Third Set of Core Indicators for Monitoring Hong Kong's AIDS Programme

Hong Kong Advisory Council on AIDS

September 2011

Revision History

Corresponding section	October 2010 edition	September 2011 edition	Reason of Revision
Indicator 8: Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results	FSW = 563 / 967 x 100% = 57.1%	FSW = 48.8% (adjusted figure)	Figures adjusted for sampling bias were adopted
Indicator 9: Percentage of most-at-risk populations reached with HIV prevention programmes	FSW: ■ 98.1% (967 / 986 x 100%) had received HIV prevention message; ■ 63.1% (622 / 986 x 100%) had received outreach education ■ 72.0% (710 / 986 x 100%) had received free condom ■ 76.5% (754 / 986 x 100%) had peer discussion	FSW (adjusted figures): ■ 99.2% received HIV prevention message; ■ 52.5% received outreach education; ■ 58.3% received free condom; & ■ 68.9% had peer discussion on safer sex or STI/HIV	
Indicator 14: Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	FSW: 967 / 986 x 100% = 98.1%	FSW = 99.2% (adjusted figure)	

Purpose

This report aims to present the local data using the framework of the United Nations General Assembly Special Session (UNGASS) on HIV / AIDS Reporting System, which can be adapted as the third set of core indicators for monitoring Hong Kong's response to HIV / AIDS.

Background

2. At the close of United Nations General Assembly Special Session on HIV/AIDS in 2001, 189 Member States adopted the Declaration of Commitment on HIV / AIDS. The Declaration reflects global consensus on a comprehensive framework to achieve the Millennium Development Goal of halting and beginning to reverse the HIV/AIDS epidemic by 2015.

3. Subsequently, the Hong Kong Advisory Council on AIDS (ACA) published the first set of core indicators for Hong Kong in a report entitled "Construction of the First Set of Core Indicators (2003) for Monitoring Hong Kong's AIDS Programmes" in 2004[1], after considering the application of the Joint United Nations Programme on HIV/AIDS (UNAIDS) guidelines for reporting the implementation of UNGASS Declaration of Commitment on HIV / AIDS in the local context. The ACA laid down three principles for the development of core indicators for Hong Kong, including (a) use of existing data as far as possible; (b) modification of UNGASS indicators as appropriate; and (c) adoption of the same methodology for data collection. In this way, a majority of the local core indicators was determined by making use of available data and supplemented by additional data collection process, e.g. questionnaire survey. Twelve core indicators were used at that time.

4. In October 2006, a second set comprising nine core indicators based on a revised UNAIDS guidelines (2005) for monitoring HIV situation in low prevalence epidemics was compiled and presented to the 56th Meeting of ACA[2]. All, except the indicator on risk behaviours of injecting drug users, were NOT required and not collected for "First set of core indicators (2003) for Monitoring Hong Kong's AIDS Programmes".

There had been more contribution by the civil society in formulating the second set of Hong Kong's core indicators.

5. Further revision was made by UNAIDS in the 2007 guidelines[3], and additional guidance was provided in the latest 2009 guidelines for the UNGASS indicators[4]. Unlike the previous guidelines, the distinction between a generalized epidemic indicator set and a Concentrated/Low Prevalence epidemic set had not been made since the 2006-2007 reporting cycle. This is due to the fact that epidemics do not fit neatly into simple dichotomous classifications. There are now 25 core national-level indicators in three categories. Countries are expected to "know their epidemic" and to review all of the indicators in the light of this knowledge to determine and explain which ones are applicable in their situation. Although Hong Kong SAR, as part of China, is not required to submit a report as a sovereign state, we had been nevertheless invited to share our information through the latest 2010 reporting cycle.

Process leading to the third set of indicators

6. The issue of presenting local data based on the UNGASS framework for monitoring the overall response to HIV / AIDS in Hong Kong was extensively discussed in the Community Forum on AIDS (CFA) and ACA again in 2010. It was noted that the use of available data (with modification of indicators) and not data purposely collected from the outset for these UNGASS indicators precluded accurate reflection of what each indicator meant for. Moreover, several UNGASS indicators were less significant to Hong Kong and cross comparison with other places should be interpreted with care as methodology adopted by different countries tends to vary. The fact that UNGASS indicators kept changing adds further difficulty in using such information to monitor the secular trend. While it might be more worthwhile to develop a local set of indicators to monitor and evaluate the local epidemic situation and response, the UNGASS indicators would nonetheless facilitate Hong Kong to benchmark its performance in the meantime.

7. As the process of preparing the report should involve all partners involved in the AIDS response, input from healthcare providers in the public sector including Blood Transfusion Service, HIV clinics and Headquarters of the Hospital Authority, relevant

government bureaux/departments including Public Health Services Branch of Centre for Health Protection in Department of Health, Education Bureau, Social Welfare Department, Department of Justice, Council for the AIDS Trust Fund, and non-governmental organisations including Family Planning Association and Midnight Blue had been sought in providing the necessary information.

8. As a follow-up to the suggestion made in the 17th meeting of CFA that The Hong Kong Coalition of AIDS Service Organization could take up the task of coordinating the input from the civil society for preparing Part B of the National Composite Policy Index (NCPI) questionnaire, AIDS Concern subsequently formed a working group and undertook the task. The information gathered by the civil society and consolidated as the NCPI (Part B), and other parts of the report, was presented and discussed at the 18th CFA meeting on 17 June 2010. The meeting suggested that (i) for indicator 20, respondents of the next Street Addicts Survey could be asked if they have used condom at the last sexual intercourse instead of last year in order to align better with the definition used in UNGASS; and (ii) for indicator 11, Education Bureau should consider surveying schools to determine whether they conducted life skills-based HIV education. In addition. the following remarks were made with reference to specific items in Part B of NCPI –

- item 3b on the extent to which services provided by civil society are included in the national AIDS budget – zero rating may be inaccurate as it did not reflect the funding by the government-funded AIDS Trust Fund.

- Item 4c on the extent to which civil society was included in monitoring and evaluation efforts at local level – zero rating may be misleading as it did not take into account the involvement of NGOs in related activities such as the community based HIV prevalence and behavioural risk surveys for Men who Have Sex with Men and Female Sex Workers.

9. The consolidated report was then presented and discussed at the 71st Meeting of ACA on 2 July 2010. Upon advice by ACA members, further amendments were made and input from Food and Health Bureau and Security Bureau was incorporated in Part A

of NCPI. Efforts were made by the secretariat to clarify relevant questions and answers with stakeholders as far as possible. Nonetheless, dissenting views remain between similar questions in Part A and Part B of NCPI. The full results are now presented in the following section, with a nutshell of the figures at Annex I. Unless otherwise specified, the information refer to the situation in year 2008. Comparisons with similar figures reported by the previous two sets of core indicators are made whenever such information exists.

National Commitment and Action Indicators

Expenditures

Indicator 1: Domestic and international AIDS spending by categories and financing sources

10. Categorical expenditure as defined by UNAIDS are not available in Hong Kong, in short of a comprehensive costing exercise. The figures from Department of Health (DH) could reflect the resource allocation in the three areas below:

(a) Treatment for sexually transmitted infections (STIs): DH operates seven Social Hygiene Clinics providing clinical services for the management of STIs in Hong Kong. It was estimated that about 20% of all STIs cases treated in Hong Kong was seen in these Social Hygiene Clinics. The service is free of charge for Hong Kong residents. Non-Hong Kong residents are charged $700 per attendance since April 2003. The expenditure under Social Hygiene Service on STIs for Hong Kong and non-Hong Kong residents cannot be separately identified and the annual expenditure is: $56 million in 2006-07 and 2007-08, and $66.0 million in 2008-09. This compares to an expenditure of $78.8M for the fiscal year 2002-03.

(b) HIV prevention: Community-level health promotion, HIV prevention and HIV testing is conducted by the Special Preventive Programme through the Red Ribbon Centre and the AIDS Counseling and Testing Service. The estimate was $20.3 million, $20.7 million and $21.7 million for the fiscal year 2006-07, 2007-08 and 2008-09.respectively. The corresponding figure for the fiscal year 2002-03 was $13.63M.

(c) HIV / AIDS Clinical care and treatment: Most HIV-infected persons in Hong Kong were managed by the Integrated Treatment Centre run by the Special Preventive Programme of DH and Queen Elizabeth Hospital of the Hospital Authority in 2008. The combined drug expenditure in the past three years is: $105 million in 2006-07, $123 million in 2007-08, $143 million in 2008-09. The drug expenditure of Integrated Treatment Centre alone for fiscal year 2002-03 was $27.27M.

11. It must be noted that the expenditures quoted must be interpreted with caution and in perspective. HIV prevention, for example, comprises a collection of activities the expenditure of which cannot be easily dissected from the intermingled efforts in laboratory testing, donor screening, harm reduction for drug users and media publicity. Community projects introduced by non-governmental organizations are largely funded by the Government via the Hong Kong AIDS Trust Fund. ATF supported $35.8 million, $18.5 million and $34.3 million worth of community projects in 2006-07, 2007-08 and 2008-09, including 42 projects worth $13.6 million in total approved under a 2-year Special Project Fund set up on 1 December 2006 devoted to HIV prevention for men who have sex with men (MSM).

Policy Development and Implementation Status

Indicator 2: National Composite Policy Index

12. The National Composite Policy Index comprises a set of questions that are divided into two parts. Part A of the questionnaire is to be administered to Government's official (National Aids Committee or equivalent) and covers five broad areas including strategic plan; political support; prevention; treatment, care and support; and monitoring and evaluation. Responses to the questions in Part A had been compiled by the secretariat as shown in Annex II. Part B of the questionnaire is to be administered to representatives from the government's primary partners including NGOs and bilateral agencies. This part covers four broad areas including human rights; civil society participation; prevention; and treatment, care and support. The questionnaire

compiled by AIDS Concern is found in Annex III.

National Programmes (blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of TB and HIV treatment, HIV testing, prevention programmes, services for orphans and vulnerable children, and education) Indicators

Indicator 3: Percentage of donated blood units screened for HIV in a quality assured manner

13. Blood safety programmes aim to ensure that all blood units are screened for transfusion-transmissible infections, including HIV, and that only those units that are non-reactive on screening tests are released for clinical use. Universal (100%) screening of donated blood for HIV and other transfusion-transmissible infections cannot be achieved without mechanisms to ensure quality and continuity in screening. Thus it is crucial that all donated blood units be screened for HIV in a quality–assured manner. The following methodologies are two key components of quality assurance in screening.

(a) The use of documented and standardized procedures (standard operating procedures) for the screening of every blood unit.

(b) Participation of the laboratories in an External Quality Assessment Scheme for HIV screening in which external assessment of the laboratory's performance is conducted using samples of known, but undisclosed, content to assess its quality system and assist in improving standards of performance.

Details of local data collection:

Purpose	To assess progress in screening of blood donations in a quality-assured manner
Data Collection Frequency	Annual
Measurement Tool	Blood donation statistics from Blood Transfusion Service of the Hospital Authority
Method of	Programme monitoring with data collected in 2008

Measurement	
Numerator	The number of donated blood units screened for HIV in a quality-assured manner
Denominator	Total number of blood units donated
Results	212,739 / 212,739 x 100% = 100%
Remarks	As testing of all locally donated blood units for HIV in a quality-assured manner has become a standard practice, this indicator is deemed unnecessary in monitoring the local response to HIV. There was no corresponding figure reported in previous sets of core indicators.

Indicator 4: Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy

14. As the HIV pandemic matures, increasing numbers of people are reaching advanced stages of HIV infection. Antiretroviral therapy has been shown to reduce mortality amongst those infected and efforts are being made to make it more affordable. Antiretroviral therapy should always be provided in conjunction with broader care and support services including counseling for family caregivers.

Details of local data collection:

Purpose	To assess progress towards providing antiretroviral therapy to all people with advanced HIV infection
Data Collection Frequency	Collected continuously at facility level and aggregated at monthly or quarterly interval
Measurement Tool	Facility-based antiretroviral therapy registers in Department of Health and Hospital Authority
Method of Measurement	Data collected as at the end of 2008
Numerator	Number of adults (or children) with advanced HIV infection who are currently receiving antiretroviral combination therapy in accordance

	with the locally relevant treatment protocol
Denominator	Number of adults (or children) with advanced HIV infection who attend the HIV clinics in Department of Health and Hospital Authority
Results	Adult male = 1,120 / 1,229 x 100% = 91.1%; Adult female = 266 / 288 x 100% = 92.4%; Overall Adult = 1,386 / 1,517 x 100% = 91.3% Children aged 15 or below = 16 / 16 x 100% = 100%
Remarks	Local HIV patients were largely taken cared by public HIV clinics in the reporting period. Advanced disease is defined as AIDS and / or CD4<200ul. Facility-based information instead of estimated numbers based on HIV prevalence estimation models, which is suggested by UNAIDS 2009 Reporting Guidelines, was used because the latter was not available. The overall figure, without segregation of adult and children, reported in the first set of core indicators was 89.4% in 2003. No such figure was reported in the second set of core indicators.

Indicator 5: Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission

15. In the absence of any preventative interventions, infants born to and breastfed by HIV-infected women have roughly a one-in-three chance of acquiring infection themselves. This can happen during pregnancy, during labour and delivery or after delivery through breastfeeding. The risk of mother-to-child transmission can be significantly reduced through the complementary approaches of antiretroviral regimens for the mother with or without prophylaxis to the infant, implementation of safe delivery practices and use of safer infant feeding practices.

