comprehensive after care service (increase motivation for change). Training programmes for ex-drug users and ex-prison inmates to become peer educators.
- 4.6. Provision of services should be cultural and gender sensitive. HIV programmes/services should be EM- centric.
- 4.7. Support groups for EM PLHIV.
- 4.8. Reduce language barriers through provision of translation. Use of multi-languages in TV/printed media/hotlines, and the internet.

Lower priorities

- 4.9. Free syringe programme for drug users and sharp boxes in different districts.
- 4.10. Increase network among organizations that serve EM community and AIDS service organizations.
- 4.11. Education within EM communities to reduce stigma and discrimination against PLHIV.

4.12. EOC should investigate if existing service providers/institutions are violating Racial Discrimination Ordinance.

Session Summary for Financing and Resources for HIV Services

1. Resources which need to be sustained, strengthened or mobilized

1.1. Financial resources

- 1.1.1. Resources to sustain VCT services.
- 1.1.2. Strengthen resources support for more services to PLHIV and their families by means of one stop service. Emotional support and mental health programmes are needed especially with the increasing HIV/AIDS cases. Mobilize community groups, such as religious groups, in the delivery.
- 1.1.3. Support infrastructure, e.g. rental and IT.
- 1.1.4. More resources for the implementation of youth education programmes.
- 1.1.5. Encourage volunteers support by providing, e.g. volunteer allowances.
- 1.1.6. More funding on prevention and care programmes. Besides, more funding is needed to support the administration.
- 1.1.7. Sustainable funding and its allocation from ATF such as salary or equipments should base on market price, in order to enhance staff recruitment and retention with experiences and expertise for implementation of projects.
- 1.1.8. More resources on the research of vaccine and treatment.
- 1.1.9. ATF to cover other expenses including NGO staff attending overseas conference (capacity building), IT, and office start up cost.
- 1.1.10. ATF should support programmes that are in good quality, and make them sustainable. Efforts are needed to retain talents in the field.

1.1.11. Extend funding cycle beyond 3 years to ensure programme sustainability.

1.1.12. Allocate resources to other populations such as ethnic minorities and women.

1.1.13. ATF to categorize recreational drug use as an individual category (separate from IDU).

Besides, funding areas should include human rights issues and gender equality.

1.1.14. NGOs to share resources, such as leverage the cost of accountant by sharing the staff among organizations.

1.2. Non financial resources

1.2.1. Psychological support and support services to the significant others of at risks groups.

1.2.2. Set up a platform, including people from private sector and advocates, to share their ideas on how to work together or support the issue.

1.2.3. Mobilize other government departments such as Education Bureau, EOC, SWD and other departments to coordinate education efforts.

1.2.4. Provide professional trainings to (prevention programme) staff members for higher quality programmes. Such training can be done by organizations, e.g. EOC.

1.2.5. Make use of the internet for mass media promotion.

1.2.6. Programmes should contain human right elements. Besides, to include drug use as a topic in the programmes.

1.2.7. Mobilize academic sector to collaborate with NGOs.

- 1.2.8. Encourage diversified personnel with different professional background (e.g. marketing, research) into the AIDS field. Facilitate cross [professional] fields collaboration. Besides, effort is needed to build up capacity of community members.
- 1.2.9. Require information / a database that contains potential private funders/foundations.
- 1.2.10. Governments of Hong Kong and Mainland China should increase collaboration in addressing cross border issues. Strengthen cross border programmes and more resources are needed to support the development of programmes. Networking with health departments in Mainland China.
- 1.2.11. Reinforce services for cross border travelers to include non-HK residents, link up with Mainland government departments, e.g. Shenzhen CDC to facilitate the work and legitimize service for cross border workers, and agree on treatment protocol between Hong Kong and Mainland China to facilitate cross border care for PLHIV.
- 1.2.12. Provide technical support such as programme planning, social marketing, release of research/surveillance data, M&E system, and dissemination of M&E data to support/advice the work of frontline workers.
- 1.2.13. Different government departments, such as SWD, Beat Drug Fund etc, should work together on cross-cities collaborations since regional epidemics may affect the epidemic in Hong Kong.
- 1.2.14. Mainstreaming AIDS NGOs work into the mainstream welfare organizations.
- 1.2.15. Increase efforts to promote acceptance of PLHIV to mainstream organizations.
- 1.2.16. Mobilize resources from e.g. professional organizations (medical, social work), law societies, volunteers employee volunteer programmes, for their involvement in

HIV/AIDS work. Mobilize resources from the community, e.g. more involvement of PLHIV.

1.2.17. Promote corporate responsibility so as to mobilize more resources to NGOs.

1.2.18. More training for social workers and teachers on HIV/AIDS. Increase training to NGO workers on public health, management, M&E, research and development.

1.2.19. Better coordination and communication to avoid overlap in services. Government and NGOs should continue to fill service gaps.

1.2.20. Support development and implementation of VCT, e.g. logistic support, guidelines and quality control.

1.2.21. Venues available and accessible for NGO activities.

1.2.22. Involvement of community members in ACA.

1.2.23. Mobilize resources and support to smaller NGOs.

2. Resources allocation and key criteria

2.1. Resource allocation should base on the needs of the community and its impact, and should be human rights based. Allocation should not simply base on the size of the potential community sub-groups, so as to cover minority marginalized group such as TG. Besides, inflation should be taken into consideration. Allocation should also take into account of and to keep pace with the increasing number of service users.

2.2. Support programmes that address in-depth psychosocial needs. They require regular and longer-term resources allocation.

- 2.3. Support programmes and services that are core to HIV prevention and care, e.g. resources for VCT service should be made more sustainable.
- 2.4. Reduce overlapping of services through coordinated efforts in resources allocation.
- 2.5. Promote cross-sectoral collaborations.
- 2.6. Base on the urgency of the issues.
- 2.7. More support and flexible funding allocation to newer/smaller organizations and marginalized groups. Sustainable funding support NGOs that are experienced in AIDS work with good track record. Comprehensive support for NGO is needed, e.g. cover their rental.
- 2.8. Community should have participation in setting ATF funding policy. Policy should be transparent.
- 2.9. Programmes should be multi-level interventions: universal level, targeted prevention, and encourage personal development. These funding should be flexible and referencing to the trend of the epidemic.
- 2.10. A Hong Kong action plan is needed which highlight details of annual targets and works, and how much is needed. On-going review, evaluation and continuous needs assessment are needed. Comprehensive planning of resources allocation by population is in need.
- 2.11. Consistent evaluation across programmes such as VCT, which aims at standardization of programmes. Funding evaluation should base on needs and works done by NGOs, not just focused on 3-year outcomes, but be more flexible and to help sustain existing resources.

- 2.12. Reference to overseas guidelines for resources allocation, e.g. size of population and programme coverage.
- 2.13. Well rounded funding consideration/allocation to cover a wider range of HIV-related issues, e.g. sexual health, mental health that could also address HIV issues (in) directly.
- 2.14. Government should take the lead in securing adequate and sustainable funding so as to enable allocating more resources, rather than asking organizations to go outside and find more resources.
- 2.15. Subsidy to HAART should continue, and ATF to consider temporary funding to new drugs that are not on the Drug Formulary.
- 2.16. Waive charges of NEP.
- 2.17. Funding for professional staff required for projects should align with market rate.
- 2.18. Resources for (sex) education to all people.
- 2.19. ATF to have clear criteria for rejection.
- 2.20. Allocation of resources should also take into the consideration of HIV/AIDS situation in nearby cities.
- 2.21. ATF can follow the SWD funding mechanism to fully support programmes and services.
- 2.22. Keep Special Project Fund arrangement in place to address immediate needs of the communities.
- 2.23. Sub-populations in PLHIV community, such as giving higher priority to older people.

2.24. Approval and disbursement of funding should be quicker to secure continuity of programmes and services.

3. Strategies which need to be continued or in place

3.1. Financial resources

3.1.1. Keep ATF as the main sponsor. In times of emerging epidemic, ATF should be flexible in addressing the situation quickly, such as MSM SPF.

3.1.2. Resources to build NGOs' capacity in areas such as management and resources planning.

3.1.3. ATF to set a threshold for triggering cash injection.

3.1.4. ATF be flexible when financing/supporting smaller size NGOs. Encourage service users to become service providers to create supportive and enabling environment.

3.1.5. More resources for surveillance in larger scale.

3.1.6. Funding is needed to support M&E, fund raising and capacity building.

3.1.7. Resources allocation for alternative approaches, e.g. Chinese medicine in treating HIV/AIDS.

3.1.8. Government to encourage support from the private sector, and to promote corporate responsibility by providing match-grant mechanism.

3.1.9. Resources to support social-structural intervention and acceptance of self-identity (e.g. PLHIV and MSM).

3.1.10. More funding to support manpower for programmes and services, and also support talent retention in the field.

3.1.11. ATF to support other groups such as at risk youth, women and ethnic minorities.

3.1.12. Resources allocation should be evidence based, with strategic plan in the allocation.

3.2. Non financial resources

3.2.1. Encourage more collaborations and partnerships within the government so that to share resources and coordinate better among them, e.g. Police, Education Bureau.

3.2.2. Mobilize community resources and extend services to mainstream organizations, e.g. elderly centre can do their own HIV prevention/education.

3.2.3. On-going review on the 5-year strategy and its action plan.

3.2.4. Involve ACA in resource allocation. Incorporate community stakeholders' participation in ACA.

3.2.5. ATF to help NGOs in their resources planning.

3.2.6. ATF can be more proactive to invite applications based on the needs of the communities and service gaps.

3.2.7. Encourage community participation with a bottom-up approach when it comes to [funding] policy formulation. It should base human rights principles.

3.2.8. Increase the number of HIV clinics. PLHIV resource centre should be set up next to these clinics.

- 3.2.9. Set up a centralized technical support to organizations for various issues, e.g. enhancing proposal writing skills.
- 3.2.10. ATF to increase communications within government so as to enhance funding applications of NGOs to various funding bodies.
- 3.2.11. Support core and recurrent programmes/services and allocate more sustainable resources similar to subvention, based on some criteria, e.g. good track record. Encourage programmes that could go beyond 3 years and make them sustainable.
- 3.2.12. All government frontline activities such as to contract out HIV testing to NGOs.
- 3.2.13. More in-depth (age, sub-populations) surveillance data.
- 3.2.14. Mandatory sex education in schools.
- 3.2.15. Promotion through different mass media.
- 3.2.16. ATF to allow flexible use of fund e.g. shifting of unused fund to other items that need more funding.
- 3.2.17. Increase access to service by collaborating with Mainland China in prevention work, e.g. HIV test for Hong Kong people in China.
- 3.2.18. Cross countries AIDS strategy to address the needs of mobile populations.
- 3.2.19. ACA to address the issue of police using condom as evidence for prosecution (against sex workers) which hinder safer sex promotion and practice.
- 3.2.20. Provide funding to support infrastructures such as rental, electricity and water, administration, staff training and development.

3.2.21. Support programmes that could encourage supportive environment for PLHIV and their family.

3.2.22. A longer term planning to address the increasing number of PLHIV and their increasing/changing needs.

4. Prioritized recommendations

The following recommendations were compiled based on the above discussions, agreed and prioritized by participants:

High priorities

4.1. Maintain the funding (allocation) flexibility and align with the changes in the epidemic (e.g. SPF) and inflation. It should be evidence-based, transparent, responsive, human rights based, with reference to international standards, while considering programme coverage and size of population.

4.2. To maintain the sustainability of ATF.

4.3. Community participation in resources allocation and funding strategy.

4.4. A centralized technical support platform for enhancing proposal writing, IT, interpret research data, NGO management, talent retention (e.g. sponsor NGO workers to attend international AIDS conference), nurture community members for future AIDS work and development of resources.

4.5. Human resources allocation, e.g. salary should be compatible with similar fields, reasonable funding and service agreement.

Medium priorities

- 4.6. Increase cross government departments and/or sectors communication, coordination, collaboration on resources and funding for AIDS work, such as Education Bureau, SWD, law enforcement and other government grant/funding.
- 4.7. Multi-faceted intervention: universal and structural interventions, e.g. anti-stigma, public education, sex education, targeted preventions, supportive environment and personal growth.
- 4.8. Put aside a certain proportion of funding and resources for PLHIV & other marginalized groups.
- 4.9. Monitoring and evaluation of programmes: technical support, funding, for comparison/standardization.
- 4.10. Subvention for projects/programmes with good track record and core activities (e.g. testing), with explicit criteria to make them to become sustainable programmes/projects.

Lower priorities

- 4.11. Increase communication, coordination, collaboration on resources and programmes with partners in Mainland China and within the region. Increase resources for cross country programmes.
- 4.12. Involvement of private sector and other community resources (monetary, technical support, internet, community groups, academia and religious group).
- 4.13. Territory-wide planning in resources allocation with on-going review.
- 4.14. To evaluate the functions of ACA and ATF so that policy-making and funding allocation are aligned.

4.15. Coordinated effort to prevent overlap in resources and programmes.

4.16. Inclusion of diversified approach such as Chinese medicine.

Session Summary for Injecting drug users (IDU)

1. Current needs of the IDU community

1.1. Prevention

- 1.1.1. Provide HIV/AIDS information for IDU who are in rehabilitation services and on the streets.
- 1.1.2. Reach out to hidden/invisible IDU, e.g. at drug dealing points.
- 1.1.3. Increase access points (such as convenient stores and installation of vending machines) for sales of clean needles. Access should be 24 hours.
- 1.1.4. Programme activities should be sensitive to IDU diverse cultures & languages. This includes those providing counseling services in drug rehabilitation centres and correctional institutions.
- 1.1.5. Ensure a drug free environment in rehabilitation centres and methadone clinics etc., and make certain the surrounding areas are also free of drugs.
- 1.1.6. Adoption of harm reduction approaches in prevention, e.g. ensure access to clean needles, needle exchange programme, shooting gallery (safety house).
- 1.1.7. Produce IEC materials in different languages to meet the needs of ethnic minorities.
- 1.1.8. Provide free condoms and safer sex education.
- 1.1.9. Put efforts in addressing cross border IDU issues.
- 1.1.10. Mobile testing service to test the compositions of drugs so that people know what they are taking.

1.2. Treatment

- 1.2.1. Set up treatment centre specifically for ethnic minorities.
- 1.2.2. More treatment services which are non-religion affiliated are needed.

1.3. Care and support

- 1.3.1. After care services should be cultural sensitive e.g. those who are discharged from correction institutions would need access to culturally sensitive social welfare and housing after care services.
- 1.3.2. Rehabilitation services, testing and counseling should be provided in correctional institutions.
- 1.3.3. Social worker to provide one-to-one service (case work) for IDU.
- 1.3.4. Support service to HIV infected IDU and their family members (including children).
- 1.3.5. More resources allocation to frontline outreach programmes.
- 1.3.6. Strengthen support and education for IDUs who are not motivated to quit drug.
- 1.3.7. Educate IDU on first aid skills to handle overdose situation.

1.4. Enabling environment

- 1.4.1. HIV/AIDS and drug use education in schools for children and their parents.
- 1.4.2. Make use of TV prime time to educate the general public on condom use. Messages should be in-depth, explicit and to encourage HIV test. Could add information on Hepatitis C in the messages.

1.4.3. Strengthen promotion and education in appropriate places, e.g. public housing estates.
Besides, targeted education for new arrivals is needed.

1.4.4. Target on risky behavior but not high risk groups so as to reduce stigma.

1.5. Strategy/policy

1.5.1. Legalize the use of marijuana as part of a harm reduction strategy.

1.5.2. Police needs to strengthen law enforcement around methadone clinics.

2. Visions in 5 years time

2.1. Zero HIV infection in IDU community.

2.2. New development in HAART and a cure of HIV/AIDS is found.

2.3. Government takes the lead in reducing discrimination.

2.4. Tailor made treatment centres for the ethnic minorities, with programmes in English and services not just provided by religious groups.

2.5. More education on the risk of different injection methods in response to the pattern of injecting drug use among young people. Besides, risk of blood borne infections through injecting drug use should be addressed by the government and NGOs.

2.6. Needle exchange/distribution programmes (at least in methadone clinics) or needle vending machines are in place, supported by law reform so that IDUs are not prosecuted by carrying needles.

- 2.7. IDU and general public are more informed on HIV/AIDS knowledge. Methadone clinics can also provide HIV education.
- 2.8. Service centre to provide combined efforts including knowledge on safe injection, education, testing and counseling.
- 2.9. Clean needles can be bought from convenient stores or vending machines. Needle collection boxes are easily available. Access should be universal.
- 2.10. More HIV and drug use education in schools (starts at early age) and psychiatric hospitals. Besides, such education should be in place and VCT service is available in prisons.
- 2.11. Service is available to test the composition of illicit drugs so that users know what they are taking.
- 2.12. Number of Nepalese IDU and their risky behavior will be reduced.
- 2.13. No more increase in young IDU. If they use drug, they don't use/share needle but use other methods such as inhalation.
- 2.14. Legalize the use of marijuana.
- 2.15. Set up safety house for IDU when they need injections, and therefore reduce the chances of disposing used needles in public areas.
- 2.16. Provide more services to non-Chinese IDU, e.g. Africans or asylum seekers, and encourage community participation.
- 2.17. Cross departments, including Customs and Police, collaboration in reducing the supply of drugs. Increase penalty to drug dealers.
- 2.18. A reduced number of drug users and therefore reduced number of clinics.

- 2.19. PLHIV who are IDU feel comfortable in seeking medical treatment. Support to family members of IDU and/or PLHIV is needed.
- 2.20. Provide HIV education to female sex workers (particularly to the new arrivals) who are also IDU. Besides, educate them on condom use.
- 2.21. An overall reduction in stigma and discrimination.
- 2.22. Free distribution of condoms (in toilets).
- 2.23. Availability of needle disposal device.
- 2.24. Increased outreach efforts to reach out to hidden/invisible IDU.

3. Strategies which need to be continued or in place

3.1. Prevention

- 3.1.1. Increase resources for greater access to HIV testing for IDU, especially those who are hidden or hard to reach.
- 3.1.2. NGOs outreach programmes and other support services should be continued, and additional resources are needed. Outreach workers to target “invisible” drug dealers for education.
- 3.1.3. Improve HIV education for ethnic minorities and new immigrants. Besides, more efforts are needed for IDU who may cross the border, share needles and have unprotected sex.
- 3.1.4. Ensure access to clean needles in late night such as purchase from convenient stores, needle dispensers in methadone clinics, or needle exchange/recycling.

- 3.1.5. Provide harm reduction services such as access to condoms and methadone in prisons.
- 3.1.6. More concerns on the co-infection of HIV and Hepatitis C. IDU seems to be more receptive to Hepatitis C because it is less sensitive (than HIV) to the community.
- 3.1.7. Training for healthcare and NGO workers, and educate them on how to make referrals for Hepatitis C carriers and access to services.
- 3.1.8. Ethnic minority peer educators are trained to educate their community. Also to enhance peer training in correctional institutions.
- 3.1.9. Provide comprehensive services for IDU who has lower level of motivation to quit drugs.

3.2. Treatment

- 3.2.1. Continue methadone clinic services

3.3. Care and support

- 3.3.1. Care and support is needed to provide to IDU who are PLHIV and their family members. Special attention is needed on those who are ethnic minorities. Service should be cultural sensitive and bridging the language barriers.
- 3.3.2. Resources to NGO/GO to support helping IDU in areas such as their employment, self-esteem and rebuilding family relationship.
- 3.3.3. More peer educators are trained.
- 3.3.4. Provide after care services and support to those, especially ethnic minorities, who are newly discharged from hospitals.

3.3.5. More resources for psychological support to IDU who are rehabilitated, and help them to build a new life to avoid relapse.

3.4. Enabling environment

3.4.1. All programmes and services should address and are sensitive to the needs of the sub-populations including ethnic minorities, new immigrants, illegal workers and refugees due to their cultural/language and other barriers. Support in languages and financial subsidies are needed to encourage them in accessing service and increase their participations.

3.4.2. Anti-discrimination education and promotion for all age groups of the general public.

3.4.3. More promotion/education in methadone clinics, school and mental health institutions.

3.4.4. The use of mass media to educate the public, and provide more in-depth education to reduce misconception on safer sex/HIV.

3.4.5. Target young people who are already taking illicit drugs and educate them proactively, to prevent them from using injecting drug use.

3.5. Strategic information

3.5.1. Sharing of information and collaborating with neighboring countries on serving mobile IDU and addressing their risk behavior.

3.5.2. Government to provide more resources to study on the trend of and changes in drug use.

3.6. Strategy/policy

3.6.1. Police does not use possession of used needles as evidence of prosecution.

3.6.2. Develop policy to facilitate needle disposal.

4. Prioritized recommendations

The following recommendations were compiled based on the above discussions, agreed and prioritized by participants:

High priorities

4.1. Provide comprehensive services, prevention and harm reduction to specific populations such as women, new arrivals, cross border travelers, ethnic minorities, illegal workers, attendees of psychiatric institutions, prison inmates, individuals who have no motivation to quit drugs. Services should be sensitive to their cultures, languages and gender. Also, community participation needs to be increased.

4.2. Increase programme coverage and provide in-depth HIV education to drug users.

4.3. Programmes to increase access to clean needles and disposal of used needles, e.g. needle exchange, vending machines, sales of needles in convenient stores and needle recycling. Provide comprehensive social services including increased case work, employment, group work and fun activities. These services are not only for IDU but also for their families and partners. Peer education approach is encouraged.

4.4. Prevent young people from using drugs through educating them and their parents.

Medium priorities

- 4.5. Increase HIV test and safer sex education. Provide one stop service, e.g. venue as shooting gallery (safety house) and access to various services such as methadone, HIV education, drug rehabilitation and referral for Hepatitis C treatment.
- 4.6. Strengthen after care services and assist IDU to rebuild their life.
- 4.7. Training to health care workers on Hepatitis C treatment referrals.
- 4.8. Police to support the implementation of harm reductions.
- 4.9. Increase work on anti-stigma and anti discrimination against IDU.

Lower priorities

- 4.10. Strengthen promotion and education in various checkpoints in the Pearl River Delta Region.
- 4.11. Continue to improve outreach programmes and to maintain methadone treatment.
- 4.12. Provide harm reductions, education and testing services in correctional institutions.
- 4.13. Increase efforts in stopping the supply of illicit drugs.
- 4.14. Research and monitor the changing trend and pattern of illicit drug use.

Session Summary for Men who have sex with men (MSM) / Transgender persons (TG)

1. Current needs of the MSM / TG communities

1.1. Prevention

- 1.1.1. Halt HIV transmission in the community.
- 1.1.2. Programmes should address the needs of different sub-populations, e.g. MSM who are newly come out, drug use, closeted MSM and transgender persons etc. Use of multi-media to ensure messages could reach out to them. Collaborations within government are required.
- 1.1.3. Interventions to deal with cross border issues need to be strengthened.
- 1.1.4. Improve access to services by expanding geographical coverage.
- 1.1.5. Implement and strengthen in-depth interventions, e.g. behavioral change, gender and sexual orientation identity and negotiation skills. Identify methods in reaching out to MSM through the Internet so that they could accept and access to health promotion message and services.
- 1.1.6. More HIV/STI rapid testing spots, e.g. saunas, and to increase incentives to encourage testing. Allocate additional resources.
- 1.1.7. HIV prevention publicity to deliver knowledge on HIV and the needs of MSM. However, when targeting the general public, they should understand that “MSM≠HIV”.
- 1.1.8. Installation of condom vending machines.

1.2. Care, support and treatment

- 1.2.1. More emotional and counseling support to MSM who use VCT, and extend the support to their partners/friends. More counseling services are needed in general.
- 1.2.2. MSM are empowered through services to build their self efficacy to counter stigma from the society.
- 1.2.3. Put more concerns on TG. Identify different methods to reach out to TG. Regard TG as an individual community but not attached to MSM.
- 1.2.4. More support to HIV infected MSM is needed. Reduce stigma within the MSM community against HIV infected MSM.
- 1.2.5. Set up a comprehensive sexual health centre for MSM.
- 1.2.6. Increase choices in medical practices, e.g. traditional Chinese medicine should be provided and encouraged for MSM. Besides, more information is needed for PLHIV on access to medical care.
- 1.2.7. Multi-sectoral collaboration: education department, health care and parents can have more collaboration.
- 1.2.8. Services (e.g. counseling hotline) to support young and newly come out MSM for accepting their self identities.

1.3. Enabling environment

- 1.3.1. Increase promotion of acceptance, and respect human (and equality of) rights of MSM, TG and PLHIV by the society and they can be themselves. This will encourage MSM to use different services.

- 1.3.2. Elimination of discrimination through sex and HIV education in primary and secondary schools. This education to be led by neutral groups, i.e. non religious groups. Education messages should be explicit, proper and positive. Make use of [community] spokesperson for health promotion message. Provide public spaces for better communications between the community and general public.
- 1.3.3. Law reform to protect the rights of LGBT couples, e.g. right to donate organ, property handling. Currently gay couples are not allowed to donate organ(s) to their partner.
- 1.3.4. Promote image and acceptance of condoms in the society.
- 1.3.5. Comprehensive sex education needs to be implemented. More education on HIV prevention to the general public.
- 1.3.6. Educate family members of MSM on HIV and MSM needs and issues. Besides, acceptance and support from family are important.
- 1.3.7. Training is needed for health care professionals, social workers, psychologists and teachers etc, on working with PLHIV and MSM. Positive attitudes of healthcare professionals when working with MSM/TG.
- 1.3.8. Reduced discrimination against MSM & PLHIV.
- 1.3.9. Legalization of gay marriage.
- 1.3.10. More activities provide and led by NGOs. Diversify services for MSM, e.g. MSM elderly home, gay churches, cafes etc, so that MSM can mingle and live normal social life.
- 1.3.11. Enhance and strengthen community ownership and responsibility of HIV prevention, e.g. more involvement of sauna owners.

1.3.12. Sustainable and long term funding from the ATF to NGOs for sustainable services and programmes.

1.3.13. Mental health services to support MSM in reducing risky behavior.

1.4. Strategic information

1.4.1. To improve sampling collection in the next HIV prevalence and risk behavioural surveillance among MSM by extending to different sub-populations.

1.4.2. More research on TG populations to understand their needs.

1.4.3. Research in MSM and drug use issues.

1.5. Strategy/policy

1.5.1. Include MSM in the consultation mechanisms, e.g. ACA.

2. Visions in 5 years

2.1. A more supportive environment with laws to protect the rights (e.g. anti-discrimination, right to marry) of MSM and the society is accepting MSM. Better understanding of homosexuality from the general public.

2.2. Diversified services to address the needs of MSM, e.g. for different age, counseling service, gay centre. There are more mainstream organizations to provide services for MSM. Besides, services available for MSM family members and partners.

2.3. Regular research/study on MSM with breakdown of population characteristics e.g. age strata, sub-groups.

- 2.4. Community to provide normal activities in order to enhance normal development of MSM, e.g. religious groups, organized activities.
- 2.5. Safer sex promotion with focus on normalization of condom use. Image of condom use become more positive.
- 2.6. Educated public, e.g. cashiers in convenient stores to sell condoms to those who are “underage.”
- 2.7. Keep the HIV prevalence low in MSM community.
- 2.8. Increased interventions provided by professionals, e.g. healthcare, social workers and teachers. More training for these professionals so that they are supportive to the MSM community.
- 2.9. Sex education included in primary school and in general study, which facilitate the normalization of different sexual orientations. Besides, the focus of sex education is not about suppressing sexual desire.
- 2.10. Healthcare workers in SHC are gay friendly. More gay friendly medical services (both in-patient and out-patient). A list of gay friendly doctors is available for reference.
- 2.11. More HIV clinics (in HA hospitals). A gay (HIV) clinic is established.
- 2.12. VCT coverage goes up to more than 80% and regular condom use (regular and casual partners) is more than 80%.
- 2.13. A comprehensive understanding to the needs of TG in terms of HIV-related service in order to reflect the situation. More NGOs provide support to TG.
- 2.14. HIV testing become universal and easily accessible, e.g. in community centres.

- 2.15. De-stigmatize MSM so that people do not associate MSM with HIV and label them as high risk group.
- 2.16. Integration of MSM service to the mainstream so that people with different background or orientation can use the same service.
- 2.17. Effective HIV treatments are available. A cure (treatment/vaccine) is found.
- 2.18. Access to earlier HIV treatment with better psychological and social support.
- 2.19. Healthcare workers who serve PLHIV had an increased understanding of MSM.
- 2.20. HIV infected MSM experience less pressure and has peer support group.
- 2.21. Increase APIs during TV prime time slot. Monitor the situation of discrimination in the mass media.
- 2.22. Society allows (tolerates) more diversified discussions on the [MSM] issue.
- 2.23. Better surveillance system through more regular research.
- 2.24. Provide information and support to bisexual women.
- 2.25. Working Group for HIV Prevention in MSM (in Red Ribbon Centre) has representatives / participation from various government departments.
- 2.26. The government new Community Care Fund will support HIV/AIDS programmes and services.
- 2.27. Information of MSM in other countries is available.
- 2.28. There is support for homosexuals from religious groups.
- 2.29. Better support Younger MSM (at school) by social workers.

- 2.30. Better support of MSM from their families.
- 2.31. Care and support services are available in different geographical locations.
- 2.32. A comprehensive one stop service for MSM and/PLHIV, e.g. testing, treatment and follow up etc. Service for PLHIV should facilitate a better quality of life.
- 2.33. Orientation information on the Internet for gay men who have just come out.
- 2.34. A conducive environment for safer sex, e.g. condoms are available in saunas, family size lubricants, condoms in different sizes. Condom packaging should be more attractive to young people.
- 2.35. Coming out of PLHIV who are also public figures to share their experiences.
- 2.36. Publicity of HIV/AIDS should be more proper and explicit.
- 2.37. More HIV prevention work on the Internet. Programmes need to cover private sex parties.
- 2.38. Generalized training on HIV for health care workers, teachers, social workers and parents etc, and for other government departments such as police.
- 2.39. All MSM are self responsible for safer sex and HIV prevention, they possess HIV knowledge and know how to refuse requests for unsafe sex.
- 2.40. More research about outcome/impact of HIV preventive measures.

3. Strategies which need to be continued or in place

3.1. Prevention

- 3.1.1. Strengthen interventions including peer education, internet outreach, support middle aged and older gay people, counseling, support to family/parents (for gay children to come out).
- 3.1.2. More outreach activities in internet and bars etc, and condom distribution. More education work should target younger MSM. Internet outreach should be more interactive such as live chat.
- 3.1.3. Provide mobile VCT services e.g. testing service in van. Ensure testing service coverage and quality, and encourage regular testing.
- 3.1.4. Peer education approach in prevention efforts, e.g. in the internet.
- 3.1.5. Use of new technology to promote new services and information on gay venues e.g. new massage parlour, bars, gym so as to facilitate HIV prevention and intervention activities.
- 3.1.6. More vision in planning and the use of health promotion approach in prevention.
- 3.1.7. Accessible condom vending machines.
- 3.1.8. Use of technology such as iphone for promotion/education.

3.2. Treatment

- 3.2.1. Continue with the existing service provided by SHS and hospitals.

- 3.2.2. Add more HAART with fewer side effects to the Drug Formulary. Keep low charges for the use of medical services.
- 3.2.3. Post-exposure prophylaxis (PEP) should be more accessible.
- 3.2.4. Set up a designated SHS for MSM and TG.

3.3. Care and support

- 3.3.1. Provide peer counseling service to MSM. Other forms of peer support and activities are needed. Include general public in service provision in order to increase their understanding on MSM and related issues.
- 3.3.2. Involvement of professional in interventions, e.g. social worker to provide counseling.
- 3.3.3. Provide information to gay men who just come out. Besides, gay/PLHIV who are out publicly will help encourage more people to come out.
- 3.3.4. MSM to increase their support to (MSM who are) PLHIV.
- 3.3.5. Segment service to address the needs of MSM with different backgrounds.
- 3.3.6. More support to family members of MSM PLHIV. More support to older and younger MSM.
- 3.3.7. Liaison is needed to bridge the communication between the community and government.
- 3.3.8. Provide more resources for follow up and counseling services after VCT.
- 3.3.9. Create PLHIV (who are MSM) social platform for their networking and education purpose.

3.3.10. Encourage acceptance by family.

3.3.11. More promotion to MSM about HIV/AIDS with positive messages such as availability of HAART and future hopes.

3.3.12. Set up gay friendly platform for their face-to-face communications for latest information and better education.

3.3.13. More services to TG including testing, medical service, information and resources.

3.3.14. Community specific empowerment programme by using life skills and coping skills training.

3.3.15. Counseling service for (MSM who are) drug users.

3.3.16. Empower care-givers in caring PLHIV (who are MSM).

3.4. Enabling environment

3.4.1. Strengthen anti-discrimination work to protect the rights of MSM, through law and education. Students, teachers, health care workers, police and social workers etc should be educated on this. A supportive environment will encourage MSM to disclose their identities.

3.4.2. Build a positive atmosphere which allows people to talk about sex-related message. Promote positive image of condom/condom use. Promotion of condom use among couples, but not just MSM.

3.4.3. Implementation of law to protect sexual orientation. Strengthen the implementation of DDO to protect the right of PLHIV. More efforts are needed to prevent health care workers' discrimination against PLHIV.

- 3.4.4. MSM are being stigmatized as having mental illness by the mass media and therefore, monitoring messages that are homo/LGBT-phobic behavior disseminated through the mass media is needed.
- 3.4.5. Programmes to promotion of harm reduction, at risk behavior and drug information should be addressed.
- 3.4.6. Change the Chinese name of “AIDS” into a less scary one.
- 3.4.7. Continue to disseminate (HIV) information on regular basis.
- 3.4.8. Include MSM and HIV topics in schools e.g. through assembly.
- 3.4.9. Mainstream NGO workers are not aware of MSM services and therefore communication needs to be improved, e.g. memo to circulate to the workers to keep them informed about the services. More mainstream NGOs to provide services to MSM.
- 3.4.10. Comprehensive sex education in primary and secondary schools. Issues such as HIV and sexuality should be discussed with open and positive attitude. Organize sex education carnivals and educate families on the issue. Provide workshops and publicities targeting parents.
- 3.4.11. Training to media workers, social workers and teachers etc on HIV and MSM issues. Produce a standard guideline for media to enhance reporting on MSM issues.
- 3.4.12. Legalization of same sex marriage.
- 3.4.13. More promotion of HIV/AIDS knowledge in the media. Use TV to advertise related promotion to MSM.

3.4.14. Increase HIV testing coverage in groups other than MSM, e.g. HIV test as part of routine body check-up.

3.4.15. More education to the general public to facilitate more discussion on MSM and HIV issues. A softer approach is encouraged when educating the public.

3.4.16. Education approaches to MSM should be more concrete and direct.

3.5. Strategic information

3.5.1. TG research and data collection should be continued and scale up.

3.5.2. MSM, (soft) drug use and risky behavior study should be carried out. Besides, more information on overseas gay parties to be available for HIV prevention and intervention activities.

3.5.3. Evaluation: comprehensive measurement of programme effectiveness, e.g. seek for inputs from sauna owners, bar owners etc.

3.5.4. Continual collaborations with NGOs.

3.5.5. Regular surveys done by the government to understand more in-depth information e.g. sexual behaviors

3.5.6. Research on teachers, health care workers on their views of MSM, to understand stigma and discrimination situation.

3.6. Strategy/Policy

- 3.6.1. Sustainable strategy and funding to support comprehensive MSM and TG work/service, with an aim to improve their quality of life and not just focus on condom use rate or number of VCT.
- 3.6.2. A strategy to address hard-to-reach MSM, e.g. young MSM, those living in remote areas etc.
- 3.6.3. Better support to NGOs.
- 3.6.4. Government takes the lead to coordinate the efforts in local responses, e.g. development of MSM strategy.
- 3.6.5. Cross departments and NGO collaborations for HIV prevention. Increase communications and liaison among community, NGOs and government.
- 3.6.6. A policy of anti-discrimination and sexual orientation.

4. Prioritized recommendations

The following recommendations were compiled based on the above discussions, agreed and prioritized by participants:

High priorities

- 4.1. Anti stigma & discrimination: law reform to protect the rights of MSM/TG, media to promote positive messages, education to the general public and training for service providers (relevant parties) regarding the MSM and TG communities.
- 4.2. Legislation of sexual orientation discrimination ordinance.

- 4.3. Education: sex and sexuality education in primary/secondary schools, training to service providers, use of multi-media for dissemination, promotion of positive image of MSM/TG and PLHIV, foster open and positive discussion about sex.
- 4.4. Comprehensive and diversified services that go beyond condom promotion and current outreach activities, such as longer term counseling & follow up, peer counseling, support for family and partners, self/identity acceptance.
- 4.5. Advocate a long term and visionary LGBT policy (same sex/TG marriage). This policy should be Government-led.
- 4.6. MSM/TG representative in ACA.

Medium priorities

- 4.7. Initiates research and provide services for TG.
- 4.8. Services are tailor-made to different market segments e.g. ages, PLHIV, those who are newly come out, TG, drug users and cross border travelers etc.
- 4.9. Adopt health promotion approach and go beyond HIV prevention.
- 4.10. Specialization of MSM/TG services, e.g. gay/TG service centre.
- 4.11. More concerns to MSM/TG who are PLHIV: anti-stigma efforts within MSM community, establish HIV infected MSM groups. Efforts should be comprehensive.
- 4.12. Increase VCT service coverage through, e.g. mobile service, and make testing regular.

Lower Priorities

- 4.13. Expand services in different geographical locations.

- 4.14. Sexual orientation mainstreaming of services with an ultimate goal of achieving equality.
- 4.15. Multi-sectoral/departments collaborations.
- 4.16. Initiate comprehensive evaluations of HIV programme for MSM/TG.
- 4.17. Increase research initiatives and behavioral surveillance that go beyond existing research agenda, e.g. reasons of (no) condom use and quality of life.

Session Summary for Male sex workers (MSW)

1. Current needs of the MSW community

1.1. Prevention

1.1.1. Increase VCT for MSW.

1.1.2. Reach out to MSW and educate them on safer sex, sexual health and HIV infection.

1.1.3. Address the diversified background of MSW (e.g. languages).

1.1.4. Educate and encourage both MSW and their clients on safer sex practices.

1.2. Treatment

1.2.1. Improve testing services: Change in NEP fee charging and protect clients' privacy in SHC.

1.2.2. Set up clinic for MSW for testing and other services.

1.3. Care and Support

1.3.1. More support to transgender MSW.

1.4. Enabling environment

1.4.1. MSW are able to find more clients and earn more money. Their working environment should be safe.

1.4.2. Avoid being arrested by, and seek equal and fair treatment from, Police.

1.4.3. Education to the general public on anti-stigma and elimination of discrimination.

1.5. Strategic information

1.5.1. More understanding and study on the MSW and HIV epidemiology.

1.5.2. More study through NGOs and internship programme to understand more about the MSW situations.

1.6. Strategy/policy

1.6.1. Law reform: police do not use condoms as evidence for prosecution.

1.6.2. Decriminalization of sex work.

1.6.3. Establish Red Light District so as to provide support and HIV prevention work.

1.6.4. One department to coordinate and formulate strategy.

2. Visions in 5 years time

2.1. Decriminalization of sex work.

2.2. Zero HIV infection/slow down in infection rate.

2.3. New services to target the needs of MSW. Services should follow their trend/changes.

2.4. Law reform.

2.5. Increase condom use rate.

2.6. MSW needs being met.

2.7. Decrease in HIV infection cases.

2.8. Free anonymous STI testing service for MSW who enter Hong Kong.

2.9. Provide support service to MSW PLHIV who enter Hong Kong.

2.10. MSW are not stigmatized.

2.11. Set up surveillance mechanism for MSW, e.g. include MSW into PRiSM or behavioral surveillance in CRiSP.

2.12. Universal and diversified sex education.

3. Strategies which need to be continued or in place

3.1. Treatment

3.1.1. Establish MSW specific clinic.

3.2. Care and support

3.2.1. More NGOs are established to provide diversified services to MSW.

3.3. Enabling environment

3.3.1. Universal access to sex education.

3.3.2. Strengthen anti-stigma efforts.

3.4. Strategic information

- 3.4.1. More platforms to explore surveillance process for MSW.
- 3.4.2. To collect more information and data by adjusting current surveillance mechanism.

3.5. Strategy/policy

- 3.5.1. Multi-sectoral efforts in decriminalizing sex work and HIV prevention.
- 3.5.2. Maintain the Working Group for HIV Prevention in MSM of Red Ribbon Centre and to consider establishing a MSW working group with more departments and service providers being involved.
- 3.5.3. Police not to use condom as evidence for prosecution.
- 3.5.4. A government-led response to MSW – anti-stigma, education, STI clinics.
- 3.5.5. NEP fee charging are waived/exempted in SHC.
- 3.5.6. Set up a platform to discuss the development of MSW and its strategy.

4. Prioritized recommendations

The following recommendations were compiled based on the above discussions, agreed and prioritized by participants:

High priorities

- 4.1. Law reform and enforcement: condoms are not used as evidence for prosecution; remove the law on solicits for any immoral purpose; decriminalization of sex work.

4.2. Universal and diversified sex education.

4.3. HIV infection and behavior surveillance, including (1) Regular surveillance such as PRiSM and CRiSP; (2) collect more MSW related information and data by adjusting current surveillance mechanism.

4.4. Anti-stigma effort that is led by the government.

Medium priorities (below priorities have the same scores, and therefore their priorities are the same)

4.5. Waive fee charging policy on NEP in SHC.

4.6. Government lead efforts in providing targeted education for MSW and their clients.

4.7. Provide support to MSW who are PLHIV.

Lower priorities

4.8. Encourage more organizations to provide services for MSW. Government to consider setting up a MSW working group.

4.9. Provide services including VCT for MSW who enter Hong Kong. Efforts are needed to address different ethnic languages.

4.10. Set up designated STI clinic for MSW.

Session Summary for People Living with HIV (PLHIV)

1. Current needs of the PLHIV community

1.1. Treatment and clinical care

- 1.1.1. Increase resources for more services including training for health care professionals and personnel such as doctors, nurses, psychologists and psychiatrists; provision of hotlines; increased number of clinics in locations, especially where there is no AIDS specific clinic such as Hong Kong Island and the New Territories.
- 1.1.2. Waiting time for medical follow up at HIV clinics is too long. Flexible clinical hours to suit PLHIV needs. Reduce the frequency of medical follow up for those PLHIV who are more healthy, but increase follow up for those who are in poor health conditions (provide outreach service at home if necessary).
- 1.1.3. Provide more information on HAART and their side effects so that PLHIV could make informed choice and decision on treatment.
- 1.1.4. Increase access to HIV testing and treatment services for migrant workers (e.g. Thai, Vietnamese. And NEP access to HAART is too expensive in Hong Kong.) Need more support (e.g. information) to enable migrant PLHIV to access to services when they return to their countries of origin.
- 1.1.5. A central platform to provide updated information (on the internet) for PLHIV such as psychosocial services provided by NGOs, knowledge on HAART etc. This can avoid confusion during service referrals.

- 1.1.6. Better connection between HA hospitals and ITC so as to improve continual patient care across different health institutions. (e.g. for PLHIV access to/refill HAART when hospitalized).
- 1.1.7. Knowledge/education on drug related conditions, e.g. lymphoma in addition to long term illnesses of HIV, side effects of HAART for PLHIV to make decision on treatment.
- 1.1.8. Enable PLHIV who are discharged from correctional services to continue their access to medical service.
- 1.1.9. Cross border collaboration to ensure access to medical treatment of PLHIV.
- 1.1.10. Maintain good quality health care services which should include comprehensive reproductive and sexual health support to infected males and females. Also, bearing in mind and observing the importance of cooperation between the private and public sectors

1.2. Community care and support

- 1.2.1. Psychological support to PLHIV and their partner (discordant couple), relatives and friends. Support from PLHIV peers is important.
- 1.2.2. One stop service to support the newly diagnosed and older PLHIV.
- 1.2.3. Services should directly address the needs of the community and they should be PLHIV centric.
- 1.2.4. Day centre for all PLHIV.

- 1.2.5. Address the needs of the newly diagnosed PLHIV, e.g. emotional support, support for their families.
- 1.2.6. Efforts to address the needs and concerns of PLHIV who use illicit drugs.
- 1.2.7. Support is needed for PLHIV who attend various clinics for medical follow up. Besides, PLHIV (e.g. those living in homes/institutions) may have problems to go to clinics for their medication, therefore support is needed to gain access to treatment.
- 1.2.8. Tailor made services / information addressing the needs of non Chinese PLHIV and the needs of older PLHIV (e.g. arrangements for those who are in elderly homes).

1.3. Enabling Environment

- 1.3.1. Health care workers (especially those who are not trained in the AIDS field) should have a positive attitude towards PLHIV and respect confidentiality of PLHIV patients. Vital to prevent discrimination in health care settings such as in hospitals.
- 1.3.2. School education and media campaign targeting the general public to reduce stigma and discrimination in the society.
- 1.3.3. Sex education for the elderly.
- 1.3.4. Government promotion on early HIV testing and related health promotion messages should not be stigmatizing.
- 1.3.5. Promote acceptance of PLHIV in the society. Empower PLHIV and promote their self-acceptance.
- 1.3.6. Training on respecting PLHIV privacy and disclosure is needed.

1.4. Strategic information

- 1.4.1. Set up platform for NGOs and Government for on-going communication and discussion.
- 1.4.2. Research on Post-Exposure Prophylaxis and set policy.

1.5. Strategy/Policy

- 1.5.1. Universal access to services including social, medical and peer support.
- 1.5.2. More community participation and consultation in government policy and service development.
- 1.5.3. Improve human rights including privacy and employment rights, e.g. exclusion of HIV testing in pre-employment body checks and rights to buy insurance not compromised by HIV positive status.

2. Visions in 5 years time

- 2.1. Reduced discrimination against and increased acceptance towards PLHIV among the general public. An increased effort in stigma reduction among the general public through mass media.
- 2.2. More clinical services are available that PLHIV could access to early HAART treatment and take shorter waiting time for services.
- 2.3. A support centre for PLHIV is set up. Support services are available for relatives/friends of PLHIV.
- 2.4. Translation service is available for non-Chinese PLHIV in general.

- 2.5. Normalize HIV testing. Normalize PLHIV and improved health conditions under current treatments.
- 2.6. Increased PLHIV participation, especially in the process of policy-making, and in other forums and meetings. An increased transparency in policy-making, government and statutory bodies, with real PLHIV participation in the process. There should be NGOs and PLHIV representative in ACA. Achieve zero discrimination against PLHIV.
- 2.7. Universal sex education. More humanized public education in primary/secondary schools.
- 2.8. Participation of general public is important.
- 2.9. Young people are educated more on anti-stigma and sex education.
- 2.10. Older PLHIV has the freedom to choose nursing homes (elderly homes would accept and admit PLHIV clients).
- 2.11. Religious groups are more open to accept PLHIV. Health care workers and staff from CSD have more training on HIV knowledge.
- 2.12. More funding from the ATF to programmes/services.
- 2.13. Personnel from the mass media are well trained on knowledge in HIV prevention and anti-stigma.
- 2.14. Information is available for PLHIV who is new immigrant or elderly.
- 2.15. An improvement in HAART and better medical care. PLHIV health conditions are improved and therefore, reduce the frequency in medical follow up.
- 2.16. Increased resources to support psycho-social needs of PLHIV, e.g. those with difficulties in their daily living would require outreaching home services.

- 2.17. More service points for PLHIV, including Hong Kong Island. Universal access to all medical services.
- 2.18. A platform to facilitate communications between medical practitioners who provide care and treatment support to PLHIV, e.g. side effect of drug, knowledge on drug interactions.
- 2.19. Provision of one stop service and holistic care to PLHIV (and their carers), including mental health, HAART, STI treatment, family planning, screening for other medical conditions, knowledge and decision on the use of HAART, skills in disclosure of HIV status.
- 2.20. PLHIV enjoys the right of autonomy, e.g. in treatment and service plan. Informed choice should be encouraged. Services are more humanized (e.g. PLHIV addressed by names instead of coded numbers) and PLHIV centric.
- 2.21. Adopt harm reduction approach in dealing with safer drug use.
- 2.22. More research is done on Post-exposure prophylaxis (PEP) and clear policy and guideline on its use.
- 2.23. A fundamental human rights based environment, in addition to anti-stigma and discrimination.
- 2.24. Inclusion of PLHIV by the society and due respect to their human rights. Effective law enforcement to protect human rights of PLHIV across government, NGOs and other employers (e.g. PLHIV is not required to release their medical history for employment).
- 2.25. Address the needs of different age groups (e.g. for younger and older PLHIV) and background, e.g. early screening services for local workers returning from overseas); access to screening/support/medical services.

3. Strategies which need to be continued or in place

3.1. Clinical care and treatment

- 3.1.1. Provide early HAART to PLHIV and strengthen their drug adherence. Information should be available on the benefits of early treatment. Charges of HAART should be kept at low cost and affordable to PLHIV. HAART should continue to be listed in the Drug Formulary. Moreover, HAART should be available in all hospitals.
- 3.1.2. Increase the number of doctors, AIDS clinics (in different locations), and other health-related services such as dental care and clinical psychologists. Expand the scope of medical services into a comprehensive one such as providing male and female health checks, family planning, screening for other medical conditions etc.
- 3.1.3. Increase education to PLHIV and the general public on Post-exposure prophylaxis (PEP).
- 3.1.4. Set up a platform for PLHIV to access the latest HIV-related information, such as treatment and NGOs services.
- 3.1.5. Empower PLHIV to make various decisions such as those related to treatment and suitable services.
- 3.1.6. More promotion on early testing is needed so as to encourage prompt access to care and treatment.

3.2. Community Care and support

- 3.2.1. NGOs need to increase counseling and support services to PLHIV and their partners/relatives. Additional resources are needed to strengthen those services.

- 3.2.2. Tailor made services to PLHIV with special needs, e.g. food on wheel, community based services and occupation therapy to older PLHIV.
- 3.2.3. Resources to NGOs need to be increased for holistic services.
- 3.2.4. Translate information from PLHIV websites (such as positivevoice.org) or make use of iPhone app to provide HIV information for MSM and supports from peers and counseling services.

3.3. Enabling environment

- 3.3.1. More training is needed for health care workers on protecting privacy of PLHIV. Besides, there should be education for personnel from the Hong Kong Correctional Services and prisoners on anti-discrimination.
- 3.3.2. Social Welfare Department should have a selection of institutions/homes that fits the needs of PLHIV. More education is needed in these settings to promote non-discriminatory and supportive environment.
- 3.3.3. More education to the general public and employers to reduce discrimination and protection of privacy by observing Disability Discrimination Ordinance and Personal Data (Privacy) Ordinance. Besides, educate PLHIV on these aspects to raise their awareness on their basic rights.
- 3.3.4. Allocate resources to support NGOs workers to attend overseas AIDS conferences to gain knowledge and skills, and for better networking. Should consider hosting international AIDS conference in Hong Kong.
- 3.3.5. Encourage medical practitioners to work in the AIDS field and educate them about positive living as well as on anti-discrimination.

- 3.3.6. Improvement of the capacity of HIV clinicians to cater for various medical needs of PLHIV so that PLHIV are not required to disclose their HIV status unnecessarily for referrals to different organizations.
- 3.3.7. Increase the promotion of positive messages about PLHIV by using various media channels. Promote acceptance of PLHIV among religious bodies.
- 3.3.8. AIDS and sex education in all schools levels. Government APIs should go beyond condom promotion, but also on anti-discrimination and promotion of human rights. Besides, there can be AIDS awareness month in Hong Kong to ensure a more sustainable message.

3.4. Cross sectors collaboration

- 3.4.1. There should be better collaborations among government departments in cross border issues.
- 3.4.2. Private laboratories can serve an important role in service referral to HIV positive cases. Promotion and communications with private laboratories are needed. Provide counselling upon the receipt of testing results. Government should provide resources to strengthen the capacity of these laboratories.
- 3.4.3. Improvement of linkage between AIDS clinics and NGOs for a one-stop service for PLHIV.

3.5. Strategic information

- 3.5.1. Upgrade all services in order to match the best international standard.

3.5.2. Conduct more research on the use of Post-Exposure Prophylaxis and improve its accessibility.

3.6. Strategy/policy

3.6.1. Active involvement and participation of PLHIV in formulating policies.

3.6.2. Develop PLHIV centric human rights Charter. A PLHIV centered strategy is needed to deal with stigma and discrimination. The strategy needs to be coordinated and implemented with the involvement of different government departments.

3.6.3. Enforcement of laws such as Disability Discrimination Ordinance and Personal Data (Privacy) Ordinance in protecting PLHIV needs to be more proactive.

3.6.4. HIV care guidelines for healthcare personnel needs to be updated.

4. Prioritized recommendations

The following recommendations were compiled based on the above discussions, agreed among and prioritized by participants:

High priorities

4.1. Medical services: increase resources for support services and clinics; increase access points and access to HAART; affordable treatment including STI and Post-Exposure Prophylaxis (latest drugs in Drug Formulary); increase PLHIV participation in treatment decisions; increase numbers of health care personnel and training (such as counselling skills); provide holistic care including family planning, mental health, counselling, dental care; special attention to sub-populations including elderly, migrant workers

(from Hong Kong to other countries), young people, ethnic minorities, women and discordant couples. Access to services is the right of PLHIV.

- 4.2. Coordinated efforts: referral and service linkage to improve access to services; increase newly diagnosed PLHIV access to NGOs services/information; strengthen the linkage among clinics/hospitals/private laboratories and NGOs; increase support services to care-givers/family members and partners/spouses.
- 4.3. Increase PLHIV representation & participation in strategy and policy development, and also in ACA. Increase the transparency of strategy and policy development. Policy should be PLHIV centric. NGOs should be represented in ACA. Besides, ACA members/policy makers are encouraged to reach out to the PLHIV community.

Medium Priorities

- 4.4. Anti-stigma & discrimination: increase education for medical service providers, correctional services personnel, any other service providers (homes, employment) and corporate. Increase education at all school levels and make use of different media channels to educate the general public.
- 4.5. Facilitate a fundamental human rights based environment, in addition to anti-stigma and discrimination.
- 4.6. A comprehensive needs assessment to understand PLHIV stigma, socio-economic status, sexual behaviour so as to advice the development of future strategy. Conduct this on a regular basis, e.g. every 3 or 5 years. This should be a cross-academia collaboration.

Lower Priorities

4.7. Organize an international AIDS conference in HK.

4.8. Law enforcement: Enforce HIV related ordinances in a proactive manner, instead of passively waiting for complaints.

Session Summary for Sex workers (SW)

(Note: The session originally scheduled to be on Female sex workers (FSW) but participants requested and agreed to include discussion on both female and male sex workers, dubbed as Sex workers.)

1. Current needs of the SW community

1.1. Prevention

- 1.1.1. Raise safer sex awareness, which is relatively low, especially among young female sex workers.
- 1.1.2. Enhance promotion/education among female sex workers (e.g. on risk of STIs and availability of services) and their clients (e.g. older clients on condom use). More promotion of knowledge of legal issues is needed.
- 1.1.3. Promotion of consistent condom use among sex workers even with their regular clients and partners.
- 1.1.4. More promotion on HIV/STI VCT is needed. Besides, the focus of promotion can be on regular checkup and testing.
- 1.1.5. Increase access to free condoms and greater variety of condoms available, so as to serve as incentives for more condom use among clients.
- 1.1.6. Increase coverage of service delivery, e.g. VCT in Mainland China to encourage testing. Also, cross border prevention efforts are needed.
- 1.1.7. Scale up outreach efforts to increase programme coverage (currently less than half of the populations is covered).

- 1.1.8. Tailor-made programmes and services to address the diversity of sex work, e.g. younger sex workers, compensated dating, karaoke hostesses. Those who are in these types of work may not perceive themselves as sex workers.
- 1.1.9. Sex workers who are in prison and illegal sex workers are difficult to reach. Their risks may be higher (anal sex without condoms among male sex workers) and therefore need interventions. Resources need to be increased to address their needs. VCT services should be provided to sex workers who are in prison. Collaborations are needed among different government departments in order to provide services to sex workers who have been arrested.
- 1.1.10. Education on Post Exposure Prophylaxis to reduce HIV infection.

1.2. Treatment

- 1.2.1. More user-friendly opening hours (such as 24 hours services or flexible opening hours) in SHC needed to cater for the diverse working hours of sex workers so as to improve access to services. Besides, shorten the waiting time to increase usage.
- 1.2.2. The current fee charging policy to NEP using SHC is a barrier in accessing to the services. NEPs (e.g. sex workers from Mainland China or other ethnic minorities) found it difficult to pay for full fare due to the high cost. For sex workers who are tested positive for HIV or other STIs, some of them do not go to SHC.
- 1.2.3. Another barrier sex workers' access to SHC service is that sex workers' privacy is not adequately respected when using the service, which can make sex workers feeling uncomfortable.

1.3. Care and Support

- 1.3.1. Access to support and care services to those who are tested HIV positive, especially in the areas of [HIV] knowledge and medical treatment.
- 1.3.2. Address the needs of non-Chinese female sex workers including language barriers and the provision of suitable medical services.

1.4. Enabling environment

- 1.4.1. Sex workers themselves need to be alert of health implications arising from entertaining requests for unsafe sex with better financial returns. Besides, skills on dealing with various “relationships” with clients (e.g. occasional clients, regular clients, boyfriends, partners etc.) to be provided (as sex workers’ perception on the nature of “relationship” will affect their decision of whether to adopt safer sex practice).
- 1.4.2. “On-the-job” training is needed, particularly training that decrease their vulnerabilities to HIV infection; enhance opportunities to engage in other employments; increase knowledge on legal issues. Programmes and services should target “newer” female sex workers and new immigrants, e.g. provision of orientation programme, life skills, and regular venues to be in place for them to gain access to information.
- 1.4.3. Use of mass media for prevention programme to encourage more open and socially acceptable discussion on sex and safer sex. However, use of printed media instead of via TV alone is needed to increase access to sex workers.

- 1.4.4. Sex workers need a safe working environment to protect their personal safety, e.g. there were numerous robbery cases against women who worked in “one-woman brothel.”
- 1.4.5. Not to classify people into “high risk group,” since it will encourage stigma. Put focus on people’s behaviours.
- 1.4.6. Sex education should be made universal. The focus should target high risk behavior and reduce stigma. Perceive female sex workers and male sex workers as one community, instead of separating into two groups.

1.5. Policy/Strategy

- 1.5.1. Re-organize the current policy on targeted HIV prevention to the general population or young female sex workers. Health promotion should be clear and to the point.
- 1.5.2. Regulation of sex work, e.g. licensing and comprehensive sexual health services.
- 1.5.3. Educate the police on right issues of sex workers.
- 1.5.4. Change the existing police practice of using confiscated condoms and lubricants as evidence in prosecution, which render distribution and consistent use of condom ineffective.
- 1.5.5. Strengthen and improve law enforcement against those clients who have (unprotected) sex without workers’ consent.

2. Visions in 5 years time

- 2.1. Zero HIV infection in sex workers’ community.

- 2.2. Increased programme coverage and expanded efforts.
- 2.3. Those who are living with HIV are supported, both financially and socially.
- 2.4. Sex workers' clients won't suggest "not to use condom."
- 2.5. Increased education of sex workers' clients so that they understand how to protect themselves and the sex workers. Besides, clients would know be aware of risks and know more about risk management.
- 2.6. Stakeholders such as sex workers' clients, pimps or mediums had improved HIV awareness.
- 2.7. Everyone knows how to use condom.
- 2.8. Risk education is provided to younger sex workers (both male and female), e.g. those involved in compensated dating.
- 2.9. Increased discussions on sex in the society.
- 2.10. Reduced stigma/[less] threatening [approach] in education.
- 2.11. Normalized HIV prevention and increased acceptance. Reduced stigma against sex workers (both female and male). When they are not stigmatized as high risk groups, they have good knowledge on safer sex and in advantageous position to help other sex workers by sharing their experiences.
- 2.12. Sex workers have increased condom use with their regular sex partners. Increase condom use in oral and anal sex.
- 2.13. Sex workers have improved knowledge on safer sex and availability of medical services.

- 2.14. More resources are available to serve the mobile populations.
- 2.15. More appropriate and in-depth prevention, e.g. when targeting female sex workers, prevention does not only focus on condom use, but more details on such as HIV knowledge, reproductive medicine which will increase their motivation and alertness. These preventions will be taught in all schools.
- 2.16. Reach out young females involved in compensated dating through internet and girls' homes.
- 2.17. Sex workers are empowered to refuse unsafe sex. They are regarded as partners in HIV prevention instead of service clients.
- 2.18. Enhanced research efforts to address insufficient data on male sex workers.
- 2.19. Sex education to the general public to facilitate general and open discussion on sex issues and safer sex. Sex education to sex work leaders/mamasan/pimps about unsafe sex and proper sexual health knowledge.
- 2.20. Targeted efforts among more mature female sex workers and clients since they are less motivated in condom use due to their health beliefs (i.e. older age and fearless of death; not infected [by HIV/STIs] without using condoms for years).
- 2.21. SHC provides service in more friendly and non-discriminatory ways, regardless of their status/background. Staff members improve their attitude to the users.
- 2.22. SHC provides standardized body check and sexual health service for all females, e.g. all sex workers are offered PAP smear.
- 2.23. Separated and designated health services for sex workers in order to reduce the waiting time of consultation and follow up.

- 2.24. Scrapped NEP fee charging policy when using SHC.
- 2.25. Condoms and lubricants are not used as evidence for prosecution.
- 2.26. Law enforcement, e.g. fewer people from other countries are allowed to work as sex workers in Hong Kong.
- 2.27. Decriminalization of sex work to reduce discrimination of the community and improve their access to services.
- 2.28. Criminalise sex workers' clients (but not the workers) who had sex with sex workers without using condom, without the worker's consent.
- 2.29. HIV/AIDS is put as a prioritized area in Government's health policy.
- 2.30. Invisible/hidden populations would surface due to more supportive (legal) environment.

3. Strategies which need to be continued or in place

3.1. Prevention

- 3.1.1. Continue to involve peer educators in prevention efforts. Strengthen training for peer educators. Allocate more resources to peer educators/projects so as to provide more information to the community.
- 3.1.2. Distribution of free and good quality condoms and lubricants.
- 3.1.3. Provide on-the-spot HIV testing service (service providers need to be well prepared and fully equipped for such).
- 3.1.4. Continue and expand outreach efforts, free VCT and other medical services.

- 3.1.5. Tailor made health information and medical services to all sex workers including drug use, STIs, social life, mental health, reasons for getting tested, related treatment services and where to get help.
- 3.1.6. Improve education on risks of diseases infection and make use of real life case stories for illustration of risks, but not to use fear approach to scare people.
- 3.1.7. Focus of prevention should be high risk behaviours but not high risk groups.
- 3.1.8. Promote use of condoms with partners of sex workers.
- 3.1.9. Provide HIV/AIDS education for prisoners and condoms in prisons.
- 3.1.10. Compulsory for sex workers' clients to use condoms.
- 3.1.11. Promotion through multi-media channels, especially collaborations with adult [sex] websites. Make use of the Internet to access to female sex workers. Education is also needed for venue owners and workers.
- 3.1.12. Increase financial support to NGOs from the ATF such as increasing mobile VCT service using car and strengthening counseling elements.

3.2. Treatment

- 3.2.1. Improvement of services provided by clinics (e.g. SHC, Family Planning Association Hong Kong) including better attitude of health care workers, comprehensive health checkup service instead of simply providing STI treatments in SHC. Besides, NEP fee charging policy should be the same as Eligible Persons due to the service needs of the community.

3.3. Care and support

- 3.3.1. More understanding on the reasons behind risk taking behaviours and follow-up with counseling service.
- 3.3.2. Collaborations with Mainland China to cover the needs of sex workers and cross border clients such as medical follow ups in Mainland China.

3.4. Enabling environment

- 3.4.1. Reduce stigma attached to HIV/AIDS and sex workers. Increase bargaining power of the community for safer sex.
- 3.4.2. More forums/platforms to enhance multi-disciplinary discussion.
- 3.4.3. Promotion and publicity messages should be more proper and appropriate.
- 3.4.4. Sex education should start at a younger age. Sex education should be comprehensive and make use of websites for such.
- 3.4.5. More education towards the general public and targeted population. Spread health promotion messages through mass media such as featured documentary and police reports. Sex workers' clients should remain as the targeted population.

3.5. Strategic information

- 3.5.1. More qualitative research studies are needed to gain in-depth understanding and help set evidence-based strategy.

3.6. Policy/Strategy

- 3.6.1. More communications and collaborations among different government bureaux / departments, e.g. emergency service, police, education bureau.
- 3.6.2. ACA has the role to advocate for reducing barriers, stigma & discriminations of the community in accessing relevant services in different settings.
- 3.6.3. Law and policy reform to protect the rights and social welfare of sex workers. Involving relevant Government departments and bureau, such as Police and Social Welfare Department.
- 3.6.4. Protection from law, i.e. condoms not being used as evidence of prosecution.
- 3.6.5. Decriminalization of sex work.

4. Prioritized recommendations

The following recommendations were compiled based on the above discussions, agreed among and prioritized by participants:

High priorities

- 4.1. Law enforcement: such as not using condom as evidence in prosecution; strengthen and improve law enforcement against those clients who have (unprotected) sex without workers' consents.
- 4.2. Targeted education for younger sex workers such as those involved in compensated dating; cross border sex workers and their clients; those who are in prisons; illegal sex workers; mature clients; sex workers who are new to the industry; non Chinese sex worker; new arrivals; industry personnel such as pimps, keepers.

- 4.3. HIV education should extend to the general public and in schools/universities. Sex education (including safer sex) should be tailor-made, explicit, proper, open-minded and positive. Make use of different and appropriate media channels such as Internet, TV and newspapers.
- 4.4. Cross government departments and regional collaboration on advocating HIV issues (e.g. Post Exposure Prophylaxis education). ACA has the role to advocate for reducing barriers, stigma & discriminations of sex workers in accessing relevant services in different settings.

Medium priorities

- 4.5. Law reform: decriminalize sex work and associated laws such as soliciting for immoral purpose.
- 4.6. ATF: scope of funding for VCT service should be beyond test kits, and to include other supporting tools & services.
- 4.7. Social Hygiene Clinic needs to be more user friendly; exempt NEP fee charging policy; ensure users' privacy; provide comprehensive sexual health service; set up clinic for sex worker.

Lower priorities

- 4.8. Continue to reduce HIV-related stigma and discrimination and strengthen these works.
- 4.9. Widen education scope to include mental health, life skills, "relationship education", occupation skills and resources for sex workers.
- 4.10. Adopt peer education approach in HIV prevention.

4.11. Continued provision of free condoms and lubricants.

Session Summary for Sex worker clients (SWC)

(Note: The session originally scheduled to be on Clients for female sex workers (FSWC) but participants requested and agreed to include discussion on clients for both female and male sex workers, dubbed as Sex worker clients.)

1. Current needs of SWC community

1.1. Prevention

- 1.1.1. Change SWC's perception about condom use – not only with sex workers but also with their partners.
- 1.1.2. Reach out to cross border travelers and provide more services and promotion.
- 1.1.3. Government to help NGOs to promote their work e.g. NGOs' hotline service.
- 1.1.4. Increase programme coverage - provide more free VCT service, outreach to sex websites/border checkpoints, more condom distribution in convenient/easy accessible locations.
- 1.1.5. Identify hidden SWC and reach out to them for more HIV prevention.
- 1.1.6. Raise awareness on HIV infection and STI.

1.2. Treatment

- 1.2.1. SWC do not have much understanding about the services in SHC and therefore, more promotion is needed.
- 1.2.2. The waiting time for result of HIV test is too long in SHC which created psychological pressure and barriers to the client when considering the use of service.

1.3. Care and support

- 1.3.1. Set up self help groups for SWC.
- 1.3.2. Provide counseling service which would address various issues such as SWC livelihood problems, which may in turn reduce their risky behaviors.
- 1.3.3. Counselling during VCT service should also focus on SWC psycho-social/family stress issues.

1.4. Enabling environment

- 1.4.1. More anti-stigma effort is needed. Sex is a taboo within the community and people rather not to talk about this, which stops people from getting tested. Setting up a red light district is needed to reduce stigma and psychological pressure (but there is contrary view that the establishment of red light districts will further stigmatise sex work and seeking sex service).
- 1.4.2. Schools should provide sex education. Teacher has a major role in this to enable young people who have risky behavior to gain more knowledge.
- 1.4.3. Use of mass media to provide sex education and include safer sex information.
- 1.4.4. Protect privacy and provide comfortable environment for clients when using testing service.
- 1.4.5. Eliminate discrimination against SWC and reduce stigma against AIDS.
- 1.4.6. AIDS workers should have good understanding on SWC culture and their languages.

2. Vision in 5 years time

- 2.1. More sex education at school and promotion through the use of multi-media such as radio. Promotion should be explicit, in-depth and with relevant content. Besides, make sex education universal.
- 2.2. Universal access to HIV testing: e.g. provide voluntary HIV and syphilis testing along with testing for illicit drugs at school/anti-drug promotion; increase testing locations.
- 2.3. Sale of condoms: packing should be flexible e.g. individual condom pack.
- 2.4. Reduce stigma by focusing on risky behaviour but not individual sub-populations.
- 2.5. Every client uses condom 100% (including oral sex) and has health check regularly.
- 2.6. Decriminalize sex work.
- 2.7. Survey to monitor the latest situation of SWC behavior.
- 2.8. Reduce stigma – being clients/ receiving condoms doesn't mean one has HIV.
- 2.9. Provide services/programmes in Guangdong province for Hong Kong men who cross the border.
- 2.10. Lower the age of consent on sexual behavior in order to help those who are young and sexually active to access to sexual health services.
- 2.11. Include HIV and safer sex information in the tourism brochure.
- 2.12. Provide one-to-one counseling service to clients.
- 2.13. Expand the provision of VCT service by increasing more understanding about SWC situations and provide more information.

- 2.14. Increase collaborations among different government departments, e.g. joint condom promotion in Macau and Shenzhen.
- 2.15. More resources for programmes/services at cross border check-points and volunteer work.
- 2.16. Zero HIV infection/reduced HIV infection rate.
- 2.17. Increase in HIV testing rate.
- 2.18. Universal HIV and syphilis testing in different settings/means.
- 2.19. A supportive environment in which visit to sex worker is not a taboo.
- 2.20. Increase the time for VCT (more than 30 minutes).
- 2.21. Target young people through the internet and make use of multi-media for education.
More education to schools to reach out to students who visit sex workers.
- 2.22. Cross-government departments collaboration and work directly with NGO to provide more services.
- 2.23. Increase training to volunteers.
- 2.24. Increase understanding on HIV prevalence in the SWC community.
- 2.25. SWC has increased knowledge on HIV/STI.

3. Strategies which need to be continued or in place

3.1. Prevention

- 3.1.1. Educate clients the knowhow of wearing condom.

- 3.1.2. Accessibility to condom should be made more easily in order to reduce embarrassment e.g. installation of condom vending machines, good quality condom, more distribution.
- 3.1.3. Increase accessibility to VCT testing services including: increase promotion; increase workers understanding to SWC culture; flexible opening hours and protect privacy. More counseling service should be provided to SWC to encourage HIV testing.
- 3.1.4. Health promotion and publicity should involve more volunteers.
- 3.1.5. Include STI prevention into HIV prevention work.
- 3.1.6. Increase outreach on the internet and cross border areas.

3.2. Treatment

- 3.2.1. Expand HIV testing in more geographical locations. Integrate HIV testing service in other healthcare settings such as private clinics, as routine test so that clients' partner can access to HIV testing service.
- 3.2.2. SHS /NGOs opening hours should be more flexible and convenient, e.g. after office hours, weekend.
- 3.2.3. Provide comprehensive body check so as to increase the intention to get tested for HIV, (but there is contrary view to this point).

3.3. Care and support

- 3.3.1. Reduce stigma among clients in order to reduce their misconceptions on HIV transmission.

- 3.3.2. Reach out to invisible community through general public education.
- 3.3.3. Increase training to peer educators.
- 3.3.4. NGOs to strengthen the link to government, so as to stream-line referral system in a way to facilitate SWC access to services.
- 3.3.5. Provide support services to SWC and their partners.
- 3.3.6. Counseling service and information on positive living is needed for PLHIV, more support is needed to their families.

3.4. Enabling environment

- 3.4.1. Increase volunteer participation to synergize publicity effort
- 3.4.2. Everyone practises 100% condom use in Hong Kong.
- 3.4.3. AIDS education, including anti-stigma as well as the use of condom, should be part of the curriculum in school. Provide face-to-face counseling to students.
- 3.4.4. Safer sex promotion together with Hong Kong Tourism Board and the Immigration Department.
- 3.4.5. Provide programme/services to those “Walk of freedom” from Mainland China.
- 3.4.6. Promotion and publicity should be sustainable. Use interactive approaches.
- 3.4.7. Sex education should target different age groups such as youth and elderly.
- 3.4.8. Universal education so as to reach out to hidden SWC populations.

3.5. Strategic information

3.5.1. Survey/surveillance on SWC is rarely done. It should be done in every 2-3 years.

3.6. Strategy/policy

3.6.1. More cross border collaborations between Hong Kong and Mainland China. Regular HIV promotion to be done by government. Increase cross department collaboration, e.g. Immigration and Police in HIV prevention.

3.6.2. Funding is needed for more reasonable human resources allocation.

3.6.3. Inclusion of government departments from Mainland China in promotion activities.

3.6.4. Government to allocate more resources to NGOs and CBOs for their work, e.g. provide more VCT service.

3.6.5. Set up of red light district in order to make sure workers are healthy. However, alternative view is that it would further stigmatise sex work and seeking sex service.

3.6.6. Government to take the lead in publicity about HIV (and related).

3.6.7. Government to provide funding to support AIDS work within the region. Besides, the government can facilitate NGO works within the region.

3.6.8. Government to formulate anti-stigma strategy to eliminate discrimination against SWC and misconception on HIV.

3.6.9. Government to subsidize private practitioners to provide HIV testing and other health check-ups, which can motivate SWC testing behavior.

4. Prioritized recommendations

The following recommendations were compiled based on the above discussions, agreed and prioritized by participants:

High priorities

- 4.1. Increase resources from government to NGO programmes and services.
- 4.2. Testing: increase promotion, increase testing points (including private and public clinics); increase free services; increase clinic opening hours; protect users' privacy and provide user friendly service.
- 4.3. Strengthen sex education in schools (including safer sex and anti-stigma) and to include it in the curriculum; provide voluntary testing service at schools.
- 4.4. Cross border collaborations among Macau, Shenzhen and Guangdong. Resources come from Hong Kong for programme implementation. Health service/promotion to "walk of freedom" Mainland China travelers and other cross border travelers.
- 4.5. More anti-stigma education.

Medium priorities

- 4.6. Use of multi-media for promotion: internet, TV, radio; in-depth education; promote NGO services; use of peer education approach; increase awareness on STI & AIDS.
- 4.7. Promote 100% condom use, including sex with SWC partners and sex workers.
- 4.8. Cross-departments collaboration, e.g. Immigration Department, ACA and Hong Kong Tourism Board.

4.9. Law reform: decriminalization of sex work; lower age of consent of sexual behavior.

Lower priorities

4.10. Conduct surveillance and research in every 2-3 years.

4.11. Set up SWC support group.

4.12. Support services to SWC families and partners, including counseling and case work.

4.13. Improve access to (good quality) condom, e.g. condom vending machine, sale of single piece of condom (in addition to packs of 3-12 condoms).

Session Summary for Youth at risk

1. Current needs of Youth at risk community

1.1. Prevention

1.1.1. Increase outreach services to reach out to young people including ethnic minorities.

1.1.2. Improve access to condoms.

1.1.3. Prevention programmes for EM sex workers who are very young. It is noted that some clients of sex workers came from different ethnicities.

1.2. Treatment

1.2.1. Increase accessibility to SHC service by having a more youth-friendly environment and ensuring positive and supportive attitudes of healthcare workers.

1.3. Care and support

1.3.1. Increase number of peer counselors and their training.

1.3.2. Service centres should be in different areas, with staff who could speak different ethnic languages.

1.4. Enabling environment

1.4.1. Provide sex and AIDS education for ethnic minorities.

1.4.2. Schools should open up to other organizations for the delivery of sex education.

- 1.4.3. Nurture a supportive environment e.g. in school, so that it is easier for youth to talk about their needs.
- 1.4.4. Sex education should focus on concepts and values, not just on safer sex. Funding for sex education should be sustainable. Make use of mass media (including internet) to deliver sex education (with correct messages).
- 1.4.5. Youth at risk should not be stigmatized (Note: e.g. police would post messages on the internet that contain moral judgment on compensated dating. Such messages may drive the girls to underground and therefore less accessible by service providers.).
- 1.4.6. Regard Youth as a “stand alone” population, but not to incorporate into other at-risk communities. It is because youth requires different sets of intervention skills.
- 1.4.7. There are service gaps for youth in general. More comprehensive efforts are needed, e.g. to address their values, developmental stages, drugs, relationships education, social life, perception on health and empowerment. They should be cultural sensitive. Include parents/family in the process.
- 1.4.8. More professional training is needed to empower professionals (e.g. social workers, teachers, health care workers) to deal with youth issues directly and equip them with necessary skills.
- 1.4.9. Sustainable funding for NGO work.
- 1.4.10. Increase support to parents.

2. Visions in 5 years time

- 2.1. Sex education to have a focus on “relationship.” Besides, sex education should be compulsory, promote positive values, include negotiation skills and discuss different issues such as sex work. Sex education topics should match the needs of youth.
- 2.2. Surveillance which collects data on youth-centric risky behavior (including sex and drug). Youth-related policy should respond to the special needs of youth.
- 2.3. Youth workers and educators have increased their skills in sex education.
- 2.4. A youth hotline to deal with different sexual health issues, such as compensation dating.
- 2.5. Society, including welfare and education sector, should encourage and support a more open atmosphere. Provide training to encourage the public to listen to young people.
- 2.6. More involvement of peer educators as they are more influential on their peers; and messages from peers may be more positively perceived and accepted.
- 2.7. Employ EM staff to implement programmes and services in their communities. More drug treatment centre for EM, and to include HIV treatment and education in the centre.
- 2.8. A community-based sexual health youth (testing) centre is set up.
- 2.9. Parents/relatives are educated on sex education.
- 2.10. Youth can develop ability and skills to make well rounded decisions.
- 2.11. Nomenclature of the session on “Youth at risk” should preferably be modified to simply “Youth” for the sake of avoiding unnecessary stigma and participation of community members.

2.12. Youth develops right attitude towards condom and condom use. Increase awareness and concerns on their sexual health. They have self efficacy in making decision relating to sex.

2.13. Sex education (including HIV/STI and safer sex) in school is more prominent and become a core component of the school curriculum.

3. Strategies which need to be sustained or in place

3.1. Prevention

3.1.1. Keep STI prevalence low in the youth population.

3.1.2. Strengthen effective HIV knowledge delivery to youth.

3.1.3. Youth can have easier access to condoms, and barriers should be reduced. (Note: Youth is not aware about their rights e.g. rights of buying condoms.)

3.1.4. Increase outreach efforts in the internet.

3.2. Care and support

3.2.1. Provide more help to non-Chinese youth.

3.2.2. Increase training for workers who deliver services e.g. peer educators. Workers should be supportive and proactive in response to the needs of youth.

3.2.3. Provide one-stop service (e.g. on the internet) to enhance access to services.

3.3. Enabling environment

- 3.3.1. Make sex education compulsory in school. Sex education should be age-specific and target the diverse background of young people, such as those who engage in sex work.
- 3.3.2. Multi-level sex education – sex education should be more in-depth, interactive and conducted in small groups. It should take into account of the identities and background of target audience: universal sex education as well as targeted sex education for those who started risky behavior at early age. Educate parents as well.
- 3.3.3. Establish youth-friendly sexual health environment, resources are needed to support youth's significant others.
- 3.3.4. University should educate health care workers on sex education and social workers providing services are youth friendly.
- 3.3.5. More effective use in data to promote law reform, e.g. decriminalization of sex work.
- 3.3.6. Use of mainstream media and the internet for promotion/publicity, and health promotion messages should be delivered on a systematic and regular basis. Make use of peak hours for wider dissemination, and make use of different languages to meet individual needs such as ethnic minorities.
- 3.3.7. Provide more funding to NGOs for at risk youth programme. Besides, additional resources are needed so that NGOs can carry out sex education in schools.
- 3.3.8. Anti-stigma (against LGBT, sex workers).
- 3.3.9. Increase EM participations. More HIV centres for EM including staff members who are EM.
- 3.3.10. Anti-discrimination campaign for sex workers for the general public.

3.4. Strategic information

3.4.1. A well rounded and comprehensive surveillance and needs assessments on youth's behavior (including HIV/AIDS, EM).

3.5. Strategy/policy

3.5.1. A strategy to promote regular HIV testing.

3.5.2. Increase youth participation in policy development.

3.5.3. In education system and policy level, there needs a change of attitude as well as policy towards sex work (e.g. decriminalization of sex work) and to reduce barriers for sex worker clients to gain access to sex services.

3.5.4. Strengthen collaborations among NGOs and government departments e.g. one-stop service for youth, instead of scattered service (such as joint efforts between Family Planning Association Hong Kong and Mother & Child Health Clinic when dealing with teenage pregnancy).

3.5.5. Set up a coordinating body (similar to the Narcotic Division) to oversee policy on sex education.

3.5.6. Reform student health services so as to meet the needs of young people.

3.5.7. Law reform: decriminalize sex work and any policy that may make youth at risk/sex workers unwilling to come forward to ask for help (but some people at the meeting think some laws over sex work are necessary).

4. Prioritized recommendations

The following recommendations were compiled based on the above discussions, agreed and prioritized by participants:

(Note: Additional post-meeting remarks on the recommendations can be found in Annex 13.)

High priorities

- 4.1. Sex education should be multi-level and comprehensive, taking into account of various factors such as age, culture, ethnicity and background (sex workers/drug use/identity); adopt suitable approaches (such as not based on fear, conduct in small group, interactive and bottom up rather than a one-way lecture, updated); sex education to be compulsory in school (i.e. part of the school curriculum). The content should go beyond HIV education and also cover relationship/values education.
- 4.2. Supportive environment: anti-stigma (sex worker/MSM/against labeling those schools/children homes/ youth centers who are active in conducting sex education to be institutes compiling of so-called “at-risk” youth); reduce taboo to talk about sex; strengthen data collection as a tool to advocate for law reform for decriminalization of sex work.
- 4.3. Training & information provision to health care workers, social workers, peer educators, counsellors, teachers & parents so as to reduce psychological barriers among young people when expressing their needs.
- 4.4. Comprehensive sexual health clinic/centre: provide testing service to different ages and racial background etc. Such service should be youth friendly and youth focused. Engage staff members who have diversified backgrounds.

4.5. Funding: diversify the funding to different sets such as NGOs, community setting and schools. Make finding sustainable.

Medium priorities

4.6. Promotion & publicity: make use of internet and other mainstream media, in multi-languages. Promotion in mainstream media to be broadcast during peak hours.

4.7. Engage more EM staff and peer educators in all services provided to EM.

4.8. A centralized and coordinated effort to oversee sex education and related matters for youth.

4.9. Reform Student Health Service (by extending the service to F.3 and above, strengthen sex education and body check in the service) and make it more user friendly.

Lower priorities

4.10. Comprehensive needs assessment on youth (sexual) behavior.

4.11. Drug rehabilitation centre should be friendly to people with different backgrounds (ethnic minorities, languages, culture, religion etc).

4.12. Advocate regular HIV testing.

4.13. Easier access to condoms and make youth understand their right in buying condoms.

Section 3 – Communities recommendations to HIV/AIDS responses in 2012 – 2016

This section reports on the key observations from the CSCM and analyses different strategies discussed and prioritized during the CSCM. The 114 recommendations generated from all the sessions are summarized for the consideration of ACA.

Part A: Observations from the CSCM

Observation 1: One key observation is the demand for addressing the diverse needs of sub-groups from different key populations. Examples of sub-groups include those from

- the EM community, namely children and youth, parents, drug users, SW and SWC, refugees and asylum seekers, domestic workers, prison inmates, community leaders, and cross border and domestic workers who are “in-between contracts;”
- the IDU community, namely women, new arrivals, cross border travellers, EM, illegal workers, and individuals who have no motivation to quit drugs and those who are in psychiatric institutions and prisons; and
- the SW community, namely SW who are new to the industry, younger persons involved in compensated dating, new immigrants, non-Chinese, cross border SW and SWC, prison inmates, illegal SW, and industry personnel such as pimps and keepers.

Observation 2: It is important for all policy makers and service providers to understand different cultures of the sub-groups and their needs in HIV prevention and care, and to tailor-make programmes and services for these sub-groups accordingly.

Observation 3: There were similar concerns and respective recommendations among participants coming from different communities. However, the levels of priorities of these recommendations as accorded by the participants vary in different sessions. For example, decriminalization of sex work was prioritized as “high” in the MSW session, while it was a “medium” priority item in SW and SWC sessions.

Observation 4: It was noted that certain well established strategies were not included in the prioritized recommendations in some sessions. For example, the need of increasing access to condom was listed as a prioritized item by some key populations (EM, youth, SW and SWC), but such strategy was not listed or explicitly expressed by others (MSW, MSM, IDU and PLHIV). However, these prioritizations should not translate into automatic negligence of such strategy.

Observation 5: There were extensive discussions on the need for an enabling environment including reduction of stigma and discrimination against most key populations. In addition to comprehensive and targeted prevention and care, more efforts are needed to sustain the low HIV prevalence in Hong Kong. These efforts include the provision of sex education to students and adults, law reform for the protection human rights among groups such as MSM and TG, capacity building for related professionals such as healthcare workers, teachers and social workers, and HIV education to the general public through multi-media channels. These efforts are crucial in nurturing an enabling environment which promotes understanding, embraces diversity, protects human rights and advocates equity for a harmonious society.