Details of local data collection:

Purpose	To assess progress in preventing mother-to-child transmission of HIV
Data Collection Frequency	Collected continuously at facility level and aggregated annually
Measurement Tool	Mother-to-child Transmission Registry managed by the Special Preventive Programme, Department of Health
Method of Measurement	Programme monitoring of antenatal services in the public sector
Numerator	Number of HIV-infected pregnant women who received antiretroviral medicines to reduce the risk of mother-to-child transmission in the public sector from January to December 2008
Denominator	Number of HIV-infected pregnant women identified and / or managed in the public sector over the same period
Results	1 / 2 x 100% = 50%
Remarks	HIV positive pregnancies were usually managed by the public sector. One of HIV infected pregnant women left Hong Kong before delivery and was lost to follow up. As reported in the first set of core indicators, 83.3% of HIV-infected women who delivered in 2002 had received a full course of antiretroviral prophylaxis. Small number of women involved accounted for the apparent variation between the figures in the two reporting period. No such figure was reported in the second set of core indicators.

Indicator 6: Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV

16. Tuberculosis (TB) is a leading cause of morbidity and mortality in people living with HIV, including those on antiretroviral therapy. Intensified TB case-finding and access to quality diagnosis and treatment of TB in accordance with international / local guidelines is essential for improving the quality and quantity of life for people living with HIV. A measure of the percentage of HIV-positive TB cases that access appropriate treatment for their TB and HIV is important.

Details of local data collection:

Purpose	To assess progress in detecting and treating TB in people living with HIV
Data Collection Frequency	Collected continuously at facility level and aggregated annually
Measurement Tool	TB-HIV Registry managed by the Tuberculosis and Chest Service, Department of Health
Method of Measurement	Programme monitoring at treatment facility level
Numerator	Number of patients started on TB treatment and received HAART within 6 months of TB diagnosis in 2008
Denominator	Number of incident TB cases among patients with advanced HIV infection managed by the DH in 2008
Results	Male = 14 / 22 x 100% = 63.6%; Female = 3 / 3 x 100% = 100%; Overall = 17 / 25 x 100% = 68.0%
Remarks	TB is endemic in Hong Kong. In particular, pulmonary TB commonly affects HIV-infected patients with all range of CD4 count. Thus, only those who have advanced HIV infection with genuine need of HAART are included in the denominator.

Indicator 7: Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results

17. No population-based survey has ever been done to provide information for this indicator. Given the low prevalence of HIV among the general population, this indicator is considered less significant in monitoring the local situation.

Indicator 8: Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results

18. In order to protect themselves and to prevent infecting others, it is important for

most-at-risk populations to know their HIV status. Knowledge of one's status is also a critical factor in the decision to seek treatment. This indicator should be calculated separately for each population that is considered most-at-risk.

Details of local data collection:

Purpose	To assess progress in implementing HIV testing and counseling among most-at-risk populations
Data Collection Frequency	Annual to every 2 years
Measurement Tool	Community-based surveys on most-at-risk populations - Men who have sex with men (MSM): HIV Prevalence and Risk Behavioural Survey of Men who have sex with men in Hong Kong (PRiSM) 2008-2009 Female sex workers (FSW): Community Based Risk Behavioural and Seroprevalence Survey for Female Sex Workers in Hong Kong (CRiSP) 2009 Heroin drug users (HDU): Universal HIV Testing Programme for Methadone Clinics' attendees (MUT) 2008, Street Addict Survey (SAS) 2008*
Method of Measurement	Standardized definition and question within individual programme and surveys respectively
Numerator	Number of respondents who have been tested for HIV during the last 12 months preceding the survey
Denominator	Number of respondents in the respective programme and surveys
Results	MSM = 300 / 843 x 100% = 35.7% FSW = 48.8% (adjusted figure) HDU = 7,723 / 9259 x 100% = 83.4% (MUT); = 503 / 583 x 100% = 86.3% (SAS)
Remarks	* 12.4% respondents reported never injected heroin before the survey but were considered at risk of HIV infection on account of their lifestyles and the possibility of advancing to the more direct

	mode of injection Exact question differ slightly among surveys. It is assumed that respondents who had received HIV tests had also known about the results. Information related to MSM not frequenting bars and saunas were not captured by PRiSM.

Indicator 9: Percentage of most-at-risk populations reached with HIV prevention programmes

19. Most-at-risk populations are often difficult to reach with HIV prevention programmes. However, in order to prevent the spread of HIV among these populations as well as into the general population, it is important that they access these services. The indicator should be calculated separately for each population that is considered most-at-risk.

Details of local data collection:

Purpose	To assess progress in implementing basic elements of HIV prevention programmes for most-at-risk populations
Data Collection Frequency	Every 2 years
Measurement Tool	MSM: PRiSM 2008-2009 FSW: CRiSP 2009 HDU: SAS 2008
Method of Measurement	Standardized questions within individual surveys In general, respondents are asked if they have received one or more of the followings: free condoms (e.g. through an outreach service, drop-in centre or sexual health clinic), HIV prevention message/service, outreach and peer discussion in the previous one year
Numerator	Number of respondents who replied “yes” to each applicable questions

Denominator	Number of respondents for each question in respective surveys
Results	MSM: ■ 90.4% (762 / 843 x 100%) had received HIV prevention information; ■ 72.4% (610 / 843 x 100%) had received free condoms FSW (adjusted figures): ■ 99.2% received HIV prevention message; ■ 52.5% received outreach education; ■ 58.3% received free condom; & ■ 68.9% had peer discussion on safer sex or STI/HIV HDU: ■ 97.4% (568 / 583 x 100%) had ever registered with methadone clinic(s) in the past 7 years
Remarks	Questions related to knowledge on access to HIV testing services and receipt of free sterile needles and syringes (e.g. by an outreach worker, a peer educator or from a needle-exchange programme) as suggested by UNAIDS 2009 Reporting Guidelines were not asked in these surveys as Hong Kong is covered by an extensive network of methadone clinics providing universal testing and had no needle-exchange programme for free sale of syringe in pharmacy with respect to HDU, and numerous HIV testing services offered by the public sector and civil society for MSM and FSW.

Indicator 10: Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child

20. Although there is no accurate data on this indicator, the number of households that are caring for orphaned and vulnerable children aged 0-17 is believed to be small in Hong Kong. Thus, this indicator is considered less significant in the local context.

Indicator 11: Percentage of schools that provided life skills-based HIV education within the last academic year

21. Life-skills based education is an effective methodology that uses participatory exercises to teach behaviours to young people that help them deal with the challenges and demands of everyday life. When adapted specifically for HIV education in schools, a life-skills based approach helps young people understand and assess the individual, social and environmental factors that raise and lower the risk of HIV transmission. When implemented effectively, it can have a positive effect on behaviours, including delay in sexual debut and reduction in a number of sexual partners.

22. Sex education (including HIV education) is an integral component of the school curriculum. Elements of sex and AIDS education are included in the subjects General Studies at primary level, Science, Biology, Liberal Studies, Health Management and Social Care at secondary level as well as Moral and Civic Education at both primary and secondary levels. While schools had not been asked specifically whether they had provided life-skills based HIV education, the Education Bureau would conduct a holistic survey to monitor the implementation of the curriculum. Development and training programme had been regularly organized for primary and secondary school teachers to enhance their capacity in conducting AIDS and sex education. Furthermore, resources materials produced by the Education Bureau were available at the website for teachers' reference. As noted in the first set of core indicators, 23% and 35% of teachers in primary and secondary schools respectively had teachers attended in-service education programmes on life-skills training, AIDS education and sex education during the school year 2002-03.

Knowledge and Behaviour Indicators

Indicator 12: Current school attendance among orphans and among non-orphans aged 10-14

23. As mentioned in Indicator 10 above, the problem of orphanage arising from HIV is considered to be insignificant in the local context.

Indicator 13: Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

24. HIV epidemics are perpetuated through primarily sexual transmission of infection to successive generations of young people. Sound knowledge about HIV is an essential pre-requisite-albeit, often an insufficient condition-for adoption of behaviours that reduce the risk of HIV transmission.

Details of local data collection:

Purpose	To assess progress towards universal knowledge of the essential facts about HIV transmission
Data Collection Frequency	Every 5 years
Measurement Tool	Youth Sexuality Survey (YSS) 2006 commissioned by the Family Planning Association
Method of Measurement	Respondents are asked the true / false questions below: 1. Only homosexuals can get AIDS (incorrect) 2. AIDS can be unknown to its carriers (correct) 3. Multiple sexual partners increases chances of AIDS (correct) 4. One can get AIDS by sharing drug needles (correct)
Numerator	Number of male or female respondents answering all questions in two samples, namely (a) aged 15 – 17 among those attending F.3 to F. 7 and (b) aged 18 – 24 among those aged 18-27, who gave correct answers to all four questions
Denominator	Number of respondents in respective samples
Results	Aged 15 – 17: ■ Male = 349 / 609 x 100% = 57.3% ■ Female = 489 / 745 x 100%= 65.6% ■ Overall = 838 / 1,354 x 100% = 61.9% Aged 18 – 24: ■ Male = 300 / 469 x 100% = 64.0% ■ Female = 316 / 440 x 100%= 71.8%

	■ Overall = 616 / 909 x 100% = 67.8%
Remarks	Although the questions asked in the YSS are different from those suggested by UNAIDS 2009 Reporting Guidelines, they are consistent across successive surveys and allow direct comparison between different cohorts. There was general improvement in the knowledge among the group aged 15 – 17 when compared to the cohort in 2001. No past figures were available for the group aged 18 – 27, which was a new group added in 2006.

Indicator 14: Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

25. Similar to the previous indicator, sound knowledge helps to alleviate HIV transmission. Again, this indicator should be calculated separately for each population that is considered most-at-risk.

Details of local data collection:

Purpose	To assess progress towards universal knowledge of the essential facts about HIV transmission among most-at-risk populations
Data Collection Frequency	Every 2 years
Measurement Tool	MSM: PRiSM 2008-2009 FSW: CRiSP 2009 HDU: SAS 2008
Method of Measurement	In PRiSM and CRiSP, respondents are asked if they have received HIV prevention message before. As for the Street Addict Survey, respondents are asked if they know sharing needle and using condom would increase and decrease the risk of HIV infection respectively.
Numerator	Number of respondents in the respective survey who have received HIV prevention message (PRiSM and CRiSP) or gave correct answers

	to all questions on HIV knowledge (SAS)
Denominator	Number of respondents in respective samples
Results	MSM: 762 / 843 x 100% = 90.4% FSW = 99.2% (adjusted figure) HDU: 583 / 583 x 100% = 100%
Remarks	The questions asked in the special surveys mentioned above were different from those suggested by UNAIDS 2009 Reporting Guidelines. It was assumed that respondents who had received HIV prevention messages had the correct knowledge. The corresponding indicators reported in the second set of core indicators, which were based on different studies and questions except HDU, were 44.8%, 65.8% and 99.1% for MSM, FSW and HDU respectively.

Indicator 15: Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15

26. A major goal in many countries is to delay the age at which young people first have sex and discourage premarital sexual activity because it reduces their potential exposure to HIV. There is also evidence suggest that first having sex at a later age reduces susceptibility to infections per act of sex, at least for women.

Details of local data collection:

Purpose	To assess progress in increasing the age at which young women and men aged 15-24 first have sex
Data Collection Frequency	Every 5 years
Measurement Tool	YSS commissioned by the Family Planning Association
Method of Measurement	Respondents are asked whether or not they have ever had sexual intercourse and if yes, they are asked: How old were you when you

	first had sexual intercourse for the first time?
Numerator	Number of male or female respondents in two samples, namely (a) aged 15 – 17 among those attending F.3 to F. 7 and (b) aged 18 – 24 among those aged 18-27, who had their sexual intercourse at or below 15
Denominator	Number of respondents in respective samples
Results	Aged 15 – 17: ■ Male = 49 / 609 x 100% = 8.0% ■ Female = 24 / 745 x 100%= 3.2% ■ Overall = 838 / 1,354 x 100% = 5.4% Aged 18 – 24: ■ Male = 11 / 469 x 100% = 2.3% ■ Female = 11 / 440 x 100%= 2.5% ■ Overall = 616 / 909 x 100% = 2.4%
Remarks	Increasingly higher proportion of respondents reported to have sexual debut at or below 15 as noted in successive YSS

Indicator 16: Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months

27. The spread of HIV largely depends upon unprotected sex among people with a high number of partnerships. Individuals who have multiple partners (concurrently or sequentially) have a higher risk of HIV transmission than individuals who do not link into a wider sexual network. No population-based survey has ever been done to provide information for this indicator, although related information for some at-risk populations is available. Given the low prevalence of HIV among the general population, this indicator is less significant in monitoring the local situation.

Indicators 17: Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse

28. Condom use is an important measure of protection against HIV, especially among people with multiple sex partners. No population-based survey has ever been

done to provide information for this indicator, although related information for some at-risk populations is available. Given the low prevalence of HIV among the general population, this indicator is less useful in monitoring the local situation.

Indicator 18: Percentage of female and male sex workers reporting the use of a condom with their most recent client

29. Various factors increase the risk of exposure to HIV among sex workers, including multiple, non-regular partners and more frequent intercourse. However, sex workers can substantially reduce the risk of HIV transmission, both from clients and to clients, through consistent and correct condom use.