Observation 6: The active participation of members from various key populations demonstrated their readiness to contribute input and support, not only during the consultation process, but also to the continuous development of strategy and policy. It is a golden

opportunity for the government to engage communities' involvement in the deliberation of different strategies and policies in the upcoming future. The first and foremost step is to involve community members, as soon as possible, at the ACA level.

Observation 7: There are some shared views across all communities on the principles behind policies, strategies, programmes and services. These principles are:

- PLHIV and specific communities centric with due respect to protect their human rights;
- Sensitivity to culture, such as languages and religions, and gender;
- Adoption of comprehensive, universal, diversified, targeted and flexible approaches;
- Community participation; and
- Coordinated efforts.

Part B Recommendations on HIV/AIDS responses in 2012 – 2016

Using the priorities highlighted in each session, they can be induced into seven action areas:

1. Scale up HIV prevention
2. Provide comprehensive and integrated treatment, care and support
3. Foster enabling environment
4. Strengthen leadership by government and other stakeholders
5. Promote supportive legal framework and public policy
6. Enhance strategic information
7. Mobilize resources

Details of the discussions and prioritized recommendations can be found in Section 2 of the report.

1. Scale up HIV prevention in key populations

1.1. The following applies to all key populations:

- 1.1.1. Increase HIV and sexual health education.
- 1.1.2. Increase access to condom and lubricant by free distribution, condom vending machine.
- 1.1.3. Improve the coverage and accessibility of VCT services through increasing promotion, operation hours and locations.
- 1.1.4. Provide and strengthen counselling service.
- 1.1.5. Increase outreach activities in more diverse locations including neighbouring areas.
- 1.1.6. Enhance peer educators' involvement in all prevention interventions.

1.2. The following applies to specific key populations:

Ethnic Minorities

- 1.2.1. Use multi-faceted prevention approach including outreach services to different sub-groups in different locations, such as Kowloon City and Wanchai districts, increase access to condoms, increase street level education, and adopt peer education approach in programme delivery.
- 1.2.2. Build capacity of the community by enabling community members to become HIV prevention workers, peer educators and healthcare workers.
- 1.2.3. Implement free syringe programme for drug users, and make sharp boxes available in different districts.
- 1.2.4. Implement comprehensive services for sub-groups on drug abuse prevention and harm reduction.

- 1.2.5. Provide harm reduction programmes to increase access to clean needles and disposal of used needles, including methods such as needle exchange, vending machines, sales of needles in convenient stores and needle recycling.
- 1.2.6. Provide comprehensive social services to IDU, their families and partners, including the use of case work, group work, peer education, and fun activities. Employment related services are also needed.
- 1.2.7. Prevent young people from using drugs through educating them and their parents.
- 1.2.8. Provide one-stop service, such as shooting gallery (safety house) to include access to various services such as methadone treatment, HIV education, drug rehabilitation and referral for Hepatitis C treatment.
- 1.2.9. Strengthen promotion and education in various checkpoints within the Pearl River Delta region.
- 1.2.10. Continue to improve outreach programmes and maintain methadone treatment.
- 1.2.11. Provide harm reduction programmes, HIV education and HIV testing services in correctional institutions.

Male sex workers

- 1.2.12. Provide services including VCT for MSW who enter into Hong Kong.
- 1.2.13. Address different language needs among MSW during service provision.

Men who have sex with men & Transgender persons

- 1.2.14. Provide comprehensive and diversified services to MSM and TG communities, such as longer term counselling and follow-up services, peer counselling, support for family and partners, and services for self/identity acceptance.
- 1.2.15. Increase VCT service coverage through different approaches, such as mobile service and promotion of regular testing.

1.2.16. Expand services to different geographical locations.

Sex workers

1.2.17. Provide targeted education for different sub-groups.

Sex worker clients

1.2.18. Increase awareness on STI.

1.2.19. Protect users' privacy upon the use of testing services.

1.2.20. Provide user friendly testing service.

1.2.21. Promote 100% condom use, including condom use with SWC's partners and sex workers.

1.2.22. Improve access to (good quality) condom via methods such as condom vending machine and selling of single package condom (in addition to packages of 3-12 condoms).

Youth at risk

1.2.23. Establish comprehensive sexual health clinic or centre for young people to provide youth friendly and youth focused services such as, testing service for youth in different ages and racial background. Engage staff members with diversified backgrounds.

1.2.24. Advocate regular HIV testing among the youth population.

1.2.25. Make condoms more easily accessible, and enable young people to understand their rights in purchasing condoms.

2. Provide comprehensive and integrated treatment, care and support

2.1. The following applies to all key populations:

- 2.1.1. Improve accessibility and affordability of healthcare services.
- 2.1.2. Change the NEP fee charging policy in SHC.
- 2.1.3. Provide more support services to members, partners and families of different communities, including the PLHIV.
- 2.1.4. Implement more support groups.
- 2.1.5. Enhance peer educators' involvement in care and support services.
- 2.1.6. Strengthen coordination of efforts among NGOs and government.

2.2. The following applies to specific key populations:

Ethnic minorities

- 2.2.1. Provide accessible and affordable health care services to EM, such that opening hours should accommodate the needs of migrant and domestic workers, construction workers and security guards.
- 2.2.2. Provide services for EM drug users, such as a drug free methadone clinic, cultural sensitive treatment centre and hostels, comprehensive after-care service to increase motivation for change, and training programmes for ex-drug users and ex-prison inmates to become peer educators.
- 2.2.3. Launch support groups for PLHIV who are ethnic minorities.
- 2.2.4. Increase network between organizations that serve the EM community and AIDS service organizations.

Injecting drug users

2.2.5. Strengthen after-care services, and assist IDU to rebuild their life.

2.2.6. Provide training for healthcare workers on Hepatitis C treatment and referrals.

Male Sex Workers

2.2.7. Provide support to MSW who are PLHIV.

2.2.8. Set up designated STI clinic for MSW.

Men who have sex with men & Transgender persons

2.2.9. Tailor-made service for different segments of the community, such as MSM/TG at different ages, those who are PLHIV, those who newly come out, TG, drug users and cross border travellers.

2.2.10. Increase caring and comprehensive efforts for MSM/TG who are PLHIV, such as efforts to reduce stigma against PLHIV within the MSM community and to establish MSM PLHIV support groups.

People living with HIV

2.2.11. Enhance medical services such as to increase resources for support services and clinics; increase access to HAART; increase affordability of treatment such as to include STI treatment and PEP to the latest drugs in Drug Formulary; increase PLHIV participation in treatment decisions; increase number of health care personnel; increase training, such as counselling skills, for health care personnel; provide holistic care including family planning, mental health, counselling, dental care; and attend to the needs of sub-groups including elderly, migrant workers (from Hong Kong to other countries), young people, ethnic minorities, women and discordant couples. Access to services is the right of PLHIV.

2.2.12. Enhance referral and service linkage to improve access to services, and to increase access of NGOs services or information for newly diagnosed PLHIV.

2.2.13. Strengthen the linkage among clinics, hospitals, private laboratories and NGOs.

2.2.14. Increase support services for care-givers, family members and partners or spouses.

Sex workers

2.2.15. Enhance services provided by SHC to become more user-friendly, to exempt NEP fee charging policy, to ensure users' privacy, to provide comprehensive sexual health service, and to set up clinic for sex workers.

2.2.16. Widen scope of services to include mental health services, life skills education, "relationship education", occupational skills and resources building for sex workers.

Sex worker clients

2.2.17. Set up support groups for SWC.

2.2.18. Develop support services to SWC partners and families, including via counselling and case-work approaches.

Youth at risk

2.2.19. Reform Student Health Service by extending the service to Form three and above students, strengthening sex education, providing body check in the service, and making it more user friendly.

2.2.20. Engage more EM staff and peer educators in all services provided to EM.

2.2.21. Enhance drug rehabilitation centres to become more user-friendly to people with diverse background, such as ethnicity, language, culture and religion.

3. Foster enabling environment

3.1. The following applies to all key populations:

- 3.1.1. Intensify efforts to reduce stigma and discrimination of people and communities infected with and affected by HIV/AIDS.
- 3.1.2. Implement compulsory and comprehensive sex education (including sexuality, HIV, relationship and value) in all school levels. Sex education should be tailor-made, explicit, proper, open-minded and positive.
- 3.1.3. Increase sensitivity to language, culture and gender differences.
- 3.1.4. Apply multi-media channels for HIV-related promotion and publicity to the general public.

3.2. The following applies to specific key populations:

Ethnic minorities

- 3.2.1. Reduce language barriers through provision of translation, and use of multi-languages for publicity and education using television, printed media, hotlines, and the internet.
- 3.2.2. Educate EM communities to reduce stigma and discrimination against PLHIV.
- 3.2.3. Advocate EOC to investigate existing violation of Racial Discrimination Ordinance by service providers and institutions.

Men who have sex with men & Transgender persons

- 3.2.4. Strengthen anti-stigma and -discrimination effort via law reform to protect the rights of MSM/TG, promote positive messages and images of MSM/TG in the media, educate the general public and train service providers regarding the MSM/TG communities, and foster an open and positive discussion about sex.

- 3.2.5. Adopt health promotion approach and go beyond HIV prevention.
- 3.2.6. Establish specialization of MSM/TG services such as gay/TG service centre.
- 3.2.7. Increase effort in sexual orientation mainstreaming of services with an ultimate goal of achieving equality.

People living with HIV

- 3.2.8. Strengthen anti-stigma and -discrimination effort via intensifying education for medical service providers, correctional services personnel, any other service providers (homes, employment) and corporate, increasing education at all school levels, and making use of different media channels to educate the general public.
- 3.2.9. Facilitate a fundamental human rights based environment, in addition to anti-stigma and anti-discrimination.
- 3.2.10. Organize an international AIDS conference in Hong Kong.

Sex worker clients

- 3.2.11. Increase promotion of NGO services.
- 3.2.12. Adopt peer education approach in the community to create acceptance and ownership.

Youth at risk

- 3.2.13. Develop multi-level, comprehensive, age, culture, ethnicity, background appropriate sex education.
- 3.2.14. Adopt suitable approaches for sex education and abandon the use of inappropriate approaches, such as fear approach.
- 3.2.15. Reduce taboo to talk about sex.
- 3.2.16. Strengthen data collection as a tool to advocate for law reform for decriminalisation of sex work.

3.2.17. Provide training and information to healthcare workers, social workers, peer educators, counsellors, teachers and parents to reduce communication and psychological barriers among these people and young people.

3.2.18. Make use of Internet and other mainstream media for promotion and publicity in multi-languages and during peak hours.

4. Strengthen leadership by government and other stakeholders

4.1. The following applies to all key populations:

4.1.1. Strengthen leadership of the Government in overall HIV/AIDS responses; specifically in the area of anti-stigma and -discrimination;

4.1.2. Encourage and facilitate multi-sectoral and departmental collaborations;

4.1.3. Encourage and facilitate cross border collaborations; and

4.1.4. Include community representatives to the ACA.

4.2. The following applies to specific key populations:

Injecting drug users

4.2.1. Liaise Police Department to support the implementation of harm reduction programmes.

4.2.2. Increase effort in stopping the supply of drugs.

Male sex workers

4.2.3. Strengthen government-led effort to provide targeted education for MSW and their clients.

4.2.4. Encourage more organizations to provide services for MSW, while setting up a MSW working group as more organizations provide services for MSW.

Men who have sex with men & Transgender persons

4.2.5. Advocate a long term, visionary and government-led LGBT policy, including same sex and TG marriage). Include MSM/TG representative to ACA.

People living with HIV

4.2.6. Increase PLHIV representation & participation in strategy and policy development, as well as at the ACA level. Increase the transparency of PLHIV centric strategy and policy development.

4.2.7. Include NGO representative to ACA.

4.2.8. Encourage ACA members and policy makers to reach out to the PLHIV community.

Sex workers

4.2.9. Encourage cross government departmental and regional collaboration to advocate for HIV issues, such as PEP education.

4.2.10. Strengthen the role of ACA to advocate for reducing barriers, stigma & discrimination of sex workers in accessing relevant services in different settings.

Sex worker clients

4.2.11. Encourage cross border collaborations among Hong Kong, Macau, Shenzhen and Guangdong.

4.2.12. Mobilize more local resources for programmes implementation across the border.

4.2.13. Provide programmes and services to Mainland travellers under the Individual Visit Scheme and other cross border travellers, via joint effort among Immigration

Department, ACA and Hong Kong Tourism Board.

Youth at risk

4.2.14. Set up centralized coordinated effort within the Government to oversee sex education and related matters for youth.

5. Promote supportive legal framework and public policy

5.1. The following applies to all key populations:

5.1.1. Foster adoption of safer sex practice by changing the current law enforcement practice of using condoms as evidence for prosecution.

5.1.2. Remove law on solicits for any immoral purpose.

5.1.3. Decriminalise sex work.

5.1.4. Waive fee-charging policy on NEP in SHC.

5.2. The following applies to specific key populations:

Men who have sex with men & Transgender persons

5.3. Enact sexual orientation discrimination ordinance.

People living with HIV

5.4. Enforce HIV related ordinances in a proactive manner.

Sex workers

5.5. Strengthen and improve law enforcement against those clients who have (unprotected)

sex without workers' consents.

Sex worker clients

5.6. Lower age of consent of sexual behaviour.

6. Enhance strategic information

6.1. The following applies to all key populations:

6.1.1. Conduct needs assessment on communities that are not covered in previous needs assessment or surveillance; and

6.1.2. Conduct qualitative research to increase understanding of behaviours of the communities.

6.2. The following applies to specific key populations:

Injecting drug users

6.2.1. Study and monitor the changing trend and pattern of drug use.

Male sex workers

6.2.2. Conduct HIV infection and behaviour surveillance by including them in the existing surveillance such as PRiSM and CRiSP and/or collect more MSW related information and data by adjusting current surveillance mechanism.

Men who have sex with men & Transgender persons

6.2.3. Initiate research and provide services for TG.

6.2.4. Initiate comprehensive evaluations of HIV programme for MSM/TG.

6.2.5. Increase research initiatives and behavioural surveillance that go beyond existing research agenda.

People living with HIV

6.2.6. Conduct multi-facet and comprehensive needs assessment to understand PLHIV stigma, socio-economic status and sexual behaviour so as to advice the development of future strategy on regular basis.

Sex worker clients

6.2.7. Conduct surveillance and research for the community in every two to three years.

Youth at risk

6.2.8. Conduct comprehensive needs assessment on youth (sexual) behaviour.

7. Mobilize resources

Recommendations for resources mobilization are mostly related to resource allocation of ATF, while other recommendations are related to funding and resource allocation from other sectors or policy.

7.1. Recommendations related to ATF:

7.1.1. Maintain funding (allocation) flexibility to align with the changes in the epidemic, such as setting of the SPF, and inflation.

7.1.2. Enhance funding allocation to be evidence-based, transparent, responsive, human-right

based, referenced to international standards, and with consideration of programme coverage and size population size.

- 7.1.3. Maintain sustainability of the ATF.
- 7.1.4. Include community participation in resource allocation and funding strategy.
- 7.1.5. Align human resources allocation so as to address the manpower resource needs of programmes.
- 7.1.6. Set aside proportionate amount of funding and resources for PLHIV and other marginalized groups.
- 7.1.7. Subsidize projects/programmes with proven track record and core HIV prevention and care activities, such as testing activities, with explicit criteria to make them sustainable.
- 7.1.8. Enhance monitoring and evaluation of programmes by providing technical support, funding, benchmark for comparison and standardization.
- 7.1.9. Increase resources from the government to NGO programmes and services.
- 7.1.10. Widen the scope of funding for VCT services to go beyond funding of test kits, but to include other supporting tools & services.
- 7.1.11. Diversify the funding into different settings such as NGOs, communities and schools. Make funding sustainable.

7.2. Recommendations related to other sectors

- 7.2.1. Set up a centralized technical support platform for proposal writing, IT support, interpretation of research data, NGO management, talent retention, capacity building of community members for future AIDS work and development of resources.
- 7.2.2. Increase cross-government departmental and -sectoral (such as Education Bureau, Social Welfare Department, law enforcement and other government grants and funding)

communication, coordination and collaboration on resources and funding for AIDS work..

- 7.2.3. Involve private sector and other community resources, such as community groups, academia and religious groups for monetary, technical and online support.
- 7.2.4. Increase communication, coordination and collaboration on resources and programmes with partners in Mainland China and within the region.
- 7.2.5. Increase resources for cross-country and -city programmes.
- 7.2.6. Increase resources for multi-faceted intervention with universal and structural interventions, such as anti-stigma activities, public education, sex education, as well as targeted preventions and interventions for personal growth.
- 7.2.7. Enhance coordinated effort to prevent overlap in resources and programmes.
- 7.2.8. Include diversified approaches such as the use of Chinese medicine.

7.3. Recommendations of policy on funding allocation

- 7.3.1. Launch a territory-wide planning mechanism in resources allocation with on-going review.
- 7.3.2. Evaluate functions of ACA and ATF to better align policy-making and funding allocation.

Annexes

Annex	Title
Annex 1	Membership of the Working Group for the CSCM
Annex 2	Schedule of the CSCM
Annex 3	Discussion framework of the CSCM <ul style="list-style-type: none"> - Generic version - Special meeting for MSW (Chinese Only)
Annex 4	Brief for table hosts and note takers <ul style="list-style-type: none"> - For key population sessions - For financing and resources session
Annex 5	Template for note-taking <ul style="list-style-type: none"> - For key populations sessions - For financing and resources session
Annex 6	List of duty persons during the CSCM
Annex 7	Summary of latest epidemiology review for various key populations
Annex 8	Summary of latest current responses for various key populations
Annex 9	Summary of ATF updates
Annex 10	Summary of pre-CSCM activities conducted by HKCASO members
Annex 11	Summary of participation statistics
Annex 12	Feedback of participants on the CSCM <ul style="list-style-type: none"> - Evaluation form - Evaluation statistics for all sessions

Annex 1 – Membership of the Working Group for the Community Stakeholders Consultation Meeting

Members:

Mr CHAU Chun-yam (BGCA)

Mr CHAU Ting-leung, Marco (Heart to Heart)

Dr HO Chi-on, Billy (CFA)

Ms HO Pik-yuk, Shara (CHOICE)

Ms WONG Wai-kwan, Loretta (AIDS Concern)

Ms YAU Ho-chun, Nora (CFA)

Ms YUEN How-sin (SRACP)

Dr Raymond LEUNG (CFA Secretariat)

Dr Francis WONG (CFA Secretariat)

Annex 2 – Schedule of the Community Stakeholders Consultation Meeting

Date	Time	Sessions	Venue
26 Jan 2011 (Wednesday)	11:00 – 14:30	Female sex workers	Exhibition Hall, 1/F Public Health Laboratory Centre 382 Nam Cheong Street, Kowloon
	18:30 – 22:00	People living with HIV/AIDS	
27 Jan 2011 (Thursday)	14:00 – 17:30	Injecting drug users	
	18:30 – 22:00	Men who have sex with men / Transgender persons	
28 Jan 2011 (Friday)	14:00 – 17:30	Financing and resources for HIV services	
	18:30 – 22:00	Ethnic minorities	
29 Jan 2011 (Saturday)	14:00 – 17:30	Youth at risk	Red Ribbon Centre
	18:30 – 22:00	Clients for female sex workers	2/F, Wang Tau Hom
1 Feb 2011 (Tuesday)	11:00 – 14:00	Male sex workers	Jockey Club Clinic, 200 Junction Road East, Kowloon

Annex 3 – Discussion Framework of the Community Stakeholders’ Consultation Meeting (Generic Version)

Community Stakeholders’ Consultation Meeting for Development of Recommended HIV/AIDS Strategies for Hong Kong 2012-2016

Consultation Meeting Facilitation & Discussion Guideline

This guideline applies to the following sessions (in alphabetical order):

1. Ethnic minorities
2. Female sex workers
3. Financing and resources for HIV Services
4. Injecting drug users
5. Male clients for female sex worker
6. Men who have sex with men / Transgender persons
7. People living with HIV
8. Youth at risk

Objectives of the meetings:

1. To report on and identify latest epidemiological trends and current responses in prevention, treatment, care and support for each particular key population.
2. To encourage small group discussion among delegates to share their experiences and ideas for each particular key population in the scope of HIV prevention and care.
3. To identify and connect common perspectives / themes among delegates and formulate recommendations for the development of HIV/AIDS Strategies for Hong Kong 2012-2016.
4. To prioritize the above strategic recommendations.

Format of the meetings:

- Each meeting consist maximum of 50 delegates, prior registration is required.

- Objectives will be achieved via presentation (Objective 1), the World Café conversation process (Objective 2), small group reporting and whole group discussions (Objective 3 & 4), and consensus building (Objective 4).
- The key advantage of World Café process is to ensure maximum participation for ALL delegates at the meeting. For more details of World Café conversation process, please refer to <http://www.theworldcafe.com>.
- Discussion will be conducted in Cantonese (except Ethnic Minorities session, which will be conducted in English if necessary). Audio recording will be arranged to facilitate documentation of discussion in each session.

Rundown for the meetings:

Time	Activities
5 min	Introduction of the meeting
30 min	Reporting on latest epidemiological trend and current responses
10 min	Introduction of World Café process & Group rules
20 min	Round 1 of World Café Discussion
20 min	Round 2 of World Café Discussion
20 min	Round 3 of World Café Discussion
20 min	Report back from table hosts
15 min	BREAK
25 min	Whole group Discussion on recommendations
30 min	Prioritizations of recommendations
15 min	Conclusion of meeting

Questions for Discussion for key population sessions:

- **Round 1** – “What are the current needs of the community?”
- **Round 2** – “How would you envision the HIV situation of the community in Hong Kong in 5 years time?”
- **Round 3** – “What strategies (1) need to be continued, and (2) need to be in place, in order to improve the situation in Hong Kong for your community?”

Questions for Discussion for Financing and resources for HIV Services session:

- **Round 1** – “What resources (include non-financial resources) need to be sustained, strengthened or mobilized to improve the HIV situation in Hong Kong? Why?”
- **Round 2** – “(1) How should resources be allocated, and (2) What are the key criteria / rationale for resource allocation, that will optimize the use of resources to improve the HIV situation in Hong Kong?”
- **Round 3** – “What strategies (1) need to be continued, and (2) need to be in place, in order to sustain both financial and non-financial resources in Hong Kong for 2012-2016?”

Note: For maximal results, delegates are encouraged to prepare their ideas prior to the meeting.

Annex 3 – Discussion Framework of the Community Stakeholders’ Consultation Meeting (Special Meeting for Male Sex Workers – Chinese Only)

二零一二年至二零一六年香港愛滋病建議策略 – 社群諮詢會議 會議討論指引

本指引適用於下列環節：

男性性工作者

會議日期、時間及地點：

2011年2月1日

上午11時至下午2時

紅絲帶中心

會議目的：

目標〔一〕：檢討最新愛滋病流行趨勢及狀況，回顧相關的預防、治療、護理和支援等回應措施。

目標〔二〕：鼓勵社群參與討論，並就愛滋病的預防及治療，提供意見。

目標〔三〕：綜合參加者意見，為二零一二年至二零一六年的香港愛滋病策略作出建議。

目標〔四〕：確立建議的優先次序。

會議模式：

- 是次會議主要由午夜藍及男性性工作者社群成員組成。參加者必須事先報名。
- 大會將採用多元的會議模式，包括：簡報〔針對目標一〕、小組討論〔針對目標二〕、小組匯報、集體討論〔針對目標三及四〕及尋求共識〔針對目標四〕等以達到會議目標。
- 如參加者人數過少，針對目標二及三的模式，將以集體討論進行。
- 會議將以廣東話進行。

會議程序:

時間	活動
15 分鐘	會議簡介及定立會議守則 <ul style="list-style-type: none">- 主持簡介是次會議目的及程序- 參加者互相介紹- 定立會議守則
15 分鐘	檢討愛滋病流行趨勢及回顧回應措施 <ul style="list-style-type: none">- 由紅絲帶中心同事簡報及回答提問
5 分鐘	討論簡介 <ul style="list-style-type: none">- 主持簡介討論模式
25 分鐘	第一輪小組討論〔15 分鐘〕及匯報〔10 分鐘〕
25 分鐘	第二輪小組討論〔15 分鐘〕及匯報〔10 分鐘〕
25 分鐘	第三輪小組討論〔15 分鐘〕及匯報〔10 分鐘〕
20 分鐘	小休
10 分鐘	集體討論 <ul style="list-style-type: none">- 主持綜合三輪討論結果及策略建議
30 分鐘	定立建議的優先次序 <ul style="list-style-type: none">- 就排列標準及方法建立共識- 就優先次序進行排列
10 分鐘	會議總結

各風險組群討論題目：

第一輪討論-- 「社群當前的需要是什麼？」

第二輪討論 -- 「試想像 5 年後社群的愛滋病情況，你會有什麼的願景及期盼？」

第三輪討論 -- 「如果要改善未來香港愛滋病的 情況，你認為〔一〕有什麼的策略及工作應該保留？及〔二〕有什麼新的策略及工作應該在香港推行？」

備註：大會鼓勵參加者在會議前就以上的討論題目作出思考及準備，以達致最佳效果。

Annex 4 -- Brief for table hosts and note takers (For key population sessions)

**Community Stakeholders’ Consultation Meeting for
Development of Recommended HIV/AIDS Strategies for Hong Kong 2012-2016
World Café Session**

Objective:

To encourage small group discussion among delegates to share experience and contribute ideas.

Format:

A total of 4-5 tables (subject to number of delegates attending the meeting), each with a total of not more than 10 participants (including a table host and a note taker) , will be set up to discuss the following 3 questions in three 20-minute rounds:

- **Round 1** – “What are the current needs of the community?”
- **Round 2** – “How would you envision the HIV situation of the community in Hong Kong in 5 years time?”
- **Round 3** – “What strategies (1) need to be continued, and (2) need to be in place, in order to improve the situation in Hong Kong for your community?”

Delegates are free to choose table and encouraged to mix with other delegates during each round of discussion. Delegates should choose table with delegates and table host that are not from their own agency.

Language:

Cantonese will be used (except for the Ethnic Minority session).

Roles and Responsibilities at each table:

Role	Responsibilities
Table host	<ul style="list-style-type: none"> ▪ Encourage delegates to share their thoughts ▪ Ensure discussion stays focused on the question for each of the 3 rounds ▪ Do NOT express own opinion ▪ Keep track of time (20 minutes for each session) ▪ Ensure all delegates at the table get a chance to provide input (if not feeling comfortable expressing opinion in public, delegates can write down thoughts on flip chart papers provided on the table) ▪ Be sensitive to delegates who are members of the community will need time articulate their thoughts / ideas

	<ul style="list-style-type: none"> ▪ Quickly summarize (1-2 minutes) discussion for the previous round of discussion at the start of each round. ▪ Report back the most mentioned / outstanding 2-3 issues for each round (6 issues all together) to the whole group at the report back (approximately 5 min each host)
Note taker	<ul style="list-style-type: none"> ▪ Capture key issues, comments and questions expressed by each delegate using notes template ▪ Do NOT participate in discussion ▪ Pass notes to World Café Analysis Team (see below)

World Café Analysis Team:

- Comprised of facilitator, rapporteur and one representative from CFA Secretariat.
- Observe table discussion on the side (do NOT participate in discussion).
- Summarize table notes of table discussions and comments written on flip charts by delegates for each of the 3 questions on powerpoint (during reporting back and break).
- Report back of summary results after the break.

Annex 4 -- Brief for table hosts and note takers (For financing and resources session)

**Community Stakeholders’ Consultation Meeting for
Development of Recommended HIV/AIDS Strategies for Hong Kong 2012-2016
World Café Session (Financing and resources for HIV Services session)**

Objective:

To encourage small group discussion among delegates to share experience and contribute ideas.

Format:

A total of 4-5 tables (subject to number of delegates attending the meeting), each with a total of not more than 10 participants (including a table host and a note taker) , will be set up to discuss the following 3 questions in three 20-minute rounds:

- **Round 1** – “What resources (include non-financial resources) need to be sustained, strengthened or mobilized to improve the HIV situation in Hong Kong? Why?”
- **Round 2** – “(1) How should resources be allocated, and (2) What are the key criteria / rationale for resource allocation, that will optimize the use of resources to improve the HIV situation in Hong Kong?”
- **Round 3** – “What strategies (1) need to be continued, and (2) need to be in place, in order to sustain both financial and non-financial resources in Hong Kong for 2012-2016?”

Delegates are free to choose table and encouraged to mix with other delegates during each round of discussion. Delegates should choose table with delegates and table host that are not from their own agency.

Language:

Cantonese will be used (except for the Ethnic Minority session).

Roles and Responsibilities at each table:

Role	Responsibilities
Table host	<ul style="list-style-type: none"> ▪ Encourage delegates to share their thoughts ▪ Ensure discussion stays focused on the question for each of the 3 rounds ▪ Do NOT express own opinion ▪ Keep track of time (20 minutes for each session) ▪ Ensure all delegates at the table get a chance to provide input (if not feeling comfortable expressing opinion in public, delegates can write down thoughts on flip chart papers provided on the table)

	<ul style="list-style-type: none"> ▪ Be sensitive to delegates who are members of the community will need time articulate their thoughts / ideas ▪ Quickly summarize (1-2 minutes) discussion for the previous round of discussion at the start of each round. ▪ Report back the most mentioned / outstanding 2-3 issues for each round (6 issues all together) to the whole group at the report back (approximately 5 min each host)
Note taker	<ul style="list-style-type: none"> ▪ Capture key issues, comments and questions expressed by each delegate using notes template ▪ Do NOT participate in discussion ▪ Pass notes to World Café Analysis Team (see below)

World Café Analysis Team:

- Comprised of facilitator, rapporteur and one representative from CFA Secretariat.
- Observe table discussion on the side (do NOT participate in discussion).
- Summarize table notes of table discussions and comments written on flip charts by delegates for each of the 3 questions on powerpoint (during reporting back and break).
- Report back of summary results after the break.

Annex 5 -- Note-taking template for note takers (For key populations sessions)

世界咖啡館討論紀錄表〔由負責紀錄的工作人員填寫〕
World Café Table Notes Template (to be filled in by table note-taker)

第一輪討論-- 「社群當前的需要是什麼？」 (1) What are the current needs of the community?

第二輪討論 -- 「試想像 5 年後社群的愛滋病情況，你會有什麼的願景及期盼？」
(2) How would you envision the HIV situation of your community in Hong Kong in 5 years time?

第三輪討論 -- 「如果要改善未來香港愛滋病的 情況，你認為〔一〕有什麼的策略及工作應該保留？及〔二〕有什麼新的策略及工作應該在香港推行？」
(3) What strategies (1) need to be continued, and (2) need to be in place, in order to improve the situation in Hong Kong for your community?

組別〔枱號〕 Table No.:	
紀錄工作人員姓名 Note taker:	
小組主持姓名 Table Host:	
其他意見及補充 (可用此表背面填寫) Brief additional comments: (Use back if needed)	

Annex 5 -- Note-taking template for note takers (For financing and resources session)

愛滋病項目財務及資源規劃 -- 世界咖啡館討論紀錄表〔由負責紀錄的工作人員填寫〕
Financing & Resources for HIV service -- World Café Table Notes Template (to be filled in by table note-taker)

第一輪討論-- 「你認為需要維持、強化或動員那方面的資源〔包括非財務上的資源〕，才可有效改善香港的愛滋病情況？為何？」(1) “What resources (include non-financial resources) need to be sustained, strengthened or mobilized to improve the HIV situation in Hong Kong? Why?”

第二輪討論 -- 「你認為〔一〕應該如何分配這些資源，及〔二〕分配的理念和原則？」
(2) (1) How should resources be allocated, and (2) What are the key criteria / rationale for resource allocation, that will optimize the use of resources to improve the HIV situation in Hong Kong?”

第三輪討論 -- 「你認為〔一〕哪一些策略值得繼續源用？及〔二〕需要推行什麼的新策略，讓香港可以持續擁有足夠的財務及非財務的資源以推行愛滋病的工作？」
(3) What strategies (1) need to be continued, and (2) need to be in place, in order to sustain both financial and non-financial resources in Hong Kong for 2012-2016?”

組別〔枱號〕 Table No.:	
紀錄工作人員姓名 Note taker:	
小組主持姓名 Table Host:	
其他意見及補充 (可用此表背面填寫) Brief additional comments: (Use back if needed)	

Annex 6 – List of Duty Persons during the Community Stakeholders Consultation Meeting

Sessions	Table Hosts	Note Takers (CFA Secretariat)	Group Discussion Analysis Team	HKCASO Representative	Resource Person
Female sex workers (26 Jan 11:00 am – 2:30 pm) 4 groups	Mr CHAU Chun Yam (BGCA)	Dr LEUNG Yiu Hong	Ms Loretta WONG (Rapporteur) Ms Winnie HO (Facilitator) Dr Raymond LEUNG (CFA Secretariat)	Mr Marco CHAU (HTH)	Mr Jason LAU (SRACP)
	Mr Marco CHAU (HTH)	Dr Francis WONG			
	Ms Shara HO (CHOICE)	Dr TAM Yat-hung			
	Ms Neda NG (AC)	Dr Ada LIN			
People living with HIV (26 Jan 6:30 pm – 10:00 pm) 4 groups	Mr David NG (SRACP)	Dr LEUNG Yiu Hong	Ms Loretta WONG (Rapporteur) Ms Winnie HO (Facilitator) Dr Raymond LEUNG (CFA Secretariat)	Mr CHAU Chun Yam (BGCA)	Mr Jimmy LO (AF)
	Mr Joe CHAN (AC)	Dr TAM Yat-hung			
	Mr Kurt WONG (AC)	Dr Francis WONG			
	Mr LUK (elements)	Dr Ada LIN			
Injecting drug users (27 Jan 2:30 pm – 5:30 pm) 3 groups	Mr Kevin LI (AC)	Mr Ken HO	Ms Loretta WONG (Rapporteur) Ms Winnie HO (Facilitator) Dr Raymond LEUNG (CFA Secretariat)	Ms YUEN How Sin (SRACP)	Mr David NG (SRACP)
	Ms Moroco LI (SRACP)	Dr TAM Yat-hung			
	Ms Celest TANG (SARDA)	Dr LEUNG Yiu Hong			

Sessions	Table Hosts	Note Takers (CFA Secretariat)	Group Discussion Analysis Team	HKCASO Representative	Resource Person
Men who have sex with men / Transgender (27 Jan 6:30 pm – 10:00 pm) 6 groups	Mr CHAU Chun Yam (BGCA)	Dr LEUNG Yiu Hong	Ms Loretta WONG (Rapporteur) Ms Winnie HO (Facilitator) Dr Raymond LEUNG (CFA Secretariat)	Ms YUEN How Sin (SRACP)	Mr Joe CHAN (AC)
	Ms Mandy CHEUNG (AC)	Dr Kenneth CHAN			
	Ms Shara HO (CHOICE)	Dr TAM Yat-hung			
	Mr Jason LAU (SRACP)	Dr Francis WONG			
	Mr Merv MOK (AC)	Dr Ada LIN			
	Ms Neda NG (AC)	Ms Bonnie NG			
Financing and resources for HIV services (28 Jan 2:00 pm – 5:30 pm) 4 groups	Ms CHAN Fei (AC)	Mr Ken HO	Ms Loretta WONG (Rapporteur) Ms Winnie HO (Facilitator) Dr Raymond LEUNG (CFA Secretariat)	Mr Marco CHAU (HTH)	Ms Esther CHOI (SAC)
	Mr CHAU Chun Yam (BGCA)	Dr LEUNG Yiu Hong			
	Mr LAU Chi Chung	Dr TAM Yat-hung			
	Mr Kurt WONG (AC)	Dr Kenneth CHAN			
Ethnic minorities (28 Jan 6:30 pm – 10:00 pm) 3 groups	Ms Mandy CHEUNG (AC)	Dr Kenneth CHAN	Ms Loretta WONG (Rapporteur) Ms Winnie HO (Facilitator) Dr Raymond LEUNG (CFA Secretariat)	Ms YUEN How Sin (SRACP)	Ms LAI Tak Yin (SJHIV)
	Ms Panda CHEUNG (AC)	Dr LEUNG Yiu Hong			
	Mr Alan DIN (SRACP)	Dr TAM Yat-hung			

Sessions	Table Hosts	Note Takers (CFA Secretariat)	Group Discussion Analysis Team	HKCASO Representative	Resource Person
Youth at risk (29 Jan 2:00 pm – 5:30 pm) 3 groups	Dr Raymond LEUNG (CFA Secretariat)	Mr Samuel CHEUNG	Ms Loretta WONG (Rapporteur)	Ms Shara HO (CHOICE)	Ms Alice CHUI (BGCA)
	Ms Panda CHEUNG (AC)	Dr Francis WONG	Ms Winnie HO (Facilitator)		
	Mr Wesley PANG (AC)	Dr Ada LIN	Dr Raymond LEUNG (CFA Secretariat)		
Male clients for female sex workers (29 Jan 6:30 pm – 10:00 pm) 4 groups	Ms Shara HO (CHOICE)	Dr Francis WONG	Ms Loretta WONG (Rapporteur)	Ms YUEN How Sin (SRACP)	Mr Rex LAU (AC)
	Ms Yuki LEE (AC)	Ms Anita CHU	Ms Winnie HO (Facilitator)		
	Mr Beethoven PUI (A-Back Up)	Dr Kenneth CHAN	Dr Raymond LEUNG (CFA Secretariat)		
	Ms Debby WONG (Caritas)	Mr Samuel CHEUNG			
Male sex workers (1 Feb 11:00 am – 2:00 pm) 1 group	Not applicable	Mr Samuel CHEUNG	Ms Loretta WONG (Rapporteur) Ms Winnie HO (Facilitator) Dr Raymond LEUNG (CFA Secretariat)	Ms YUEN How Sin (SRACP)	Mr Beethoven PUI (A-Back Up)

Annex 7 – Summary of latest epidemiology review for various key populations

(key populations in alphabetical order):

	Pages
1. Clients of Female sex workers (FSWC)	148
2. Ethnic minorities (EM)	154
3. Female sex workers (FSW)	163
4. Injecting drug users (IDU)	169
5. Men who have sex with men (MSM)	177
6. Male sex workers (MSW)	184
7. People living with HIV (PLHIV)	188
8. Youth at risk	194
9. Key data sources for the epidemiology review	203

Revision History

Old Version	Summary of Revision
January 2011 edition	FSWC review: under the sentinel surveillance, the table (page 4 of the FSWC review) has been revised.
	Ethnic minorities review: under the population size estimation, the population size of Indonesian (page 2 of the EM review) has been revised from 87,000 to 88,000.

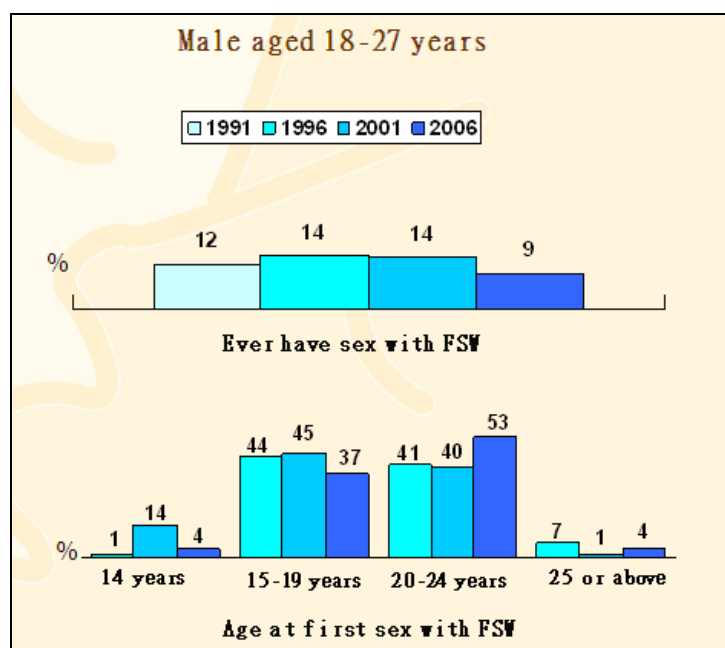
Review of epidemiology for Clients of female sex workers (FSWC)

(Note: this review focus on male clients of FSW only)

[draft for discussion only]

Population size estimation

- Over 4,400 youth were polled in the Youth Sexuality Survey (YSS) in 2006 by the Family Planning Association Hong Kong. The survey comprised of three parts: two parts under a school survey covering students of Form One to Form Two (F.1-F.2), and Form Three to Form Seven (F.3-F.7) respectively, and a third part was a random sampling of household survey on youth aged between 18 and 27.
- YSS (2006): 9% of male aged 18-27 reported to have ever had sex with FSW.
- YSS (2006): Among these males, over half of them had their first sexual encounter with FSW at the age of 20-24, and about 41% had their first sexual encounter with FSW below 20 years old.



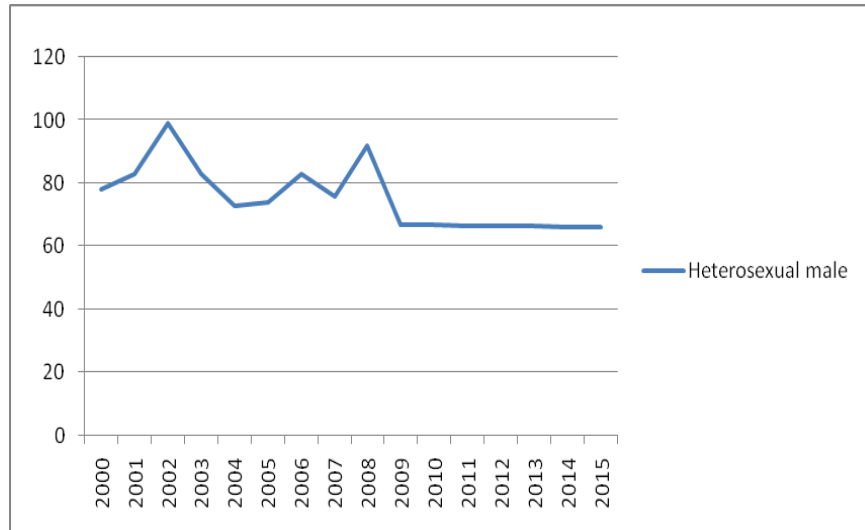
- Applying mid-year population of 2009 where there was 446,200 male aged 18-27 (based on Census 2009, Census & Statistics Department), the size of FSW clients who are 18-27 years old is estimated to be about 40,000.
- A benchmarking study in 1998, by using random telephone survey of 1,020 male respondents aged 18-60, gave an estimated 14% of males had engaged in commercial sex in the past 6 months².

² Lau JTF et al. Behavioural surveillance of sexually-related risk behaviours of the Chinese male general population in Hong Kong: a benchmark study. *AIDS Care* (2001;13(2):221-232.

- The size of FSW clients who are 18-60 years old can be derived to be over 300,000 in 2009, assuming the proportion who engaged in commercial sex from the 1998 study does not change, based on the application of the Census 2009 data.

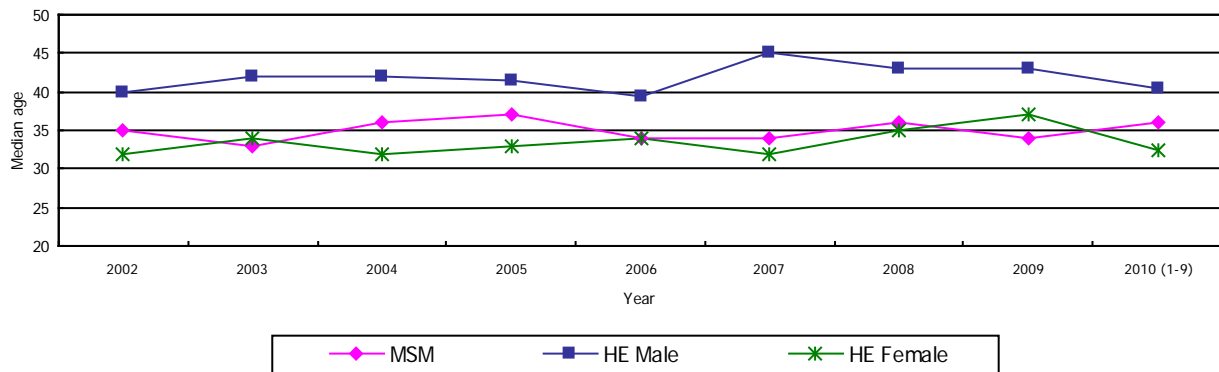
HIV/AIDS reporting system

Trend and projection



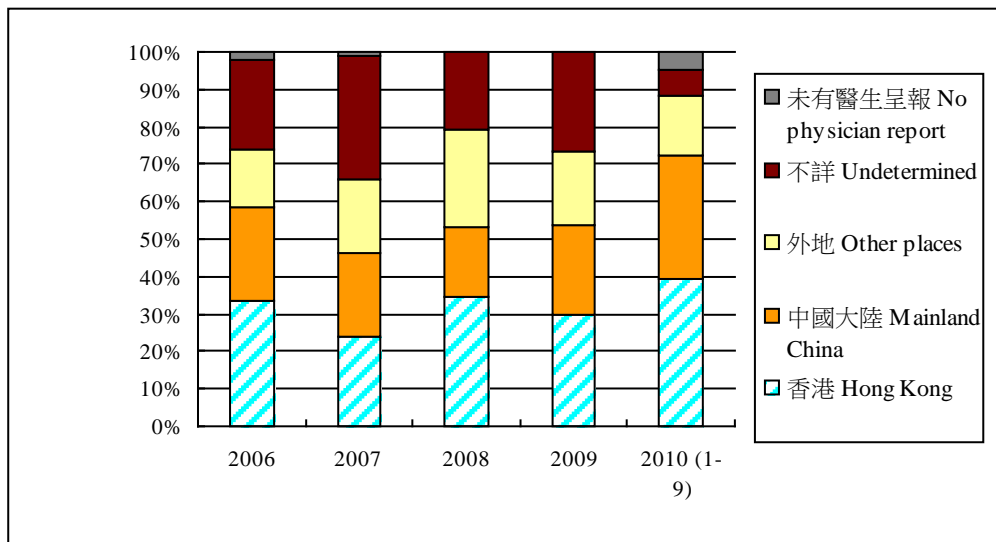
- Number of HIV cases attributable to being FSW clients is not available in the reporting system. A very crude approximation can be made by drawing the number of male heterosexual contact HIV cases (note that male heterosexual contact HIV case does not necessarily equal to male heterosexual contact with FSW, these could be male heterosexual contact with other regular or non- regular partners).
- A general downward trend is observed for overall male heterosexual contact HIV cases.
- Between 60-70 male heterosexual contact HIV cases annually are expected to be reported, and the trend will be expected to remain stable at this level for the coming 5 years, based on the past 5 years data in the year 2005-09.

Age



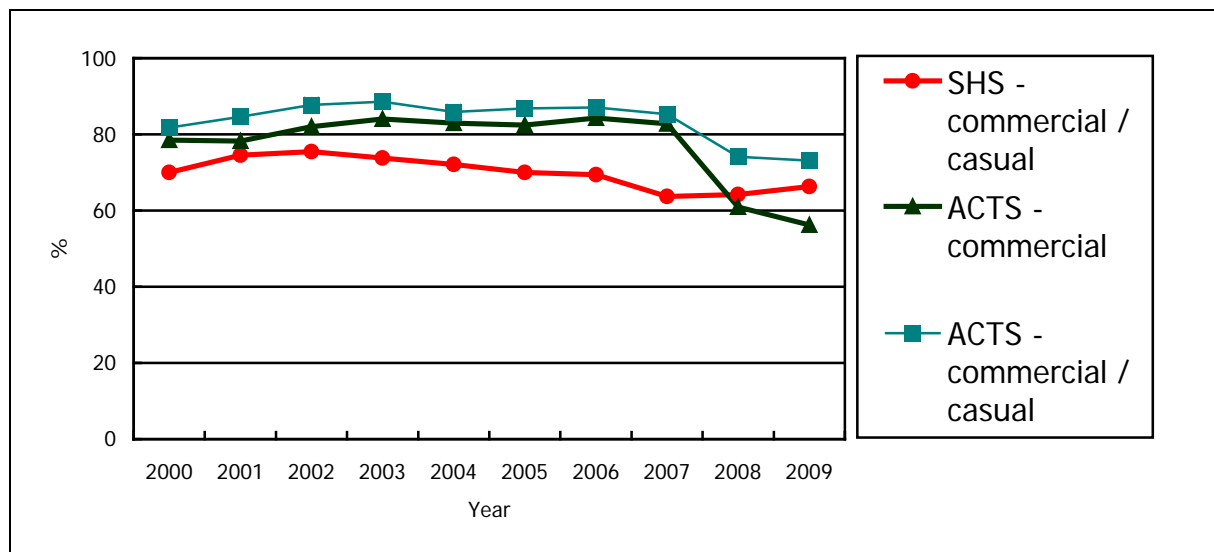
- The median age of heterosexual male HIV cases were 40-45 years old upon HIV diagnosis.

Suspected location



- 25%-40% of heterosexual male cases acquired HIV locally.
- 20%-32% of heterosexual male cases acquired in Mainland China.
- Less than 10% of heterosexual male cases acquired outside Hong Kong, but NOT from Mainland China.

Sentinel surveillance



- From various sentinel sites, roughly 60%-80% of all adult heterosexual males had sex with commercial sex partners in the past 6-12 months (note that the sentinel sites captured a biased sample i.e. AIDS Counseling Testing Services (ACTS) and Social Hygiene Services (SHS) would have attendees reported a higher level of sexual activity or engagement of high risk behaviour than the general population. They were also usually with symptoms of STI.)
- From the above data sources, 25%-42% of FSW Clients reported to be married.

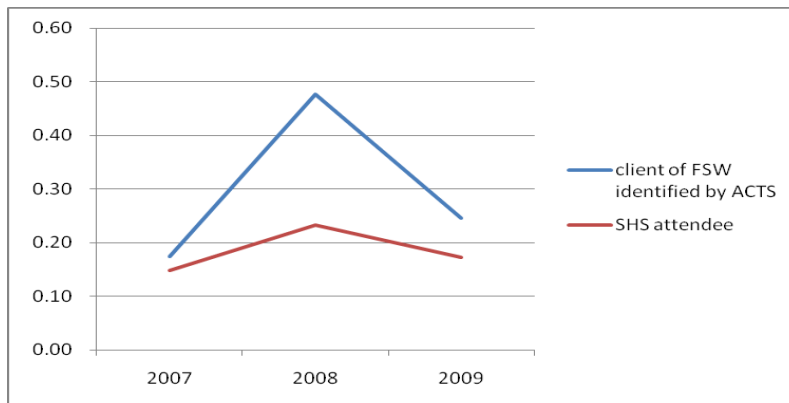
Age

- FSW clients who are below 25 years old: 13%-17% in ACTS (2007-2009); 23%-40% in SHS (2007-2009); 18%-28% in Correctional Services Department (CSD) (2007-2009); 0%-2% in Shek Kwu Chau Drug Rehabilitation Centre (SKC) (2007-2009).
- FSW clients who are 60 or above years of age: 2%-3% in ACTS (2007-2009); 28%-37% in SHC (2007-2009); 1% in CSD (2007-2009); 1%-9% in SKC (2007-2009).
- Clients at a younger age were more likely to be sampled at ACTS while clients at an older age were more likely to be sampled at SHS.

Ethnicity

- 88%-98% of FSW clients across all sentinel sites (ACTS, SHS, CSD, SKC) were Chinese.

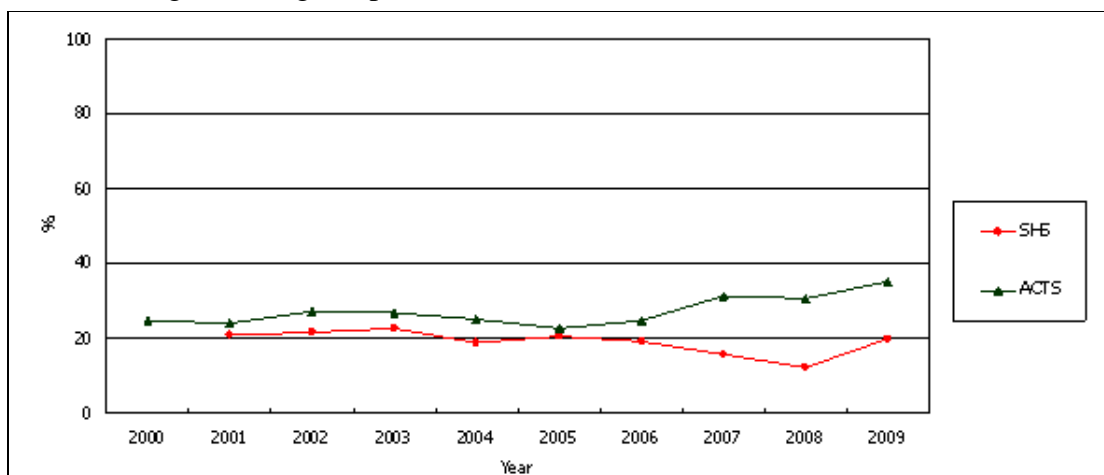
HIV prevalence in FSW clients



- Sentinel surveillance revealed HIV prevalence of 0.17%-0.48% in ACTS, which are slightly higher than than general SHS attendees prevalence, regardless of whether they were FSW clients. Linked data between HIV prevalence and FSW clients at SHS is not available. (note that 64%-66% of SHC male heterosexual attendees were FSW clients).

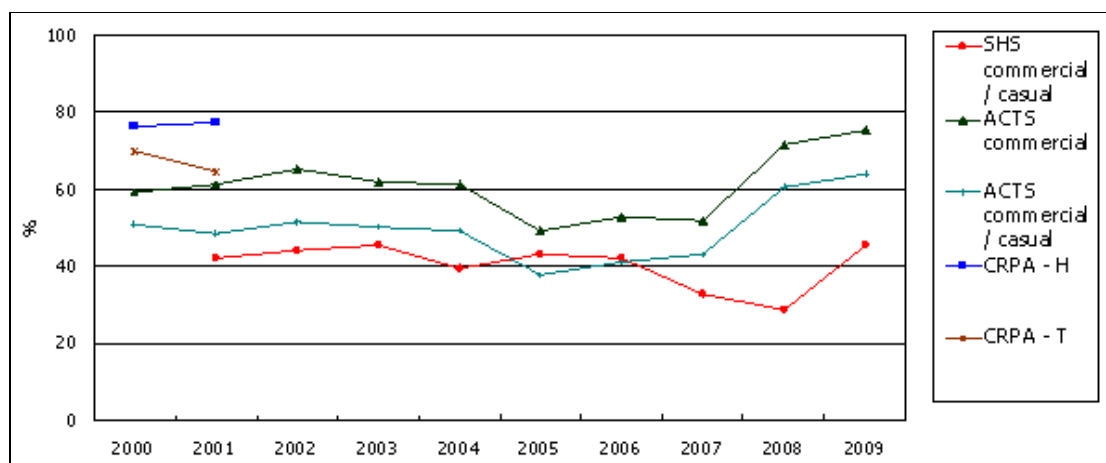
Risk behaviours

Condom usage with regular partners



- ACTS and SHS: 12%-35% consistent condom use with regular partners among adult heterosexual men.

Condom usage with commercial / casual partners



- ACTS (2007-2009): 52%-75% consistent condom use with commercial partner.
- SHS (2007-2009): 33%-46% consistent condom use with commercial/casual partner.

Drug Injecting behaviour

- ACTS (2007-2009): 0.5%-0.7% of FSW clients reported to have ever been Injecting Drug Users (IDU) and 0.2% reported to be current IDU.
- SHS (2007-2009): 0.02% of client of FSW reported to be current IDU.
- SKC (2007-2009): However, in drug rehabilitation centre, 69%-73% of FSW clients reported to be current IDU.

HIV testing

- ACTS (2008-2009): 26%-27% of FSW clients have had HIV test in the past one year.

Review of epidemiology for Ethnic minorities

[draft for discussion only]

Population size estimation

- Ethnic minorities in this epidemiological review are defined in simplified manner, namely people with ethnicities that are non-Chinese, non-Caucasian, and non-mixed (the “mixed” group is often appeared as an entity in the Census data, and this review does not regard “mixed” as ethnic minorities arbitrarily). This is by no means suggesting people with different ethnicities fall into such overly simplified categories, but for the purpose of this review, these categorizations are used.
- Based on the 2006 Population By-census³, out of the 6,800,000 population in Hong Kong, approximately over 4.2% of the entire population as Asians (other than Chinese), while over 0.5% as Caucasians and about 0.2% as mixed. The rest were all ethnic Chinese (95%).

3

表 3.1 二零零一年及二零零六年按種族及常住居民／流動居民劃分的少數族裔人士數目（續）
Table 3.1 Ethnic Minorities by Ethnicity and Usual Residents/Mobile Residents, 2001 and 2006
(Cont'd.)

年份 Year	種族 Ethnicity	常住居民 Usual Residents		流動居民 Mobile Residents		總計 Total	
		數目 (百分比 ⁽¹⁾) Number (Percentage ⁽¹⁾)	百分比 %	數目 (百分比 ⁽¹⁾) Number (Percentage ⁽¹⁾)	百分比 %	數目 (百分比 ⁽¹⁾) Number (Percentage ⁽¹⁾)	百分比 %
2006	亞洲人 (非華人) Asian (other than Chinese)						
	菲律賓人 Filipino	112 016 (99.6)	33.3	437 (0.4)	7.2	112 453 (100.0)	32.9
	印尼人 Indonesian	87 713 (99.9)	26.1	127 (0.1)	2.1	87 840 (100.0)	25.7
	印度人 Indian	19 320 (94.5)	5.7	1 124 (5.5)	18.6	20 444 (100.0)	6.0
	尼泊爾人 Nepalese	15 654 (98.1)	4.7	296 (1.9)	4.9	15 950 (100.0)	4.7
	日本人 Japanese	12 833 (97.3)	3.8	356 (2.7)	5.9	13 189 (100.0)	3.9
	泰國人 Thai	11 507 (96.7)	3.4	393 (3.3)	6.5	11 900 (100.0)	3.5
	巴基斯坦人 Pakistani	10 670 (96.0)	3.2	441 (4.0)	7.3	11 111 (100.0)	3.2
	韓國人 Korean	4 543 (94.4)	1.4	269 (5.6)	4.5	4 812 (100.0)	1.4
	其他亞洲人 Other Asian	7 713 (98.2)	2.3	138 (1.8)	2.3	7 851 (100.0)	2.3
	小計 Sub-total	281 969 (98.7)	83.9	3 581 (1.3)	59.4	285 550 (100.0)	83.4
	白人 White	34 760 (95.5)	10.3	1 624 (4.5)	26.9	36 384 (100.0)	10.6
	混血兒 Mixed						
	華人父或母 With Chinese parent	14 269 (95.6)	4.2	663 (4.4)	11.0	14 932 (100.0)	4.4
	其他混血兒 Other Mixed	3 010 (95.3)	0.9	150 (4.7)	2.5	3 160 (100.0)	0.9
	小計 Sub-total	17 279 (95.5)	5.1	813 (4.5)	13.5	18 092 (100.0)	5.3
	其他 ⁽²⁾ Others ⁽²⁾	2 162 (99.5)	0.6	10 (0.5)	0.2	2 172 (100.0)	0.6
	總計 Total	336 170 (98.2)	100.0	6 028 (1.8)	100.0	342 198 (100.0)	100.0
	全港人口 Whole population	6 645 220 (96.8)		219 126 (3.2)		6 864 346 (100.0)	

註釋：(1) 括號內的數字顯示在總計中所佔的百分比。
(2) 這些數字包括「黑人」、「拉丁美洲人」等。

Notes: (1) Figures in brackets represent the percentages in respect of the total.
(2) The figures include "Black", "Latin American", etc.

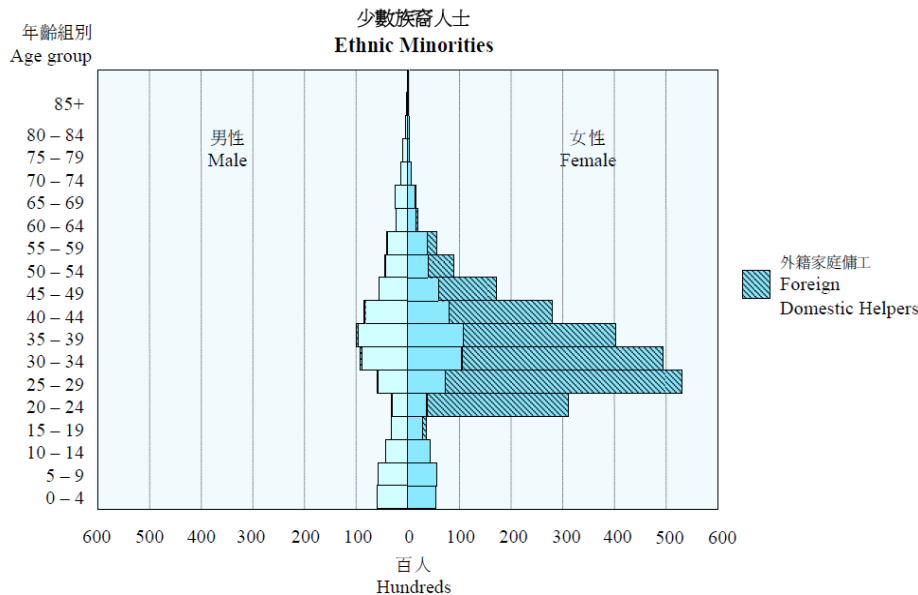
- Among the ethnic minorities, the top 5 ethnic groups were Filipino (over 112,000), Indonesian (about 88,000), Indian (over 20,000), Nepalese (about 16,000), and Japanese (over 13,000).

Gender and age

圖 3.1 二零零一年及二零零六年少數族裔人士及全港人口的人口金字塔 (續)

Chart 3.1 Population Pyramids for Ethnic Minorities and the Whole Population, 2001 and 2006 (Cont'd.)

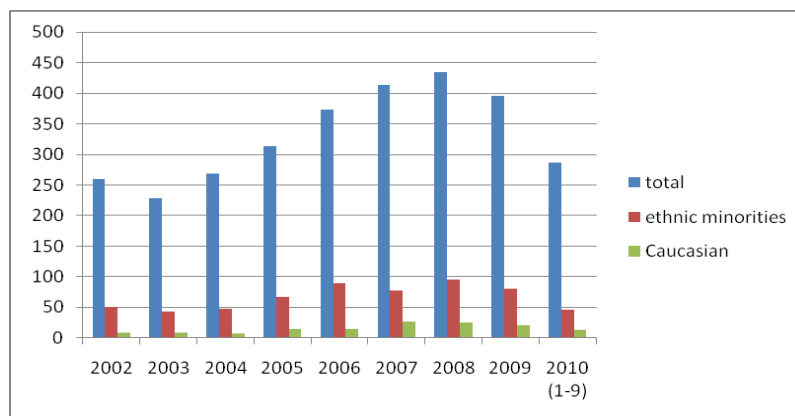
2006



- Majority of the ethnic minorities were female aged 20-49 years old, attributable to the foreign domestic helper population.

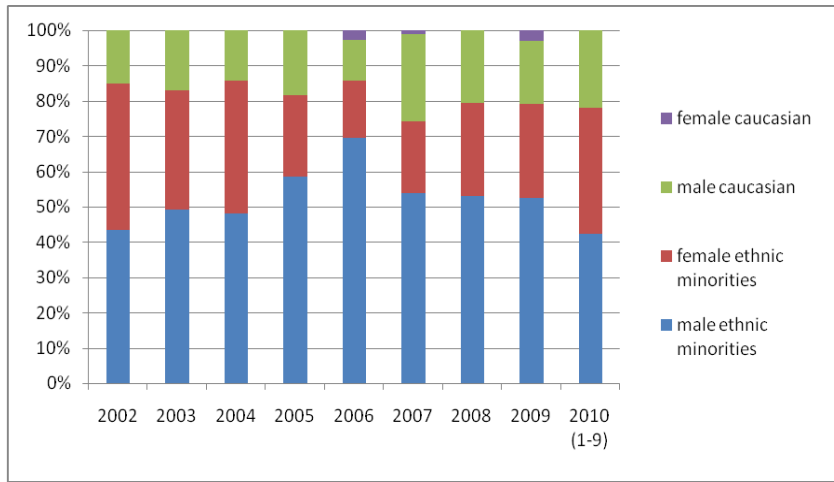
HIV/AIDS reporting system

Trend



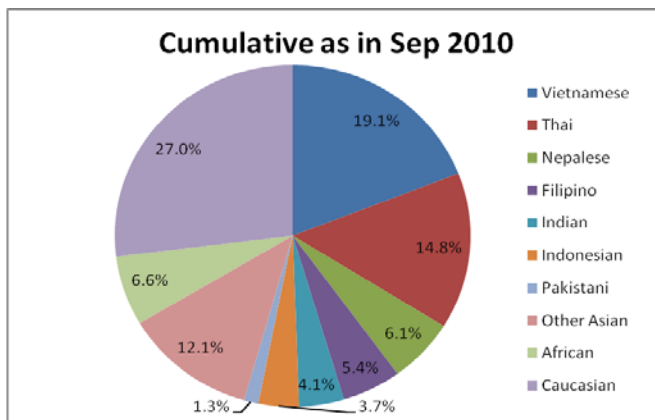
- Annual number of HIV reported cases attributed by ethnic minorities ranged from 67 to 96 cases from 2005 to 2009, corresponding to 19%-24% of all HIV reported cases, as opposed to the Caucasians that ranged from 15-27 cases, corresponding to 4%-6.5% of all HIV reported cases.

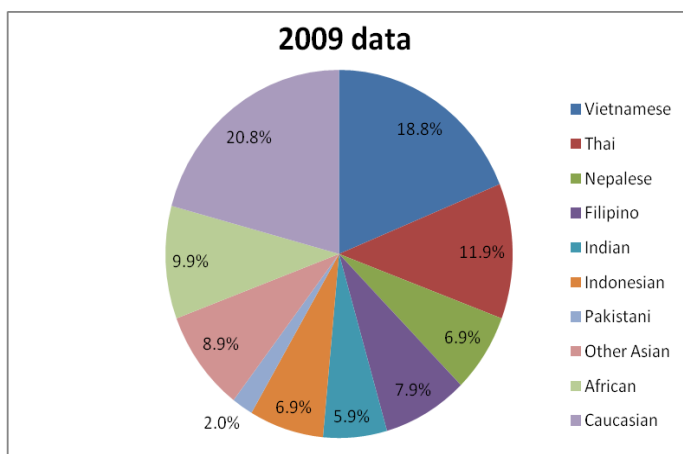
Gender



- When only pooling ethnic minorities and Caucasian together, an increasing trend of HIV cases in female ethnic minorities was observed in recent years, from about 20% in 2005 to over 25% in 2010 (q1-q3).
- The trend for male Caucasians appeared to be relatively stable, at slightly more than 20% in recent years.
- On the other hand, male ethnic minorities, despite a decreasing trend, remained with considerable proportion, i.e. over 40% in 2010 (q1-q3).
- Female Caucasian cases are rarely reported.

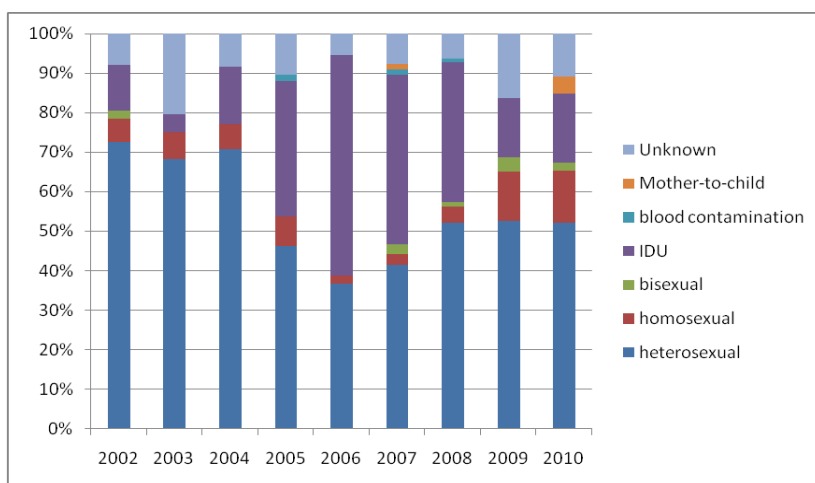
Further breakdown in Ethnicity





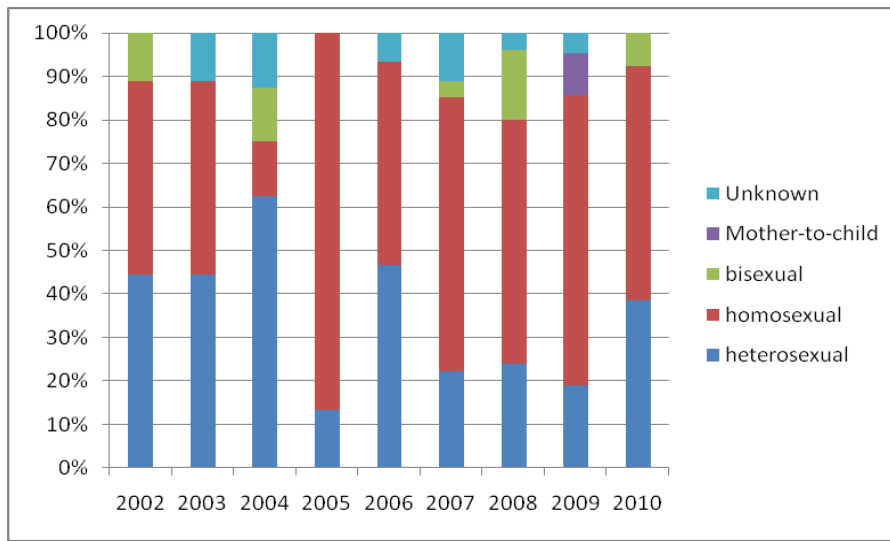
- When only pooling the ethnicities other than Chinese together cumulatively, the top 3 ethnic groups for HIV reported cases were Caucasian (27%), followed by Vietnamese (19%), and Thai (15%).
- Comparatively, in 2009 only, the top 3 ethnic groups for HIV cases remained the same, i.e., Caucasian (21%), Vietnamese (19%), and Thai (12%).

Risk of transmission among ethnic minorities



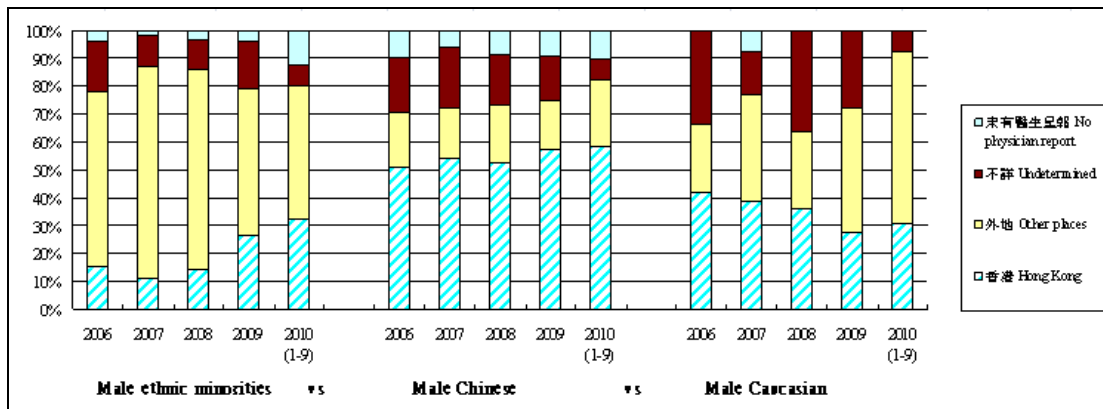
- Heterosexual transmission accounted for over 50% of cases in ethnic minorities in 2008-2010, while homosexual and bisexual accounted for less than 20% of HIV cases in the captioned period.
- Injecting Drug Users (IDU) used to be of higher weighting of transmission route in 2005-2008 among ethnic minorities with >30%-50%, but fewer IDU cases were reported in 2009-2010, with slightly more than 10%.

Risk of transmission among the Caucasians

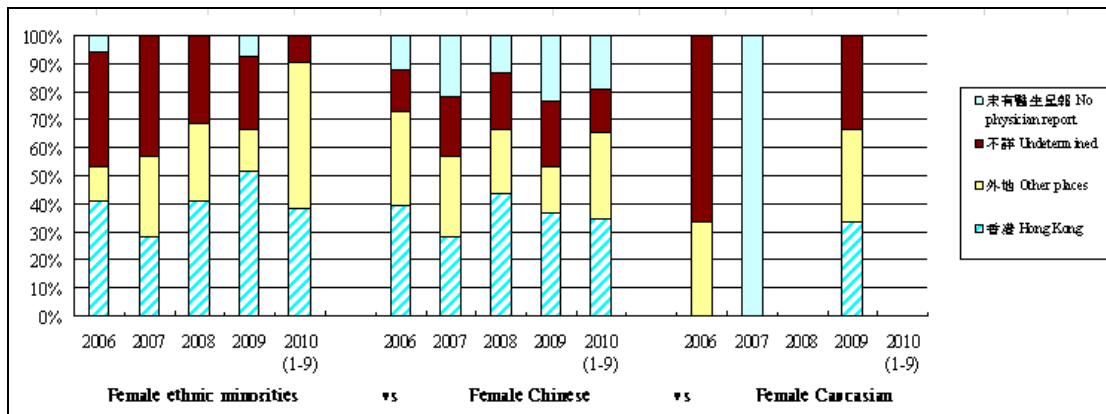


- Homosexual and bisexual transmission were the major route of transmission among the Caucasians, i.e. consistently over 50% since 2007, followed by heterosexual i.e. about 20%-40% in the corresponding period.

Suspected location of infection

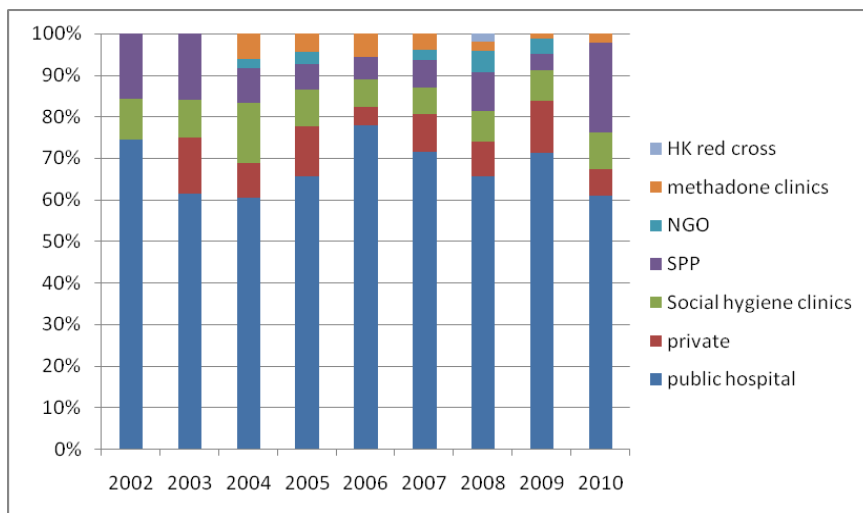


- Compared with Chinese male, male ethnic minorities appeared to acquire the infection in other places rather than in Hong Kong. However, the proportion of local acquisition is catching up in recent years, i.e. from 10% in 2007 to over 30% in 2010 (q1-q3). Caucasian male were more likely to acquire the infection in other places, while approximately 30% of infections among them were acquired in Hong Kong in 2009 and 2010 (q1-q3).



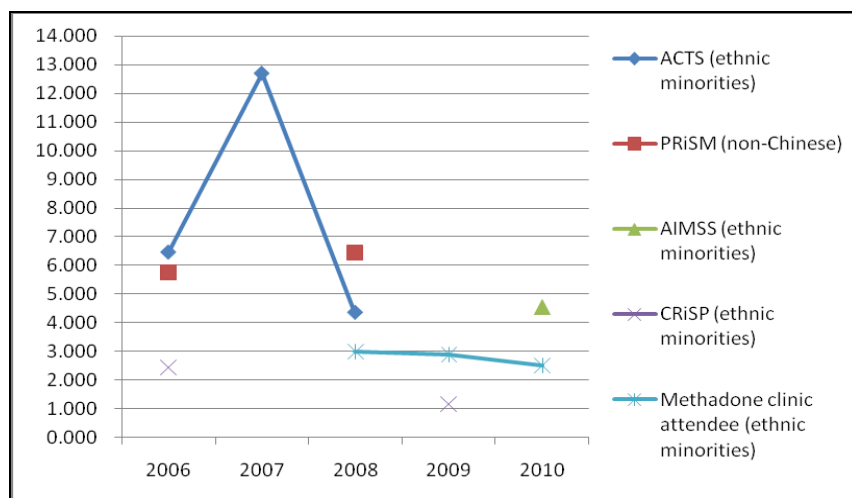
- Pattern for female is more difficult to interpret because of smaller number of cases. In 2010 (q1-q3), more female ethnic minorities appeared to acquire the infection in other places (50%) rather than in Hong Kong (40%).

Reporting source



- NGO took up less than 5% of HIV diagnosis for ethnic minorities.

HIV prevalence in Ethnic minorities



- Surveillance among various testing services revealed HIV prevalence of 4.5%-6.4% among MSM ethnic minorities from the two PRiSM studies and the AIMSS study, while non-Chinese female sex worker (FSW) from the two CRiSP studies had HIV prevalence of 1.1%-2.4% (note: only the category “non-Chinese” was used in the CRiSP 2009 study, the category “ethnic minorities” was not used). Ethnic minority methadone clinic attendees had HIV prevalence of 3%-3.8%. Ethnic minorities attending AIDS Counseling and Test Services (ACTS) fluctuated more widely in terms of HIV prevalence, ranging from 4.3% to 12.7%. However, it is note worthy that the sample size was small (only 46-63 cases, including referral cases with reactive HIV rapid test result.).

Risk behaviours

Consistent condom use

(Source: ACTS)*	2007	2008	2009
Asian with RSP	37%	23%	40%
Asian with CoSP	71%	81%	73%
(Source: SHS)**			
Asian with RSP	3%	13%	6%
Asian with Co / Ca SP	14%	25%	20%
*referring to consistent condom use in past 1 year			
**referring to consistent condom use in past 3 months			

- AIMSS (2010): Consistent condom usage among MSM ethnic minorities was 17% with their regular sex partner (RSP), and 59% with their casual sex partner (Ca SP) in the

past 6 months.

- In year 2007-09, the level of consistent condom use among ethnic minorities based on the Social Hygiene Services (SHS) data was generally lower than the level based on the ACTS data, for both RSP and Co / Ca SP.
- Ethnic minorities at SHS had low consistent condom use of only 20% with their commercial (Co) or casual (Ca) sex partner (SP) in 2009, while 73% from ACTS had consistent condom use.

HIV testing history

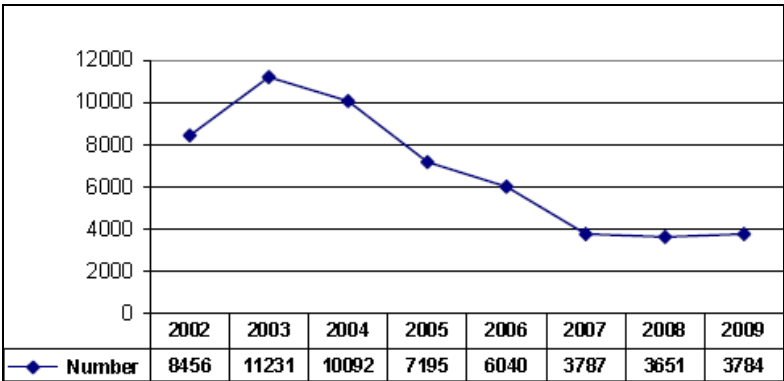
- Methadone clinics (2008): 72% of methadone clinic attendees who are ethnic minorities were tested for HIV in the year of 2008.
- Methadone clinics (2009): 71% of methadone clinic attendees who are ethnic minorities were tested for HIV in the year of 2009.
- CRiSP (2009): 59% of non-Chinese FSW tested for HIV in the past year. (note: only the category “non-Chinese” was used in the CRiSP 2009 study, the category “ethnic minorities” was not used.)
- PRiSM (2008): 58% of ethnic minorities MSM reported to have tested for HIV in the past year.
- AIMSS (2010): 45% of ethnic minorities MSM reported to have tested for HIV in the past year.

Review of epidemiology for Female sex workers (FSW)

[draft for discussion only]

Population size estimation

- A local paper in 1993⁴ has quoted that there were approximately 200,000 FSW in Hong Kong, without description of the data source. Data from other published articles suggested the range between 20,000 and 100,000 of FSW in year 2000 and 2002^{5,6} in Hong Kong.
- Commercial sex work was described as heterogeneous and highly mobile from these sources.
- A mapping of FSW was performed in August 2006 and July 2009 as the CRiSP studies. It was estimated about 10,500 and 7,100 of FSW respectively in 2006 and 2009, in Hong Kong. Because of the hidden nature of FSW, such that some are highly controlled by pimps, while others may have illegal status, these numbers were likely to be underestimated.
- Applying the mapping estimation of CRiSP studies (in 2006 and 2009), there are about 0.34%-0.48% of female population aged 15-49 in Hong Kong worked as FSW,.



- Data from Immigration Department of HKSARG showed the number arrested for sex work involvement decreased from over 8,000 in 2002 to over 3,000 in 2009, although the numbers are likely to be underestimations.

⁴ Housewives in sex industry. South China Morning Post 3 May 1993.

⁵ www.ziteng.org.hk/platform/pfc03_e.html

⁶ www.ziteng.org.hk/platform/pfb01_c.html

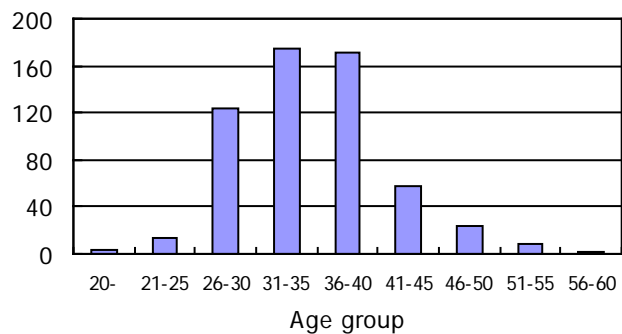
Mapping of sex work settings

	2009 Jun		2006 Sep [^]		2006 Sep (R)	
OWB	2540	35.6%	930	8.8%	930	10.7%
KNC	3875	54.3%	6200	58.8%	6200	71.3%
BAR	261	3.7%	560	5.3%	560	6.4%
SSW	115*	1.6%	2360 [^]	22.4%	520*	6.0%
MAS/BRO	146*	2.0%	190*	1.8%	190	2.2%
<i>Foot massage/hair salon</i>	55	0.8%				
<i>Sauna</i>	150	2.1%	300	2.8%	300	3.4%
Total	7142		10540		8700	

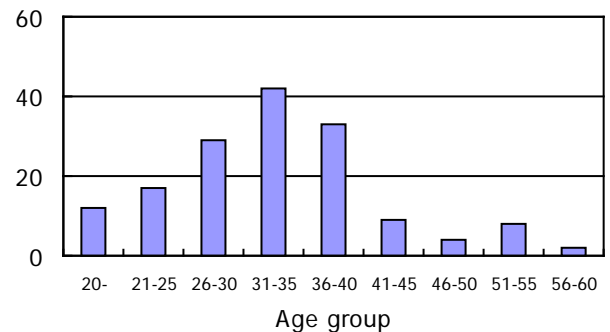
- CRiSP studies: The change in mapping is abrupt, as there was massive redevelopment of old districts where closure of major sex work establishment took place between 2006 and 2009, which could lead to a more than 40% reduction in nightclub, but a 3-fold increase in number of one woman brothels.

Age

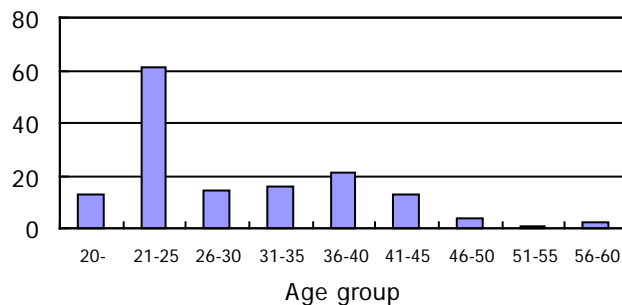
One woman brothel



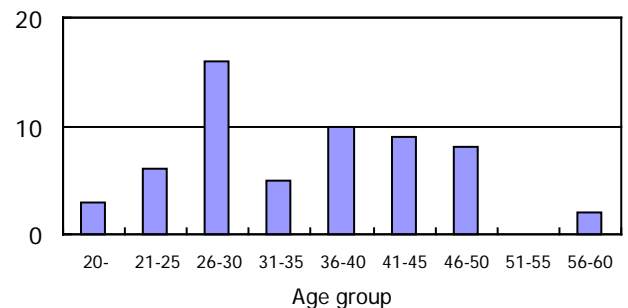
Karaoke nightclub



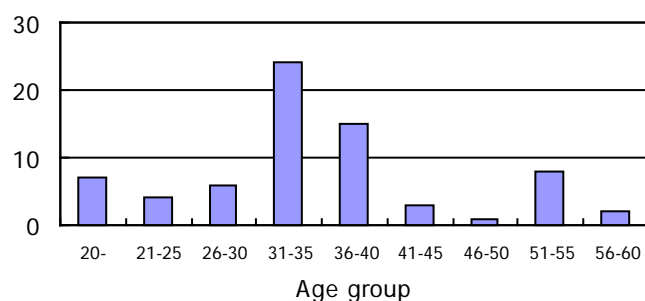
BAR

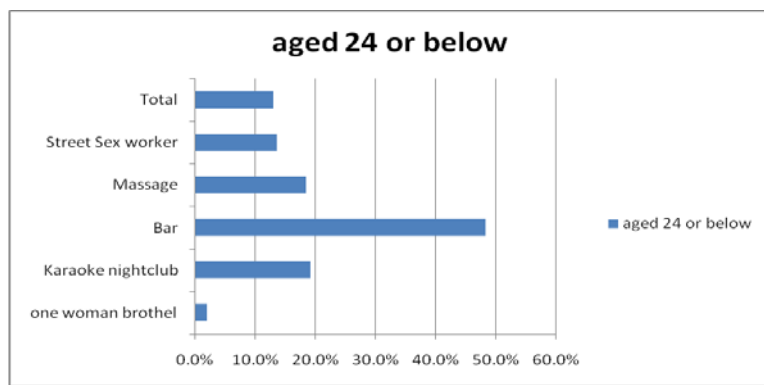


Street Sex worker



Massage





- CRiSP (2009): FSW from Bars were likely to be younger with median age 25, and close to 50% of them aged 24 or below. For Street sex workers, there appeared to have one younger (20s) and one older (40s or more) subgroups.