Details of local data collection:

Purpose	To assess progress in preventing exposure to HIV among sex workers through unprotected sex with clients
Data Collection Frequency	Every 2 years
Measurement Tool	FSW – CRiSP 2009
Method of Measurement	Respondents are asked if they have used a condom with their most recent client?
Numerator	Number of respondents who reported that a condom was used in last vaginal or anal sex with client
Denominator	Number of respondents who reported having commercial sex in Hong Kong in the last 3 months
Results	96% (adjusted figure)
Remarks	CRiSP included those who had engaged in commercial sex in the last 3 months, as opposed to the last 12 months defined by the UNAIDS 2009 Reporting Guidelines. In 2008, the proportion of male Social Hygiene Service attendees indicating always or frequent use of condoms for commercial sexual

	activities was 62.7%, in contrast to 96% reported by FSW in CRiSP. Cross-border commercial sex activities could be a potential factor accounting for the apparent discrepancy. The corresponding figures as shown by the second set of core indicators were 79.4% and 67.7% of male clients of FSW had reported the use of condom in last sex with FSW in Hong Kong and Mainland China respectively. Male sex workers are not separately identifiable in PRiSM and hence no related data can be reported. Nonetheless, a small scale survey which interviewed 137 male sex workers was conducted by Midnight Blue and CUHK from July 2007 to March 2008. Among those who had reported corresponding mode of commercial sex with clients, 71.4% and 66.7% of the respondents said that they had consistently used condoms every time they had anal sex and vaginal sex respectively.

Indicator 19: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

30. Condoms can substantially reduce the risk of the sexual transmission of HIV. Consequently, consistent and correct condom use is important for men who have sex with men because of the high risk of HIV transmission during unprotected sex. In addition, men who have anal sex with other men may also have female partners, who could become infected as well. Condom use with their most recent male partners is considered a reliable indicator of longer-term behaviour.

Details of local data collection:

Purpose	To assess progress towards preventing exposure to HIV among men who have unprotected anal sex with a male partner
Data Collection Frequency	Every two years
Measurement	MSM – PRiSM 2008-2009

Tool	
Method of Measurement	Respondents are asked sexual partnerships in the preceding 6 months, about anal sex within those relationships and about condom use when they last had anal sex
Numerator	Number of respondents who reported that a condom was used every time (with regular and non-regular partners) and the last time (with non-regular partners) they had anal sex
Denominator	Number of respondents who reported having anal sex with a male partner in Hong Kong in the last six month
Results	Use condom in last anal sex with non-regular partner = 372 / (843 x 59.5% x 82.3%) x 100% = 90.1% Use condom every time in anal sex with non-regular partner = 309 / 414 (i.e. 843 x 59.5% x 82.3%) x 100% = 74.6% Use condom every time in anal sex with regular partner = 204 / 458 (i.e. 843 x 62.3% x 87.2%) x 100% = 44.5%
Remarks	Some respondents had anal sex with both regular and non-regular partners in the last six months preceding the survey. Preferably, condom use in last anal sex should be reported in accordance to the UNAIDS 2009 Reporting Guidelines for ease of comparison. The corresponding figure reported in the second set of core indicators, with no segregation on type of sex partner, was 66% based on survey of clients attending HIV testing provided by a NGO.

Indicator 20: Percentage of injecting drug users who reported the use of a condom at last sexual intercourse

31. Safer injecting and sexual practices among injecting drug users are essential, even in countries where other modes of HIV transmission predominates, because: (i) the risk of HIV transmission from contaminated injecting equipment is extremely high; and (ii) injecting drug users can spread HIV (e.g. through sexual transmission) to the other population.

Details of local data collection:

Purpose	To assess progress towards preventing sexual transmission of HIV
Data Collection Frequency	Every two years
Measurement Tool	SAS 2008
Method of Measurement	Respondents are asked if they have had sexual intercourse with regular partner in the last year and about frequency of condom use
Numerator	Number of respondents who reported that a condom was used regularly
Denominator	Number of respondents who have had sexual intercourse with regular partners in the last year
Results	144 / 407 x 100% = 35.4%
Remarks	Non-IDU is included in the denominator In contrast to the UNAIDS 2009 Reporting Guidelines, the time frame of asking the respondents for sexual intercourse (last year in SAS vs last month in UNGASS) and using condom (frequency of use in the last year in SAS vs last sex in UNGASS) are different.

Indicator 21: Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected

32. Relevant information is available for very high-risk group respondents obtained in the Street Addicts Survey, which are defined as those respondents admitted injecting heroin regularly and sharing needles with others in the past three months prior to the survey.

Details of local data collection:

Purpose	To assess progress in preventing injecting drug use-associated HIV transmission

Data Collection Frequency	Every two years
Measurement Tool	SAS 2008
Method of Measurement	Respondents are asked for questions that categorize them into very high-risk group before they are asked about their current practices of using a sterile needle when they inject drugs.
Numerator	Number of respondents who reported using sterile injecting equipment currently
Denominator	Number of respondents in the very high-risk group of injecting drugs
Results	76 / 164 = 46.3%
Remarks	In contrast to the UNAIDS 2009 Reporting Guidelines, the time frame of asking the respondents for injecting drug practice (last 3 months in SAS vs last month in UNGASS) and using sterile injecting equipment (current practice in SAS vs last injection in UNGASS). Respondents were asked if they had used new needles or cleansed needles in a relatively safe manner. In 2008, the proportion of new or readmitted injecting drug users of methadone clinics who indicated always using a new disposable needle was 80.2%.

Impact Indicators

Indicator 22: Percentage of young women and men aged 15-24 who are HIV infected

33. This indicator is mainly applicable to countries with generalized epidemics and hence less significant in the local context.

Indicator 23: Percentage of most-at-risk populations who are HIV infected

34. Most-at-risk populations typically have the highest HIV prevalence in countries with either concentrated or generalized epidemics. In many cases, prevalence among the se populations can be more than double the prevalence among the general population. Reducing prevalence among most-at-risk populations is a critical measure of a

national-level response to HIV. This indicator should be calculated separately for each population that is considered most-at-risk.

Details of local data collection:

Purpose	To assess progress on reducing HIV prevalence among most-at-risk populations
Data Collection Frequency	Annual to every two years
Measurement Tool	MSM – PRiSM 2008 CSW – CRiSP 2009 IDU – MUT 2008
Method of Measurement	This indicator is calculated using data from HIV test conducted among members of most-at-risk population groups in the sentinel sites or respondents recruited in venues sampled by special surveys
Numerator	Number of members or respondents of the most-at-risk populations who test positive for HIV
Denominator	Number of members or respondents of the most-at-risk populations tested for HIV
Results	MSM: 37 / 833 x 100% = 4.4% After adjustment for sampling bias = 4.3% FSW: 2 / 986 x 100% = 0.2% After adjustment for sampling bias = 0.05% HDU: 36 / 7,954 x 100% = 0.45%
Remarks	There are limitations for the existing surveys in capturing certain subgroups in the most-at-risk populations, e.g. young MSM who did not commonly visit saunas and bars / discos were not sampled by PRiSM; access to certain venues with female commercial sex workers were not allowed when conducting CRiSP due to various reasons. As reported by the second set of core indicators, HIV prevalence was 2.48% among MSM attending VCT services and 0.32% among HDU covered by MUT. No corresponding figure for FSW was reported.

Indicator 24: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

35. One of the goals of any antiretroviral therapy programme is to increase survival among infected individuals. As provision of antiretroviral therapy is scaled up in countries around the world, it is also important to understand why and how many people drop out of the treatment programmes. These data can be used to demonstrate the effectiveness of those programmes and highlight obstacles to expanding and improving them.

Details of local data collection:

Purpose	To assess progress in increasing survival among infected adults and children by maintain them on antiretroviral therapy
Data Collection Frequency	Monthly data among cohorts that have completed 12 months of treatment collected continuously at facility level and aggregated annually
Measurement Tool	Facility-based antiretroviral therapy registry kept by Department of Health and Hospital Authority
Method of Measurement	Cohort analysis report form
Numerator	Number of adult (or children) patients who are still alive and on antiretroviral therapy at 12 months after initiating treatment in 1 January to 31 December 2007
Denominator	Number of adult (or children) patients attending HIV Clinics in Department of Health and Hospital Authority who initiated antiretroviral therapy who were expected to achieve 12-month outcomes within the period from 1 January to 31 December 2007, including those who have died since starting therapy, those who have stopped therapy, and those recorded as lost to follow-up at month 12
Results	Adult male = 158 / 167 x 100% = 94.6%;

	Adult female = 31 / 32 x 100% = 96.9%; Overall Adult = 189 / 199 x 100% = 95.0% Children aged 15 or below = 1 / 1 x 100% = 100%
Remarks	Local HIV patients were largely taken care by public HIV clinics in the reporting period.

Indicator 25: Percentage of infants born to HIV-infected mothers who are infected

36. In high-income countries, strategies such as antiretroviral therapy during pregnancy and following birth, and those the use of breastfeeding substitutes have greatly reduced the rate of mother-to-child transmission. In fact, universal antenatal HIV testing programme has been introduced into Hong Kong since September 2001. The aims of the programme are to promote healthy pregnancy and reduce MTCT of HIV.

Details of local data collection:

Purpose	To assess progress towards eliminating mother-to-child HIV transmission
Data Collection Frequency	Annual
Measurement Tool	Mother-to-child transmission registry managed by the Special Preventive Programme, Department of Health
Method of Measurement	Ongoing programme monitoring with data collected in 2008
Numerator	Number of HIV infection on babies born to their infected mothers
Denominator	Number of HIV-infected pregnancies identified and / or managed in public sector
Results	0 / 1 x 100% = 0%
Remarks	HIV positive pregnancies were usually managed by the public sector. There were a total of two HIV infected pregnant women delivered in 2008. One of them left Hong Kong before delivery and was lost to

	follow up. The corresponding indicator reported in the first set of core indicators was 0%. No such figure was reported in the second set of core indicators.

References

1. Construction of the First Set of Core Indicators (2003) for Monitoring Hong Kong's AIDS Programmes – Hong Kong Advisory Council on AIDS (2004)
2. UNAIDS Core Indicators for Monitoring Hong Kong's AIDS Programme – 2005 Interim Report – Hong Kong Advisory Council on AIDS Paper 14/2005-2008 (2006)
3. United Nations General Assembly Special Session on HIV/AIDS, Monitoring the Declaration of Commitment on HIV/AIDS, Guidelines on Construction of Core Indicators 2008 Reporting – Joint United Nations Programme on HIV/AIDS (2007)
4. United Nations General Assembly Special Session on HIV/AIDS, Monitoring the Declaration of Commitment on HIV/AIDS, Guidelines on Construction of Core Indicators 2010 Reporting – Joint United Nations Programme on HIV/AIDS (2009)

Annex I

Recommended Third Set of Core Indicators for Monitoring Hong Kong's HIV/AIDS Programme

	Indicator	Data period	Result
Expenditures			
1.	Fund spent by the Government ● Treatment for sexually transmitted infections ● HIV Prevention ● HIV/AIDS clinical care and treatment ● AIDS Trust Fund (ATF)	Financial Year 2008-09	STI Treatment: $66 million HIV Prevention: $21.7 million HIV/AIDS clinical care and treatment: $103 million ATF: $34.3 million
Policy Development and Implementation Status			
2.	National Composite Policy Index	2008 – 2010	Details in NCPI questionnaire
Programmes			
3.	Percentage of donated blood units screened for HIV in a quality assured manner	2008	100%
4.	Percentage of adults and children with	2008	Adult male = 91.1%; Adult female = 92.4%; Overall Adult = 91.3%

	advanced HIV infection receiving antiretroviral therapy		Children ≤ 15 = 100%
5.	Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission	2008	50%
6.	Percentage of patients in the TB-HIV Registry managed by DH that received treatment for TB and HIV	2008	Male = 63.6%; Female = 100%; Overall = 68.0%
8.	Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results	2008 – 2009	Men who have sex with men (MSM)= 35.7% Female sex workers (FSW) = 48.8% Heroin drug users (HDU) = 83.4% (Methadone clinic attendees); & 86.3% (Street Addict Survey)
9.	Percentage of most-at-risk populations reached with HIV prevention programmes	2008 – 2009	MSM: ● 90.4% received HIV prevention information; & ● 72.4% received free condoms FSW: ● 99.2% received HIV prevention message; ● 52.5% received outreach education; ● 58.3% received free condom; & ● 68.9% had peer discussion

			HDU: ● 97.4% ever registered with methadone clinic(s) in the past 7 years

Knowledge and Behaviour			
13.	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	2006	Aged 15 – 17: ■ Male = 57.3% ■ Female = 65.6% ■ Overall = 61.9% Aged 18 – 24: ■ Male = 64.0% ■ Female = 71.8% ■ Overall = 67.8%
14.	Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	2008 – 2009	MSM = 90.4% FSW = 99.2% HDU = 100%
15.	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	2006	Aged 15 – 17: ■ Male = 8.0% ■ Female = 3.2%

			■ Overall = 5.4% Aged 18 – 24: ■ Male = 2.3% ■ Female = 2.5% ■ Overall = 2.4%
18.	Percentage of female and male sex workers reporting the use of a condom with their most recent client	2007 – 2009	FSW = 96% MSW = 71.4% (every time with anal sex) 66.7% (every time with vaginal sex)
19.	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	2008 – 2009	90.1% (last anal sex with non-regular partner); 74.6% (every time in anal sex with non-regular partner) 44.5% (every time in anal sex with regular partner)
20.	Percentage of injecting drug users who reported regular use of a condom with regular partners in the last year	2008	35.4%
21.	Percentage of injecting drug users who reported using sterile injecting equipment as a current practice	2008	46.3%

Impact			
23.	Percentage of most-at-risk populations who are HIV infected	2008 – 2009	MSM = 4.3% FSW = 0.05% HDU = 0.45%
24.	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	2007	Adult male = 94.6%; Adult female = 96.9%; Overall Adult = 95.0% Children $\leq$ 15 = 100%
25.	Percentage of infants born to HIV-infected mothers who are infected	2008	0%

Annex II

National Composite Policy Index (NCPI) questionnaire

Part A

[to be administered to government officials]

I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?

(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes	~~No~~	~~Not Applicable (N/A)~~

Period covered: 2007-2011 *[write in]*

IF NO or NOT APPLICABLE, briefly explain why.

***IF YES*, complete questions 1.1 through 1.10; *IF NO*, go to question 2.**

1.1 How long has the country had a multisectoral strategy?

Number of Years: 16 *[write in]*

1.2 Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

Sectors	Included in strategy		Earmarked budget	
Health	Yes	~~No~~	Yes	~~No~~
Education	Yes	~~No~~	Yes	~~No~~
Labour	~~Yes~~	No	~~Yes~~	No
Transportation	~~Yes~~	No	~~Yes~~	No
Military/Police	~~Yes~~	No	~~Yes~~	No
Women	~~Yes~~	No	~~Yes~~	No
Young people	~~Yes~~	No	~~Yes~~	No
Other*: *[write in]*	Yes	No	Yes	No

* Any of the following: Agriculture, Finance, Human Resources, Justice, Minerals and Energy, Planning, Public Works, Tourism, Trade and Industry.

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?

1.3 Does the multisectoral strategy address the following target populations, settings and cross-cutting issues?

Target populations	
a. Women and girls	a. Yes ~~No~~
b. Young women/young men	b. Yes ~~No~~
c. Injecting drug users	c. Yes ~~No~~
d. Men who have sex with men	d. Yes ~~No~~
e. Sex workers	e. Yes ~~No~~
f. Orphans and other vulnerable children (Not applicable)	f. ~~Yes~~ No
g. Other specific vulnerable subpopulations★ clients of sex workers, people living with HIV/AIDS	g. Yes ~~No~~
Settings	
h. Workplace	h. Yes ~~No~~
i. Schools	i. Yes ~~No~~
j. Prisons	j. Yes ~~No~~
Cross-cutting issues	
k. HIV and poverty	k. Yes ~~No~~
l. Human rights protection	l. Yes ~~No~~
m. Involvement of people living with HIV	m. Yes ~~No~~
n. Addressing stigma and discrimination	n. Yes ~~No~~
o. Gender empowerment and/or gender equality	o. Yes ~~No~~

1.4 Were target populations identified through a needs assessment?

Yes	~~No~~

IF YES, when was this needs assessment conducted?

[write in]

Year: 2006
Epidemiological analysis, community assessment, consultation with stakeholders, opinion survey, and programme evaluation was carried out prior to formulation of the current recommended strategies under the Hong Kong Advisory Council on AIDS

★ Sub-populations other than injecting drug users, men who have sex with men and sex workers, that have been locally identified as being at higher risk of HIV transmission (e.g., clients of sex workers, cross-border migrants, migrant workers, internally displaced people, refugees, prisoners).

IF NO, explain how were target populations identified?

1.5 What are the identified target populations for HIV programmes in the country?

Men who have sex with men (MSM), commercial sex workers (CSW) and their clients, injecting drug users (IDU), people living with HIV/AIDS.

[write in]

1.6 Does the multisectoral strategy include an operational plan?

Five priority areas for action and eight targets in the form of deliverable/ desired outcome with a description of stakeholders and players pivotal to achieving the tasks were set out.

Yes	~~No~~

1.7 Does the multisectoral strategy or operational plan include:

a. Formal programme goals?	Yes	~~No~~
b. Clear targets or milestones?	Yes	~~No~~
c. Detailed costs for each programmatic area?	~~Yes~~	No
d. An indication of funding sources to support programme implementation?	Yes	~~No~~
e. A monitoring and evaluation framework?	Yes	~~No~~

1.8 Has the country ensured "full involvement and participation" of civil society* in the development of the multisectoral strategy?

Active involvement	~~Moderate involvement~~	~~No involvement~~

IF active involvement, briefly explain how this was organised: Consultation has been conducted with relevant stakeholders. 7 working groups for community assessment & evaluation addressing different target groups were convened under the Community Forum on AIDS with active participation of civil society.

* Civil society includes among others: networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; community-based organizations; organizations of key affected groups (including men who have sex with men, sex workers, injecting drug users, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

IF NO or MODERATE involvement, briefly explain why this was the case:

1.9 Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Not applicable

~~Yes~~	~~No~~

1.10 Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy? Not applicable

~~Yes, all partners~~	~~Yes, some partners~~	~~No~~

IF SOME or NO, briefly explain for which areas there is no alignment / harmonization and why

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?

~~Yes~~	~~No~~	N/A

2.1 ***IF YES***, in which specific development plan(s) is support for HIV integrated?

a.	National Development Plan	Yes	No	N/A
b.	Common Country Assessment / UN Development Assistance Framework	Yes	No	N/A
c.	Poverty Reduction Strategy	Yes	No	N/A
d.	Sector-wide approach	Yes	No	N/A
e.	Other: *[write in]*	Yes	No	N/A

2.2 ***IF YES***, which specific HIV-related areas are included in one or more of the development plans?

HIV-related area included in development plan(s)		
HIV prevention	Yes	No
Treatment for opportunistic infections	Yes	No
Antiretroviral treatment	Yes	No
Care and support (including social security or other schemes)	Yes	No
HIV impact alleviation	Yes	No
Reduction of *gender* inequalities as they relate to HIV prevention/ treatment, care and/or support	Yes	No
Reduction of *income* inequalities as they relate to HIV prevention/ treatment, care and /or support	Yes	No
Reduction of stigma and discrimination	Yes	No
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes	No
Other: *[write in]*	Yes	No

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

~~Yes~~	No	~~N/A~~

3.1 ***IF YES***, to what extent has it informed resource allocation decisions?

Low					High
0	1	2	3	4	5

4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?

Yes	~~No~~

4.1 ***IF YES***, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of the uniformed services?

Behavioural change communication	~~Yes~~	No
Condom provision	~~Yes~~	No
HIV testing and counselling	Yes	~~No~~
Sexually transmitted infection services	~~Yes~~	No
Antiretroviral treatment	~~Yes~~	No
Care and support	Yes	~~No~~
Others: *[write in]*	Yes	No

If HIV testing and counselling *is provided* to uniformed services, briefly describe the approach taken to HIV testing and counselling (e.g, indicate if HIV testing is voluntary or mandatory etc):

Voluntary HIV testing and counselling is available in Correctional Services Department. The Custom & Excise Department promulgates a Standing Circular (No. 76/1996) to promtoe awareness of HIV among colleagues, to educate colleagues not to discriminate against HIV infected and to show concern to them. C&ED appointed officers to handle inquiries and requests for assistance from HIV infected staff in confidence.

5. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?

Yes	~~No~~

5.1 ***IF YES,*** for which subpopulations?

a.	Women	Yes	~~No~~
b.	Young people	Yes	~~No~~
c.	Injecting drug users	Yes	~~No~~
d.	Men who have sex with men	Yes	~~No~~
e.	Sex Workers	Yes	~~No~~
f.	Prison inmates	Yes	~~No~~
g.	Migrants/mobile populations	Yes	~~No~~
h.	Other: *[write in]*	Yes	No

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

The principle of non-discrimination is guaranteed by Article 25 of the Basic Law and Article 22 of the Hong Kong Bill of Rights Ordinance Cap. 383 (BORO). Article 22 of the BORO provides "All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the laws shall prohibit any discrimination and guarantee to all persons equal and effective protection against discriminiation on any ground such as race, colour, national or social origin, property, birth or other status." Vulnerable subpopulations above may fall within the ground of 'other status' for the purposes of Article 22 of the BORO.

Briefly comment on the degree to which these laws are currently implemented:

see the response below

Response to Q 5.1

"Briefly comment on the degree to which these laws are currently implemented:"

The BORO binds only the Government and all public authorities and any person acting on behalf of the Government or a public authority.

The Disability Discrimination Ordinance, Cap. 487 ('DDO') renders unlawful discrimination against persons on the ground of their or their associates' disability in respect of their employment, accommodation, education, access to partnerships, membership of trade unions and clubs, access to premises, educational establishments, sporting activities and the provision of goods, services and facilities. The DDO also prohibits harassment and vilification of persons with a disability and their associates. The term 'associate', in relation to a person, is defined in section 2 of the DDO to include –

(a) a spouse of the person;
(b) another person who is living with the person on a genuine domestic basis;
(c) a relative of the person;
(d) a carer of the person; and
(e) another person who is in a business, sporting or recreational relationship with the person.

Because of the definition of disability under the DDO includes the presence of organisms in the body that cause or are capable of causing disease or illness, persons who are infected with HIV and their associates are protected under the provisions of the DDO. A person who considers that he/she is being discriminated against on the ground of his/her disability (i.e. infected with HIV), or on the ground of his/her associate's disability (i.e. infected with HIV), may lodge a complaint with the Equal Opportunities Commission ('EOC') or institute civil proceedings in the District Count against the alleged discriminator. Where a complaint is lodged with the EOC, the EOC will investigate into the complaint and provide assistance to the complainant including, inter alia, assistance by way of conciliation and giving advice.

6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?

~~Yes~~	No

6.1 ***IF YES,*** for which subpopulations?

a.	Women	Yes	No
b.	Young people	Yes	No
c.	Injecting drug users	Yes	No
d.	Men who have sex with men	Yes	No
e.	Sex Workers	Yes	No
f.	Prison inmates	Yes	No
g.	Migrants/mobile populations	Yes	No
h.	Other: *[write in]*	Yes	No

IF YES, briefly describe the content of these laws, regulations or policies:

Briefly comment on how they pose barriers:

7. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?

Yes	~~No~~

7.1 Have the national strategy and national HIV budget been revised accordingly?

Yes	~~No~~

7.2 Have the estimates of the size of the main target populations been updated?

Yes	~~No~~

7.3 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of current and future needs	~~Estimates of current needs only~~	~~No~~

7.4 Is HIV programme coverage being monitored?

Yes	~~No~~

(a) ***IF YES***, is coverage monitored by sex (male, female)?

Yes	~~No~~

(b) ***IF YES***, is coverage monitored by population groups?

Yes	~~No~~

IF YES, for which population groups?

MSM, CSW, IDU, People living with HIV/AID managed in the public sector

Briefly explain how this information is used:
The information is used for planning and evaluation of relevant programmes.

(c) Is coverage monitored by geographical area?

~~Yes~~	No

IF YES, at which geographical levels (provincial, district, other)?

Hong Kong is a small city and hence monitoring of programme coverage is done on the whole territory only

Briefly explain how this information is used:

7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes	~~No~~

Overall, how would you rate *strategy planning efforts* in the HIV programmes in 2009?										
2009	Very poor									Excellent
	0	1	2	3	4	5	6	7	(8)	9	10

Since 2007, what have been key achievements in this area:

See 7.5a below

What are remaining challenges in this area:

Continually high level of infections among men who have sex with men (MSM) against a relatively stable trend in reported cases. Increasing demand for quality health care especially in the provision of standard lifelong treatment for a growing number of HIV patients. Clients of female sex workers and MSM who source partners through the internet remain hard to reach. More engagement of vulnerable populations and people living with HIV in directing related programmes.

7.5a

The Advisory Council on AIDS has formulated its 5-year "Recommended HIV/AIDS Strategies for Hong Kong 2007-2011". Five priority areas for action and eight targets in the form of deliverable/desired outcome with a description of stakeholders and players pivotal to achieving the tasks were set out. A Mid-term Review of the Strategies conducted in 2009 indicated that most targets had been achieved to a large extent.

II. POLITICAL SUPPORT

Strong political support includes: government and political leaders who speak out often about AIDS and regularly chair important AIDS meetings; allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

1. Do high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?

President/Head of government	~~Yes~~	No
Other high officials	Yes	~~No~~
Other officials in regions and/or districts	Yes	~~No~~

2. Does the country have an officially recognized national multisectoral AIDS coordination body (i.e., a National AIDS Council or equivalent)?

Yes	~~No~~

IF NO, briefly explain why not and how AIDS programmes are being managed:

2.1 ***IF YES***, when was it created?

Year: 1990 *[write in]*

2.2 ***IF YES***, who is the Chair?

Name: Professor CHEN Char-nie Position/Title: Chairman, Hong Kong Advisory Council of AIDS *[write in]*

2.3 ***IF YES***, does the national multisectoral AIDS coordination body:

have terms of reference?		Yes	~~No~~
have active government leadership and participation?		Yes	~~No~~
have a defined membership?		Yes	~~No~~
IF YES, how many members?	20 *[write in]*		
include civil society representatives?		Yes	~~No~~
IF YES, how many?	7 *[write in]*		
include people living with HIV?		~~Yes~~	No
IF YES, how many?	*[write in]*		
include the private sector?	0	Yes	~~No~~
have an action plan?		Yes	~~No~~
have a functional Secretariat?		Yes	~~No~~
meet at least quarterly?		Yes	~~No~~
review actions on policy decisions regularly?		Yes	~~No~~
actively promote policy decisions?		Yes	~~No~~
provide opportunity for civil society to influence decision-making?		Yes	~~No~~
strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?		Yes	~~No~~

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?