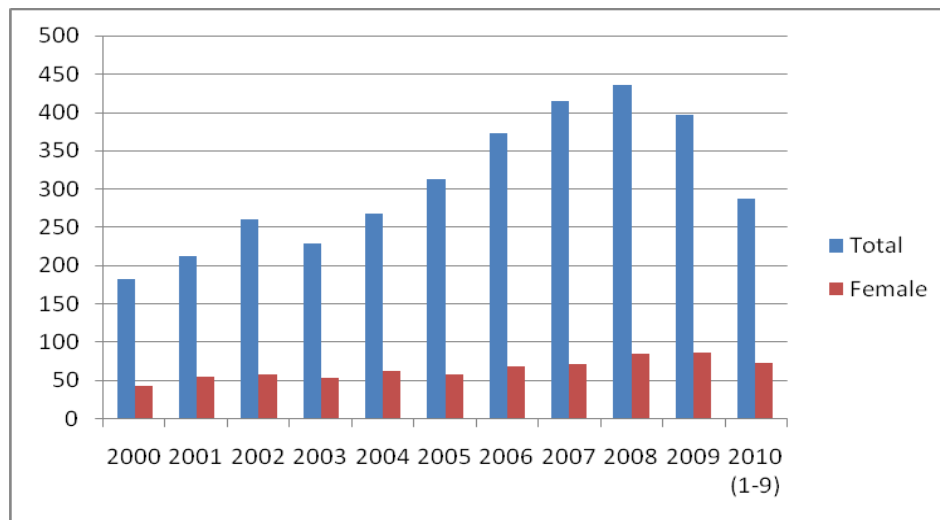
Ethnicity

	OWB	KNC	BAR	MBR	SSW	Total	Adjusted
Ethnicity							
Chinese	542 (93.8%)	145 (99.3%)	1 (0.7%)	59 (98.3%)	59 (100.0%)	806 (81.7%)	(93.6%)
Non-Chinese	34 (5.9%)	0 (0.0%)	142 (99.3%)	1 (1.7%)	0 (0.0%)	177 (18.0%)	(5.9%)
Thai	26 (4.5%)	0 (0.0%)	54 (37.8%)	0 (0.0%)	0 (0.0%)	80 (8.1%)	(3.1%)
Filipinos	1 (0.2%)	0 (0.0%)	88 (61.5%)	0 (0.0%)	0 (0.0%)	89 (9.0%)	(2.4%)
Others	7 (1.2%)	0 (0.0%)	0 (0.0%)	1 (1.7%)	0 (0.0%)	8 (0.8%)	(0.5%)
Missing	2 (0.3%)	1 (0.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	3 (0.3%)	(0.5%)
	<i>N=578</i>	<i>N=146</i>	<i>N=143</i>	<i>N=60</i>	<i>N=59</i>	<i>N=986</i>	

- CRiSP (2009): Over 93% of FSW were Chinese.

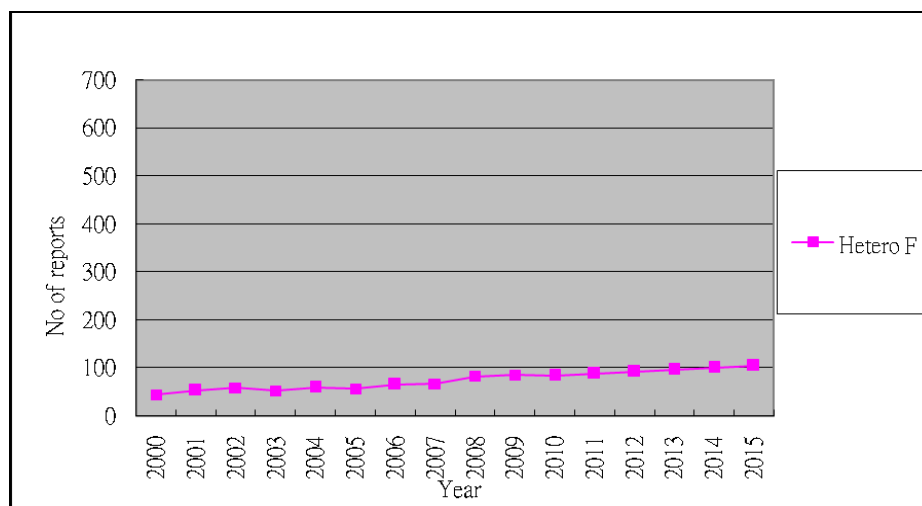
HIV/AIDS reporting system

Trend



- Our reporting system did not capture the identification of FSW. In general, number of female HIV reports rised gradually, from 55 cases in 2001 to 87 cases in 2009. The proportion of female cases appeared to stay between 17%-25% (note that female cases do not equal to FSW cases).
- If applying the mapping estimation of CRiSP studie, about 0.34%-0.48% of female population aged 15-49 in Hong Kong worked as FSW. Assuming the reported female HIV cases are representative of the general female population, fewer than one HIV positive FSW case is expected to be reported annually.

Projection



- Based on past data in year 2000-2009, an average annual increment of 4%-4.7% will be expected in 2010-2015, which will translate into 85-105 females HIV cases annually

until 2015. Thus, fewer than 1 HIV positive FSW case annually will be expected in 2010-2015.

HIV prevalence and behavioural risks

		2006	2009
ACCESS to prevention	Ever heard of HIV prevention message	96%	99%
	Received free condoms in past year	55%	58%
	Contacted with outreach workers about STI & HIV/AIDS prevention in past year	45%	53%
	Ever tested for HIV	54%	64%
	Tested for HIV in past year	45%	49%
BEHAVIOURAL risk	Regular condom use in vaginal/anal sex with their clients in last week	92%	95%
	Condom use in last vaginal sex with client	93%	96%
	Ever injection of heroin	3%	0.8%
	Recent (6 mons) injection of heroin	-	0.04%
HIV	Adjusted HIV prevalence	0.19%	0.05%

Condom usage

- SHS (2009): 31% consistent condom use with regular non-commercial sex partner in past 3 months.
- SHS (2009): 27% condom use at last sex with regular non-commercial sex partner.
- CRiSP (2009): 21% consistent condom use with boyfriend/husband in past 6 months.
- SHS (2009): 94% condom use at last sex with casual or commercial partner.
- SHS (2009): 94% consistent condom use with casual or commercial partner in past 3 months.
- CRiSP (2009): 91% (adjusted to various sex work settings) consistent condom use with client in past week.
- CRiSP (2006): 86% (adjusted to various sex work settings) consistent condom use with client in past week.

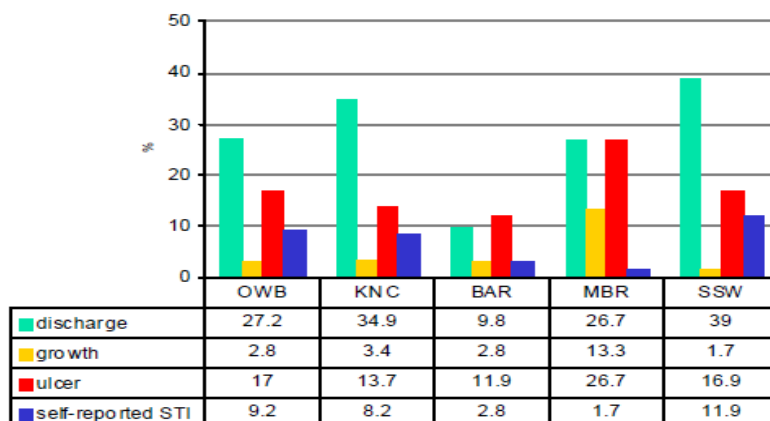
Sex work settings	One woman brothel	Karaoke nightclub	Bar	Street sex worker	Massage
2006	99%	80%	96%	95%	87%
2009	98%	87%	94%	88%	87%

- CRiSP studies: Condom use varied across different sex work settings.

HIV testing history

- CRiSP studies: Less than half (45%-49%) were tested for HIV in year 2006 and 2009.

Sexually Transmitted Infections (STI) in past 6 months



Box 20. Self reports of STI and genital symptoms in past 6 months.

- CRiSP (2009): Self reported STI in past 6 months were higher among FSW working as Street sex worker (SSW), in one woman brothel (OWB), and at Karaoke nightclub (KNC), comparing to FSW from Bars and massage parlours (MBR), who had lower level of self reported STI.

Review of epidemiology for Injecting drug users (IDU)

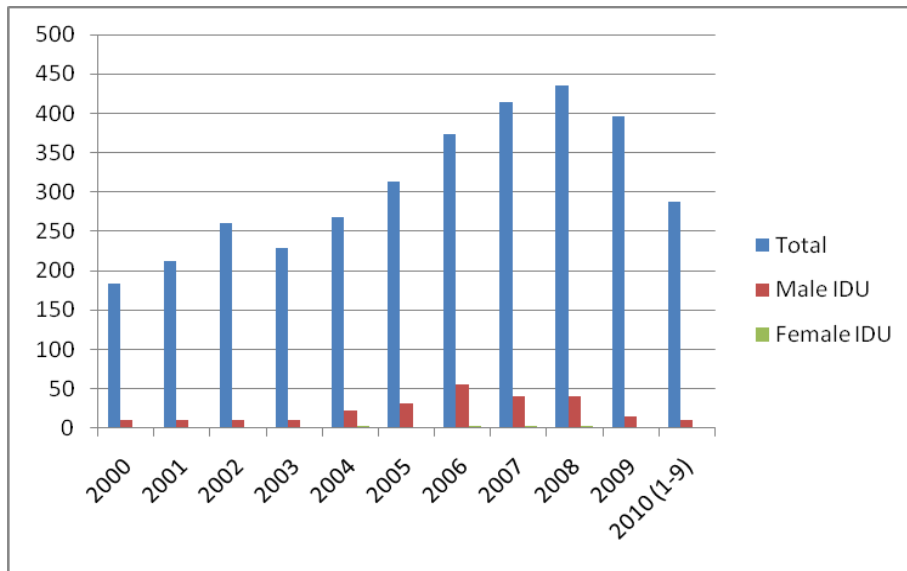
[draft for discussion only]

Population size estimation

- Estimation for the injecting / heroin drug users has taken reference from three major data sources: Central Registry of Drug Abuse (CRDA), Methadone Treatment Programme (MTP) and Street Addict Survey (SAS). Defining IDU has been a difficult topic as movement in and out of injecting behaviour can be very frequent, that the population size for IDU can be changed accordingly depending on the time point one is measuring.
- Based on CRDA, there were about 13,600 and 14,200 of drug users in 2007 and 2008 respectively, of which about 57% and 52% were taking heroin by injection, corresponding to about 7,700 and 7,400 IDU in Hong Kong.
- Based on MTP, a total of 11,117 attendees were recorded in 2009, in which approximately 4,600 attendees were newly admitted or readmitted, suggesting possible drug injecting behaviour prior to the point of care at MTP (though only 25-35% newly admitted attendees admitted drug injecting upon attendance in year 2002-2009). The rest in the MTP were either on maintenance or detoxification therapy and strictly speaking not drug abusers. However, among these individuals it is worth-noting that 20%-40% of opiate test were positive among MTP attendees (although opiate test data is not very reliable), thus, suggesting another 1,300 to 2,600 might need to be added to those newly or readmitted cases, corresponding to very rough estimates of about 6,000-7,000 injecting drug users in Hong Kong, based on the MTP estimates.
- Based on SAS, between 67%-88% of the sample reported drug injecting in past month in year 2005 onward. Given over 94% of the SAS sample attended MTP, the survey findings might provide possible projection to MTP finding, giving about 11,800 population of MTP attendee plus street addicts, in which an overall of 7,900-10,400 reported drug injecting behaviour in past month in Hong Kong.
- The general trend of decreasing heroin use has also been observed from the CRDA data.

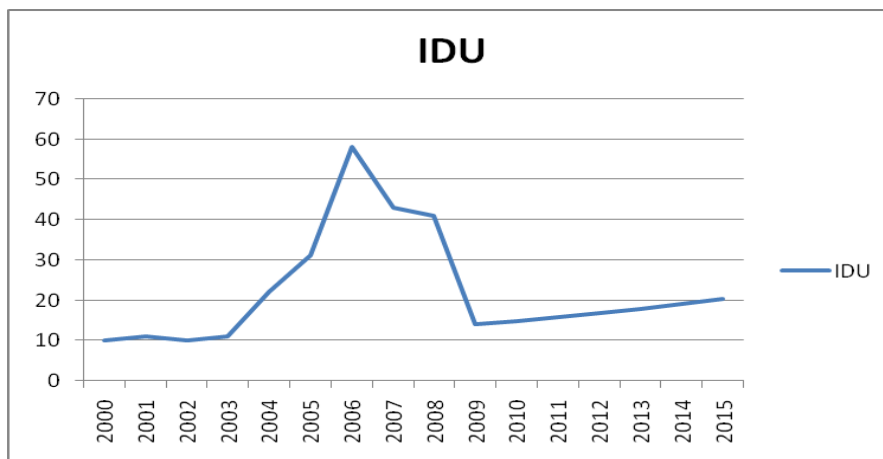
HIV/AIDS reporting system

Trend



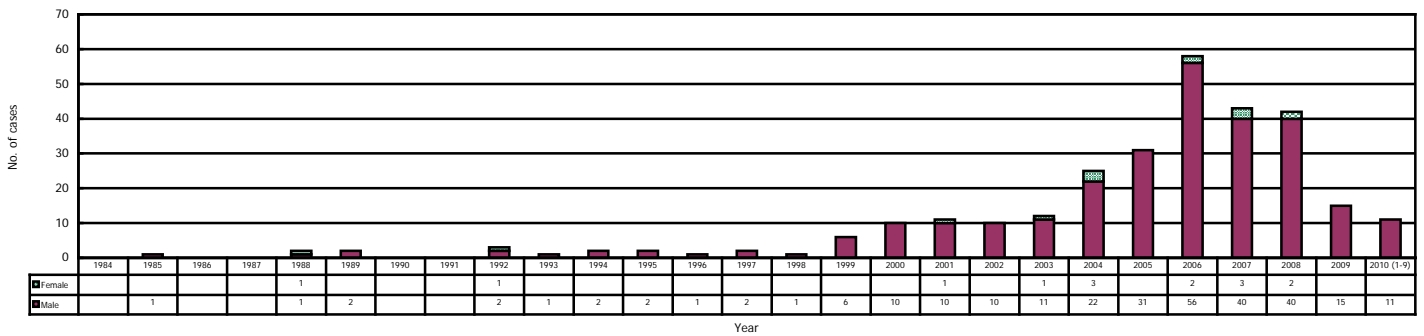
- Number of HIV reported cases contributed by IDU remained on low level after its peak in year 2006-08.
- Male predominated in IDU's contribution by taking over 90% of cases since 2005.

Projection



- Based on past data in year 2005-2009, an average modest increment of 6.3% in HIV cases among IDU will be expected in 2010-2015, which translates into not more than 20 HIV cases annually until 2015.

Gender



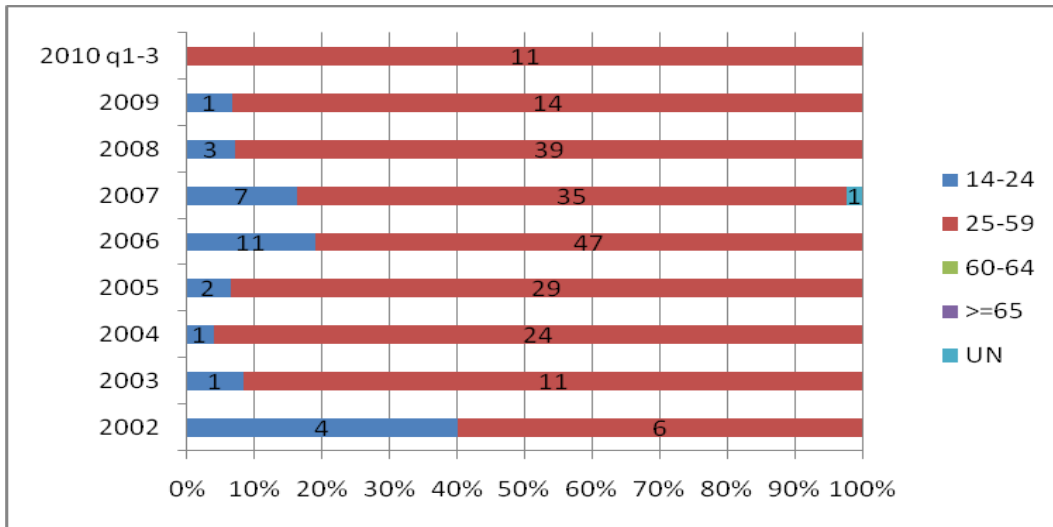
- Male overwhelmingly predominated, with male to female ratio close to 10:1.

Ethnicity

Year	Chinese	Asian	Caucasian	African	Unknown	% Chinese	% Asian	% Vietnam
2002	4	6	0	0	0	40%	60%	60%
2003	10	2	0	0	0	83%	17%	8%
2004	18	7	0	0	0	72%	28%	24%
2005	8	23	0	0	0	26%	74%	68%
2006	7	50	0	0	1	12%	86%	72%
2007	10	33	0	0	0	23%	77%	70%
2008	8	34	0	0	0	19%	81%	76%
2009	3	12	0	0	0	20%	80%	67%
2010 (q1-3)	3	8	0	0	0	27%	73%	64%

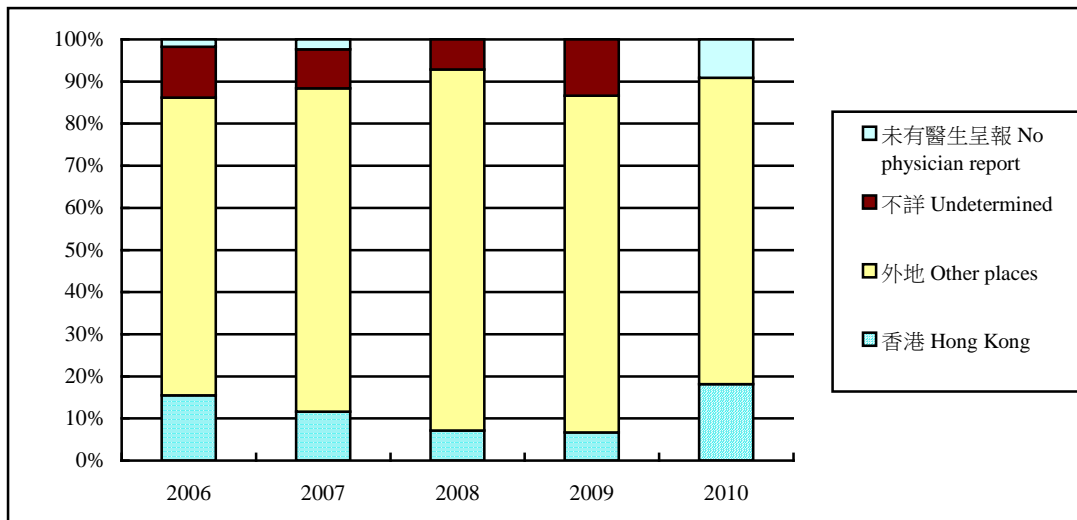
- More than 70% of IDU reported cases are Asians (other than Chinese), of which most were Vietnamese.

Age



- The age group of 14-24 is shrinking in proportion, i.e., < 10% in recent the 3 years.
- There is no reported HIV cases from the above 60 years old age group.

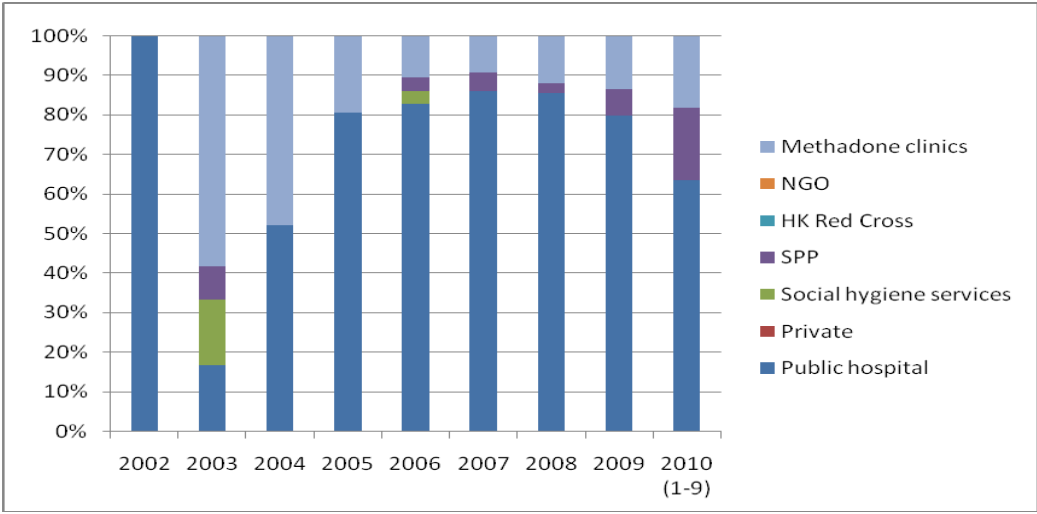
Suspected location



- Less than 20% of the reported cases acquired HIV locally.
- Approximately 70%-80% of IDU acquired HIV outside Hong Kong.
- Among those, acquisition in Vietnam was the most common place.

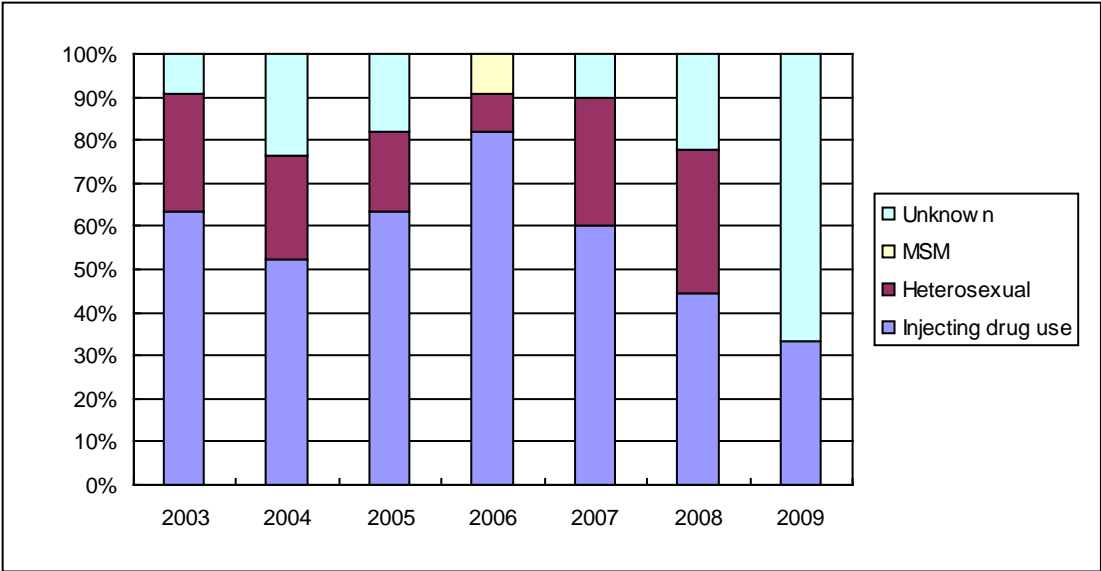
2006	2007	2008	2009	2010
39	27	29	11	6
67%	63%	69%	73%	55%

Reporting source



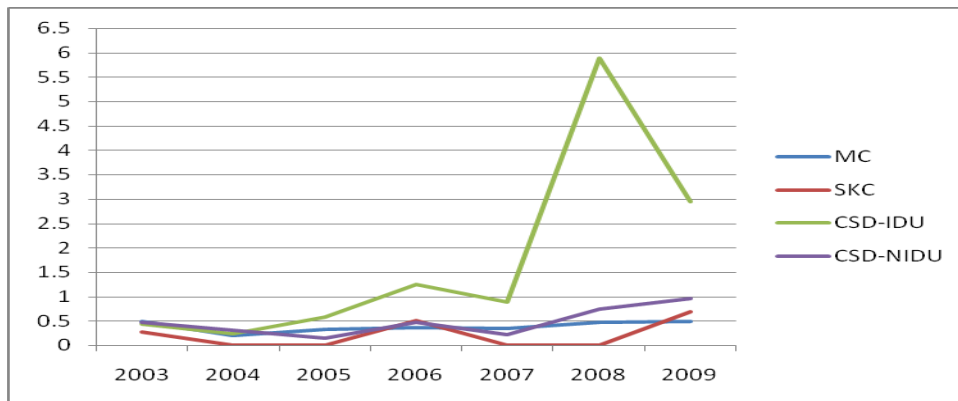
- There was no reported case from NGO in recent years. This does not mean NGO did not provide testing for IDU, but IDU who tested positive for HIV might not be reported to have IDU as their exposure categories.

Exposure risk among HIV positive methadone clinic attendees



- Approximately 30%-60% in 2007 to 2009 of service users under HIV positive methadone user registry was attributable to the injective drug use exposure category.

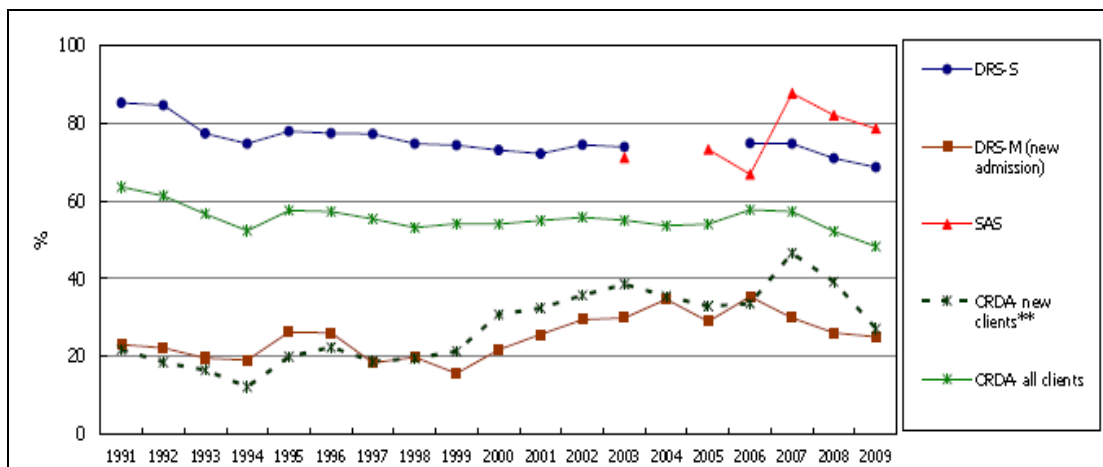
HIV prevalence in IDU



- Sentinel surveillance, including Methadone Clinic attendees (MC) and Shek Kwu Chau rehabilitation centre (SKC), generally revealed a low level of HIV prevalence among drug users, consistently below 0.5% over the past years (note that the breakdown into IDU is not available). This prevalence level is comparable to the data in Correctional Services Department (CSD) for the non injecting drug users (CSD-NIDU).
- HIV prevalence, however, was considerably higher among ever injecting users in CSD, in year 2007 to 2009 with a range between 1% and 6%. Most of this was attributed to prisoners with Vietnamese origins (50% in 2007, 58% in 2008 and 100% in 2009).

Risk behaviour

Current IDU

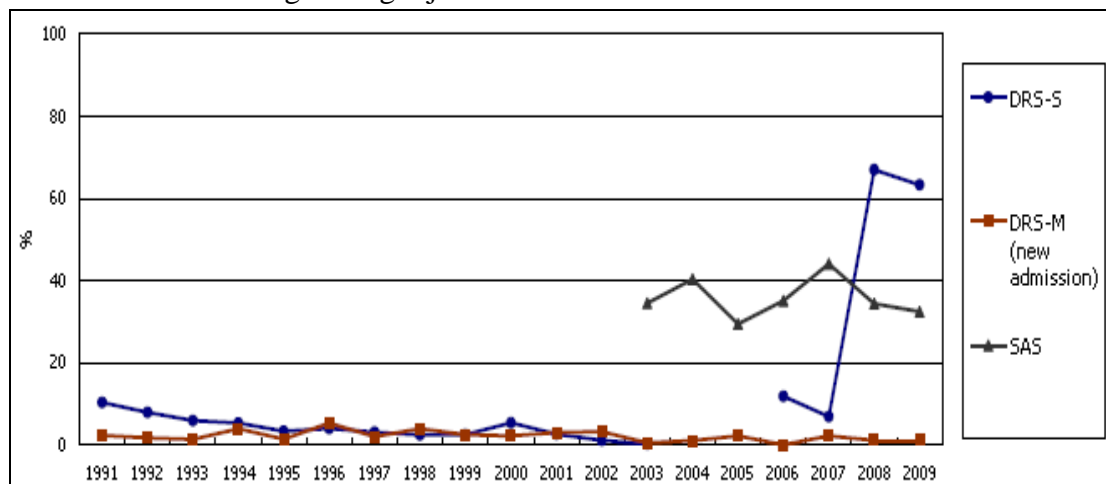


- SKC (or DRS-S) and SAS where peer interviewers were used captured a higher level of drug injecting behavior reported. About 60% and 80% of respondents reported to have injected drugs consistently in past 6 months and 1 month respectively.
- MC (or DRS-M) where doctors were the interviewers captured a lower level of drug

injecting behavior reported at point of care, i.e. 25%-35% among the newly admitted attendees. Although this level is considered to be underreported, however it is still comparable to the newly admitted drug users based on CRDA (which referred to drug injecting behavior in the past 1 month). Thus, new drug users in general appeared to be less likely to engage in drug injecting behavior.

- For all reported drug users in CRDA, between 48%-57% of them were IDU (reporting to have injected drugs in the past 1 month).

Current needle sharing among injector



- Between 30%-44% of IDU reported to have shared needles in the past 1 month based on SAS (2003-2009).
- MC (or DRS-M) again captured a lower level of needle sharing behavior, that way below 3% among the newly admitted drug users reported to have shared needle at the point of care.
- SKC (or DRS-S) fluctuated more widely, that between 7% and 67% of IDU reported to have shared needles in the past 6 months.

Condom usage

- SAS (2007-2009): 13%-30% of all drug users reported to have consistent condom use with RSP in the past 1 year; 82%-91% of all DU reported to have consistent condom use with FSW in the past 3 months; and 77%-93% of DU reported to have consistent condom use with FSW in China in past 3 months.
- SKC (2007-2009): 67%-81% of drug users reported to have had sex in past 6 months. Among them, 2%-21% reported to have condom use with RSP in the last sexual encounter, and 82%-95% reported condom use with FSW in the last sexual encounter.
- MC (2008-2009): 4%-8% of newly admitted drug users reported to have had sex with FSW in the past 1 year. 17%-19% of drug users reported to have consistent condom

use in past year for all partner types.

- CSD (2007-2009): 24%-26% of IDU reported to have consistent condom use with RSP in the past 1 year; 54%-71% of male ever IDU reported to have consistent condom use with FSW in past year; 44%-55% of IDU reported to have condom use at the last sexual encounter with RSP; 66%-84% of IDU reported to have condom use with FSW at the last sexual encounter.

HIV testing history

- SAS (2007-2009): 79%-89% of DU reported to have tested for HIV in the past 1 year.
- MC (2008-2009): 76%-78% of all MC attendees reported to have ever tested for HIV; while 76%-81% in from the newly admitted category, and 80% from the readmitted category.
- Methadone Clinic Universal Testing Programme (MUT) (2008-2009): 84%-87% of those entering the MUT reported to have ever tested for HIV, among them, 93% were newly admitted and 90%-92% were readmitted drug users.
- SKC (2007-2009): 12%-80% of drug users reported to have ever tested for HIV.
- CSD (2007-2009): 20%-28% of ever IDU reported to have ever tested for HIV.

Review of epidemiology for Men who have sex with men (MSM)

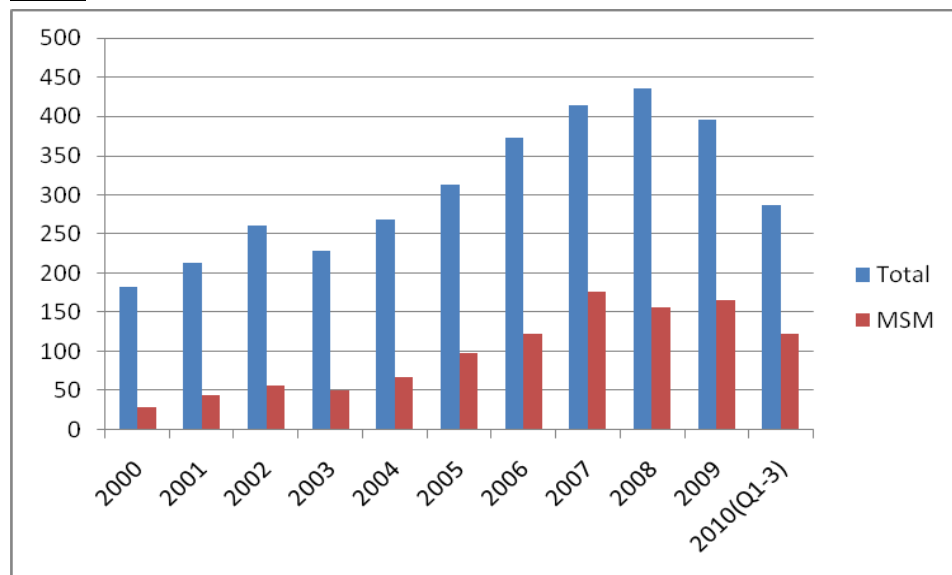
[draft for discussion only]

Population size estimation

- A benchmark population based behavioral study in 2001⁷, which sampled about 15,000 men aged 18-60 using computer assisted telephone interview, provided an estimation of the size of MSM population at risk for HIV infection. The study showed that 4.5% of the men sampled ever had sex with another men.
- Two percent had sex with another men in the last 6 months (active MSM), 22.3% of them reported to have had anal sex (i.e., 0.45% of all men being interviewed).
- As at end of 2009, the male population aged 18-60 were over 2.1 million [C&SD, 2009], and according to the 2006 by-Census data, 97% of male population aged 18-60 were Chinese.
- Applying the above data, the population size of men who have ever reported to have had sex with men derived for the year of 2009 in Hong Kong would be over 96,000. Such figure would include over 42,000 of active MSM (had sex with another men in the last 6 months) and over 10,000 of MSM with recent anal sex.
- About 6% of the MSM from the AIMSS 2010 study had sex with female partners in the past 6 months.

HIV/AIDS reporting system

Trend

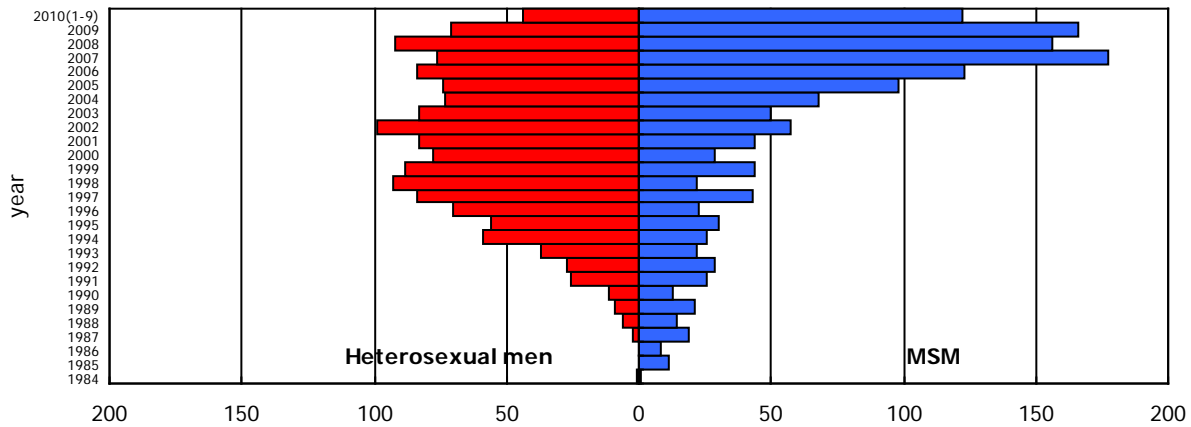


- Number of HIV reported cases from the MSM population rose from the last decade to its

⁷ J T F Lau et al. HIV related behaviours and attitudes among Chinese men who have sex with men in Hong Kong: a population based study. Sex Trasm Infect 2004; 80: 459-465.

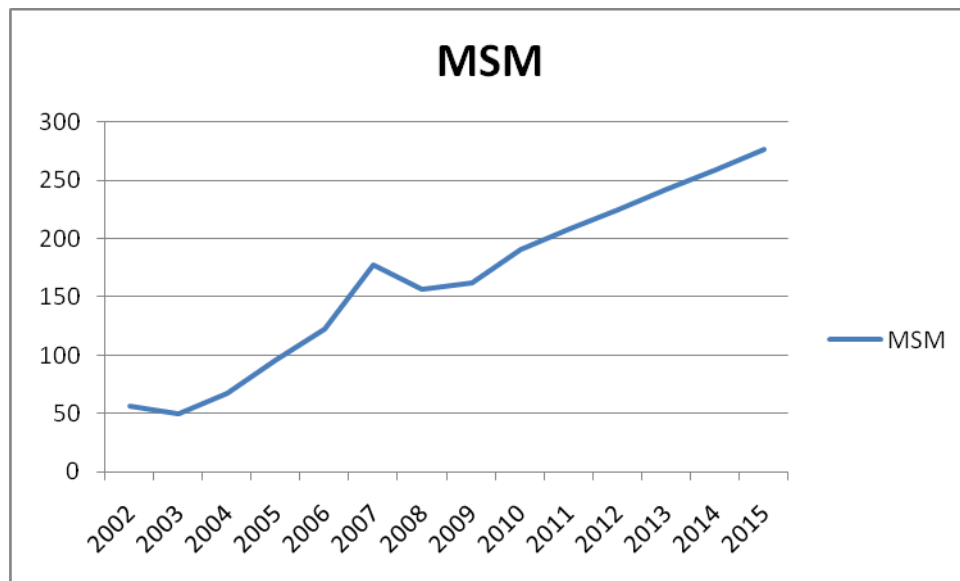
peak in 2007-08, and then appeared to be leveling off.

- About 150 MSM HIV cases are being reported annually. About 40% of all HIV reported cases are accountable by MSM since 2007.



- The number of MSM HIV reported cases exceeded the number of heterosexual men HIV reported cases since 2005.

Projection



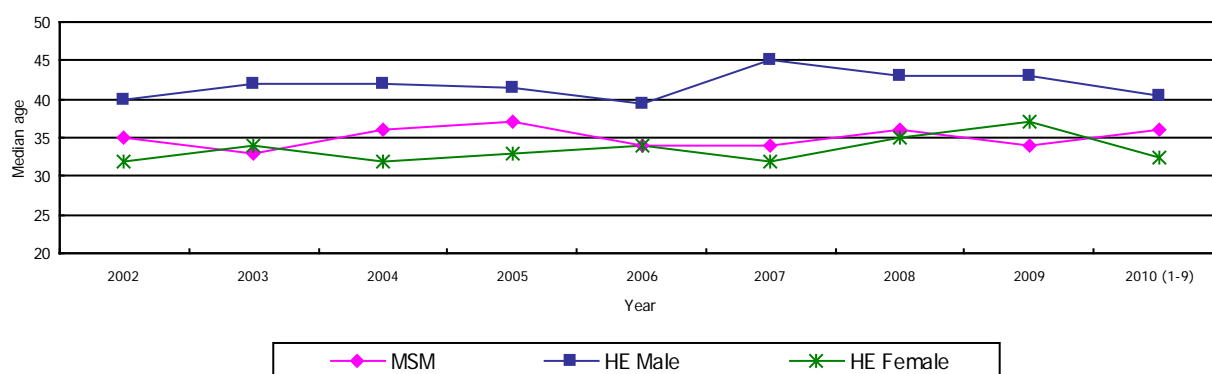
- It is projected that the number of MSM HIV reported cases will continue to increase gradually, based on regression method using past 10 year's data.

Ethnicity

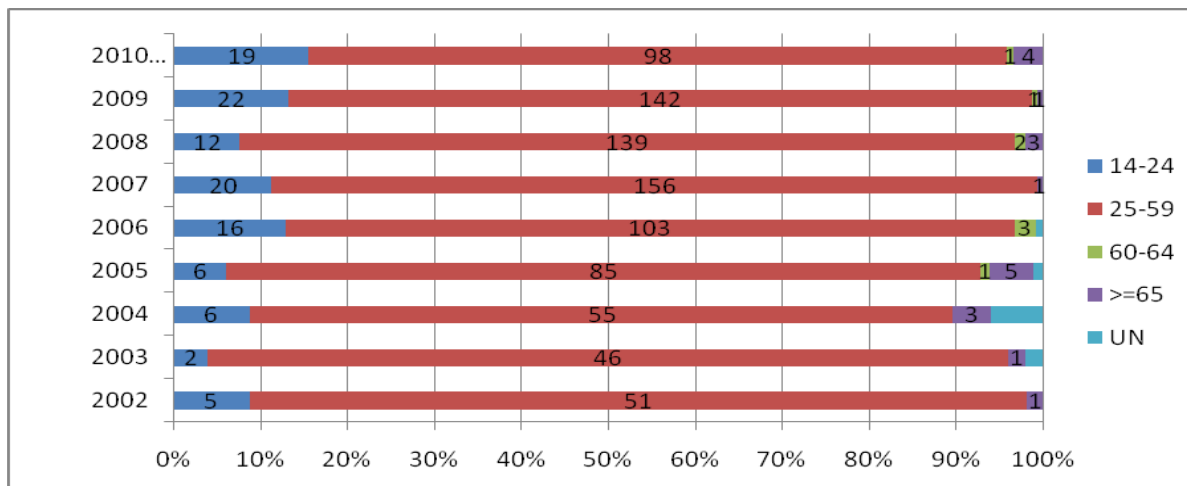
Year	Chinese	Asian	Caucasian	African	Unknown	% Chinese
2002	48	4	5	0	0	84%
2003	43	2	4	1	0	86%
2004	63	3	2	0	0	93%
2005	78	5	13	0	2	80%
2006	113	1	7	1	1	92%
2007	155	4	18	0	0	88%
2008	133	5	18	0	0	85%
2009	137	13	14	0	2	83%
2010 (q1-3)	107	6	8	1	0	88%

- From 2007-2010 (q1-3), 80-90% of all MSM HIV reported cases were Chinese.

Age

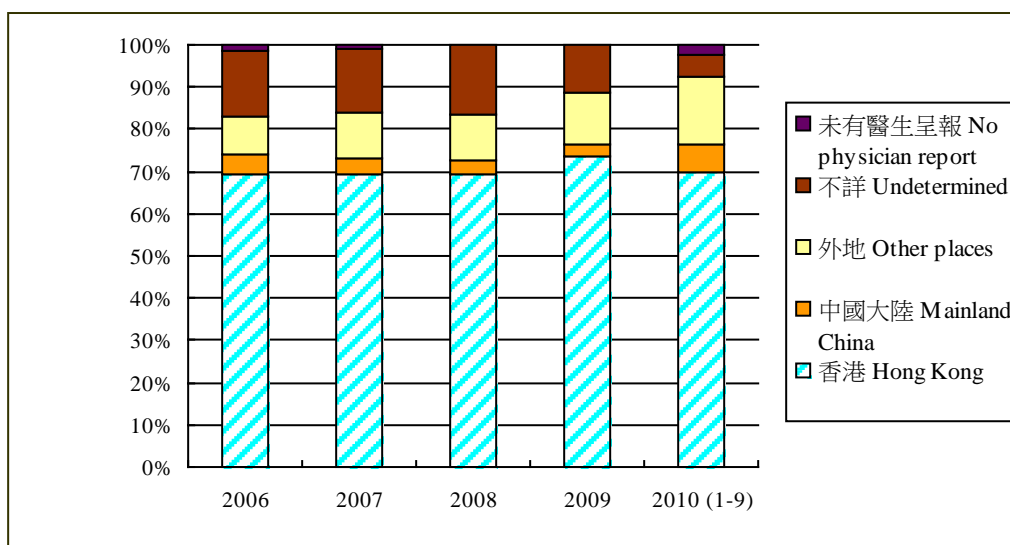


- Since 2002, median age is stabilized at around 35 years old upon HIV diagnosis on the whole.



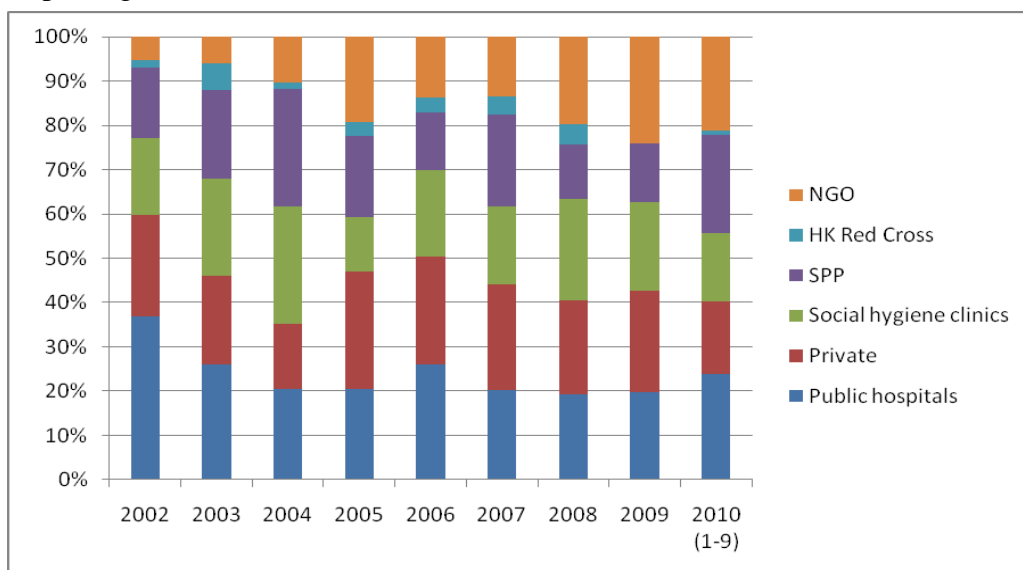
- Since 2002, the 14-24 age group accounted for 10%-15% of all MSM HIV reported cases.
- Since 2002, the >60 age group accounted for <5% of MSM HIV reported cases.

Suspected location



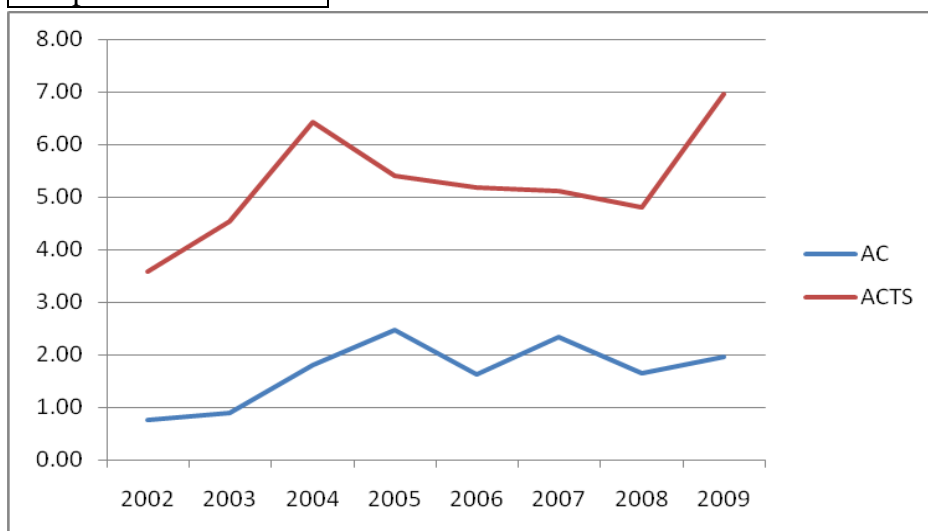
- Since 2006, about 70% of MSM HIV reported cases reported to have acquired HIV locally.
- Since 2006, less than 5% of MSM HIV reported cases reported to have acquired HIV from Mainland China.
- Since 2006, less than 20% of MSM HIV reported cases reported to have acquired HIV from places outside of Hong Kong other than Mainland China.

Reporting source



- Since 2008, more than 20% of MSM HIV diagnosis were reported by NGO.

HIV prevalence in MSM



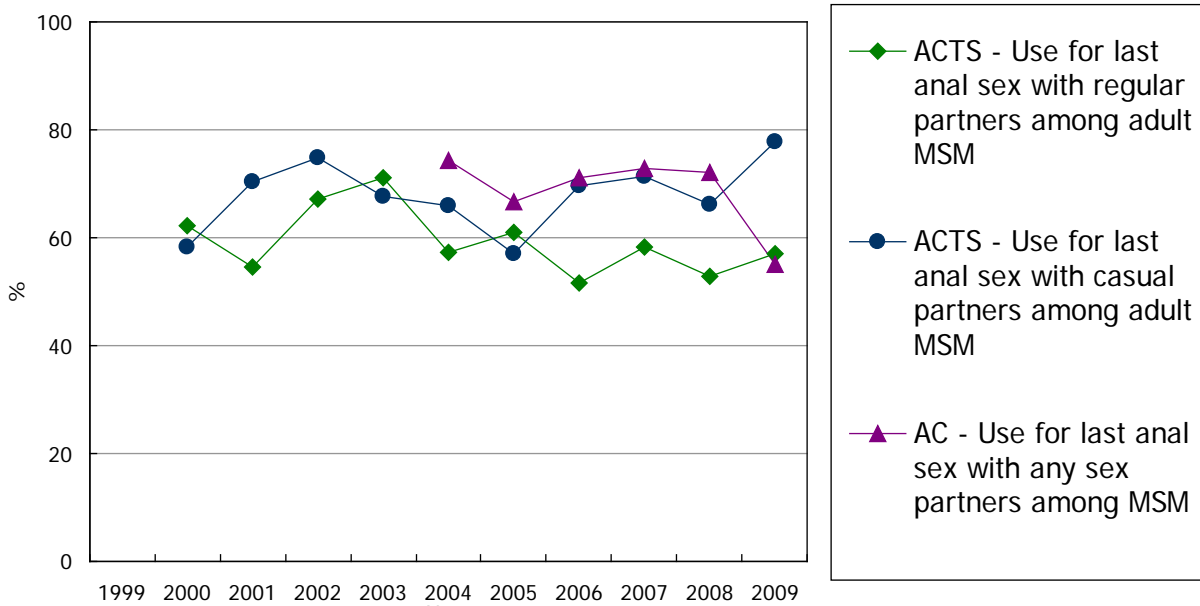
- Sentinel surveillance revealed a gradually rising prevalence from the NGO sentinel point at about 2% of prevalence rate, while there observes a wider fluctuation in prevalence from ACTS due to smaller number of test, at an average of 5% prevalence rate over the years.
- PRiSM studies revealed prevalences of 4% in 2006 and 4.3% in 2008, while the AMISS studies revealed prevalences of 5.3% in 2009 and 5.5% in 2010.

Risk behaviours

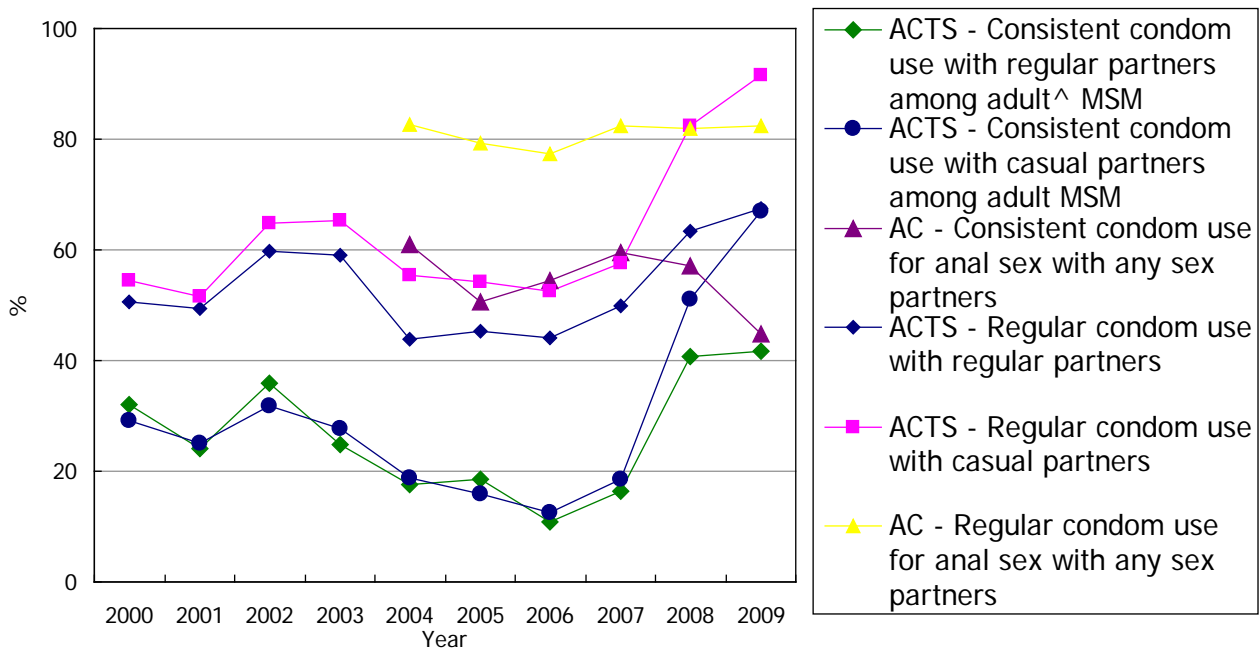
Multiple sex partnership

- ACTS (2009): The median number of sex partners among MSM in the past year for regular partner is 1; for commercial partner is 2-3; and for casual partner is 3-4.

Condom usage



- ACTS (2009): less than 80% used condom at last anal sex with casual partner.
- ACTS (2009): less than 60% used condom at last anal sex with regular partner.
- AC (2009): less than 60% used condom at last anal sex with any partner.



- ACTS (2009): Consistent (always) condom usage with regular and non regular sex partner increased from <20% for both categories pre-2007 to respectively 42% and 67%.
- PRiSM (2006): Consistent condom usage with RSP 41% and NRSP 73%
- PRiSM (2008): Consistent condom usage with RSP 45% and NRSP 75%
- AIMSS (2010): Consistent condom usage with RSP 35% and NRSP 54%

HIV testing history

- PRiSM (2008): 57% of MSM reported to have ever tested for HIV and 35% of MSM reported to have tested for HIV in past year.
- ACTS (2008): 68% of MSM reported to have ever tested for HIV and 35% of MSM reported to have tested for HIV in past year.
- ACTS (2009): 73% of MSM reported to have ever tested for HIV and 37% of MSM reported to have tested for HIV in past year.
- AIMSS (2010): 61% of MSM reported to have ever tested for HIV and 39% of MSM reported to have tested for HIV in past year.

Sexually transmitted infection (STI) consultation

- PRiSM (2008): 16% of MSM reported to have ever consulted for STI.
- ACTS (2008): 14% of MSM reported to have ever consulted for STI.
- ACTS (2009): 14% of MSM reported to have ever consulted for STI.
- AIMSS (2010): 23% of MSM reported to have recently consulted for STI.

Review of epidemiology for Male sex workers (MSW)

[draft for discussion only]

Population size estimation

- There is no scientific estimation of the population size of MSW in Hong Kong. A paper, published in 2009, sampled 351 Men having Sex with Men (MSM) in the city of Shenzhen in 2007 by using respondent-driven sampling (RDS), with the result showing the RDS adjusted proportion of money-boys (i.e. MSW) among MSM was 9%.⁸
- Based on the AIMSS study (an internet survey on MSM) 2010, 5.9% of the MSM recruited via internet reported ever been paid for sex in the past 6 months.
- A benchmark population based behavioral study in 2001⁹, which sampled about 15,000 men aged 18-60 using computer assisted telephone interview, provided an estimation of the size of MSM population at risk for HIV infection. The study showed that 4.5% of the men sampled ever had sex with another man, including 2% having sex with another men in the last 6 months (active MSM). Among these active MSM, 22.3% of them had anal sex (i.e., 0.45% of the subjects) during those 6 months.
- Applying male population aged 18-60 as at end 2009 [C&SD], there were over 2.1 million of male in Hong Kong. Based on the Census data in 2006, 97% of these MSM were Chinese.
- Applying the above data, the population size of men who have ever reported to have had sex with men derived for the year of 2009 in Hong Kong would be over 96,000. Such figure would include over 42,000 of active MSM (had sex with another men in the last 6 months) and over 10,000 of MSM with recent anal sex behavior. Using 5.9%-9% of MSM being MSW as a rough estimation, there would be about 2,400 – 3,700 of MSW in Hong Kong.

HIV/AIDS reporting system

- No distinction could be made between MSM and MSW in terms of epidemiology based on data in HIV/AIDS reporting system. References can be made from the epidemiological review in MSM.

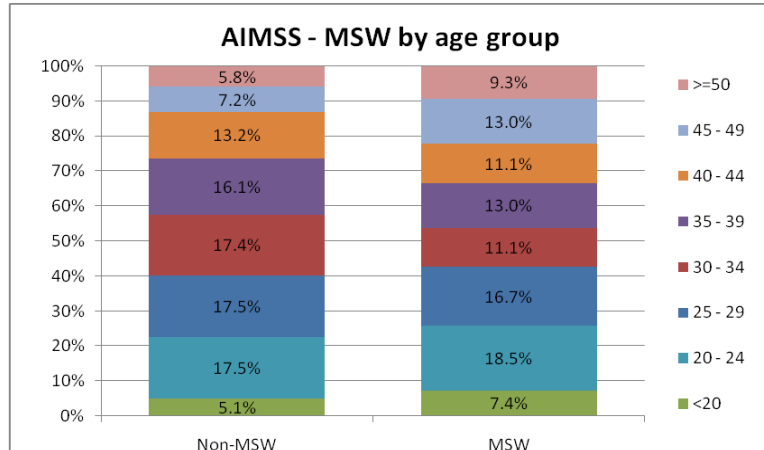
⁸ Hongjie Liu et al. Money Boys, HIV Risks, and the Associations between Norms and Safer Sex: A Respondent-Driven Sampling Study in Shenzhen, China. *AIDS Behav* 2009 Aug;13(4):652-62.

⁹ J T F Lau et al. HIV related behaviours and attitudes among Chinese men who have sex with men in Hong Kong: a population based study. *Sex Transm Infect* 2004; 80: 459-465.

MSM recruited via internet who self-reported as MSW

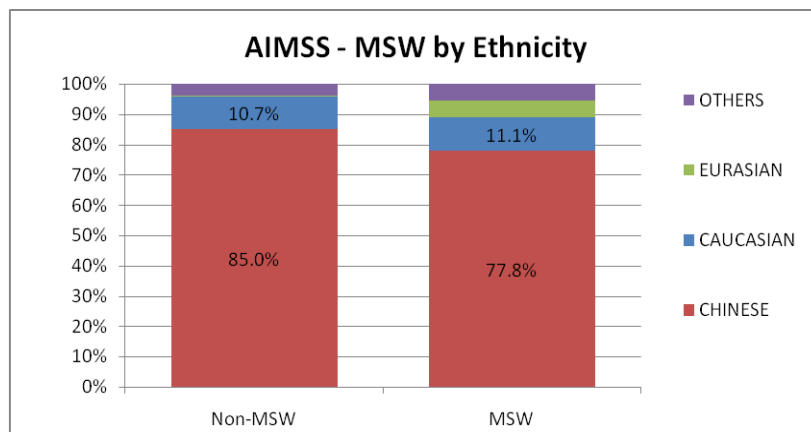
(Note that only 54 respondents self-reported as MSW in this study, thus the sample was small.)

Age



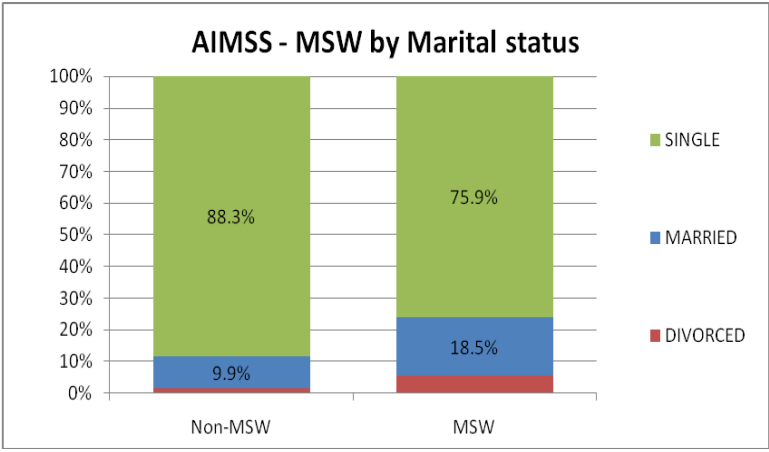
- AIMSS (2010): The age structure appeared to be similar between MSW and those who have not self-reported to be MSW (non-MSW), except for a higher proportion of MSW being older than 45 years old (22.3%) when compared with non-MSW (13%).

Ethnicity



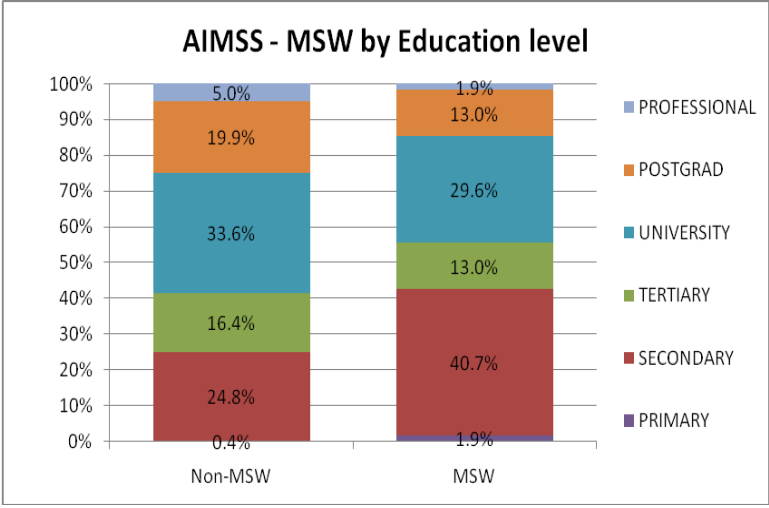
- AIMSS (2010): MSW appeared to be of slightly fewer proportion as Chinese (78% of MSW reported to be ethnic Chinese vs 85% of non-MSW reported to be ethnic Chinese) but higher proportion as Eurasian (6% of MSW reported to be ethnic Eurasian vs 0.5% of non-MSW reported to be ethnic Eurasian).

Marital status



- AIMSS (2010): A higher proportion of MSW appeared to be married (18% of MSW reported to be married vs 10% of non-MSW reported to be married).

Education level



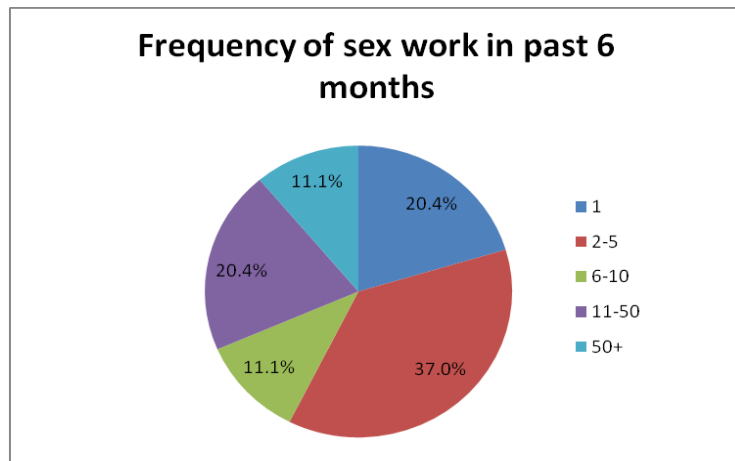
- AIMSS (2010): Despite considerably high level of education among MSM from this study, non-MSW appeared to have attained a relatively higher level of education, 75% with tertiary or above level of education. While 57% of MSW have attained level of education with tertiary or above.

Self reported HIV prevalence in MSW

- AIMSS (2010): Overall, 4.9% of the MSM recruited in this internet study self reported to be HIV positive in 2010. Breaking down this percentage, 8.3% of the MSW reported to be HIV positive, as compared with 4.6% of non-MSW reported to be HIV positive in this internet study.

Risk behaviours

Frequency of sex work



- AIMSS (2010): Over 50% of MSW reported to have engaged in paid sex less than once a month.

Condom usage

- AIMSS (2010): When having sex with their commercial male sex partner in the past 6 months, 57% of MSW reported to have consistent (always) condom use, compared with 66% of non-MSW.
- AIMSS (2010): When having sex with their regular male sex partner in the past 6 months, consistent (always) condom use was reported in 26% of MSW, compared with 37% of non-MSW.

HIV testing history

- AIMSS (2010): 46% of MSW reported to have tested for HIV in the past year, compared with 38% of non-MSW.

Sexually transmitted infection (STI) consultation

- AIMSS (2010): 15% of MSW reported to have ever consulted for STI in the past 6 months, compared with 8% of non-MSW.

Review of epidemiology for People living with HIV (PLHIV)*

(*based on HIV/AIDS reporting system with which known death is excluded)

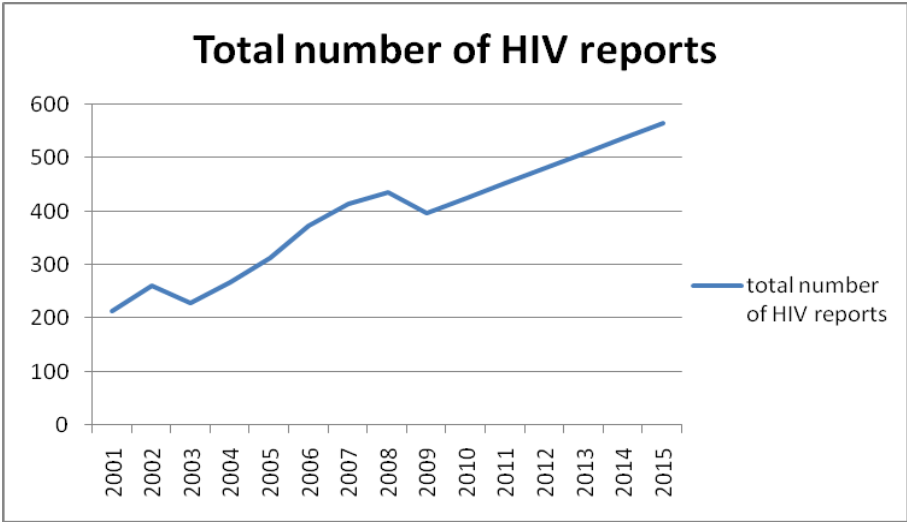
[draft for discussion only]

Population size

Estimation

- Since the first case of HIV report in 1984, a total of 4,730 cases have been reported as of the third quarter of year 2010.
- After excluding the known death from the reporting system, a total of 4,179 cases are believed to be living with HIV. However, there is no data to suggest the number of cases that are residing in Hong Kong. This figure is also very likely to be underestimated, as there are infected individuals who are yet to get tested for HIV, or they might already be tested for HIV, but not reported to our reporting system.

Projection



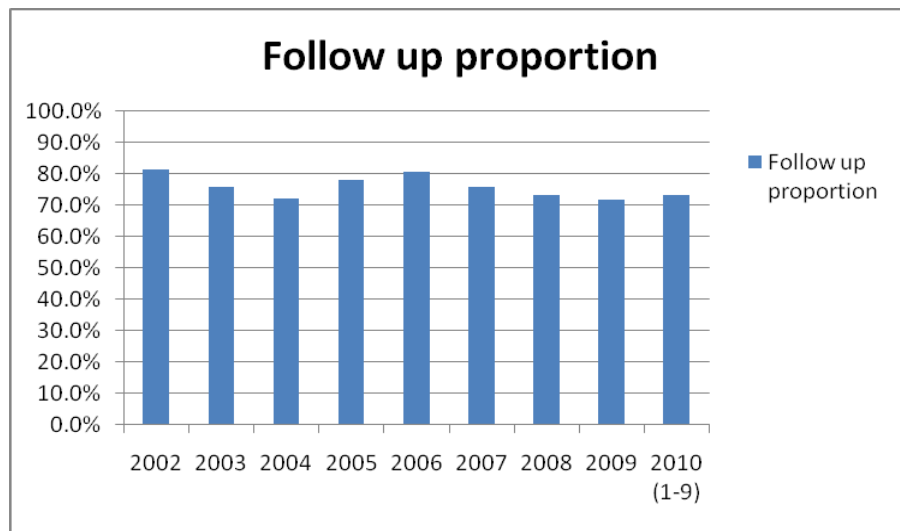
- Based on past reported data over various at risk populations, projection of the total number of HIV reports is made. An annual increment of 5.3%-7.2% is expected, which corresponds to 420-560 new cases reported annually until 2015. More than 2,000 new reports are expected in the coming years of 2011-2015.

HIV/AIDS reporting system

Progression to AIDS within 3 months

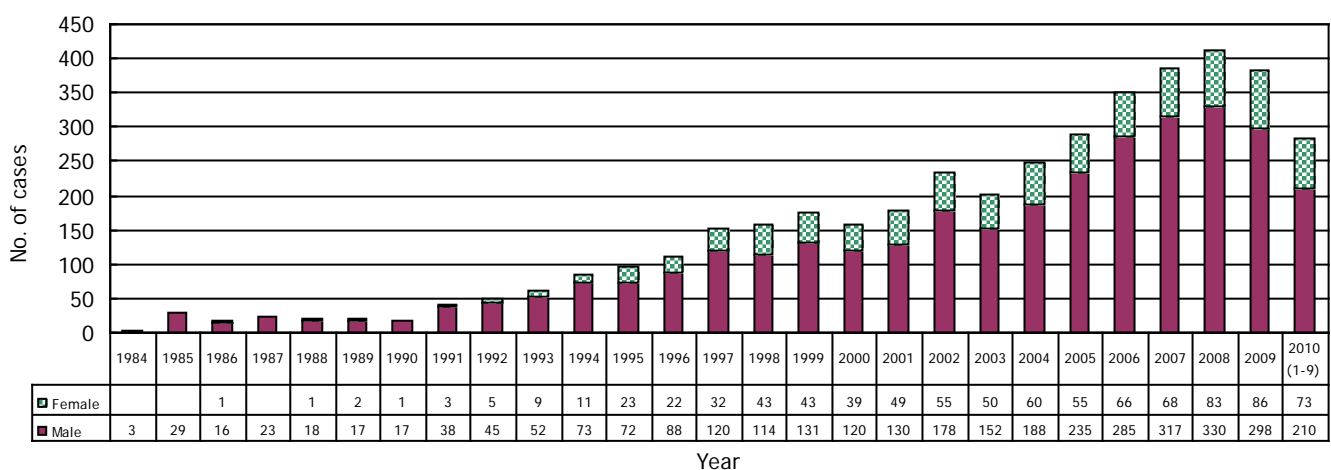
- The proportion of AIDS progression within 3 months of HIV reporting decreased from over 20% in the pre-HAART era to 13%-18% in the years of 2007-2010. This proportion, however, still suggests a considerable proportion of infected individuals were having delay in testing and/or treatment.

Proportion with follow up care at HIV clinics



- Over the years, roughly between 70% and 80% of the reported cases were being followed up at HIV clinics in Hong Kong.

Gender



- Male gender has been dominating over female in the epidemic in Hong Kong, with over 80% of the reported cases being male until 2007.
- The weighting by female cases has been gradually rising and they accounted for over

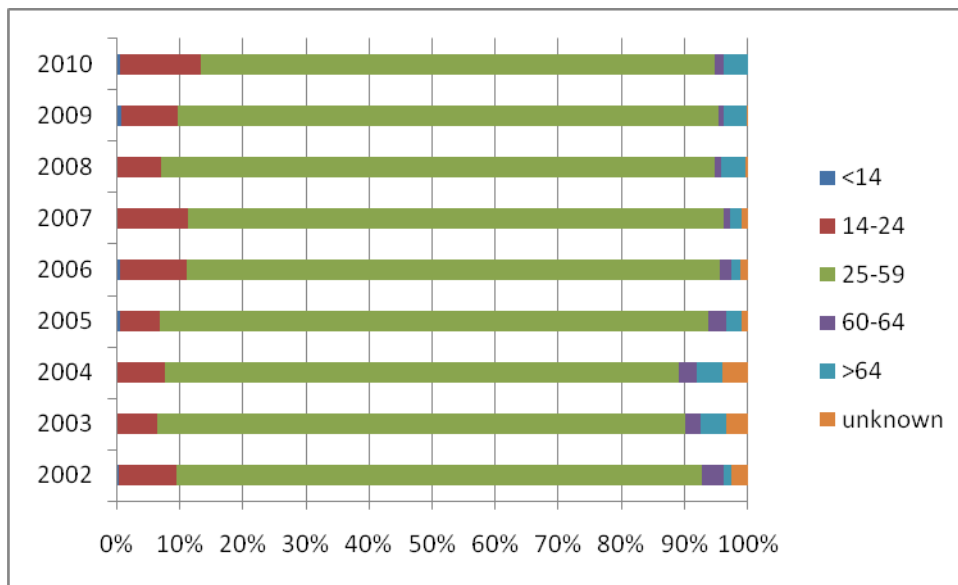
25% of all cases in the first three quarters in the year of 2010.

Ethnicity

Year	Chinese	Asian	Caucasian	African	Unknown	% Chinese
2002	161	47	8	2	15	69%
2003	137	32	8	5	20	68%
2004	167	43	7	5	26	67%
2005	176	59	14	6	35	61%
2006	225	77	15	9	25	64%
2007	239	70	27	5	44	62%
2008	246	87	24	8	48	60%
2009	235	70	21	10	48	61%
2010 (q1-3)	186	36	13	10	38	66%

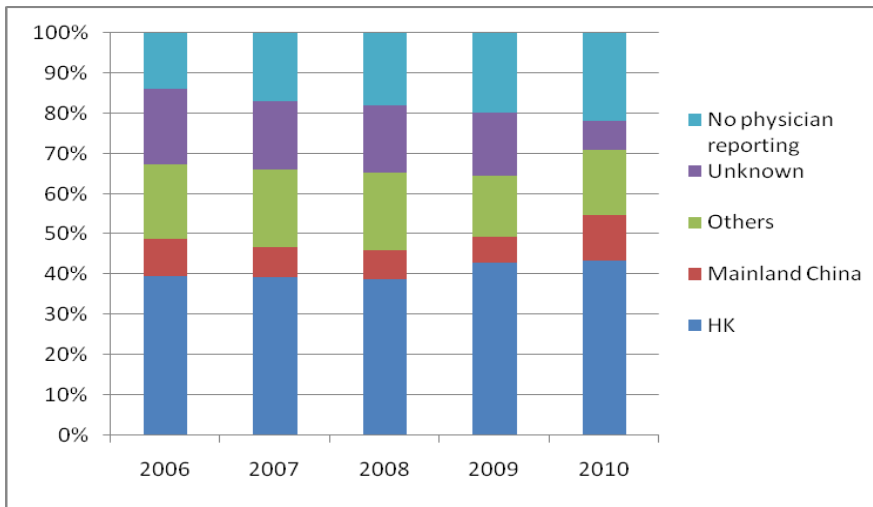
- 60%-66% of HIV reported cases were Chinese in the years of 2007-2010.

Age



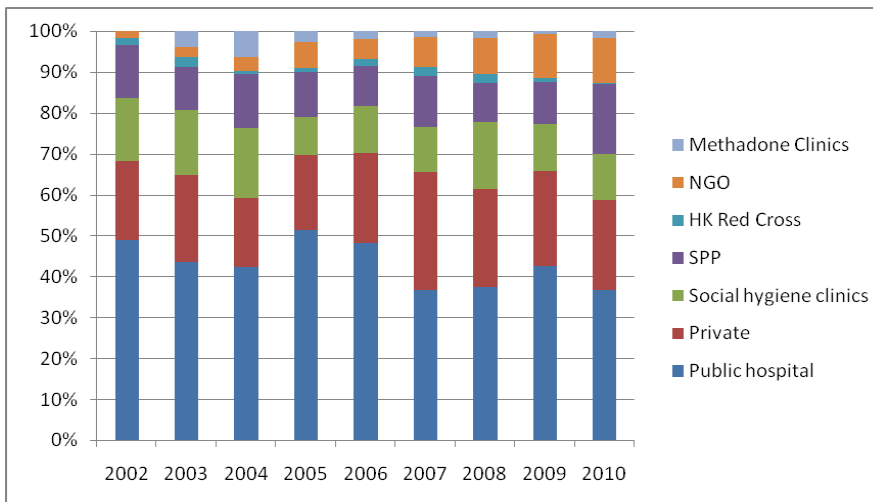
- Majority (about 80%) of the cases aged 25-59 upon their HIV diagnosis.
- Less than 10% aged below 24 years old, while less than 5% aged above 64 years old.

Suspected location



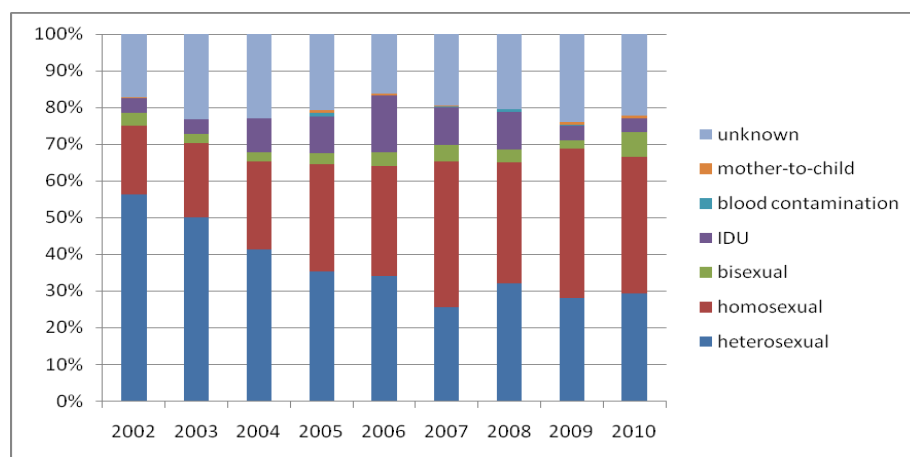
- About 40% of the PLHIV acquired the infection locally.
- Not more than 10% acquired from Mainland China.
- Less than 20% acquired from places outside of Hong Kong, but other than Mainland China.

Reporting source



- There was increased proportion of reported cases from NGO, which took up about 12% of HIV diagnosis in 2009-2010.

Suspected route of transmission



- There was an increasing trend of homosexual and bisexual as suspected route of transmission in recent years.
- Over 40% of PLHIV were accounted for homosexual and bisexual as the suspected route of transmission in 2009-2010 (q1-3).
- Heterosexual transmission was reduced in weighting, but still ranked the 2nd largest share as the suspected route of transmission following homosexual and bisexual transmission, and it accounted for about 30% of transmission route in 2009-2010 (q1-3).
- IDU as the suspected route of transmission remained low, with less than 5% in 2009-2010 (q1-3).

Risk behaviour

- Risk behaviour can be quantified by using proxy of sexually transmitted diseases (STD) presented in PLHIV under care at HIV clinic.
- Based on a report by SPP¹⁰, there was about 0.0008-0.0025 new STD episodes per person-months among the active PLHIV (those who were followed up at least once in the past year) at at KBITC in the years of 2002-2006, which suggests some level of unprotected sex was still present among PLHIV under care.

¹⁰ Tracking the characteristics and outcome of HIV/AIDS patients cared for at the Integrated Treatment Centre – A Report of 1999 to 2006. Special Preventive Programme, Centre for Health Protection, Department of Health, Hong Kong Aug 2007.

Box C11. *New sexually transmitted diseases (STD) in active patients

	2002	2003	2004	#2005	#2006
No. of patients with new STD	11	15	7	22	26
No. of STD episodes	14	16	7	23	28
Follow-up person-months	6122	7242	8249	9361	11117
New STD incidence density (episodes/person-months)	0.0023	0.0022	0.0008	0.0025	0.0025

*include primary and secondary syphilis, gonorrhoea, genital Chlamydia and trichomoniasis at or after second clinic visit

#screening for asymptomatic gonorrhoea and Chlamydia using urine samples done in 2005 and 2006

Review of epidemiology for Youth at risk

[draft for discussion only]

Population size estimation

- Based on Census and Statistic Department, the mid-2009 population size for aged 15-24 were 435,900 for male and 443,300 for female. Of which 220,900 males were aged 15-19 as compared with 208,800 females.
- Assuming the prevalence of active MSM of 2% is the same across different age groups, that would correspond to about 8,600 active MSM youth aged 15-34 for the year of 2009 in Hong Kong who had sex in past 6 months (note that age specific prevalence of active MSM from the study¹¹ is not available).
- Based on Central Registry of Drug Abuse (CRDA), there were 3,000-3,500 drug users reported to be aged below 21 in 2007-2009 (note that data breakdown up to age 25 not available, and the 2009 CRDA report is not yet published. Such data is based on special request to the Security Bureau), which generally reflected a gradually rising trend in young drug users, occupying 22%-24% of all drug users reported in 2007-2008 (Data based on 2007-2008 CRDA report). Among these young drug users, only 1.8%-2.1% of them abused opiate as compared with ketamine abusers (80-85%) and triazolam/midazolam/zopiclone abusers (1.1%-1.7%). Among the above mentioned groups, 50%-52% of those who used heroin and triazolam/midazolam/zopiclone would inject drugs, whereas only 0.7% of those using ketamine would inject drugs. Hence, the IDU youth population is expected to be low.
- Based on CRiSP 2009, respectively 3% from one woman brothel, 20% from karaoke nightclub, 52% from bar, 15% from street sex worker, and 18% from massage parlour were FSW below the age of 26 years old, which corresponds to a total population of approximately 1,000 young FSW (below 26 years old) in 2009. Applying the proportions of youth in different sex work settings to the 2006 mapping of FSW from the CRiSP 2006 study, there were about 1,900 young FSW in 2006.
- Based on YSS 2006, 9% of males aged 18-27 reported to have ever had sex with a FSW. When applying the mid-2009 population, about 40,000 (aged 18-27) young FSW clients are estimated in Hong Kong.
- A random telephone survey of 1,020 male respondents aged 18-60 in 1998, gave an estimated 14% who had engaged in commercial sex in the past 6 months¹². Among them about 16% of those aged between 18-30 years old had visited commercial sex

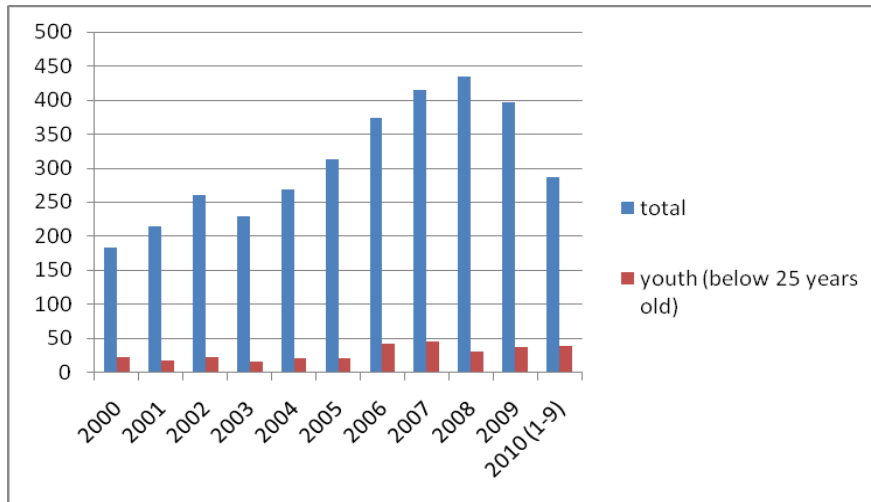
¹¹ Lau JTF et al. HIV related behaviours and attitudes among Chinese men who have sex with men in Hong Kong: a population based study. *Sex Transm Infect* 2004;80:459-465.

¹² Lau JTF et al. Behavioural surveillance of sexually-related risk behaviours of the Chinese male general population in Hong Kong: a benchmark study. *AIDS Care* (2001;13(2):221-232.

worker in the past 6 months. This corresponds to about 90,000 young FSW clients (aged 18-30) in Hong Kong.

HIV/AIDS reporting system

Trend



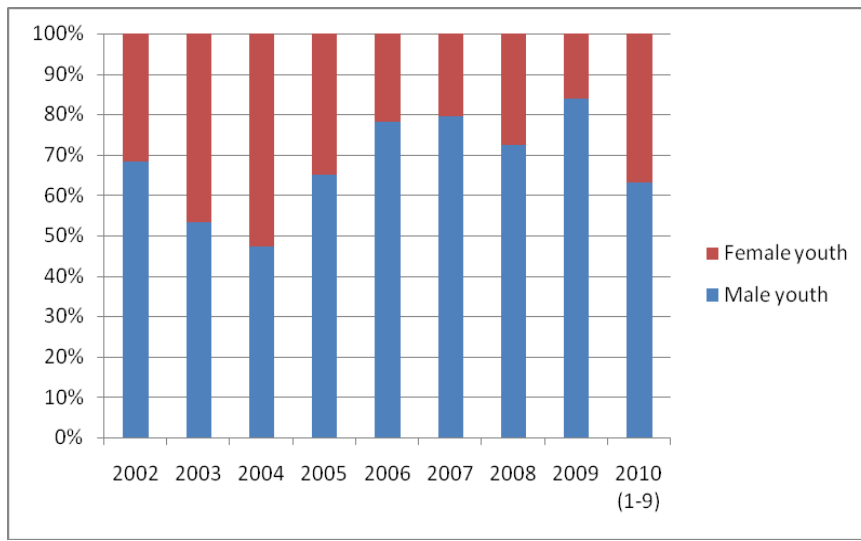
- Annual number of HIV reported cases attributed by the youth population (below 25 years old) ranged from 29 to 44 cases in the recent 5 years, corresponding to 7%-13% of all HIV cases.

Ethnicity

Year	Chinese	Asian	Caucasian	African	Unknown	% Chinese
2002	15	5	0	0	2	68%
2003	8	1	1	1	4	53%
2004	9	7	0	1	2	47%
2005	12	4	0	0	4	60%
2006	27	12	1	0	1	66%
2007	25	13	0	0	6	57%
2008	23	4	0	1	1	79%
2009	25	3	3	0	6	68%
2010 (q1-3)	24	6	0	3	5	63%

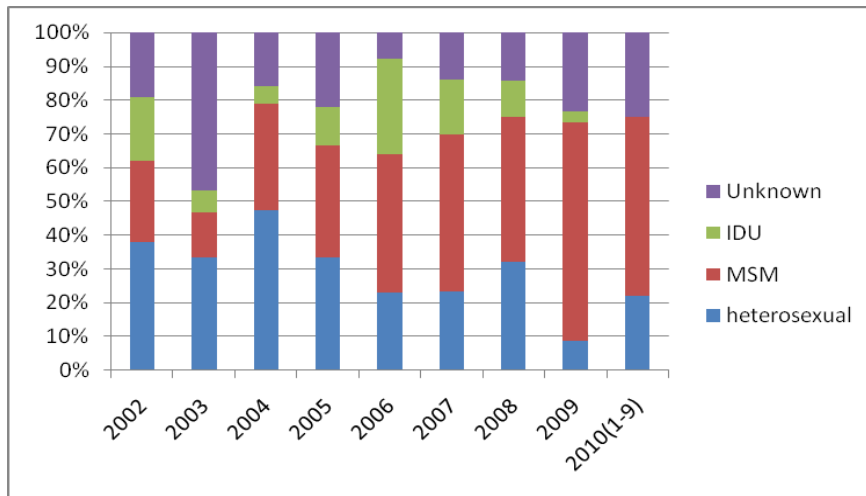
- Among the youth HIV cases, 57%-79% of them were ethnic Chinese.

Gender



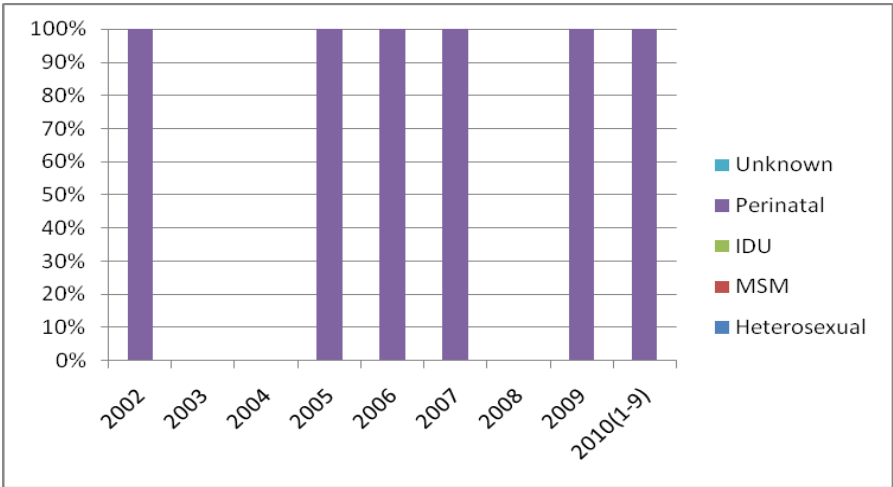
- Consistently over 60% of the youth HIV cases were attributed by male in the years of 2005-2010(q1-q3).

Risk of transmission (aged 14-24 years old)



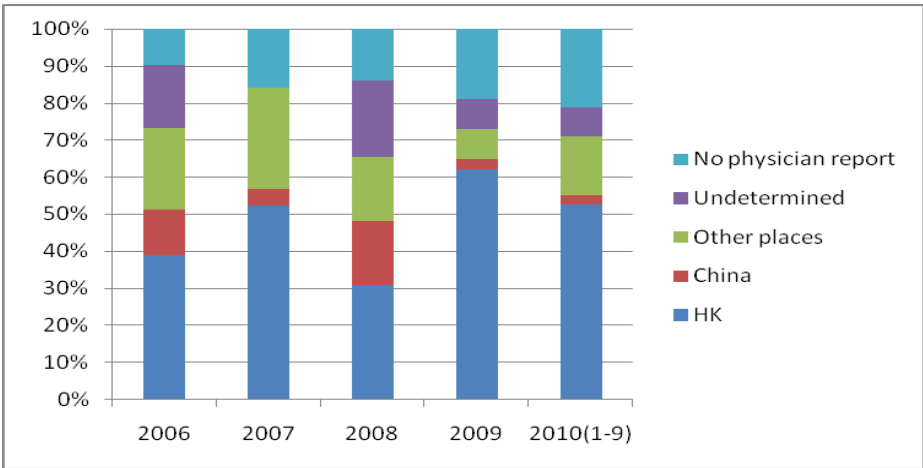
- Over 50% of youth HIV cases reported to be in the recent 2 years, there 10%-20% of youth HIV cases reported to be heterosexual.

Risk of transmission (aged below 14 years old)



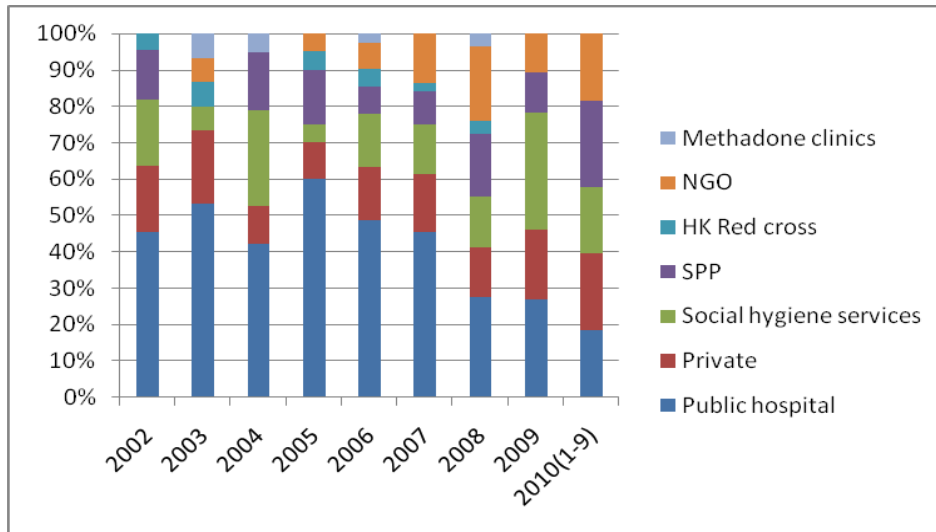
- For those cases aged below 14 years old upon HIV diagnosis, all of them reported to have acquired the infection via perinatal transmission.

Suspected location



- About 53%-62% of the youth HIV cases reported to have acquired HIV locally in 2009-2010.
- Not more than 5% of the youth HIV cases reported to have acquired from Mainland China.
- Not more than 20% of the youth HIV cases reported to have acquired outside of Hong Kong, but other than places from Mainland China.

Reporting source



- NGO took up less than 20% of youth HIV diagnosis annually over the years.

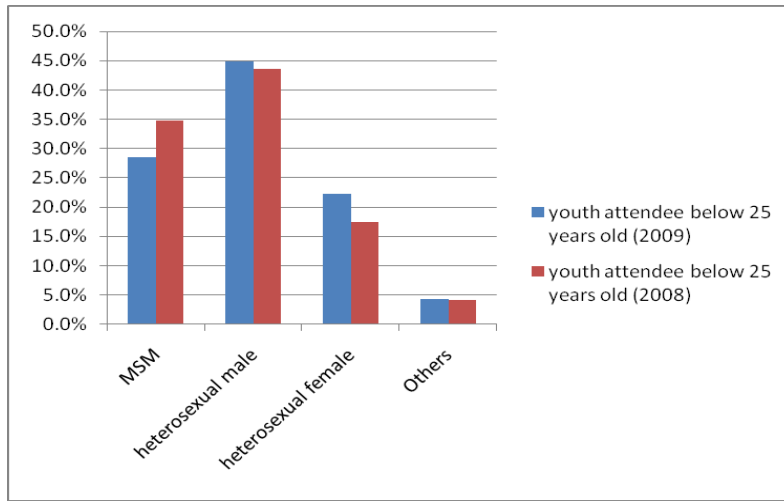
HIV prevalence in Youth



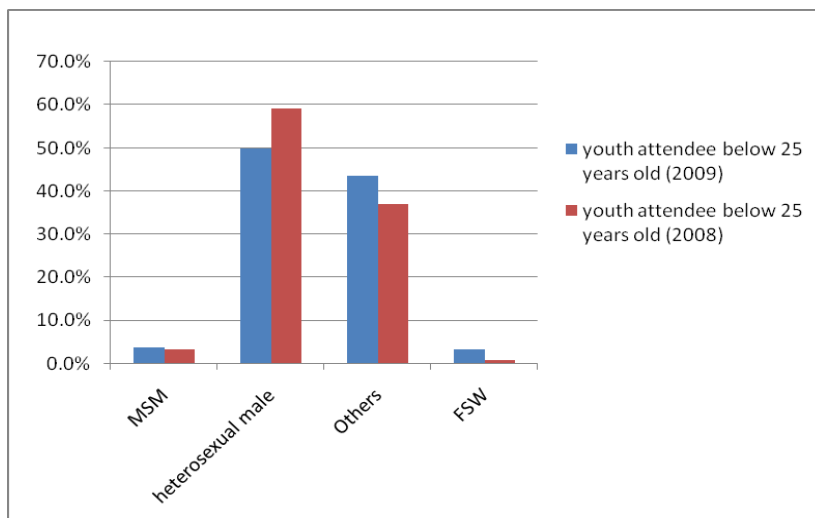
- In the year of 2006-2010, surveillance studies (including PRiSM and AIMSS) and testing services (such as service from AIDS Concern) revealed HIV prevalence of 0.7%-2.6% among MSM youth, while young attendees at ACTS had HIV prevalence of 0.9%-1.8%, and young methadone clinic attendees had HIV prevalence of 2%-2.2%.

Risk behaviours

Youth using ACTS



- Among youth attendees (below 25 years old), majority were males, either heterosexual males (more than 40%) or MSM (more than 25%), while 18%-22% were heterosexual females (for both 2008 and 2009).



Youth using at SHS

- Among youth attendees at SHS, more than 50% were heterosexual males and more than 5% were MSM or FSW for both 2008 and 2009.

Youth using methadone clinic

- Among the IDU attending the Methadone Clinics only 11% (45-52 attendees) reported to be below 25 years old in 2008-2009.

Sexual exposure in past year (Source: ACTS)

	2007	2008	2009
Youth aged below 25 with RSP	51%	63%	65%
Youth aged below 25 with CoSP	23%	24%	21%
Heterosexual Male aged below 25 with RSP	43%	58%	59%
Heterosexual Male aged below 25 with CoSP	54%	52%	46%
MSM aged below 25 with RSP	50%	63%	68%
MSM aged below 25 with CaSP	83%	55%	67%

- There is a generally increasing trend in youth having sex with regular sex partner (RSP), but a decreasing trend in youth having sex with commercial sex partner (CoSP) or casual sex partner (CaSP) in 2007-09. These trends applied to both heterosexual male youth and MSM youth.
- About 60%-68% of youth (including heterosexual or MSM) had sex with RSP, while 21%-67% had sex with CoSP / CaSP in 2009.

Consistent condom use

(Source: ACTS)*	2007	2008	2009
Youth aged below 25 with RSP	22%	29%	38%
Youth aged below 25 with CoSP	44%	76%	87%
Heterosexual Male aged below 25 with RSP	31%	41%	51%
Heterosexual Male aged below 25 with CoSP	47%	77%	87%
MSM aged below 25 with RSP	11%	27%	33%
MSM aged below 25 with CaSP	11%	41%	50%
*referring to consistent condom use in past 1 year			

- There is a generally lower consistent condom usage among youth when having sex with RSP, when comparing to having sex with CoSP or CaSP.
- In 2007-2009, the level of consistent condom use increased, and the increase was more obvious when having sex with CoSP or CaSP, than with RSP.
- In 2009 alone, 33%-51% consistent condom use was reported among youth (including heterosexual male youth and MSM) when having sex with their RSP.
- Overall, youth had higher level of consistent condom use with their CoSP, at about 87%.

- However, MSM youth seem to have a lower consistent condom use with their causal sex partner at about 50% in 2009.

(Source : SHS)*	2007	2008	2009
Youth aged below 25 with RSP	17%	25%	18%
Youth aged below 25 with Ca / Co SP	32%	28%	34%
Heterosexual Male aged below 25 with RSP	23%	29%	27%
Heterosexual Male aged below 25 with Ca / Co SP	39%	28%	40%
*referring to consistent condom use in past 3 months			

- Data from Social Hygiene Service, however, did not appear the same as in ACTS. The increase in consistent condom usage among youth was not observed.
- In SHS 2009, only 18% of the youth reported consistent condom use with their RSP and only about 34% reported consistent condom use with their CaSP or CoSP.
- In PRiSM 2008, MSM youth (aged below 25 years old) reported 41% consistent condom use with their regular sex partner in past 6 months, as compared with 74% consistent condom use with their non regular sex partner in the past 6 months.
- In AIMSS 2010, MSM youth (aged below 25 years old) reported 29% of consistent condom use with their RSP in the past 6 months, as compared with 47% consistent condom use with their CaSP, and 20% consistent condom use with their CoSP in the past 6 months.

HIV testing history

- Methadone Clinics (2008): 76% of drug users (aged below 25 years old) reported to have tested for HIV in that year.
- Methadone Clinics (2009): 67% of drug users (aged below 25 years old) reported to have tested for HIV in that year.
- PRiSM (2008): 28% of MSM youth (aged below 25 years old) reported to have tested for HIV in the past year.
- AIMSS (2010): 33% of MSM youth (aged below 25 years old) reported to have tested for HIV in the past year.

Sexually Transmitted Infections (STI) consultation

- PRiSM (2008): 9% of MSM youth (aged below 25 years old) reported to have ever consulted for STI other than HIV.
- AIMSS (2010): 12% of MSM youth (aged below 25 years old) reported to have ever

consulted for STI other than HIV.

Key data sources for the epidemiology review (in alphabetical order by the names of data source)

Name of data source	Description	Data collection frequency	Data collection methods	Organization
AC - AIDS Concern	Provides data for HIV prevalence and behavioral surveillance among Men having Sex with Men in Hong Kong.	Ongoing	Via voluntary testing service and behavioral survey	AIDS Concern
ACTS - AIDS Counseling and Testing Service	Provides data for HIV prevalence and behavioral surveillance among all people in Hong Kong.	Ongoing	Via voluntary testing service and behavioral survey	Special Prevention Programme (SPP), Department of Health
AIMSS - Asia Internet MSM Sex Survey	Provides data for behavioral surveillance among Men having Sex with Men in Asia.	Annual	Via internet based behavioral survey	Fridae Hong Kong Ltd.
CRDA - Central Registry of Drug Abuse	Provides relevant drug abuse statistics for monitoring changes in drug abuse trends and characteristics of drug abusers to facilitate the planning of anti-drug strategies and drug abuse programmes in Hong Kong.	Ongoing	Via collation of information regularly on drug abuse cases reported by law enforcement departments, treatment and welfare agencies, hospitals and clinics, and tertiary institutions	Narcotic Division, Security Bureau

Name of data source	Description	Data collection frequency	Data collection methods	Organization
CRiSP-Community Based Risk Behavioural and Seroprevalence Survey for Female Sex Workers in Hong Kong	Provides information to understand the trend of HIV prevalence among Female sex workers and provide data for planning of prevention activities.	2006 & 2009	Via urine sampled HIV test and interviewed behavioral survey at various commercial sex establishment settings identified via mapping exercise	Special Prevention Programme (SPP), Department of Health and HKCASO
CSD – Hong Kong Correctional Services Department	Provides data for HIV prevalence and behavioral surveillance among prison inmates in Hong Kong.	Ongoing	Via unlinked anonymous screening using urine samples and behavioral survey	Hong Kong Correctional Services Department
HIV/ AIDS reporting system	Provides data for HIV/AIDS reported cases in Hong Kong.	Ongoing	Via HIV/AIDS voluntary reporting system	Special Prevention Programme (SPP), Department of Health
MTP - Methadone Treatment Programme / MC - Methadone Clinics	Provides data for behavioral surveillance among newly admitted / re-admitted attendees in Hong Kong.	Ongoing	Via behavioral survey	Narcotics and Drug Administration Unit, Department of Health

Name of data source	Description	Data collection frequency	Data collection methods	Organization
MUT - Methadone Universal HIV (urine) Testing Programme	Provides data on HIV prevalence among Methadone Clinic attendees in Hong Kong.	Ongoing	Via HIV voluntary (urine) testing service	Narcotics and Drug Administration Unit, Department of Health
PRiSM - HIV Prevalence and Risk behavioural Survey of Men who have sex with men in Hong Kong	Provides data to understand the trend of HIV prevalence among Men who have sex with men and provided data for planning of prevention activities in Hong Kong	2006 & 2008	Via urine sampled HIV test and interviewed behavioral survey at various gay venues (bar, club and sauna) identified via mapping exercise	Special Prevention Programme (SPP), Department of Health
SAS - Street Addict Survey	Provides data for behavioral surveillance among street drug addicts in Hong Kong.	Annual	Via street outreach behavioral surveys conducted by peer outreach workers	Society for Aid and Rehabilitation of Drug Abusers (SARDA)
SHS - Social Hygiene Service	Provides data for HIV prevalence and behavioral surveillance among SHS attendees in Hong Kong.	Ongoing	Via voluntary testing and behavioral survey	Social Hygiene Service, Department of Health

Name of data source	Description	Data collection frequency	Data collection methods	Organization
SKC - Shek Kwu Chau rehabilitation centre / DRS-S	Provides data for HIV prevalence and behavioral surveillance among attendees of the rehabilitation center in Hong Kong.	Annual	Via unlinked anonymous screening using urine samples and behavioral survey	Society for Aid and Rehabilitation of Drug Abusers (SARDA)
YSS - Youth and Sexuality Study	Provide data on the patterns and trends among local youths in respects of their sexual knowledge, attitude and practice. The survey comprised of three parts: two parts under a school survey covering students of Form One to Form Two (F.1-F.2), and Form Three to Form Seven (F.3–F.7) respectively, and a third part was a random sampling of household survey on youth aged between 18 and 27.	Every 5 years	Via secondary school students survey and household telephone survey	The Family Planning Association of Hong Kong

Annex 8 – Summary of latest current responses for various key populations

(in alphabetical order):

	Pages
1. Ethnic minorities (EM)	208
2. Female sex workers (FSW) and their Clients	212
3. Injecting drug users (IDU)	218
4. Men who have sex with men (MSM) and Male sex workers (MSW)	223
5. People living with HIV (PLHIV)	231
6. Youth at risk	238

Revision History

Old Version	Summary of Revision
January 2011 edition	FSW and their Clients current responses: a table for summarized responses from non-governmental sector has been added (page 5 of the FSW and Clients document).

Current Response in HIV Prevention among Ethnic minorities (EM)

Local responses from 2007 onwards

1. Ethnic minorities (EM) may be less accessible to services provided to the general public because of cultural or language issues. Non-Chinese Asians are of particular concern. The current response is mainly related to HIV prevention among EM who are injecting drug users (IDU) and female sex workers (FSW), although some programmes are also provided to the general EM communities and migrant workers. The current activities are summarized in the box below.

Box 1. Summary of current activities for preventing HIV infection among EM

1. Methadone treatment programme and associated activities
2. Prevention programmes for IDU and FSW
3. Community educational programmes
4. Reproductive health programme for Asian migrant workers
5. HIV voluntary counseling and testing service
6. Treatment of HIV infected persons in public HIV clinics

2. The methadone treatment programme and associated programmes remain the largest HIV prevention service among drug users. Among 8,300 effective registrations (attended at least once in the previous 28 days) as at end 2010, 6.6% were non-Chinese. Registered users are offered methadone daily for drug detoxification or maintenance, annual voluntary urine testing for HIV, free condom distributed in the clinics, counseling and other social support services and support for HIV treatment and care if they are infected.

3. Two NGOs have HIV prevention programmes with peer education, educational groups, training and counseling specifically to non-Chinese, mainly Nepalese, heroin abusers in methadone clinics and in the community. Give away items with promotional messages are distributed. Some of the sessions also involve picking up used needles and syringes on the streets or parks. About 50 peer educators are mobilized and over 3,600 clients are reached annually. One NGO reaches out non-Chinese inmates in correctional institutions for HIV prevention via talks, workshops, counseling, training of peer educators, and distribution of education materials. Likewise, at least six NGOs and one community group have HIV prevention programmes targeting non-Chinese FSWs who work in one-woman brothel (Thai, Vietnamese and Indonesian) and bars (Filipino and Thai). Health promotion materials and condoms are distributed during outreach and peer educational sessions. Individuals (IDU or FSW) who are identified to have high risk behaviours are referred for additional intervention and testing for HIV.

4. Enhancing community health literacy with special attention to the needs of EM groups is a strategy adopted by the Department of Health (DH) to effectively control communicable diseases. Since 2005, DH has set up two 24 hours hotline with pre-recorded information on HIV/AIDS and Sexually Transmitted Diseases in Tagalog, Vietnamese, Thai, Hindi, Indonesian, Nepali and Urdu, made available health education materials in four South Asian languages and promoted relevant messages through EM schools and radio programmes. Starting from 2004, one NGO organizes community carnival annually with an aim to raise awareness of AIDS among ethnic minorities and the public, and to promote a more tolerant and accepting society for people living with HIV/AIDS. Several thousands of participants from different ethnic backgrounds including Filipinos, Thais, Indonesians, Sri Lankans, Pakistanis and international students attend the event each year. The same NGO also runs a reproductive health programme for about 1,000 Asian migrant workers annually to

educate them about reproductive rights through outreach and workshops, and conducts researches on pre-employment medical check-up and access to sexual and reproductive health services and information among women migrant domestic workers.

5. Highly subsidized specialist HIV management is provided by the three major public HIV clinics run by DH (Kowloon Bay Integrated Treatment Centre) and Hospital Authority (Queen Elizabeth Hospital and Princess Margaret Hospital) for eligible persons¹³ (holder of HK Identity Card and children aged below 11 years who are HK residents), who also enjoy free medical consultation and treatment on sexually transmitted illnesses provided by Social Hygiene Service of DH. About 20% and 13.8% of patients seen in DH HIV clinic are non-Chinese and non-Chinese Asians (mainly Thai, Vietnamese, Nepalese, Filipino and Indian) respectively. One NGO runs an integrated sexual health clinic which provides FSW with accessible, affordable and non-stigmatising sexual health services, with special focus on marginalized groups such as non-Chinese and non-Hong Kong residents who are difficult to access or not eligible to receive free medical service in Hong Kong.

6. The AIDS Counselling and Testing Service (ACTS) operated by DH offers community-based, voluntary and free HIV counseling and testing service to EM with language assistance upon request. Beside, EM may access similar HIV testing and counseling services provided by at least 11 NGOs. During the period from 2007 – 2009, about 10% and 3% of ACTS users were non-Chinese and non-Chinese Asians respectively.

7. Various activities are taking place to track HIV situation in Hong Kong for improving prevention and control of HIV infection. In addition to the voluntary HIV reporting system,

¹³ Fees and Charges for Public Health Care Services provided by the Department of Health http://www.dh.gov.hk/english/useful/useful_fee/useful_fee_os.html and Fees and charges of medical services provided by Hospital Authority http://www.ha.org.hk/visitor/ha_visitor_index.asp?Parent_ID=10044&Content_ID=10045&Ver=HTML

HIV prevalence among those who join the universal testing programme in methadone clinics can be analyzed by ethnicity groups. Tracking of risk behavioral trend including Central Registry of Drug Abuse maintained by Security Bureau, admission/ readmission survey at methadone clinics, prisons and drug treatment and rehabilitation centres and ACTS also capture data on ethnicity.

Current Response in HIV Prevention among Female sex workers (FSW) and their Clients

1. In Hong Kong, the response to the HIV epidemic for Female sex workers (FSW) and their male clients is steadily developing in coverage and the diversification of intervention modes. Advisory Council on AIDS (ACA), in the current "Recommended HIV/AIDS Strategies For Hong Kong 2007-2011", which was published in May 2007, stated the continual importance in curbing the growth in sex workers and clients as key prevention effort for the heterosexual population by expanding prevention programmes targeting risk behaviors, as well as, ensuring good access to HIV prevention services. Cross border sexual behavior research and surveillance initiatives are also urged. The Council for the AIDS Trust Fund (ATF) continues to be the key funding source for HIV prevention for these populations.

Local responses from 2007 onwards

2. Concerted efforts from the Government, non-governmental organizations (NGO) and other stakeholders within the community has helped strengthened the current responses to the HIV epidemic for FSW and their male clients, which are summarized as below:

Box 1. Summary of current activities for preventing HIV among FSW and their male clients

- | |
|---|
| <ol style="list-style-type: none">1. Outreach activities to commercial sex establishment / venues2. Voluntary counseling and testing (VCT) service (both HIV and STI tests) for FSW and their clients3. Condom and health promotion material distribution4. Internet outreach intervention |
|---|

5. Peer counseling and education projects
6. Hotline / Drop-in service / Counseling service
7. Public AIDS Counselling and Testing Service (ACTS)
8. Public HIV clinics and STI clinics
9. HIV-related researches targeting FSW and their clients, including territory-wide surveillance for FSW

3. Efforts targeting FSW continues to be key part of the overall HIV prevention efforts in Hong Kong. There are six NGOs and one community group with programmes or projects targeting FSW. At the same time, there are five NGOs with projects targeting sex worker clients, including those with cross border traveling behavior. ATF is the main funding body for most of the projects carried out by NGOs. NGOs have coordinated and collaborated among themselves in maximizing coverage for FSW, given the high mobility of such population. Most NGOs provide intervention activities with diverse nature, including outreach, testing service for HIV and STI, peer education, condom and health promotion material distribution and internet based outreach activities.

4. There are two NGOs specifically serving FSW, including HIV and STI related service. These services include outreach activities, workshops, peer education projects, testing services, drop-in and hotline services. Together, these reach close to 8,000 FSW each year. In addition, there are five other NGOs and one community group conducting projects specific to FSW and their clients, most of which are supported by ATF. Among the ATF-funded projects, outreach activities are conducted in various entertainment establishments. These ATF projects have an annual attendance of over 31,000 FSW and clients from 2007 onwards.

5. The role of NGOs in the provision of counseling and testing service (both HIV and STI)

has also become more significant. There are six NGOs which provide testing service to FSW and their clients. Of the six NGOs providing testing service, four of such services are funded by ATF. These include both centre-based testing, as well as testing service via outreach. At least one NGO also provide treatment service for FSW for STIs infection. Overall, ATF funds over 1,500 tests conducted by NGOs each year for both FSW and their clients.

6. The distribution of condoms and health promotion material has always been a major and indispensable component of HIV prevention. All NGOs involved in HIV prevention target FSW and their clients distribute condoms and health promotion materials in their projects. Over 109,000 units of condom have been distributed to FSW and their clients via these projects in 2009. Also, over 84,000 units of health education/promotion materials have been delivered each year via these projects since 2007.

7. Peer education or projects with peer component plays an important role in HIV prevention. The two FSW specific NGOs both have peer components in their services, while among the ATF supported programmes from other NGOs, majority of the projects have peer components. Overall, ATF supports close to 800 sessions of peer education workshops among the projects. In addition to peer education / peer components, ATF funds education workshops with around 200 attendances as well as group sessions (including educational groups and support groups) with over 500 attendances each year since 2007.

8. Online intervention has become another major health promotion channel and platform for outreach prevention activities within the sex industry. Community members of the sex industry are frequent users of such mode of communication. Three NGOs obtained funding from ATF with online intervention components. Over 1,200 attendances were recorded via

internet-based outreach sessions through these projects in 2009. Intervention components include instant messages, online banner and email communications.

9. Young female sex workers serving male clients, has become a concerning phenomenon in Hong Kong. In addition to efforts targeting FSW in general, which inevitably cover Young FSW, two NGOs are conducting specific programmes for these young women (one of which is funded by ATF and the other one is funded by other funding source). Since 2007, one such programme is supported by the ATF specifically targeting young female sex workers at entertainment venues, providing interventions for their high risk behavior, including drug taking behavior. In 2007 and 2008, this programme reached up to 300 young female sex workers and distributed 45,000 units of health promotion and education material. There also exist other services provide by other AIDS or mainstream youth NGOs targeting young female sex workers for intervention. These services may not specifically aim at HIV prevention (but include HIV messages) in nature, and they are not funded by the ATF. At least one NGO report to have reached over 300 contacts of young female sex workers in 2009 via small group work and internet outreach.

10. The Red Ribbon Centre is the prevention and health promotion arm of Special Preventive Programme (SPP), the AIDS Unit under Department of Health. 240,000 of condoms and 5,000 unit of souvenir have also been distributed to FSW via different NGOs in each year.

11. SPP provided centre-based VCT service and hotline counseling service free to all people through its AIDS Counselling and Testing Service (ACTS) centre. Among those attending the centre, majority of them claimed heterosexual as the suspected route of transmission (67.7% in 2007; 72.9% in 2008; 74.4% in 2009). Highly subsidized specialist HIV

management is provided by the three major public HIV clinics run by DH (Kowloon Bay Integrated Treatment Centre) and Hospital Authority (Queen Elizabeth Hospital and Princess Margaret Hospital) for eligible persons¹⁴ (holder of HK Identity Card and children aged below 11 years who are HK residents), who also enjoy free testing, medical consultation and treatment on sexually transmitted illnesses provided by Social Hygiene Service of DH. However, Non-eligible persons (NEP) can only access to those service at fee for service. Thus, testing service provided by different NGOs serve crucial complementary role in providing testing services for FSW, especially the NEP FSW.

12. Since 2007, two FSW HIV research projects have been carried out by NGOs and academic institutions funded by ATF. At least one research on FSW clients' cross border behavior has been conducted which is not supported by ATF. In addition, the CRiSP 2009 (Community Based Risk Behavioural and Seroprevalence Survey for Female Sex Workers in Hong Kong 2009), which was community-based and comprised collecting an urine sample for HIV antibody testing and a questionnaire on safer sex practice and sexual risk behaviour were conducted as a concerted effort of the SPP, NGOs and academic institutions.

Table 1. Summarized Responses from the Non-governmental Sector

Types of Intervention	Coverage	Funding Source
VCT	1,500 Tests / year	Funded by ATF
Condom Distribution	10,900 / year	Funded by ATF

¹⁴ Fees and Charges for Public Health Care Services provided by the Department of Health http://www.dh.gov.hk/english/useful/useful_fee/useful_fee_os.html and Fees and charges of medical services provided by Hospital Authority http://www.ha.org.hk/visitor/ha_visitor_index.asp?Parent_ID=10044&Content_ID=10045&Ver=HTML

Health promotion material	84,000 / year	Funded by ATF
Peer Education workshops	800 session / year	Funded by ATF
Education workshop	200 attendances / year	Funded by ATF
Groups sessions	500 attendances / year	Funded by ATF
Internet outreach	1,200 contacts / year	Funded by ATF
Young female sex workers (outreach, group sessions, internet outreach)	150 contacts / year (in 2007 & 2008) 300 contacts / year (in 2009)	Funded by ATF Other funding source

Current Response in HIV Prevention among Injecting drug users (IDU)

Local responses from 2007 onwards

1. Both the government and non-governmental organizations (NGO) are playing active part in the current response on prevention of HIV infection through injecting drug use in Hong Kong. Both drug prevention and harm reduction approaches are used. The current activities are summarised in the box below.

Box 1. Summary of current activities for preventing HIV infection among IDU in HK

1. Methadone treatment programme
2. Prevention activities in methadone clinics:
 - a. Universal HIV urine testing programme
 - b. Individual and group counselling services by social workers
 - c. Distribution of condom and HIV prevention materials
 - d. Risk assessment and follow up of HIV infected drug users by social workers
 - e. DH Working Group on control of HIV infection among drug abusers for coordinating prevention activities
3. Outreach programmes with collection of used needles, distribution of condoms etc. by various NGOs
4. Educational programmes at drug treatment and rehabilitation centres, halfway houses and prisons
5. Public education on harm reduction
6. Voluntary HIV testing and counseling service
7. Treatment of HIV infected drug users in public HIV clinics
8. Surveillance activities:
 - a. Behavioural risk assessment at admission/readmission to methadone clinics

- b. Annual street addict survey
- c. Universal testing programme in methadone clinics
- d. Unlinked anonymous testing in prisons and SKC drug treatment centre

2. The methadone treatment programme under the Department of Health (DH) remains the largest drug treatment service for HIV prevention among drug users. Through a network of 20 methadone clinics which open 365 days a year, the methadone treatment programme has a daily attendance of over 6,000. As at December 2010, some 8,400 clients were registered with the programme, 98% of whom were under the maintenance scheme and 2% were under the detoxification scheme. The mean age of the clients was 49 with a male to female ratio of 7 to 1. A local study has reported that consistent use of methadone and a daily dose of more than 60 mg are associated with lower frequency of injections thus lowering the risk of HIV infection.

3. Other HIV prevention activities in methadone clinics include -

(a) A universal voluntary HIV urine testing programme has been fully implemented since 2004 in view of the increasing amount of HIV positive cases. In the past 4 years, a coverage rate of around 80% has been maintained and more than 7,500 HIV tests were done annually for the methadone users. A total of 61 new HIV infections have been diagnosed since its pilot in July 2003.

(b) Currently about 1,890 cases¹⁵ are receiving care by social workers in methadone clinics. Group and individual counseling services are identified to have positive impact on successful detoxification and acceptance of HIV urine testing.

¹⁵ SARDA Annual Report 2009 - 2010

- (c) Condoms are given to all newly admitted patients and are freely distributed in the methadone clinics. Over the last four years, more than 93,000 condoms were distributed annually.
- (d) All HIV infected drug users at methadone clinics are regularly followed up and supported by doctors and social workers of the methadone clinics. Regular risk assessments are performed with risk reduction measures continuously reinforced so as to prevent HIV spread from the infected persons. A new programme providing enhanced social support services to HIV infected methadone clinic attendees has been implemented since 2006.
- (e) A multi-disciplinary Working Group on Control of HIV Infection among Drug Abusers has been set up by DH to coordinate HIV prevention activities in methadone clinics since March 2005. The group has quarterly meeting to discuss common issues and improve on HIV prevention.

4. Four out of seven substance abuse clinics in the Hospital Authority (HA) also provide services including drug treatment, counselling by social worker, occupational therapy, self help group, religious support to narcotic drug abusers.

5. Two NGOs and one community group have peer outreach teams for HIV prevention to heroin abusers. During outreach, promotion items such as leaflets, tissue packs, condoms were distributed and people with higher risk behaviours are identified for more intensive intervention and testing for HIV. Some of the sessions also involved picking up used needles and syringes on the streets or parks. For programmes funded by ATF during the period from year 2007 to 2009, the average annual attendances were 21,459 by community

outreach, 2,291 by educational groups and 178 by counseling.

6. The Correctional Services Department (CSD) and 17 NGOs provide drug treatment and rehabilitation centres in Hong Kong through compulsory, voluntary, residential or out-patient treatment for heroin abusers. Together they run 43 centres with the total capacity approximating 1,750.¹⁶ A proportion of these residential drug treatment and rehabilitation centres have HIV education programmes for inmates and staff arranged by NGOs or DH. Since 2005, talks, workshops, counseling, training of peer educators and distribution of education materials on HIV prevention have been regularly conducted in more than 12 correctional institutions by one NGO. In collaboration CSD, DH has been distributing close to 10,000 pre-exit kits containing HIV prevention messages to inmates prior to their discharge.

7. Building on the success of a mass media campaign initiated in 2002, DH maintains a website, a hotline and regular educational activities to advocate the harm reduction approach for HIV prevention among drug abusers.

8. Besides Methadone Clinics and the AIDS Counselling and Testing Service operated by DH, IDU may access community-based, voluntary and free HIV counseling and testing service specially provided to them by at least three NGOs.

¹⁶ Fifth Three-year Plan on Drug Treatment and Rehabilitation Services in Hong Kong (2009-2011). Accessible in www.nd.gov.hk

9. Specialist HIV management is provided by the three major public HIV clinics run by DH and HA for eligible persons¹⁷ (holder of HK Identity Card and children aged below 11 years who are HK residents). Cases diagnosed at methadone clinics of the DH are referred to DH HIV clinic for management. The social workers in methadone clinics play important role in improving adherence to medical treatment among HIV infected drug users and maintain frequent communication with HIV workers through regular case conference and other communications.

10. Various activities are taking place to track HIV situation among drug users in Hong Kong for improving prevention and control of HIV infection in this population. In addition to the voluntary HIV/AIDS reporting system, there are HIV prevalence studies in methadone clinics (universal testing programme), the largest voluntary residential treatment centre and prisons (unlinked anonymous testing) where an estimated one third of the population are injecting drug users. Sources of information for tracking behavioral trend include Central Registry of Drug Abuse maintained by Security Bureau, admission/ readmission survey at methadone clinics, prisons and drug treatment and rehabilitation centres, and street addict survey. Moreover, all blood specimens diagnosed HIV positive at the public laboratories also undergo HIV-1 subtyping to identify cluster of HIV infection. To better study the HIV epidemiology in Pearl River Delta Region, an electronic platform for systematic collection of HIV surveillance data was established in June 2005 to enhance the exchange and analysis of such information.

¹⁷ Fees and Charges for Public Health Care Services provided by the Department of Health http://www.dh.gov.hk/english/useful/useful_fee/useful_fee_os.html and Fees and charges of medical services provided by Hospital Authority http://www.ha.org.hk/visitor/ha_visitor_index.asp?Parent_ID=10044&Content_ID=10045&Ver=HTML

Current Response in HIV Prevention among Men who have sex with men (MSM) and Male sex workers (MSW)

3. In Hong Kong, the response to the HIV epidemic in MSM has been greatly enhanced since 2006. Advisory Council on AIDS (ACA), in the current "Recommended HIV/AIDS Strategies for Hong Kong 2007-2011", which was published in May 2007, listed targeted HIV prevention in MSM as the most pressing priority. Funding policy also plays a key role in strengthening the local response to the epidemic. The Council for the AIDS Trust Fund (ATF) adopted strategic funding policy to enhance and accelerate HIV prevention in MSM through the launching of Special Project Fund (SPF) for MSM in December 2006. Favourable policy support and strategic funding have together helped nurture a conducive environment for the up scaling of response to the HIV epidemic in MSM over the last few years.

Local responses from 2007 onwards

4. Concerted efforts from the Government, non-governmental organizations (NGO) and other stakeholders within the community have strengthened the current responses to the HIV epidemic in MSM, which are summarized as below:

Box 1. Summary of current responses to HIV prevention among MSM

- | |
|--|
| <ol style="list-style-type: none">10. Outreach or centre-based peer counseling and education projects for MSM11. VCT service for MSM12. Condom and lubricant distribution to MSM13. Outreach internet intervention at gay websites and health promotion via internet14. HIV prevention campaigns targeting MSM |
|--|

15. Public AIDS Counselling and Testing Service (ACTS)

16. Public HIV clinics and STI clinics

17. HIV-related researches targeting MSM

3. Strengthened community involvement and partnership, and close collaboration among the Government and other stakeholders such as non-governmental organizations (NGOs) are key components in the response to the epidemic. The number of NGOs with projects targeting MSM has increased markedly to ten. ATF is the main funding body for most of the projects carried out by NGOs, with the rest being supported by other funding sources or through self-raised funds (such as charity events or donations). Coordination and collaboration among NGOs has resulted in community-based projects of diverse nature, covering various aspects of HIV prevention work. These projects target various sub-groups of the MSM community, such as youth, MSM living with HIV, those who abuse psychotropic drugs, attendees of private sex parties, and commercial male sex workers and their clients. Prevention activities such as promoting HIV awareness and safer sex, peer counselling and education, and voluntary counselling and testing (VCT) services are delivered via various settings and media, such as venue-based social functions or activities, saunas, bars, gay events and dance parties, private sex parties, and the internet platform.

4. There have been more than 62 projects, with 48 of them being supported by ATF. Among the 48 ATF-funded projects, 15 are research projects while 33 of them involved prevention activities or support services in various settings. The 33 non-research projects involve activities in various settings, with some of them involving more than one delivery setting (19 involve fixed venues such as bars, saunas, discos, pubs and massage parlours; 18 involve centre-based activities such as VCT, hotline support and empowerment workshops; four involve non-fixed venues such as circuit dance parties and private sex parties; ten with

internet-based outreach activities).

5. The role of NGOs in the provision of VCT has also become more significant. There has been seven NGOs which provided VCT in their projects. There are 16 VCT-related projects with 15 of them being funded by ATF. Among these 15, ten involve providing centre-based VCT while 11 involve providing outreach-based VCT such as testing at saunas and private sex parties. Overall, close to 2,700 HIV tests are performed each year through the delivery of VCT by NGOs. For projects funded by ATF, around 66,000 attendances through community outreach, 930 attendances through counseling, 600 attendances through groups or workshops, and 260 attendances through training for peer educators were recorded each year since 2007.

6. The distribution of condoms and lubricant, and other health promotion materials have always been a major and indispensable component of HIV prevention. There are six NGOs which distributed condoms and lubricant in their projects. Together, they have delivered at least 17 projects with condom and lubricant distribution, of which 16 are ATF-funded. More than 268,000 condom and lubricant packs are distributed to the MSM community via these projects each year since 2007. During the same period, an annual average of 5,800 units of health education/promotion materials are delivered and 2,000 calls received by hotlines via projects funded by ATF.

7. Internet, with its ever-increasing coverage and importance as a communication media, has become another major health promotion channel and platform for outreach prevention activities. Six NGOs have obtained funding from ATF to deliver ten internet projects altogether. Over 10,500 attendances were recorded each year via internet-based outreach sessions of these projects. A typical outreach session lasted about three hours and the

number of contacts which could be established in one session could range from four to 20. On average, 31,000 hit counts of websites provided by ATF-funded projects were recorded each year.

8. Male sex workers serving male clients, due to the nature of its work and its MSM status, are among one of the more at-risk and vulnerable sub-groups in the MSM community. Over the years, there have been five ATF-funded projects by one NGO targeting male sex workers. Prevention activities being covered include VCT; distribution of health promotion materials; distribution of condoms and lubricant; peer education workshops and hotline service.

9. There have been four HIV prevention campaigns targeting MSM run by the Red Ribbon Centre (RRC). The first three campaigns involved venue-based publicity and health promotion, and covered about 80 gay venues such as bars and saunas as well as gay magazines and websites. The fourth and current campaign was an internet-based viral campaign. Apart from the condom and lubricant packs being distributed during the major campaigns, condom and lubricant packs are made accessible to the gay community through distribution via NGOs, or at gay venues such as saunas and bars. In total, over 150,000 condom and lubricant packs have been distributed by RRC each year since 2007.

10. SPP provide centre-based VCT service and hotline counseling service free to all people through its AIDS Counselling and Testing Service (ACTS) centre. Among those attending the centre, about 25% of them claim homosexual/bisexual as the suspected route of transmission. In total, about 500 MSM received VCT service provided by SPP each year between year 2007 and 2009. The designated hotline for gay men registered an annual average of over 500 calls during the period from 2007 to 2010. Free HIV testing service is also provided at the Social Hygiene Service under the Department of Health for the eligible

persons¹⁸ (holder of HK Identity Card and children aged below 11 years who are HK residents).

11. Specialized HIV management for those infected is provided by three HIV clinics, namely the Kowloon Bay Integrated Treatment Centre (KBITC) of SPP and the two clinics located at Queen Elizabeth Hospital (QEH) and Princess Margaret Hospital (PMH) run by the Hospital Authority. About 60% of those infected are catered for by the service provided at KBITC. In 2006, the number of active MSM clients (attending KBITC during the year of 2006) was about 380 and there were a total of about 440 new MSM cases since then (as of the end of 2010). KBITC have also organized three safer sex campaigns targeting MSM clients living with HIV.

12. Research activities undertaken by the Government, academic institutions, and NGOs have provided important data and findings to help inform the local response to the epidemic. Over 22 MSM-related HIV research projects have been carried out by NGOs and academic institutions, with 15 of them being funded by ATF while SPP have carried out eight research projects. These include the two PRiSM (HIV Prevalence and Risk Behavioural Survey) studies, which were community-based and comprised collecting urine sample for HIV antibody testing and a questionnaire on safer sex practice and sexual risk behaviours.

Table 1. Summarized Responses from the Government

¹⁸ Fees and Charges for Public Health Care Services provided by the Department of Health http://www.dh.gov.hk/english/useful/useful_fee/useful_fee_os.html and Fees and charges of medical services provided by Hospital Authority http://www.ha.org.hk/visitor/ha_visitor_index.asp?Parent_ID=10044&Content_ID=10045&Ver=HTML

Health promotion and prevention

- 3 venue-based campaigns by RRC
 - 80 gay venues (e.g. bars, saunas) and gay magazines, websites
- 1 internet-based viral campaign by RRC
- 450,000 condom and lubricant packs distributed by RRC

VCT and hotline service by ACTS

- VCT for about 500 MSM clients per year
- 500 calls received via 2117 1069 per year

HIV treatment

- Kowloon Bay Integrated Treatment Centre of SPP (60% of patients)
 - 380 active MSM clients in 2006 (attending KBITC in 2006)
 - 440 new MSM cases since 2006 (as of end of 2010)
- Queen Elizabeth Hospital and Princess Margaret Hospital (40% of patients)

Research

- 8 MSM-related studies e.g. PRiSM studies

Table 2 Summarized Responses from the Non-governmental Sector

Number of NGOs with MSM projects: 10 NGOs			
<p>Projects:</p> <ul style="list-style-type: none"> ● More than 62 projects (48 ATF-funded and 14 non ATF-funded) ● 48 ATF-funded projects <ul style="list-style-type: none"> ■ 33 with prevention activities and support services <ul style="list-style-type: none"> ◆ 19 at fixed venues e.g. bars, saunas, pubs, massage parlours ◆ 18 with centre-based activities e.g. VCT, hotline, workshops ◆ 4 with non-fixed venues e.g. private sex parties, circuit dance parties ◆ 10 with internet-based outreach activities ■ 15 research projects ● 14 non ATF-funded projects <ul style="list-style-type: none"> ■ 7 with prevention activities and support services ■ 7 research projects 			
Type of Intervention	No. of NGOs	Coverage	Funding source
Voluntary Counseling and Testing (VCT)	7	15 ATF projects <ul style="list-style-type: none"> ● 10 with centre-based VCT ● 11 with outreach VCT 1 non ATF-funded projects 2,700 HIV tests per year	15 ATF-funded 1 non ATF-funded
Distribution of Condom and Lubricant packs	6	16 ATF projects 1 non ATF-funded project 268,000 packs distributed per year	15 ATF-funded 1 non ATF-funded

Distribution of Health Promotion Material	6	16 ATF projects 1 non ATF-funded project 31,000 hit counts per year 5,800 units distributed per year 2,000 calls to hotlines per year	15 ATF-funded 1 non ATF-funded
Internet Outreach	6	10 projects 10,500 attendances per year	All ATF-funded
Community Outreach	6	19 projects 66,000 attendances by community outreach per year 930 attendances by counseling per year 600 attendances by groups or workshops per year 260 attendances by training of peer educators per year	All ATF-funded

Current Response to HIV treatment, support and care among People Living with HIV (PLHIV)

Medical treatment and related care

1. There are three local HIV clinics providing anti-viral treatment for PLHIV. Clients with their HIV status confirmed can be referred to one of the three clinics, namely the Kowloon Bay Integrated Treatment Centre (KBITC) run by Department of Health (DH), and Special Medical Service in Queen Elizabeth Hospital (QEH) and Princess Margaret Hospital (PMH) run by Hospital Authority (HA). Eligible persons¹⁹ (holder of HK Identity Card and children aged below 11 years who are HK residents) are charged at highly subsidized rate (\$100 first attendance and \$60 at subsequent attendance, plus drug cost at \$10 per item). Those with financial difficulties can apply waiver through medical social worker.

2. Opened in 1999 and operated from Mondays to Fridays, KBITC provides integrated medical service to PLHIV and their significant others. Apart from HIV treatment, clinical management of medical conditions related to HIV is also available. These include treatment for hepatitis, metabolic conditions such as hypertension and diabetes, screening and treatment of sexually transmitted infections (STIs), day ward for minor operation and procedures, dermatology clinic to patients with skin problems, and psychiatric specialist consultation. Moreover, on-going counseling is offered to meet the needs of individual and to provide physical and psychosocial interventions. Medical social service, partner counseling and

¹⁹Fees and Charges for Public Health Care Services provided by the Department of Health

http://www.dh.gov.hk/english/useful/useful_fee/useful_fee_os.html

and Fees and charges of medical services provided by Hospital Authority

http://www.ha.org.hk/visitor/ha_visitor_index.asp?Parent_ID=10044&Content_ID=10045&Ver=HTML²⁰ Fees and Charges for Public Health Care Services provided by the Department

of Health http://www.dh.gov.hk/english/useful/useful_fee/useful_fee_os.html

referral service are also available. PLHIV requiring in-patient care can be referred to PMH for treatment.

3. The multidisciplinary team, with nurse specialists, medical social workers, clinical psychologists and dietitians, of Special Medical Service in QEH and PMH provides wide range of out-patient and in-patient HIV medical service.

4. Children affected by HIV are followed up in Pediatrics units in Queen Mary Hospital and QEH under HA.

Support service to PLHIV and their caregivers (as summarized in Table 1)

5. Local non-government organizations (NGO) provide support services to PLHIV and their caregivers. There are at least four NGOS providing services to PLHIV, including support service to medical care, psychosocial support and empowerment activities.

6. Support service to medical care

NGOs offer programmes to fill up the medical service gap, including home and hospital visits, home care service, and escort to clinic follow-up. One NGO provides free transport service to clinic follow up, and free soup delivery service. A multi-disciplinary Day Centre and physiotherapy service is available to provide rehabilitation and reintegration.

7. Psychosocial support

Psychosocial support service in form of sharing/support groups, counseling service (face-to-face, telephone and internet) and social gatherings organized by the NGOs strengthen support among PLHIV and their caregivers. A resource corner by a local NGO is available to lend out tangible goods, such as wheelchair and electric appliance to PLHIV in need.

8. Empowerment activities

Talk on HIV treatment/care and mental health have been organized by NGOs for PLHIV and their caregivers. Training of peer volunteers and volunteer work including anti-discrimination workshops have also been arranged to empower PLHIV.

Table 1: Summary of HIV treatment, support and care among PLHIV

Type of Service	Annual estimated coverage	Funding source*
Support Service to medical care		
Home visit (including home care service) and hospital visit	3386 sessions	ATF, NGO general funding or other funding source
Home care service via phone contact	7552 sessions	35% from ATF and 65% from fund raising#
Escort to clinic follow up	3 sessions	NGO general funding or other funding source
Free transport service to clinic follow up	994 trips	NGO general funding or other funding source
Free soup delivery service	1110 flakes	NGO general funding or other funding source
Day centre	1936 sessions (12,000 people served)	35% from ATF and 65% from fund raising#
Physiotherapy service	1224 sessions	
Psychosocial support		
Counseling service, sharing/support group to PLHIV and their caregivers	337 sessions	ATF
Social gatherings	98 sessions	NGO general funding or other funding source
Blog (sharing experience of PLHIV)	7747 viewers	NGO general funding or other funding source
Resource corner	Data not available	NGO general funding or other funding source

Empowerment activities		
Talk on HIV treatment and mental health to PLHIV and caregivers	8 sessions	ATF, NGO general funding or other funding source
Training of peer volunteers	170 sessions	ATF, NGO general funding or other funding source
Anti-discrimination workshop or activities to public, schools and organizations	53 sessions (> 93711 attendance)	ATF, Department of Health, NGO general funding or other funding source
Production of resource directory to PLHIV	1000 copies	ATF
Others		
Survey of PLHIV on service need	170 targets	NGO general funding or other funding source

*ATF = AIDS Trust Fund; NGO general/other funding: from public or private (including Pharmacological companies) donation, fund raising, membership fee and fund other than ATF.

Based on information from single NGO which provide these unique service

Financial assistance

9. PLHIV and their families can apply for a special support fund by Social Welfare Department (SWD) for temporary financial assistance.

10. For PLHIV who acquired infection through blood or blood products, financial assistance can be acquired through grants of ex-gratia payment and a long-term financial scheme from AIDS Trust Fund.

11. The Comprehensive Social Security Assistance Scheme provides a safety net for those who have resided in HK for more than seven years and cannot support themselves financially.

12. PLHIV as assessed by doctors with significant disability can apply for the disability allowances.

13. One NGO provides a PLHIV support fund for emergency financial support to PLHIV while awaiting approval for the support fund by SWD.

Employment

14. There are various employment services provided by the Labor Department to the general public that can be accessed by PLHIV. The Employment Services Division provides free employment and recruitment services to job seekers and employers. The Youth Employment Division implemented the Youth Work Experience and Training Scheme since 2002 for young people aged 15 to 24 years with education attainment below degree level.

15. The Employee Retraining Board (ERB) provides retraining to the unemployed with junior secondary education or below to strengthen their skills for employment. In collaboration with ERB, patient retraining and vocational settlement services are available in QEH and PMH to enable patients with chronic illness to rejoin the workforce.

Public education and addressing stigma/discrimination

16. Various workshops and activities (including telephone interviews by journalists, university students, as well as interviews in radio broadcast) on HIV knowledge and anti-stigma have been organized by NGOs and the government for public education to

promote acceptance to PLHIV as summarized in Table 1.

17. A survey to PLHIV was carried out to look into stigma/discrimination in the pre-employment process.

18. PLHIV and their associates are protected under Disability Discrimination Ordinance (Cap 487), a law that has been enacted since 1996 to protect people with a disability against discrimination, harassment and vilification on the ground of their disability. The law enforces protection in the areas of employment, education, sport activities, access to, disposal and management of premises, and provision of goods, services and facilities.

19. The privacy interest of PLHIV concerning their HIV status is protected under Personal Data Privacy Ordinance (Cap 486). Personal data shall be collected for necessary and lawful purpose only, and consent must be given to collect data that can only be used for the purpose originally stated at the time of collection. HIV/AIDS-related information of employees should be kept strictly confidential and kept only on medical files. Access to such information should be strictly limited to medical personnel, and such information may only be disclosed if legally required or with the consent of the person concerned.

Current Response in HIV Prevention among Youth at risk

1. In Hong Kong, the response in HIV Prevention among youth at risk is shifted and intensified in segments of the most at risk groups, namely the Men who have sex with men (MSM) and Female Sex Worker (FSW), from the vulnerable youth and youth from the general population. Advisory Council on AIDS (ACA), in the current "Recommended HIV/AIDS Strategies For Hong Kong 2007-2011", which was published in May 2007, stated that youth related HIV prevention is to be integrated into media programmes, publicity campaigns and education activities to increase public awareness. HIV prevention is also effected through AIDS education and sex education which is integrated into school moral and civic education for youth. Funding from the Council for the AIDS Trust Fund (ATF) has also been re-prioritized in funding youth programmes targeting those who are most at-risk to HIV infection.

Local responses from 2007 onwards

2. Non-governmental organizations (NGO) play a vital role in targeting youth most at-risk to HIV infection. These programmes mostly target MSM youth as well as young FSW. On the other hand, many NGOs continue to provide HIV related sexual health programmes for vulnerable youth. The current responses comprise of multi-facet approaches to HIV prevention and sexual health promotion, which are summarized as below:

Box 1. Summary of current activities for preventing HIV infection among Youth at risk

18. Outreach activities

19. Internet outreach and online intervention

20. Peer education projects

21. Education workshops
22. Voluntary counseling and testing (VCT) service (both HIV and STI tests)
23. Condom and health promotion material distribution
24. Drop-in service
25. Public AIDS Counselling and Testing Service (ACTS)
26. Public HIV clinics and STI clinics

3. Efforts targeting MSM youth is a key part of HIV prevention efforts targeting youth who are most at-risk to HIV infection. There are three NGOs with at least eight projects (all are funded by ATF) targeting MSM youth. In addition, there are at least two NGO provide programmes targeting young FSW in Hong Kong, of which, one is funded by ATF. On the other hand, there are at least three NGOs providing HIV specific education programmes and/or sexual health promotion programmes targeting vulnerable youth (including youth with drug taking behavior, multiple sex partners and young inmates of correctional institutions). Two of the aforementioned programmes are funded by ATF, while one is funded by other funding sources or through self-raised funds.

4. Volume of response targeting MSM youth has flourished since the launching of the Special Project Fund (SPF) under ATF in 2006. Since 2007, ATF (including SPF) have funded eight projects targeting MSM youth which together reached close to 630 contacts of MSM youth per year via community outreach. As a result, these projects contribute to the significant increase of services for MSM youth, including over 4,000 internet outreach contacts reached, over 180 HIV tests conducted, close to 160 peers trained in education workshops, over 1,660 health education / promotion material distributed, close to 5,000 condom / lubricant packs being distributed, over 100 contacts reached by workshops conducted in each year. At least seven websites constructed and one hotline in operation.

5. Young FSW serving male clients, has become a phenomenon of concern in Hong Kong. In addition to efforts targeting FSW in general, which inevitably cover young FSW, two NGOs are conducting specific programmes for these young women (one of which is funded by ATF and the other one is funded by other funding source). Since 2007, one such programme is supported by the ATF specifically targeting young FSW at entertainment venues, providing interventions for their high risk behavior, including drug taking behavior. In 2007 and 2008, this programme reached up to 300 young FSW and distributed 45,000 units of health promotion and education material. There also exist other services provide by other AIDS or mainstream youth NGOs targeting young FSW for intervention. These services may not specifically aim at HIV prevention (but include HIV messages) in nature, and they are not funded by the ATF. At least one NGO reports to have reached over 300 contacts of young FSW in 2009 via small group work and internet outreach.

6. Many young people in Hong Kong are involved in different types of vulnerable behavior including psychotropic drug abuse and having multiple sex partners. Programmes targeting these young people are important to reduce their vulnerabilities in HIV infection. While there are numerous youth service providers who are possibly organizing different types of sex education activities for youth with vulnerable behavior, there are at least three NGOs coordinating programmes targeting these young people. Of these programmes, two are funded by ATF, and the key modes of intervention are education workshops and peer education programmes. In 2007 and 2008, at least 75,000 vulnerable youth are reached while close to 400 HIV tests are conducted by these NGOs. Of the programme that is funded by other funding source, close to 6,000 are reached via workshops / small groups, while close to 600 are reached via outreach since 2007. Internet programme also reach up to 700 vulnerable youth via this programme.

7. Although young people from the general population are generally considered to have low risk of HIV infection, substantial volume of effort is contributed by NGOs and the government in HIV education for these young people. Since 2007, the ATF supports seven projects, which covered 51,200 general youths in the community each year. Workshop, peer education and health promotion material distribution are the key modes of intervention. Other interactive activities such as drama and game booth were also used as means of education. There also exist other HIV related educational programmes, by at least one NGO, to young people from the general population which is not funded by the ATF.

8. The Red Ribbon Centre (RRC) the prevention and health promotion arm of Special Preventive Programme (SPP), the AIDS Unit under Department of Health. Since 2007, 69 projects have been approved by “Red Ribbon in Action,” organized by RRC, to encourage local community groups to organize and implement AIDS education activities by providing financial and technical support. In the process of planning and implementing the AIDS education activities, local community groups will have a chance to acquire knowledge about AIDS, sex and psychotropic drug abuse; and to further promote related messages among peer groups. In addition, main campaigns and events, such as school tours and concerts, have together reached close to 1,000 young people from the general population by the RRC each year.

9. SPP provided centre-based VCT service and hotline counseling service free to all people through its AIDS Counselling and Testing Service (ACTS) centre. Among those attending the centre, approximately one quarter to one-fifth claimed that they were aged 15-24 (25.3% in 2007; 21.6% in 2008; 19.1% in 2009). Public HIV testing service is also provided at the Social Hygiene Clinics under the Department of Health, which provide treatment of sexually

transmitted infections (STI) for the eligible persons²⁰ (holder of HK Identity Card and children aged below 11 years who are HK residents) free of charge in Hong Kong.

²⁰ Fees and Charges for Public Health Care Services provided by the Department of Health
http://www.dh.gov.hk/english/useful/useful_fee/useful_fee_os.html
and Fees and charges of medical services provided by Hospital Authority
http://www.ha.org.hk/visitor/ha_visitor_index.asp?Parent_ID=10044&Content_ID=10045&Ver=HTML

Annex 9 – Summary of ATF Updates

Revision History

Old Version	Summary of Revision
January 2011 edition	<p>Paragraph 5: “Resource allocation of the ATF in different action areas from 2007/09 to 2009/10 is shown in Table 2,” has been revised to “Resource allocation of the ATF in different action areas from 2007/08 to 2009/10 is shown in Table 2.”</p>
	<p>Table 2: “Resource allocation of ATF funding by prioritized areas, 2007/09 – 2009/10” has been revised to “Resource allocation of ATF funding by prioritized areas, 2007/08 – 2009/10.”</p>

Summary of ATF Updates

1. The AIDS Trust Fund (ATF) was established by the Hong Kong Government in 1993, with a sum of HK\$350 million. Its aim is to provide assistance to HIV-infected haemophiliacs, and to generally strengthen medical, support services and public education on AIDS. The ATF provides financial funding in the areas of ex-gratia payment (EGP), medical and support services (MSS) and publicity and public education (PPE).
2. In view of the rising trend in the community of Men having Sex with Men (MSM), ATF set up a Special Project Fund (SPF) to scale up community response in MSM. Launched on December of 2006, SPF supported HIV prevention and research projects targeting MSM in two fiscal years. SPF granted approximately HK\$13.6 million and supported 42 projects in two years. Upon its expiry in August of 2008, SPF has been subsumed under the ATF proper application channel.
3. As of 31st of March, 2009, the accumulated income of ATF from establishment on 20th of April, 1993 was HK\$222.6 million. With total grants accumulated to HK\$390.1 million, the ATF balance stood at HK\$182.5 million.
4. A total of 1,118 applications were processed by ATF since its establishment in 1993, of which 73.3% (820 applications) were approved. A breakdown on funding from April of 1993 to March of 2010 is shown in Table 1.

Table 1. Number of applications and amount of fund approved by the Council of the AIDS Trust Fund, 20th April, 1993 to 31st March, 2010

Financial Year	93/ 94 to 03/ 04		04/ 05		05/ 06		06/ 07		07/ 08		08/ 09		09/ 10		Total	
	No.	Amount (\$M)	No.	Amount (\$M)	No.	Amount (\$M)	No.	Amount (\$M)	No.	Amount (\$M)	No.	Amount (\$M)	No.	Amount (\$M)	No.	Amount (\$M)
PPE	380	72.428	5	2.065	9	19.295	9	21.258	6	8.377	7	25.102	8	10.422	424	158.948
MSS	107	131.070	3	3.297	7	13.107	5	10.219	2	2.468	2	7.857	9	6.013	135	174.030
Ex- gratia Payments	58	33.624	1	1.019	0	0	0	0	0	0	0	0	0	0	59	34.643
Additional Ex- gratia Payment	0	0	0	0	36	8.058	58	12.548	8	2.960	29	7.251	29	7.592	160	38.409
Special Project Fund	0	0	0	0	0	0	15	4.316	22	7.646	4	1.375	1	0.271	42	13.608
Total	545	237.122	9	6.381	52	40.460	87	48.341	38	21.450	42	41.586	47	24.298	820	419.638

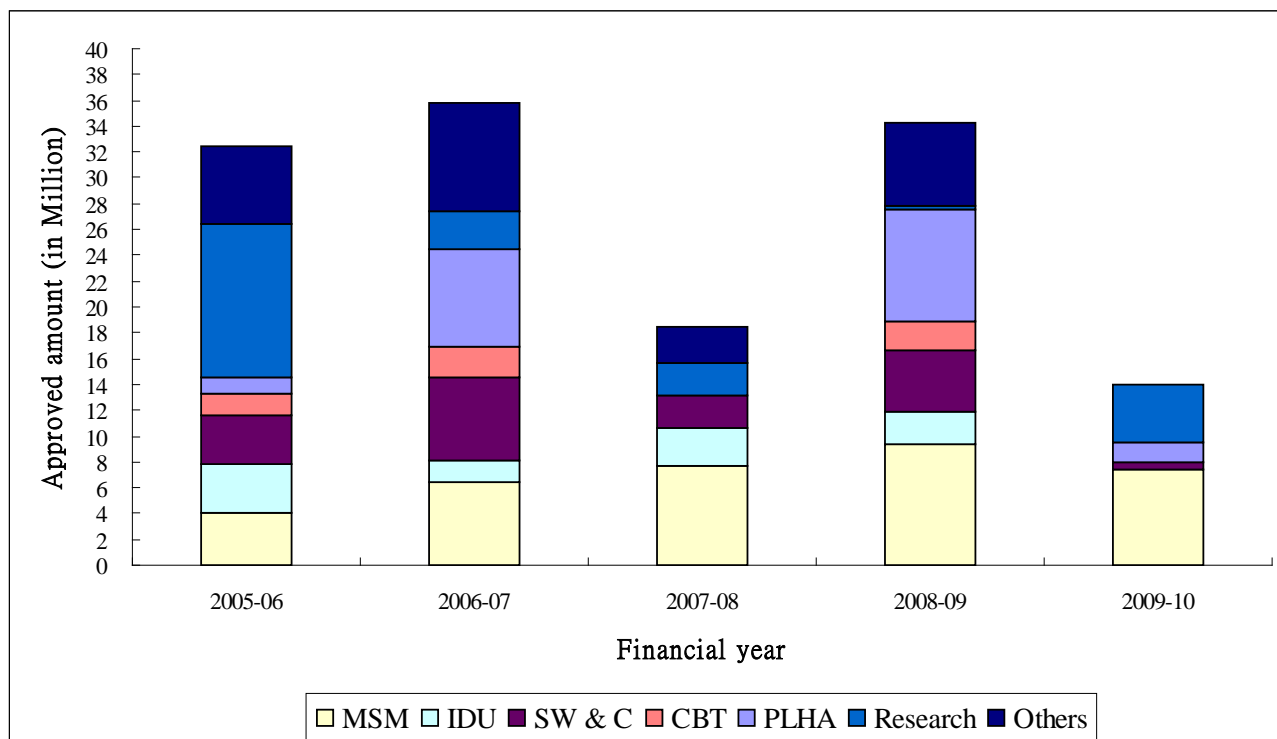
5. The Hong Kong Advisory Council on AIDS (ACA) highlighted five prioritized areas targeted for HIV prevention in the “Recommended HIV/AIDS Strategies for Hong Kong 2007 to 2011,” published in May 2007. These prioritized groups included Men having Sex with Men (MSM), Injecting Drug Users (IDU), Commercial Sex Workers (CSWs) and their clients, Cross-border Travellers (CBT); and People living with HIV/AIDS (PLHIV). Resource allocation of the ATF in different action areas from 2007/08 to 2009/10 is shown in Table 2.

Table 2. Resource allocation of ATF funding by prioritized areas, 2007/08 – 2009/10

	ATF Resource Allocation (Proportion)
MSM	35%
IDU	8%
CSWs and clients	15%
CBT	3%
PLHA	15%
Research	10%

6. Figure 1 shows graphic display of the approved amount of ATF funds to different prioritized groups from the financial year 2005/06 to 2009/10.

Figure 1. Resource allocation of ATF funding by prioritized areas, 2005/06 – 2009/10



Annex 10 – Summary of pre-CSCM activities conducted by HKCASO members

Background:

In order to mobilize active participation of member agencies and community stakeholders to the CSCM, HKCASO has made substantial preparation through its member agencies and network with the key populations and civil societies.

The preparation divided into three phrases and covered the key populations. The mobilization started with the core connected communities and extended to cover the society at large in final stage.

Target Stakeholders:

1. (Target A) Key populations: Sex workers, Injection drug user, Men who have sex with men, Transgender persons, People living with HIV, Sex worker clients, related youth and Ethnic minority.
2. (Target B) Other targeted communities further included by Working Group of Community Stakeholders' Consultation Meeting: NGOs and GO, academics, related disciplines and public.

Timeframe	Target Stakeholders	Key Messages	Means and Activities
Immediately after the First Working Group meeting	A	Announcement of the launch of the CSCM, the CSCM updated progress and appealed for mobilizing and preparation of community participation.	<ol style="list-style-type: none"> 1. Notices being sent to HKCASO member agencies to start mobilizing the connected communities; 2. Approaches included while not exhaustive: <ul style="list-style-type: none"> -face-to-face contact -telephone and email -internet forum and groups -organizing view collection meetings / focus groups to prepare and to promote participation

			-agency internal memorandum.
After the Second Working Group meeting & before the CSCM	A&B	<ol style="list-style-type: none"> 1. Announcement of the launch of registration the CSCM and its progress; 2. Introduction of World Café; 3. Call for enrolment; 4. Call for filling in the online survey on the ACA website; 5. Call for giving views to ACA through available means if not attending the CSCM; 6. Encourage the use of HKCASO member agencies support to channel the views if so 	<ol style="list-style-type: none"> 1. Invitation announcement to be forwarded to HKCASO member agencies, Hong Kong Council of Social Services, NGOs and other stakeholders provided with access to relevant ACA website; 2. Encourage member agencies to forward the message to connected communities and stakeholders; 3. Encourage member agencies to facilitate connected community stakeholders to know how to participate and enroll; 4. Means include while not exhaustive: <ul style="list-style-type: none"> ■ face-to-face contact; ■ telephone contact; ■ emails with follow up contact; ■ mass emails to target participants; ■ Facebook page event; ■ internet forum and groups; ■ view collection meetings / focus groups to prepare and to promote participation ■ agency internal memorandum; ■ facilitation of enrolment among community members; ■ invitation through peer counselors; ■ Acquiring support from website host to release invitation and appeal.

		needed.	
After the CSCM	A&B	<ol style="list-style-type: none"> 1. Call for feedback towards the first draft of the Report on the CSCM; 2. Call for further collection of views towards the formulation of policy; 3. Collection of feedback to Working Group. 	<ol style="list-style-type: none"> 1. Announce to HKCASO member agencies, Hong Kong Council of Social Services, NGOs and other stakeholders provided with access to relevant ACA website; 2. Encourage member agencies to forward the message to connected communities stakeholders; 3. Encourage member agencies to facilitate connected community stakeholders to feedback to HKCASO and/or the Working Group; 4. Inform and call for feedback on the draft of Report and to collect further views towards the formulation of policy through membership network by means below while not exhaustive: <ul style="list-style-type: none"> ■ HKCASO website, Ex-co meetings and Sub-committees on Sex Industry and sub-committee on MSM ■ face-to-face contact; ■ telephone contact; ■ email with follow up contact; ■ mass email to target participants through established facebook page; ■ internet forum and groups; ■ view collection meetings / focus groups to collect feedback; ■ agency internal memorandum; ■ invitation through peer counselors; ■ Acquiring support from website host to release invitation and appeal. ■ liaison with public media to collect views from public

Annex 11 – Summary of Participation Statistics

Sessions	No. of Participants Enrolled prior to Meeting	No. of Individuals attended	No. of Organization Representatives	Total No. of Participants	Number of Recommendations Formulated
Female sex workers	26	13	20	33	10
People living with HIV	30	14	17	31	8
Injecting drug users	14	9	10	19	15
Men who have sex with men / Transgender persons	73	50	17	67	17
Financing & resource mobilization for HIV services	31	5	22	27	16
Ethnic minorities	12	7	10	17	12
Youth at risk	23	9	16	25	13
Male clients for Female sex workers	19	11	11	22	13
Male sex workers	8	3	4	7	10
Total	236	121	127	248	114

Annex 12 –Feedback of participants on the CSCM (Evaluation Form)

Community Stakeholders’ Consultation Meeting for the Development of Recommended HIV/AIDS Strategies Evaluation Form

1. What did you expect before coming to this consultation session?

2. From where / whom did you first know about this consultation session?

3. How would you rate the following items? (Please circle the most appropriate answer)

	Very poor	Poor	Fair	Good	Excellent	Not Applicable
3.1 Report on latest epidemiological trend and current responses	1	2	3	4	5	N/A
3.2 Group Discussion	1	2	3	4	5	N/A
3.3 Report back from table hosts	1	2	3	4	5	N/A
3.4 Whole group discussion on recommendations	1	2	3	4	5	N/A
3.5 Prioritizations of recommendations	1	2	3	4	5	N/A

4. How much do you agree with the following sentences for today’s consultation session?

(Please circle the most appropriate answer)

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Not Applicable
4.1 I am satisfied with the registration process.	1	2	3	4	5	N/A
4.2 The information provided is useful for discussion.	1	2	3	4	5	N/A
4.3 My involvement is important.	1	2	3	4	5	N/A
4.4 The size of audience is just right.	1	2	3	4	5	N/A
4.5 The venue is suitable for the consultation meeting.	1	2	3	4	5	N/A
4.6 The facilitators (session facilitator and table hosts) have done a good job	1	2	3	4	5	N/A
4.7 This session has led to useful recommendations for formulating HIV / AIDS Strategies.	1	2	3	4	5	N/A

<p>5. Other comments / suggestions:</p> <hr/> <hr/> <hr/> <hr/> <hr/>	<p>6. Personal particulars (optional)</p> <p>Organisation: _____</p> <p>Post: _____</p> <p>Name: _____</p>
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~~ Thank You! ~~

Annex 12 – Feedback of participants on the CSCM - Evaluation statistics for all sessions (No. of responds = 127)

Note: Results from Questions 1, 2, 5 and 6 (Open-ended questions) are excluded in this summary

How would you rate the following items?

		Very poor	Poor	Fair	Good	Excellent	NA/missing
3.1 Report on latest epidemiological trend and current responses	N (%)	0 (0%)	2 (2%)	39 (31%)	60 (47%)	20 (16%)	6 (5%)
3.2 Group Discussion	N (%)	0 (0%)	4 (3%)	20 (16%)	74 (58%)	28 (22%)	1 (1%)
3.3 Report back from table hosts	N (%)	0 (0%)	5 (4%)	33 (26%)	67 (53%)	19 (15%)	3 (2%)
3.4 Whole group discussion on recommendations	N (%)	0 (0%)	7 (6%)	37 (29%)	57 (45%)	22 (17%)	4 (3%)
3.5 Prioritizations of recommendations	N (%)	2 (2%)	11 (9%)	32 (25%)	56 (44%)	20 (16%)	6 (5%)

How much do you agree with the following sentences for today's consultation session?

		Strongly disagree	Dis-agree	Neutral	Agree	Strongly agree	NA/missing
4.1 I am satisfied with the registration process.	N (%)	1 (1%)	0 (0%)	11 (9%)	76 (60%)	37 (29%)	2 (2%)
4.2 The information provided is useful for discussion.	N (%)	1 (1%)	4 (3%)	17 (13%)	71 (56%)	33 (26%)	1 (1%)
4.3 My involvement is important.	N (%)	0 (0%)	2 (2%)	10 (8%)	69 (54%)	45 (35%)	1 (1%)
4.4 The size of audience is just right.	N (%)	2 (2%)	11 (9%)	29 (23%)	67 (53%)	16 (13%)	2 (2%)
4.5 The venue is suitable for the consultation meeting.	N (%)	1 (1%)	10 (8%)	17 (13%)	68 (54%)	28 (22%)	3 (2%)
4.6 The facilitators (session facilitator and table hosts) have done a good job	N (%)	0 (0%)	0 (0%)	11 (9%)	64 (50%)	50 (39%)	2 (2%)
4.7 This session has led to useful recommendations for formulating HIV/AIDS Strategies.	N (%)	0 (0%)	3 (2%)	16 (13%)	73 (57%)	31 (24%)	4 (3%)

Annex 13 – Post meeting feedback

A. Feedback collected at the CFA meeting on 15 March 2011

1. During the IDU session, a participant was dissatisfied that his suggested recommendation (legalization of marijuana) was taken out by voting, as consented by participants, of all before prioritization. He said that this should be avoided as far as possible in future exercise.

2. Some suggestions expressed during small group discussion / World Café were not recorded by note-takers or reported by table hosts, and no supplementary remarks were given by the discussants concerned during the corresponding sessions. For example, a participant said he had voiced out the need for ATF to abandon the practice of withholding 10% of approved budget until submission of all reports, as this affects the vitality of small NGOs; the same participant said that he had suggested making use of information technology more extensively for the purpose of staff supervision and field survey during CSCM, but the point was not recorded in the meeting report.

3. More time should be allocated for small group discussions or else another platform is needed to allow more elaboration of ideas generated.

4. More time should be allowed for consensus building as voting of recommendations had biased against those views that were expressed or concerned by the minority, who should be fully respected to minimize their vulnerabilities.

5. The summary of current response focused mainly on direct services and interventions available to the key populations under discussion, but not on issues of the wider environment.

B. Feedback received from HKCASO

Per request of the Secretariat of the Meeting, the HKCASO had held a discussion on 22 March 2011 to collect views on the Draft Report. Below is the note of the views. It is a summary note and does not necessarily represent all the ideas of members sitting at the meeting. It also does not represent all the views of member agencies. This is collected for reference and to be conveyed as partial feedback of member agencies towards the Draft Report.

1. It is a very good minute.
2. It is hard to identify focus. The prioritization is not explicit.
3. The minor points are suggested to be screened out.
4. The suggested ideas are too abstract. There is no concrete measure or strategy to be suggested.
5. The translation is not well connected between English and Chinese. For example, the concept of “normalization” is not equivalent to
6. The report is quite long and not reader friendly. It is not easy to identify target community nor to pick out the concerned issues as they are mixed together. Yet it is with understanding that it would be hardly to cover all the target population as there were so many groups and communities. e.g. It is difficult to identify areas concerning PLHIV if not reading through all the pages.
7. The time between notice and the Meeting is not sufficient enough to equip the stakeholders to participate actively in this discussion approach. It should take two

weeks at least to prepare stakeholders.

8. It is difficult for certain stakeholders to speak out views within 15 minutes in a group of 6 to 8 persons. It is too demanding for them to express freely and fully their views.
9. The World Café is a good approach for discussion if add up 5 minutes more. It would have better effect to facilitate discussion.
10. The information and references prepared for the meeting are very useful and of great value to support discussion.
11. The preparation and organizing of Meeting is transparent. It is very worth to note.
12. The prioritization requires longer time to process, to allow participants to think through. The time is too rushed and pressing to giving vote. Some participants, their voices might be passive or non-verbal are difficult to express. E.g. TG members expressed difficulties.
13. The participation of community members was extended and more direct than last time.
14. The acquired information concerning the agenda was different among participants which caused imbalanced participation.
15. It is suggested that capacity building should be provided to enhance involvement with equal readiness. i.e. Not only attend but to participate.

C. Post-meeting remarks on the recommendations for Youth at risk submitted by AIDS Concern are listed as below -

On Recommendation 4.1. Sex education should be multi-level and comprehensive, taking into account of various factors such as age, culture, ethnicity and background (sex workers/drug use/identity); adopt suitable approaches (such as not based on fear, conduct in small group, interactive and bottom up rather than a one-way lecture, updated); sex education to be compulsory in school (i.e. part of the school curriculum). The content

should go beyond HIV education and also cover relationship/values education.

Extra remarks for recommendation 4.1:

1. Monitoring and evaluation mechanism should be in place to ensure the quality of the sex education efforts (both in-school and school-drop out) in Hong Kong. The government/ACA should take up the leading role in coordinating the development of the mechanism and indicators. The monitoring and evaluation indicators should be developed with the consensus of youth. The evaluation process should include feedback from youth, not only from schoolteachers and master, government officers.
2. Sex education should not only be conducted in conventional cultural school setting. Programs should also be funded to reach out school drop outs/ youth in vocational or non-conventional cultural school settings.
3. The government/ACA should take up the leading role in coordinating youth sexual health promotion work, which should include sex education, with related governmental bureau.
4. If ACA regards youth sex education as non-ACA prioritized concern; please provide us the exact governmental department, contact person, number and email for the community to follow-up. The community has the right to know whom they should approach for such a concern.

On Recommendation 4.2. Supportive environment: anti-stigma (sex worker/MSM/against labelling those schools/children homes/ youth centers who are active in conducting sex education to be institutes compiling of so-called “at-risk” youth); reduce taboo to talk about sex; strengthen data collection as a tool to advocate for law reform for decriminalization of sex work.

Extra remarks for recommendation 4.2:

1. Data collection should not only focus on law reform and decriminalization of sex work, but also comprehensive needs assessment on youth (sexual) behavior and reproductive health quality. The indicators of the assessment should consult frontline youth workers and youth.

On Recommendation 4.3. Training & information provision to health care workers, social workers, peer educators, counsellors, teachers & parents so as to reduce psychological barriers among young people when expressing their needs.

Extra remarks for recommendation 4.3:

1. The training should be in-depth. Monitoring and evaluation mechanism should be in place to ensure the quality of the mentioned training efforts. The government/ACA should take up the leading role in coordinating the development of the mechanism and indicators.
2. The government/ACA should coordinate with universities, institutes and related governmental bureaus to institutionalize proper sex educators training to the mentioned professionals (for example, compulsory sexual health promotion training for potential school teachers/ doctors in universities).

On Recommendation 4.4. Comprehensive sexual health clinic/centre: provide testing service to different ages and racial background etc. Such service should be youth friendly and youth focused. Engage staff members who have diversified backgrounds.

Extra remarks for recommendation 4.4:

1. Before setting up the comprehensive sexual health clinic/centre for youth, a survey

should be conducted to review the quality of the EXISTING (youth) sexual health centre. The survey must include feedback of youth and youth workers. A definition of “youth friendly service” or a declaration of “youth-friendliness” should be in place with the consultation and consensus with youth. The service provided by the centre should be based on that definition.

2. So far, from the feedback AIDS Concern collected from the youth community – youth-friendly sexual health service should include: 24 operation hours, free of charge for all reproductive health check up and treatment, peers stationed in the centre to introduce the service and provide friendly counselling, more clinics, centers set up in different districts, workers with good attitude – not blaming the youth, not (in)directly pushing the youth to make certain decision, the workers simply play the role of health service provider /counselor rather than law enforcer and let the youth know no law enforcement by centre workers, unless the youth wish to).
3. Monitoring and evaluation mechanism should be in place to ensure the quality of the centre/clinic. The government/ACA should take up the leading role in coordinating the development of the mechanism and indicators. The monitoring and evaluation indicators should be developed with the consensus of youth. The evaluation process should include feedback from youth, not only from youth workers, parents and government officers.

On Recommendation 4.5. Funding: diversify the funding to different sets such as NGOs, community setting and schools. Make funding sustainable.

Extra remarks for recommendation 4.5:

1. The funding allocation should not only focus on the HIV infection number of the community. The government/ACA should take into account of youth’s sexual health

risk factors (for example, increasing number of female youth opt for comparatively elder/adult male rather than their same-aged peers as sex partners) and developmental needs.

2. The community understand and agree with the importance of "evidence-based" in funding allocation, therefore funding should be provided by the government/ATF to conduct large scale and comprehensive youth reproductive health surveillance (for example, the infection rate of STI, testing rate among high risk youth). The government should play an active role in providing funding and technical support while related NGO can help to provide frontline support.

On Recommendation 4.8. A centralized and coordinated effort to oversee sex education and related matters for youth.

Extra remarks for recommendation 4.8:

If the government/ACA think it is not their duty to pay such kind of efforts, please provide us the exact governmental department, contact person, number and email for the community to follow-up. The community has the right to know whom they should approach for such a concern.

On Recommendation 4.12. Advocate regular HIV testing.

Extra remarks for recommendation 4.12:

HIV testing should be provided for and promoted to even the underage youth. They are the most vulnerable and at-risk among all. The government/ACA should have such moral courage to take care of underage youth sexual health development and play role model for the NGO to follow.

End of Report