Yes	~~No~~	~~N/A~~

IF YES, briefly describe the main achievements:

The Community Forum on AIDS provides a platform whereby the views of organizations and individuals involved in HIV/AIDS advocacy education and services can be directly shared and collected. Under an open and participatory approach, the Community Forum on AIDS had developed the first set of local quality assurance guidelines on HIV voluntary counselling and testing services and HIV prevention through peer education in community settings. The Red Ribbon Centre under the Department of Health has fostered community participation in AIDS education and research among AIDS service and mainstream NGOs.

Briefly describe the main challenges:

Mutual understanding in all forms of partnership. Alignment of common concerns among stakeholders. Identification and promulgation of promising and innovative practices, multi-sectoral collaborations, human capacity and other resources which need to be sustained, strengthened or mobilized. Staff turnover in relevant agencies.

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?

Percentage: Not applicable because there was no global budget on HIV and no annual ceiling for the funding allocation from AIDS Trust Fund (ATF), where financial support for community-based programmely mainly come from. *[write in]*

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Information on priority needs	Yes	~~No~~
Technical guidance	Yes	~~No~~
Procurement and distribution of drugs or other supplies	~~Yes~~	No
Coordination with other implementing partners	Yes	~~No~~
Capacity-building	Yes	~~No~~
Other: *[write in]*	Yes	No

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies?

Yes	~~No~~

6.1 ***IF YES***, were policies and laws amended to be consistent with the National AIDS Control policies?

Yes	~~No~~

IF YES, name and describe how the policies / laws were amended:

The Legislative Council chose to incorporate HIV/AIDS in the anti-discrimination Ordinance. The enactment of the Disability Discrimination Ordinance greatly helped to remove the discrimination which AIDS patients and carriers had been subject to, The Ordinance also provides that the request for information of a medical nature would itself be unlawful unless it is absolutely necessary to determine whether the job applicant can carry out the requirement of the job.

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:

NIL

Overall, how would you rate the *political support* for the HIV programme in 2009?

2009	Very poor										Excellent
	0	1	2	3	4	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:

Special Project Fund rolled out for programmes targeting MSM by the ATF from Dec 2006 - Feb 2009. Coorganized the first "Consultation on Health Sector Response to HIV / AIDS Among MSM in Asia Pacific" in collaboration with WHO WPRO, UNDP, UNAIDS and APCOM in Feb 2009.

What are remaining challenges in this area:

The success of keeping HIV prevalence low in Hong Kong and the fact that most resources were concentrated on a few vulnerable populations only has affected the engagement of the wider community.

III. PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the *general population*?

Yes	~~No~~	~~N/A~~

1.1 ***IF YES***, what key messages are explicitly promoted?

✓ Check for key message explicitly promoted

a. Be sexually abstinent	√
b. Delay sexual debut	√
c. Be faithful	√
d. Reduce the number of sexual partners	√
e. Use condoms consistently	√
f. Engage in safe(r) sex	√
g. Avoid commercial sex	
h. Abstain from injecting drugs	√
i. Use clean needles and syringes	√
j. Fight against violence against women	
k. Greater acceptance and involvement of people living with HIV	√
l. Greater involvement of men in reproductive health programmes	
m. Males to get circumcised under medical supervision	
n. Know your HIV status	√
o. Prevent mother-to-child transmission of HIV	√
Other: *[write in]*	

1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes	No

2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

Yes	~~No~~	~~N/A~~

2.1 Is HIV education part of the curriculum in:

primary schools?	Yes	~~No~~
secondary schools?	Yes	~~No~~
teacher training?	Yes	~~No~~

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes	~~No~~

2.3 Does the country have an HIV education strategy for out-of-school young people?

~~Yes~~	No

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions *for most-at-risk or other vulnerable sub-populations?*

Yes	~~No~~

IF NO, briefly explain:

3.1 ***IF YES***, *which populations* and *what elements of HIV prevention* do the policy/strategy address?

✓ Check which specific populations and elements are included in the policy/strategy

	IDU*	MSM**	Sex workers	Clients of sex workers	Prison inmates	Other populations* *[write in]*
Targeted information on risk reduction and HIV education	√	√	√	√	√	
Stigma and discrimination reduction						General population
Condom promotion	√	√	√	√	√	
HIV testing and counselling	√	√	√	√	√	
Reproductive health, including sexually transmitted infections prevention and treatment	√	√	√	√	√	
Vulnerability reduction (e.g. income generation)	N/A	N/A		N/A	N/A	
Drug substitution therapy	√	N/A	N/A	N/A	N/A	
Needle & syringe exchange		N/A	N/A	N/A	N/A	

* IDU = injecting drug user

* MSM = men who have sex with men

Overall, how would you rate *policy* efforts in support of HIV prevention in 2009?											
2009	Very poor										Excellent
	0	1	2	3	4	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:

The current recommended strategies for HIV/AIDS response 2007-2011 set out by ACA aligns stakeholders including service providers and funding agency to focus on common goals, targets and target populations. There were comprehensive policies and strategies covering the education of most population subgroups.

What are remaining challenges in this area:

The absence of policy on stigma and discrimination reduction among most at-risk populations, namely IDU, sex workers and their clients and prison inmates may affect their access to HIV prevention services.

4. Has the country identified specific needs for HIV prevention programmes?

Yes	~~No~~

IF YES, how were these specific needs determined?

Through consensus building after reviewing the local epidemiology, deliberations of community assessment, results of opinion survey, consultation with and evaluation in target populations.

IF NO, how are HIV prevention programmes being scaled-up?

4.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access		
Blood safety	Agree	~~Don't Agree~~	~~N/A~~
Universal precautions in health care settings	Agree	~~Don't Agree~~	~~N/A~~
Prevention of mother-to-child transmission of HIV	Agree	~~Don't Agree~~	~~N/A~~
IEC* on risk reduction	Agree	~~Don't Agree~~	~~N/A~~
IEC* on stigma and discrimination reduction	Agree	~~Don't Agree~~	~~N/A~~
Condom promotion	Agree	~~Don't Agree~~	~~N/A~~
HIV testing and counselling	Agree	~~Don't Agree~~	~~N/A~~
Harm reduction for injecting drug users	Agree	~~Don't Agree~~	~~N/A~~
Risk reduction for men who have sex with men	Agree	~~Don't Agree~~	~~N/A~~
Risk reduction for sex workers	Agree	~~Don't Agree~~	~~N/A~~
Reproductive health services including sexually transmitted infections prevention and treatment	Agree	~~Don't Agree~~	~~N/A~~
School-based HIV education for young people	Agree	~~Don't Agree~~	~~N/A~~
HIV prevention for out-of-school young people	~~Agree~~	Don't Agree	~~N/A~~
HIV prevention in the workplace	Agree	~~Don't Agree~~	~~N/A~~
Other: *[write in]*	Agree	Don't Agree	N/A

Overall, how would you rate the efforts in the *implementation* of HIV prevention programmes in 2009?

2009 Very poor ... Excellent

0 1 2 3 4 5 6 7 **8** 9 10

Since 2007, what have been key achievements in this area:

Safer sex and HIV prevention/testing campaigns to MSM community. HIV awareness media programme to general public. Scale up of voluntary HIV counselling and testing service for most-at-risk populations. Rapid HIV testing added to universal antenatal testing for late presenting pregnant women in all public hospitals.

What are remaining challenges in this area:

A greater proportion of youth who are MSM, female sex workers and their clients reporting high risk behaviours. Access to non-venue based MSM, sex workers and their clients. Sustainability, continuous improvement and innovate of preventive efforts.

* IEC = information, education, communication

IV. TREATMENT, CARE AND SUPPORT

1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).

Yes	~~No~~

1.1 ***IF YES***, does it address barriers for women?

Yes	~~No~~

2.1 ***IF YES***, does it address barriers for most-at-risk populations?

Yes	~~No~~

2. Has the country identified the specific needs for HIV treatment, care and support services?

Yes	~~No~~

IF YES, how were these determined?

Through community assessment for people living with HIV/AIDS conducted in 2006, ongoing monitoring of people living with HIV and HIV infected hemophiliacs under care in public sector, regular review and advice by the Scientific Committee on AIDS and STI and research commissioned by the government or funded by AIDS Trust Fund (ATF).

IF NO, how are HIV treatment, care and support services being scaled-up?

2.1 To what extent have the following HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have acces		
Antiretroviral therapy	Agree	~~Don't Agree~~	~~N/A~~
Nutritional care	Agree	~~Don't Agree~~	~~N/A~~
Paediatric AIDS treatment	Agree	~~Don't Agree~~	~~N/A~~
Sexually transmitted infection management	Agree	~~Don't Agree~~	~~N/A~~
Psychosocial support for people living with HIV and their families	Agree	~~Don't Agree~~	~~N/A~~
Home-based care	Agree	~~Don't Agree~~	~~N/A~~
Palliative care and treatment of common HIV-related infections	Agree	~~Don't Agree~~	~~N/A~~
HIV testing and counselling for TB patients	Agree	~~Don't Agree~~	~~N/A~~
TB screening for HIV-infected people	Agree	~~Don't Agree~~	~~N/A~~
TB preventive therapy for HIV-infected people	Agree	~~Don't Agree~~	~~N/A~~
TB infection control in HIV treatment and care facilities	Agree	~~Don't Agree~~	~~N/A~~
Cotrimoxazole prophylaxis in HIV-infected people	Agree	~~Don't Agree~~	~~N/A~~
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree	~~Don't Agree~~	~~N/A~~
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree	~~Don't Agree~~	~~N/A~~
HIV care and support in the workplace (including alternative working arrangements)	Agree	~~Don't Agree~~	~~N/A~~
Other: *[write in]*	Agree	Don't Agree	N/A

3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?

Yes	~~No~~

4. Does the country have access to *regional* procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy drugs, condoms, and substitution drugs?

~~Yes~~	No

IF YES, for which commodities?: *[write in]*

Overall, how would you rate the efforts in the *implementation* of HIV treatment, care and support programmes in 2009?										
2009	Very poor									Excellent
	0	1	2	3	4	5	6	7	8	9 (10)

Since 2007, what have been key achievements in this area:

Gradual introduction of various components into the public health prevention programme for patients under the care of in the Integrated Treatment Centre. Establihsed a new HIV clinic at Princess Margaret Hospital in 2009.

What are remaining challenges in this area:

Meeting the increasing demand for quality health care services especially the provision of standard lifelong treatment for a growing number of persons living with HIV.

5. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

~~Yes~~	~~No~~	N/A

5.1 ***IF YES***, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

5.2 ***IF YES***, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No

5.3 ***IF YES***, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes	No

IF YES, what percentage of orphans and vulnerable children is being reached? % *[write in]*

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?										
2009	Very poor									Excellent
	0	1	2	3	4	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:

What are remaining challenges in this area:

IV. MONITORING AND EVALUATION

1. Does the country have *one* national Monitoring and Evaluation (M&E) plan?

~~Yes~~	In progress	~~No~~

IF NO, briefly describe the challenges:

see the response given in the next page

1.1 ***IF YES***, years covered: *[write in]*

1.2 ***IF YES***, was the M&E plan endorsed by key partners in M&E?

Yes	No

1.3 ***IF YES***, was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes	No

1.4 ***IF YES***, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners	Yes, most partners	Yes, but only some partners	No

IF YES, but only some partners or IF NO, briefly describe what the issues are:

Response to Q. 1 of Section IV of NCPI (Part A)

"Does the country have *one* national Monitoring and Evaluation (M&E) plan?"

If NO, briefly describe the challenges:

The Hong Kong HIV surveillance system run by Special Preventive Programme of the Department of Health comprises four major programmes. They are (a) voluntary HIV/AIDS case-based reporting; (b) sentinel surveillance and studies on HIV prevalence; (c) STI caseload statistics; and (d) behavioural studies. In addition, several registries are maintained to monitor special features of the epidemiological situation. The information is contributed by many stakeholders in the public sector and NGOs. Results captured by the surveillance system are regularly shared with stakeholders and the public through press briefings, meetings, publications and the internet. The surveillance information has been used for planning, monitoring and evaluation of strategies and programmes. The Hong Kong Advisory Council on AIDS, which have members including community leaders, professionals and representatives of voluntary agencies and Government departments, has deliberated using UNGASS indicators to monitor the local response on HIV/AIDS since 2003. However, this was done by using available data (with modification of indicators) and not data purposely collected from the outset for these UNGASS indicators. As a result, there was plan to work on specifications for the indicators, and development of an agreed process for collecting and reporting on them among stakeholders to better monitor and evaluate the local response to the HIV epidemic.

2. Does the national Monitoring and Evaluation plan include?

a data collection strategy	Yes	No
IF YES, does it address:		
routine programme monitoring	Yes	No
behavioural surveys	Yes	No
HIV surveillance	Yes	No
Evaluation / research studies	Yes	No
a well-defined standardised set of indicators	Yes	No
guidelines on tools for data collection	Yes	No
a strategy for assessing data quality (i.e., validity, reliability)	Yes	No
a data analysis strategy	Yes	No
a data dissemination and use strategy	Yes	No

3. Is there a budget for implementation of the M&E plan?

Yes	In progress	No

3.1 ***IF YES***, what percentage of the total HIV programme funding is budgeted for M&E activities? % *[write in]*

3.2 ***IF YES***, has *full* funding been secured?

Yes	No

IF NO, briefly describe the challenges:

3.3 ***IF YES***, are M&E expenditures being monitored?

Yes	No

4. Are M&E priorities determined through a national M&E system assessment?

Yes	No

IF YES, briefly describe how often a national M&E assessment is conducted and what the assessment involves:

IF NO, briefly describe how priorities for M&E are determined:

5. Is there a functional national M&E Unit?

Yes	~~In progress~~	~~No~~

IF NO, what are the main obstacles to establishing a functional M&E Unit? The Special Preventive Programme under Department of Health serves as the functional M&E unit in Hong Kong. However, no budget has been earmarked for establishing and implementing an overall M&E plan for Hong Kong yet.

5.1 ***IF YES***, is the national M&E Unit based

in the National AIDS Commission (or equivalent)?	Yes	~~No~~
in the Ministry of Health?	Yes	~~No~~
Elsewhere? *[write in]*	Yes	No

5.2 ***IF YES***, how many and what type of professional staff are working in the national M&E Unit?

Number of permanent staff: 3		
Position: Medical Officer *[write in]*	Full time / ~~Part time?~~	Since when?: 1985
Position: Nursing Officer *[write in]*	Full time / ~~Part time?~~	Since when?: 2004
[Add as many as needed] Position: Statistical Officer	Full time	Since 2002
Number of temporary staff:		
Position: *[write in]*	Full time / Part time?	Since when?:
Position: *[write in]*	Full time / Part time?	Since when?:
[Add as many as needed]		

5.3 ***IF YES***, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes	~~No~~

IF YES, briefly describe the data-sharing mechanisms:

Over the years, agreement has been sought from various partners including healthcare providers in the public sector, public health laboratories, other government departments and NGOs to provide specified statistics regularly through established channels to responsible officers working in the HIV Surveillance Office of the Special Preventive Programme.

What are the major challenges?

Standardization on the specification of indicators and quality assurance of data collected from various sources. Building of strategy and capacity for data analysis and dissemination.

6. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?

No	~~Yes, but meets irregularly~~	~~Yes, meets regularly~~

6.1 Does it include representation from civil society?

A Working Group on Control of HIV Infection among Drug Abusers, which comprise representatives from an NGO and an agency which provide volunteer service in methadone clinics, has quarterly meeting to coordinate HIV prevention activities including M&E activities of the universal HIV testing programme among attendees in the clinics.

Yes	No

IF YES, briefly describe who the representatives from civil society are and what their role is:

7. Is there a central national database with HIV- related data?

Yes	~~No~~

7.1 ***IF YES***, briefly describe the national database and who manages it *[write in]*

see response for Question 1 in this section

7.2 ***IF YES***, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?

a. Yes, all of the above

b. Yes, but only some of the above: Partial information on the estimated size and distribution of vulnerable populations and people living with HIV, *[write in]* and coverage and utilization of services among target populations.

c. No, none of the above

7.3 Is there a functional* Health Information System?

At national level	Yes	~~No~~
At subnational level ***IF YES***, at what level(s)? Not applicable *[write in]*	Yes	No

*(*regularly reporting data from health facilities which are aggregated at district level and sent to national level; and data are analysed and used at different levels)*

8. Does the country publish at least once a year an M&E report on HIV and on, including HIV surveillance data?

Yes	~~No~~

9. To what extent are M&E data used

9.1 in developing / revising the national AIDS strategy?:

Low					High
0	1	2	3	4	5

Provide a specific example:

Latest epidemiology and local responses were used to review the progress of preceding strategies and inform the formulation of the current strategies set out by the Hong Kong Advisory Council on AIDS.

What are the main challenges, if any?

Consensus building among stakeholders and additional resources for coming up an overall M&E plan.

9.2 for resource allocation?:

Low					High
0	1	2	3	4	5

Provide a specific example:

A proposed resource allocation plan for AIDS Trust Fund on HIV prevention, treatment, care and support based on local epidemiology was devised in 2009.

What are the main challenges, if any?

The lack of comprehensive information on the size of at-risk populations, coverage of intervention programmes, and HIV incidence has affected the effective use of M&E data for planning of resource allocation.

9.3 for programme improvement?:

Low					High
0	1	2	3	4	5

Provide a specific example:

Evaluation findings for social marketing campaigns were used to inform the planning of future programmes on prevention and surveillance.

What are the main challenges, if any?

Routine statistics inflexible to answer specific questions. Timing of regular surveys and programme evaluation needs much coordination. Resource implication for conducting ad hoc study to evaluate programmes.

10. Is there a plan for increasing human capacity in M&E at national, subnational and service-delivery levels?:

a. Yes, at all levels

b. Yes, but only addressing some levels: There was plan to increase the overall capacity of the civil society on M&E and to develop a local set of indicators for monitoring and evaluation of the Hong Kong-wide response. *[write in]*

c. No

10.1 In the last year, was training in M&E conducted

At national level?	~~Yes~~	No
IF YES, Number trained:		*[write in]*
At subnational level? Not applicable	Yes	No
IF YES, Number trained:		*[write in]*
At service delivery level including civil society?	Yes	~~No~~
IF YES, Number trained:	83	*[write in]*

10.2 Were other M&E capacity-building activities conducted other than training?

Meetings were arranged between an external consultant and stakeholders with emphasis on the need to improve the local M&E activities.

Yes	~~No~~

IF YES, describe what types of activities: *[write in]*

Overall, how would you rate the *M&E efforts* of the HIV programme in 2009?											
2009	Very poor										Excellent
	0	1	2	3	4	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:

Mid-term review of the eight targets of the Recommended HIV/AIDS Strategies for Hong Kong 2007-2011. Evaluation of social marketing campaigns on HIV prevention among MSM. Evaluation of public health programmes in HIV Clinic under Department of Health.

What are remaining challenges in this area:

Capacity building for developing and implementing a M&E plan for Hong Kong.

Annex III

AIDS concern
關懷愛滋

Established in 1990, AIDS Concern is a registered charity
關懷愛滋成立於一九九零年，爲一間註冊慈善機構

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BY EMAIL

UNAIDS
20 Avenue Appia
CH-1211 Geneva 27
Switzerland
C/O: Dr. Ka-hing WONG, Consultant (Special Preventive Programme)
Center for Health Protection, Department of Health, HKSAR

June 15, 2010

Dear Sir / Madam,

RE: UNGASS Core Indicators – Indicator 2 (Part B) National Composite Policy Index

Greetings from AIDS Concern! I am writing to submit the **UNGASS Core Indicators – Indicator 2 (Part B) National Composite Policy Index** for Hong Kong.

AIDS Concern formed a workgroup to become the technical coordinator for part B of the NCPI on March 29, 2010. The workgroup was responsible to undertake the desk review, to carry out interviews and meetings as needed, to bring together relevant stakeholders, and to facilitate collating and consolidating the NCPI data. Both the Hong Kong Coalition of AIDS Service Organizations (HKCASO) and Department of Health have supported AIDS Concern to take up the role of technical coordinator. A plan was drafted and circulated on the tasks, timeframe, process and the scope of the exercise, and subsequently, the final draft of the report is completed and enclosed.

The process of compilation of the data included:

- A desk review was carried out by AIDS Concern to compile the first draft of the document.
- A stakeholder list was built.
- Three drafts of the document were sent out to stakeholders via email for first round of comments. Telephone interviews were conducted as needed.
- A discussion meeting was conducted to discuss draft views to reach consensus AND to include all dissenting views regarding the content. Information gaps were identified during the meeting and further input was sought from members of the civil societies.
- Two additional drafts of the document were sent out to stakeholders after inputs were collected, via email for final comments.
- A final draft is completed and to be submit to the UNAIDS office.

The process started on March 29, 2010 and completed on June 14, 2010.

The stakeholder list was built based the following rationale:

- All member agencies of HKCASO ((full and associate members)
- NGOs who are currently conducting AIDS related programmes (recipient list provided by the Council of the AIDS Trust Fund, the major governmental grant body in Hong Kong)
- Referrals / suggestions by stakeholders who are from the above two categories.

A full list of the stakeholders involved is enclosed with this letter.

In the process of the consultation, there are several limitations to the process and the content in compilation of the document. It is suggested that readers of the submitted document should bear in mind the limitations of this document, and credibility and comprehensiveness of the document is subject to the reader's discretion.

Limitations:

- The consultation process and compilation of the document was completed within a very short time frame. Thus, only one interactive discussion meeting (the discussion meeting) was held.
- Due to the short period of time, AIDS Concern is unable to reach out to every single individual for consultation. We rely on the stakeholders who are already in the process to spread the words to others who might be interested to give comments. Thus, the list may not be as comprehensive as we would like it to be.
- Academics were not initially included, but not excluded from the process. We relied on stakeholders to contact and encourage academics with relevant experience to give input.
- Human right organizations were not initially included, but not excluded from the process. We relied on stakeholders to contact and encourage these organizations with relevant experience to give input.

This exercise is first of its kind to be conducted in Hong Kong. AIDS Concern is committed to reflect the Hong Kong situation as much as possible via this document. Our principle is to make the process as transparent and accountable as possible. Should you have any questions regarding the process and the final document, please do not hesitate to contact myself at +852 2898-4411 or via email at loretta@aidsconcern.org.hk.

Thank you very much for your attention.

Yours sincerely,

Loretta Wong
Chief Executive

Enclosure.

Stakeholder List:

A back up
Action for REACH OUT
AIDS Concern
Boys' and Girls' Clubs Association of Hong Kong -- Project Touch
Caritas -- Play Safe
Chi Heng Foundation
CHOICE
Civil Rights for Sexual Diversities
Community Programme Research on AIDS, Chinese University HK
Equal Opportunities Commission (Hong Kong)
Heart to Heart
Hong Kong AIDS Foundation
Hong Kong Federation of Women's Centres
Hong Kong Red Cross
Midnight Blue
Rainbow of Hong Kong
Society for AIDS Care
St. John's Cathedral HIV Education Centre
Teen Aids
The Salvation Army
The Society for the Aid and Rehabilitation of Drug Abusers (SARDA)
The Society of Rehabilitation and Crime Prevention
Zi Teng

Part B: I Human Rights

1. Does the country have laws and regulations that protect people living with HIV against discrimination? (including both general non-discrimination provisions and provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.)

Yes ✓ No

IF YES, specify if HIV is specifically mentioned and how or if this is a general nondiscrimination provision: [write in] Right to equality and non-discrimination is protected by Article 25 of Basic Law and Article 22 of the HK Bill of Rights Ordinance Cap. 383. Disability Discrimination Ordinance - A law that has been enacted to protect people with a disability against discrimination, harassment and serious vilification and victimization on the ground of their disability, including HIV infection. The law gives you protection against discrimination, harassment or vilification in the areas of employment, education, access to and disposal and management of premises, provision of goods, services and facilities, practising as barristers, as well as clubs and sporting activities.

2. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable subpopulations?

Yes ✓ No

2.1 IF YES, for which populations?

a. Women	✓ Yes	No
b. Young people	Yes	✓ No
c. Injecting drug users	✓ Yes	No
*d. Men who have sex with men	Yes	✓ No
e. Sex Workers	Yes	✓ No
f. Prison inmates	✓Yes	No
*g. Migrants/mobile populations	Yes	✓ No

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

Equal Opportunities Commission oversees implementation of the 4 discrimination ordinances – Sex Discrimination Ordinance(SDO), Family Status Discrimination Ordinance(FSDO), Race Discrimination Ordinance(RDO) and Disability Discrimination Ordinance(DDO).

Right to equality and non-discrimination is protected by Article 25 of Basic Law and Article 22 of the HK Bill of Rights Ordinance Cap. 383.

Human rights of Prison inmates are protected by Prison Rules (Chapter 234A)

Briefly describe the content of these laws:

Sex Discrimination Ordinance(SDO) – to protect anyone (both men and women, irrespective of the gender of the harasser) from discrimination on the basis of sex, marital status and pregnancy, and sexual harassment.

Disability Discrimination Ordinance (DDO) - Though in general, “drug addiction” may come within the meaning of “disability” under the DDO, the “illicit use of drug” or “substance abuse” per se is unlikely to be covered under the DDO.

Prison Rules (Chapter 234A)- All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person. Any prison inmate who appears to be out of health deserves special notice and care of medical officers.

Briefly comment on the degree to which they are currently implemented

EOC has been willing to take on individual HIV discrimination cases, investigate and seek for amicable settlement between the aggrieved person and the respondents. However, there are limitations/obstacles during the process of reporting discrimination cases or implementation of the discrimination laws:

- Lack of independent witnesses or circumstantial evidences supporting the

alleged complaints

- When the complainee organizations do not admit the alleged acts of discrimination and the cases cannot be resolved by conciliation/mediation and further legal actions are considered, usually the complainants (PLHIV) do not wish to further pursue on the complaints because of emotional pressure brought by stigma/ discrimination attached to the disease
- There has not been a comprehensive effort in monitoring the degree of discrimination against PLHIV in the various aspects, for example, employment discrimination. Formal investigation (a statutory power of EOC) is not undertaken to investigate the situations.

*d. Men who have sex with men

No non-discrimination laws or regulations currently exist to specify protections for the population. From 2000 onwards, there have been attempts to examine the possibility of the legislation of a Sexual Orientation Discrimination Bill by the government and the Legislative Council. Yet no action has been taken by the HKSAR government despite repeated calls from the community and from the United Nations Human Rights Committee and Committee for Economic, Social and Cultural Rights (CESCR).

*g. Migrants/mobile populations

The legislation prohibits discrimination on the ground of a person's "race" (i.e. "race", "colour", "descent", or "national or ethnic origin") according to Racial Discrimination Ordinance (RDO). Anyone in Hong Kong, including the migrant population, who feels being discriminated on the ground of their "race", can seek redress through the RDO. Whether the claim is successful or not would depend on the merits of individual case. "Migrant status" in itself is not defined as "race" under the RDO.

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations?

Yes ✓ No

3.1 IF YES, for which subpopulations?

a. Women	Yes	✓ No
b. Young people	✓ Yes	No
c. Injecting drug users	Yes	✓ No
d. Men who have sex with men	✓ Yes	No
e. Sex Workers	✓ Yes	No
f. Prison inmates	Yes	✓ No
g. Migrants/mobile populations	✓ Yes	No
h. Other: [write in]	Yes	No

IF YES, briefly describe the content of these laws, regulations or policies:

b) Sex education is not included in primary and secondary curriculum, but in a form of instruction guidelines.

d) No legislation of a Sexual Orientation Discrimination Bill by the government and the Legislative Council.

e) As stated, Sections 131, 137, 139, 143, 144, 145, 147 and 147A of Crimes Ordinance Cap.200 criminalize sex trade and all activities related to it (for example: living on earnings of prostitution or keeping a vice establishment).

g) Preventive measures from the government are universal to the public. All citizens (with Hong Kong Identity Card) enjoy heavy subsidization by the government on the HIV treatment, care and support if they are with confirmed HIV status.

Briefly comment on how they pose barriers:

b) Few schools implement a comprehensive sex education. Although HK Government has completed guidelines for implementation of comprehensive sex education, there is no policy to ensure its actual implementation. In addition, the guideline was never updated since its conception in 1997. That hinders an effective prevention of young people.

d) Without the legislation, there is possibility to develop a policy discriminates gay men and this may present obstacles to effective HIV efforts.

e) Under these conditions, NGOs have difficulties to contact sex workers

because of resistance or refusal from brothels like night clubs. This hinders the effectiveness of the preventive measures.

g) Non-eligible Person (NEP, without Hong Kong Identity Card), need to pay full cost for public health care services. Many SW (Female and male) are NEP and the policy prohibits them from looking for HIV/AIDS and STI treatment services.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Yes ✓ No

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

Recommended HIV/AIDS Strategy 2007-2011
One of the guiding principles: "Building supportive and enabling environment. A non-discriminatory environment receptive to human rights is conducive to effective programme intervention."

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most-at-risk populations and/or other vulnerable subpopulations?

Yes ✓ No

IF YES, briefly describe this mechanism:

The Equal Opportunities Commission keeps a comprehensive record of all enquiries and complaints made by people with disabilities, including people living with HIV/AIDS.

The Gender Identity and Sexual Orientation Unit (GISOU) under the Constitutional and Mainland Affairs Bureau of the HKSAR government has a mandate to set up and maintain a hotline for enquiries and complaints in relation to sexual orientation and gender identity, including discrimination

cases, with a corresponding record system.

NGOs have its own mechanism in recording discrimination cases they countered, including HIV discrimination and discrimination against most-at-risks populations in Hong Kong, such as sexual minorities.

6. Has the Government, through political and financial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and programme implementation?

Yes ✓ No

IF YES, describe some examples:
According to the Government, Community Forum on AIDS (CFA) includes representatives of vulnerable communities to HIV/AIDS, which is to provide a platform whereby the view and expertise of organizations and individuals involved in HIV/AIDS advocacy, education and services can be directly shared and collected, to support policy formulation at the Advisory Council on AIDS (ACA) level.

The Government appoints the membership of CFA and ACA. However, the appointment system does not require involvement of PLHIV and most at risk group members. CFA involved representatives from NGOs and 2 known PLHIV but there is no representative of most at risk groups. In the ACA level, neither PLHIV nor representative of most at risk groups are found.

In the formulation of Recommended HIV/AIDS Strategy 2007-2011, 7 workgroups were set up under CFA. Although NGOs, PLHIV and most at risk groups members were involved in the workgroups, the procedures ensuring the representativeness of the community representatives were not known. The workgroups were only involved in the initial process of the strategy formulation and there was no proper consultation and involvement of the workgroups afterward. The whole process lasted for 3 months only.

7. Does the country have a policy of free services for the following:

a. HIV prevention services	✓ Yes	No
b. Antiretroviral treatment	✓ Yes	No
c. HIV-related care and support interventions	✓ Yes	No
d. Other: [write in]	Yes	No

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:

"Sustaining access to quality treatment and care for people living with HIV/AIDS," is one of the 5 prioritized areas of action stated in the 2007-2011 Recommended AIDS Strategy in Hong Kong. Quality treatment and care includes the following principles:

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

HIV Medicine and Care Programme is one of the four main core programmes of Special Preventive Programme. Clinical and community services are provided in the Integrated Treatment Center, Queen Elizabeth Hospital, Princess Margaret Hospital and Queen Mary Hospital for paediatric cases. HIV testing and counseling services are free to public.

Preventive measures from the government are universal to the public. HIV testing and counseling services are free to public. All citizens (with Hong Kong Identity Card) enjoy heavy subsidization by the government on the HIV treatment, care and support if they are with confirmed HIV status (including all allied health services provided by the health care system).

In addition, PLHIV is one of the prioritized areas stated by the AIDS Trust Fund (Governmental Grant), thus access to funding for PLHIV care and support intervention.

HIV related care and support interventions, including social support, financial

support, counseling support, legal advice, self-help group, human and patients right education are provided by various NGOs in Hong Kong for free.

8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?

Yes ✓ No

Preventive measures from the government are universal to the public. HIV testing and counseling services are free to public. All citizens (with Hong Kong Identity Card) enjoy heavy subsidization by the government on the HIV treatment, care and support if they are with confirmed HIV status.

8.1 In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

Yes ✓ No

9. Does the country have a policy to ensure equal access for most-at-risk populations and/or other vulnerable subpopulations to HIV prevention, treatment, care and support?

Yes No ✓ (Detailed barriers in Human Rights: 3.1 (g))

IF YES, briefly describe the content of this policy:

9.1 IF YES, does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations?

Yes No

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:

10.Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Yes No✓

Policy prohibiting HIV screening for general employment purposes does not exist. However, the Draft Code of Practice on Employment under the DDO published by the Equal Opportunities Commission for public consultation recently recommends “health screening is more appropriate after the selection process is completed and the person considered best suited to the job has been identified. Health screening at an earlier stage should not be used as a means to screen out candidates with disabilities. It would be good practice that medical test or health screening are only conducted after a conditional job offer has been made.” The consultation will end on July 8, 2010, and the final quote is expected to become effective and be issued towards the end of 2010.

The existing Code of Practice on Employment under the Disability Discrimination Ordinance recommends the use of consistent selection criteria, which should be specifically related to a job but not a disability, for recruitment, promotion, transfer, training, dismissal and redundancy as well as terms and conditions of employment.

11.Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

Yes No✓

Hong Kong does not have a comprehensive Statute specifically on clinical research. However, major institutions (Hospital Authority, Department of Health and Universities) have their own research ethical review committees.

11.1 IF YES, does the ethical review committee include representatives of civil society including people living with HIV?

Yes No

IF YES, describe the approach and effectiveness of this review committee:

12. Does the country have the following human rights monitoring and enforcement mechanisms?

– Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work.

Yes ✓ No

There are independent human rights monitoring and enforcement mechanisms including the Equal Opportunities Commission (EOC), the Ombudsman, Law Reform Commission, the Office of the Privacy Commissioner for Personal Data, the Independent Police Complaints Committee and Department of Justice (DOJ).

– Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment

Yes ✓ No

The Equal Opportunities Commission oversees the implementation of Disability Discrimination Ordinance - A law that has been enacted to protect people with a disability against discrimination, harassment and vilification on the ground of their disability, including HIV infection. Review committees within government departments, Independent human rights monitoring and enforcement mechanisms including the Ombudsman, Law Reform Commission, the Office of the Privacy Commissioner for Personal Data and the Independent Police Complaints Committee monitor human rights abuses in general.

– Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

Yes No ✓

IF YES on any of the above questions, describe some examples:

13. In the last 2 years, have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work?

Yes ✓ No

The Equal Opportunities Commission provides general trainings/courses on the discrimination ordinances to members of the judiciary. These trainings are not specifically about HIV and relevant human rights issues.

14.Are the following legal support services available in the country?

– Legal aid systems for HIV casework

Yes ✓ No

The Legal Aid Department supports any person who has reasonable grounds for taking or defending a legal action. There is no specific legal aid system for HIV casework.

– Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

Yes ✓ No

Given that the advice sector in Hong Kong is largely under-developed, there are limited number of organizations (including private, non-governmental and university institutions) providing legal services to people living with HIV at pro-bono or reduced cost.

– Programmes to educate, raise awareness among people living with HIV concerning their rights

Yes ✓ No

Programmes (such as IEC material, workshops, peer support group) to educate and awareness raising on patients right and human right are provided by various groups such as NGOs and PLHIV self-help group.

15. Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes ✓ No

Stigma and discrimination reduction programmes are implemented by government and NGOs.

IF YES, what types of programmes?

Media	✓ Yes	No
School education	✓ Yes	No
Personalities regularly speaking out	✓ Yes	No

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009?

2009 Very poor Excellent

0 1 2 3 4 5 6 [7] 8 9 10

Since 2007, what have been key achievements in this area:

Much more clear goals and indicators were set in the Recommended HIV/AIDS Strategies 2007 – 2011.

What are remaining challenges in this area:

In the “Recommended HIV/AIDS Strategy 2007-2011,” no recommendations specifically promote and protect human rights in relation to HIV. Only a guiding principle of “Building supportive and enabling environment. A

non-discriminatory environment receptive to human rights is conducive to effective programme intervention" was recommended.

Projects that deal with human rights, laws and policies relating to people living with HIV and other most-at-risk populations are not prioritized area of the ATF. ATF should thoroughly review its funding strategy to accommodate this area of work.

Lack of Comprehensive Sex education in youth prevention.

Brothels like night clubs would refuse to any potential contact from community to sex workers, hindered the effectiveness of the preventive measures.
Doubt on representativeness in policies under current participation structure.

Overall, how would you rate the effort to enforce the existing policies, laws and regulations in 2009?

2009 Very poor Excellent

0 1 2 3 4 5 6 7 8 9 10

Since 2007, what have been key achievements in this area:

Revision of Code of Practice on Employment under the Disability Discrimination Ordinance is working in progress by the Equal Opportunities Commission.

What are remaining challenges in this area:

- There is a recommended AIDS Strategy. However, it is not an overall, comprehensive strategy across government bureaus and departments to enforce policies, laws and regulations in relation to HIV/AIDS.
- Need of more transparent and improved intra-government collaboration and cooperation
- The HIV/AIDS Strategies in Hong Kong is 'Recommended' and a more apparent commitment of the Government is needed.

Part B : II Civil Society* Participation

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

Low High
0 1 2 3 4 5

Comments and examples:

- The Hong Kong Coalition of AIDS Services Organizations (HKCASO) has been actively advocating on policy issues relating to HIV/AIDS in Hong Kong since 1998. Issues include: effective prioritization of vulnerable groups for prevention and intervention; inclusion of PLHIV in the Hong Kong Advisory Council on AIDS (ACA) and representatives from all high risk groups in the Community Forum on AIDS (CFA) under ACA and ACA; sustainable funding support. HKCASO also responded to legal issues related to HIV/AIDS.
- Representatives of HIV/AIDS NGOs actively participate in CFA to provide opinions to strengthen strategy/policy formulations.
- The appointment system of CFA and ACA does not require involvement of PLHIV and most at risk group members. CFA involved representatives from NGOs,1 known PLHIV and one representative from a PLHIV group but there is no representative of most at risk groups. In the ACA level, neither PLHIV nor representative of most at risk groups are found.
- In the formulation of Recommended HIV/AIDS Strategies 2007-2011, 7 workgroups were set up under CFA. Although NGOs, PLHIV and high risk groups members were involved in the workgroups, there was actually no proper and transparent procedures to ensure the representativeness of the community representatives. The workgroups were only involved in the initial process of the strategy formulation. After the CFA submitted the work group reports to ACA, no civil society participation was involved in formulating the final strategy by ACA. The whole process lasted for 3 months only.
- More active participation of NGOs in HKCASO could empower the coalition and uplift the prevention and care.
- HIV/AIDS related NGOs were involved in a forum on HIV/AIDS development under the Health Panel of the Legislative Council in 2007.

*** Civil society includes among others: networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations;AIDS service organizations; community-based organizations; organizations of key affected groups (including men who have sex with men,injecting drug users, sex workers, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. Forthe purpose of the NCPI, the private sector is considered separately**

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?

Low High

0 1 2 [3] 4 5

Comments and examples:

- The ACA formulates local strategic plan and NGOs are involved in CFA under ACA. Strategic plan and execution, funding guidelines are reported by the Government and discussed in regular CFA meetings to collect opinions from NGOs.
- Lack of participation from the civil society in the ATF funding budgeting process. Civil society lacks the channel to voice out their needs to the ATF, in contrast to the strategic planning process.
- In the formulation of Recommended HIV/AIDS Strategies 2007-2011, 7 workgroups were set up under CFA. Although NGOs, PLHIV and most at risk groups members were involved in the workgroups, there was actually no proper and transparent procedures to ensure the representativeness of the community representatives. The workgroups were only involved in the initial process of the strategy formulation. After the CFA submitted the work group reports to ACA, no civil society participation was involved in formulating the final strategic by ACA. The whole process lasted for 3 months only.

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included in

a. the national AIDS strategy?

Low High

0 1 2 3 [4] 5

The strategy in Hong Kong is a recommended one only.

b. the national AIDS budget?

Low High
[0] 1 2 3 4 5

There is no specific national budget for HIV but the budget is included in budgets of government departments.

c. national AIDS reports?

Low High
0 [1] 2 3 4 5

The Department of Health had formulated the 'Mid-term Review of the Recommended HIV/AIDS Strategies for Hong Kong 2007-2011' in 2009 without consulting the civil society. In respond to the situation, HKCASO compiled a document to give comments and to pose questions to the Mid-term Review document, which was submitted to the Department of Health.

Comments and examples: In the 2007-2011 Recommended HIV/AIDS Strategy from ACA, prioritized area includes prevention for MSM, FSW, FSWC, IDU, MTCT and public education. Government AIDS Trust Fund (ATF) supports most of the relevant NGO programmes. NGO prevention programmes for at risk Youth in general, woman, Ethnic minorities, FSW rights advocacy, are not supported by ATF due to the prioritization of Recommended HIV/AIDS Strategies 2007-2011 and this affects the financial sustainability of the programmes.

4. To what extent is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. developing the national M&E plan?

Low High
[0] 1 2 3 4 5

b. participating in the national M&E committee / working group responsible for coordination of M&E activities?

Low High
[0] 1 2 3 4 5

c. M&E efforts at local level?

Low High
[0] 1 2 3 4 5

Comments and examples:

The Government is initiating the development of the M&E system and NGOs are involved.

5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)?

Low High
0 1 2 3 [4] 5

Comments and examples:

<u>HIV/AIDS NGOs</u>
A back up – MSM
AIDS Concern – MSM, FSW, SWC, Youth, PLHIV, General Public
Chi Heng Foundation – China AIDS Orphan
CHOICE- MSM, FSW
Hong Kong AIDS Foundation – MSM, PLHIV, Youth, General Public, Cross-border travelers (including MSM and FSWC)
Society for AIDS Care – PLHIV
Teen Aids - Youth

<u>PLHIV self-help group</u>
Heart to Heart

Legal advocacy group
Civil Rights for Sexual Diversities

Mainstream NGOs with HIV/AIDS programmes
Hong Kong Federation of Women's Centres- Women
St. John's Cathedral HIV Education Centre- Ethnic minotiries
BGCA Project Touch – Sex Education- MSM Youth
Caritas (Play Safe)- Youth, MSM, FSW
The Society of Rehabilitation and Crime Prevention - IDU, FSW, ethnic minorities, prison inmates
Hong Kong Red Cross

Research Unit
Community Programme Research on AIDS CUHK
AIDS Institute, Li Ka Shing Faculty of Medicine, The Unversity of Hong Kong
Stanley Ho Centre for Emerging Infectious Diseases, Faculty of Medicine, The Chinese University of Hong Kong
Centre for Comparative & Public Law, Hong Kong University

Organization of Gay Man
Rainbow of Hong Kong

Organization of Female Sex Worker
Action for REACH OUT
Zi Teng

Organization of Male Sex Worker
Midnight Blue

6. To what extent is civil society able to access:

a. adequate financial support to implement its HIV activities?

Low High
0 1 2 3 4 5

b. adequate technical support to implement its HIV activities?

Low High
0 1 2 [3] 4 5

Comments and examples:
HIV activities were financially supported by the AIDS Trust Fund on application basis. Regular trainings and various technical supports upon request were provided by the government.

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?
Only percentage with quantitative evidence will be reported. For the items which a designated percentage cannot be estimated, qualitative elaborations are provided below.

Prevention for youth	<25%	25-50%	51–75%	>75%
Prevention for most-at-risk-populations	<25%	25-50%	51–75%	>75%
- Injecting drug users	<25%	25-50%	51–75%	>75%
- Men who have sex with men	<25%	25-50%	51–75%	>75%
- Sex workers	<25%	25-50%	51–75%	>75%
Testing and Counselling	<25%	25-50%	51–75%	[>75%]
Reduction of Stigma and Discrimination	<25%	25-50%	51–75%	>75%
Clinical services (ART/OI)*	[<25%]	25-50%	51–75%	>75%
Home-based care	<25%	25-50%	51–75%	>75%
Programmes for OVC**	[<25%]	25-50%	51–75%	>75%

*ART = Antiretroviral Therapy; OI=Opportunistic infections
**OVC = Orphans and other vulnerable children

Prevention for Youth: At least 6 NGOs has specific programmes targeting young people for HIV prevention. There also exists many NGOs with ad hoc HIV educational projects. Numerous NGOs provide ongoing or ad hoc sex

education to young people in Hong Kong.

Prevention for MSM: In the past 3 years, MSM prevention programmes flourished due to the implementation of Special Project Fund. There exist at least 8 NGOs providing proactive prevention programmes (including outreach, online outreach, testing services, peer support, workshops, campaigns) for MSM in Hong Kong. Department of Health also provides outreach and coordination effort for MSM programmes, and social marketing campaign for the MSM community.

Prevention for IDU: Active programs for injecting drug users in the methadone clinics and outreach programs have achieved a high coverage in the IDU community. Of an estimated 13,000 injecting drug users in Hong Kong between 9,000 and 10,000 of them are enrolled at the methadone clinics at any one point in time. Coupled with forward looking local policies supporting harm reduction and ready access to clean equipment, these efforts have helped to effectively control HIV among IDUs. (Tim Brown, Living in the Edge report. 2006 p.5).

At least two NGOs also provide peer educator training programme, harm reduction workshop, and Voluntary Counseling and Testing service for HIV, Hepatitis C and Syphilis.

Prevention for Sex Workers: At least 7 NGOs are providing active programmes for sex workers (at least 2 NGOs are providing services for male sex workers, while at least 6 are providing for female sex workers). Programmes include outreach, online outreach, testing services, peer support, workshops, advocacy, right-based education, life skill education. Clinical services for Sexually Transmission infections are provided by Social Hygiene clinic (Department of Health) at free charge for Eligible persons. NEPs are required to pay the full cost of such services.

Testing and Counseling: There has been an increase in the number of reported HIV cases over recent years. In response to the HIV epidemic, ATF has been providing extra funding to NGOs to scale up provision of HIV counselling and testing services with DH providing training and technical support to the concerned NGOs. The number of testing cum counselling services provided by Department of Health in 2006, 2007 and 2008 is 2807, 3695 and 2719

respectively, while the corresponding figures provided by NGOs as funded by ATF is estimated to be 2472, 5911 and 8348. Thus, 75.4% of counseling and testing services are provided by NGOs in 2008. The statistics for 2009 are pending.

Although the NGOs are providing most of the Testing and Counseling service, according to statistics provided by Department of Health, the source of HIV infection referrals (Jan – Mar 2010) are distributed as below:
Public Hospitals / clinics / Labs: 32.7%
Private Hospitals / clinics / Labs: 24.8%
Department of Health AIDS Unit: 19.8%
Department of Health Social Hygiene Clinic (STI clinic): 10.9%
AIDS Services Organizations (NGOs): 10.9%
Drug rehabilitation services: 1%
However, whether counseling service is provided by the above services varies from service to service.

Reduction of Stigma and Discrimination: Various NGOs have either specific stigma reduction programmes or peripheral stigma and discrimination reduction efforts. Department of Health launched stigma reduction programme on yearly basis which includes Public announcement, publicity campaigns and collaborations with local TV channels for stigma reduction messages in situation comedy and local radio stations for stigma reduction programmes.

Clinical services (ART/OI): Clinical services are currently provided by the Department of Health and Hospital Authority. There are three outpatient clinics in Hong Kong. The civil society does not provide any clinical service for ART or OI.

Home based care: One NGO provides specific home based care services for PLHIV, while other NGOs provide non-HIV specific home care services for anyone who is eligible for service. PLHIV also has access to community nurse services provided by the Hospital Authority.

Programmes for OVC are not applicable in Hong Kong.

Overall, how would you rate the efforts to increase civil society participation in

2009?

2009 Very poor Excellent

0 1 2 3 4 5 6 7 8 9 10

Since 2007, what have been key achievements in this area:

An increase of number of AIDS-related NGOs with funding support by ATF.

What are remaining challenges in this area:

- Sustainable partnership between GO & NGO & Community, among NGOs
- Involvement of PLHIV and community members in policy decision process.
- Technical supports for funding application and programme implementation for small and newly developed NGOs, community groups.
- Sustainable government financial support to NGOs and community groups.

Part B: III Prevention

1. Has the country identified the specific needs for HIV prevention programmes?

Yes ✓ No

IF YES, how were these specific needs determined? Refer to Human Right Question 6 If Yes Part
IF NO, how are HIV prevention programmes being scaled-up?

To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access		
Blood safety	✓ Agree	Don't Agree	N/A
Universal precautions in health care settings	✓ Agree	Don't Agree	N/A
Prevention of mother-to-child transmission of HIV	✓ Agree	Don't Agree	N/A
IEC* on risk reduction	✓ Agree	Don't Agree	N/A
IEC* on stigma and discrimination reduction	✓ Agree	Don't Agree	N/A
Condom promotion	✓ Agree	Don't Agree	N/A
HIV testing and counseling	✓ Agree	Don't Agree	N/A
Harm reduction for injecting drug users	✓ Agree	Don't Agree	N/A
Risk reduction for men who have sex with men	✓ Agree	Don't Agree	N/A
Risk reduction for sex workers	✓ Agree	Don't Agree	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	✓ Agree	Don't Agree	N/A
School-based HIV education for young people	Agree	✓ Don't Agree	N/A

HIV Prevention for out-of-school young people	Agree	✓ Don't Agree	N/A
HIV prevention in the workplace	Agree	✓ Don't Agree	N/A
Other programmes: [write in]			

* IEC = information, education, communication

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

2009 Very poor Excellent

0 1 2 3 4 5 6 7 8 9 10

Since 2007, what have been key achievements in this area:

- An increase of number of VCT services being carried out.
- An increase of number of NGOs serving diversified vulnerable subpopulations.

What are remaining challenges in this area:

- Only few schools implement a comprehensive sex education since it was not mandated by the government in the education curriculum. Impediment of prevention work among youth was found in expanding the breadth of programmes.
- Brothels like night clubs have never been reachable. They are of high risk as they refuse to any potential contact from community, avoiding being caught red-handed as carrying activities related to sex trade, such as living on earnings of prostitution, with a condom as an evidence. A number of international corporations have HIV workplace policy in place. However, the local workplace HIV programmes remain to be underdeveloped.
- For Prison inmates, limited resources in response to the increasing number of young prisoners with drug use background who experienced unprotected sex induced by substance abuse.
- For IDUs, there is lack of knowledge on the risk of sharing needle for new arrivals from mainland China. Language is also a barrier of access to the prevention service and to receiving knowledge for the non ethnic Chinese who are IDUs in Hong Kong, especially if they do not understand English and, or Chinese.

Part B: IV Treatment, Care and Support

1. Has the country identified the specific needs for HIV treatment, care and support services?

Yes ✓ No

IF YES, how were these specific needs determined?
Government identifies treatment and care services through researches, Community Assessment and Evaluation on HIV Prevention for People Living with HIV/AIDS in Hong Kong in 2006, on going monitoring of conditions of patients and services in HIV specialized government clinics and hospitals. There is no systematic assessment of needs for PLHIV support services (e.g. support group, PLHIV family support, volunteer work) except the 2006 community assessment mentioned above. A PLHIV self-help group, conducted a PLHIV needs research in 2008.
IF NO, how are HIV treatment, care and support services being scaled-up?

1.1 To what extent have HIV treatment, care and support services been implemented?

HIV prevention component	The majority of people in need have access		
Antiretroviral therapy	✓ Agree	Don't Agree	N/A
Nutritional care	✓ Agree	Don't Agree	N/A
Paediatric AIDS treatment	✓ Agree	Don't Agree	N/A
Sexually transmitted infection management	✓ Agree	Don't Agree	N/A
Psychosocial support for people living with HIV and their families	✓ Agree	Don't Agree	N/A
Home-based care	✓ Agree	Don't Agree	N/A
Palliative care and treatment of common HIV-related infections	✓ Agree	Don't Agree	N/A

HIV testing and counseling for TB patients	✓ Agree	Don't Agree	N/A
TB screening for HIV-infected people	✓ Agree	Don't Agree	N/A
TB preventive therapy for HIV-infected people	✓ Agree	Don't Agree	N/A
TB infection control in HIV treatment and care facilities	✓ Agree	Don't Agree	N/A
Cotrimoxazole prophylaxis in HIV-infected people	✓ Agree	Don't Agree	N/A
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	✓ Agree	Don't Agree	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree	✓ Don't Agree	N/A
HIV care and support in the workplace (including alternative working arrangements)	Agree	✓ Don't Agree	N/A
Other programmes: [write in]	Agree	Don't Agree	N/A

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?

2009 Very poor Excellent

0 1 2 3 4 5 6 7 8 [9] 10

Since 2007, what have been key achievements in this area:

In 2009, the Government established a new HIV clinic in Princess Margaret Hospital.

What are remaining challenges in this area:

- Only 66.2% of newly reported HIV cases were managed at government specialized treatment services in fourth quarter of 2009 according to

Government HIV surveillance and epidemiology report. The remaining PLHIV are probably lack of formal supports that may put their health and public health at risks.

2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes No N/A ✓

2.1 IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes No

2.2 IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes No

2.3 IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes No

IF YES, what percentage of orphans and vulnerable children is being reached?

% [write in]

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?

2009 Very poor Excellent

0 1 2 3 4 5 6 7 8 9 10

Since 2007, what have been key achievements in this area: What are remaining challenges in this area: