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

Summary for the Session on Ethnic Minorities

July 2011

Community Forum on AIDS, Hong Kong Advisory Council on

AIDS and Hong Kong Coalition of AIDS Service Organizations

The Community Forum on AIDS (CFA) and the Hong Kong Coalition of AIDS Service Organizations (HKCASO) jointly organized a Community Stakeholders Consultation Meeting comprising eight sessions on key populations and a session on resources for local AIDS response from 26 January to 1 February 2011. The Meeting, steered by a working group formed by CFA and HKCASO, sought to engage stakeholders in informed discussion to shape the formulation of the local strategies on HIV/AIDS. A generic framework of discussion and prioritization was adopted in all sessions. This summary contains information on the latest epidemiology and current response presented in the session on ethnic minorities, and suggestions generated by the participants. The views and information contained in this summary are as collected and gathered from the Meeting and do not necessarily represent those of CFA and HKCASO. Summaries of other sessions and a full report of the Meeting can be downloaded from the Virtual AIDS Office (www.aids.gov.hk).

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Review of epidemiology

[draft for discussion only]

Population size estimation

- Ethnic minorities in this epidemiological review are defined in simplified manner, namely people with ethnicities that are non-Chinese, non-Caucasian, and non-mixed (the "mixed" group is often appeared as an entity in the Census data, and this review does not regard "mixed" as ethnic minorities arbitrarily). This is by no means suggesting people with different ethnicities fall into such overly simplified categories, but for the purpose of this review, these categorizations are used.
- Based on the 2006 Population By-census[1], out of the 6,800,000 population in Hong Kong, approximately over 4.2% of the entire population as Asians (other than Chinese), while over 0.5% as Caucasians and about 0.2% as mixed. The rest were all ethnic Chinese (95%).

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1 http://www.censtatd.gov.hk/products_and_services/products/publications/statistical_report/population_and_vital_events/index_tc_cd_B1120050_dt_latest.jsp

表 3.1 二零零一年及二零零六年按種族及常住居民／流動居民劃分的少數族裔人士數目（續）

Table 3.1 Ethnic Minorities by Ethnicity and Usual Residents/Mobile Residents, 2001 and 2006 (Cont'd.)

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

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

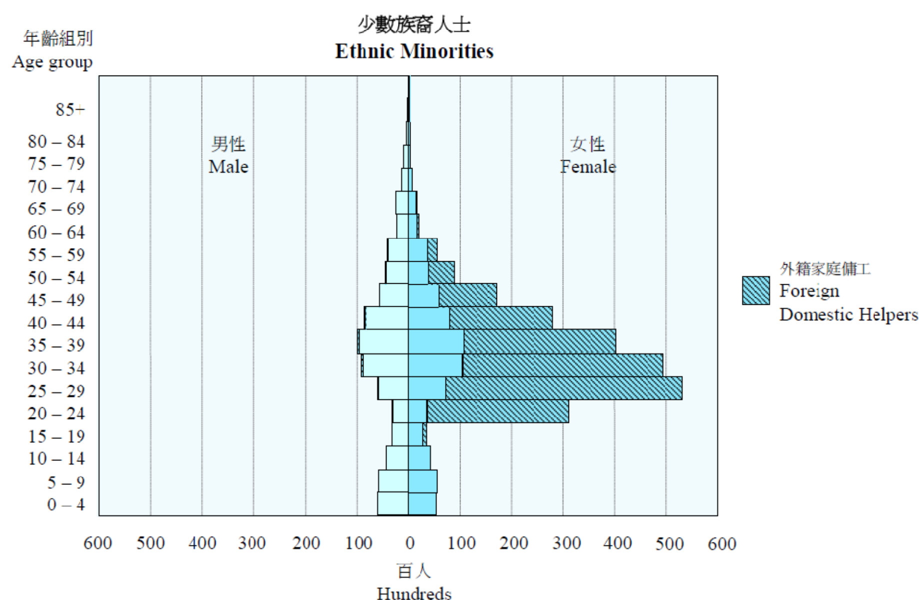
Notes : (1) Figures in brackets represent the percentages in respect of the total.
(2) The figures include "Black", "Latin American", etc.

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

Gender and age

圖 3.1　二零零一年及二零零六年少數族裔人士及全港人口的人口金字塔（續）
Chart 3.1　Population Pyramids for Ethnic Minorities and the Whole Population, 2001 and 2006 (Cont'd.)

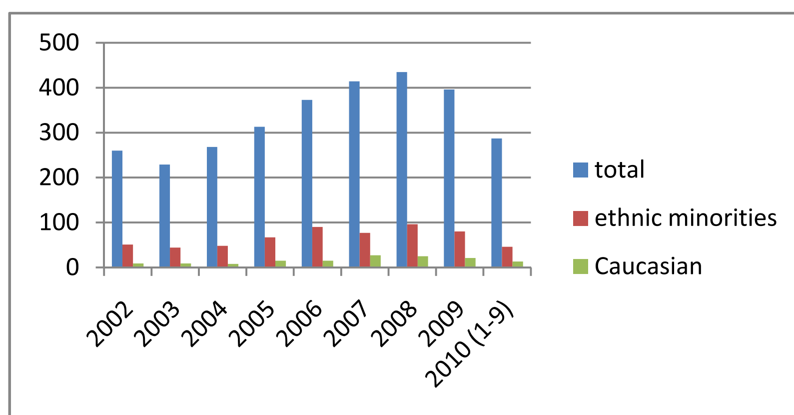
2006



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

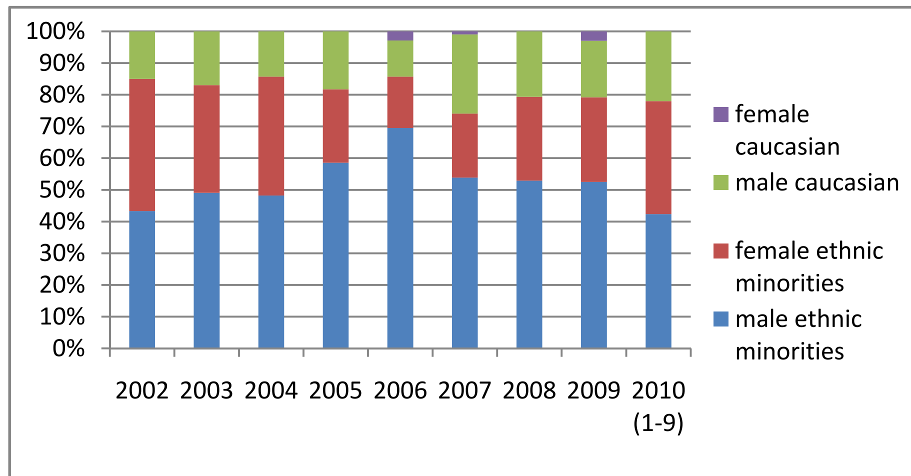
HIV/AIDS reporting system

Trend



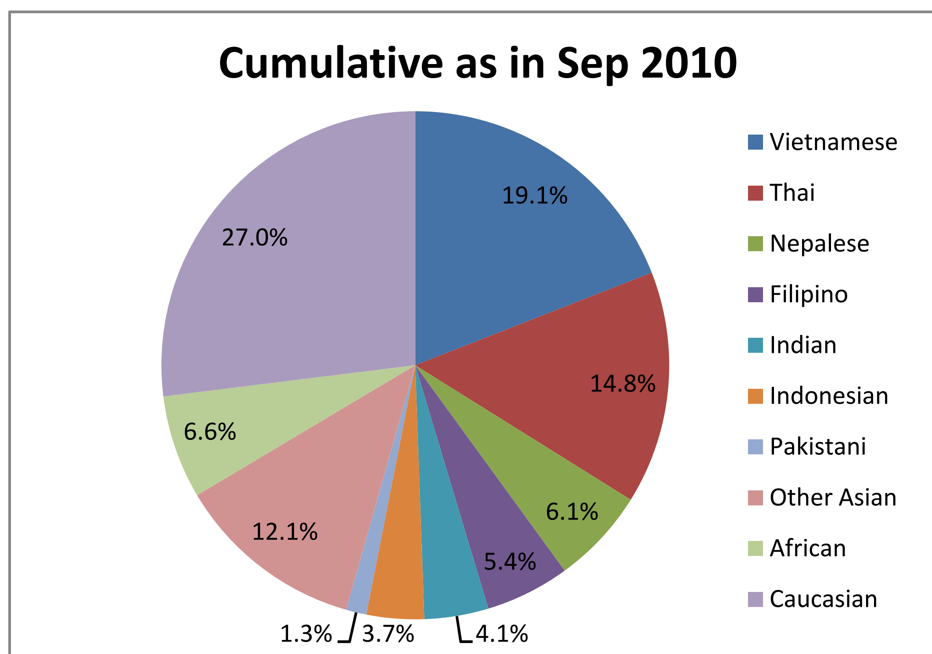
- Annual number of HIV reported cases attributed by ethnic minorities ranged from 67 to 96 cases from 2005 to 2009, corresponding to 19%-24% of all HIV reported cases, as opposed to the Caucasians that ranged from 15-27 cases, corresponding to 4%-6.5% of all HIV reported cases.

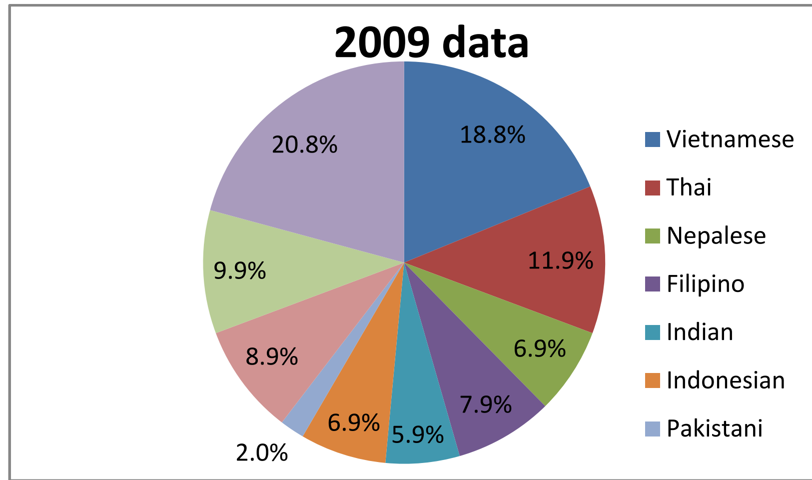
Gender



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

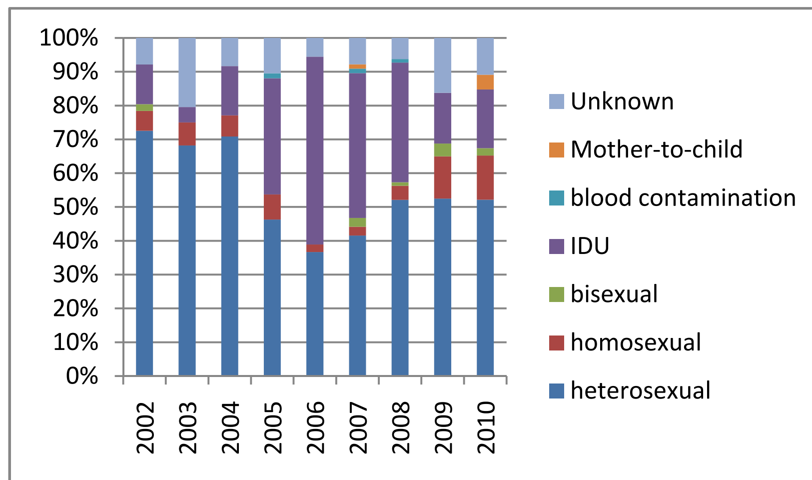
Further breakdown in Ethnicity





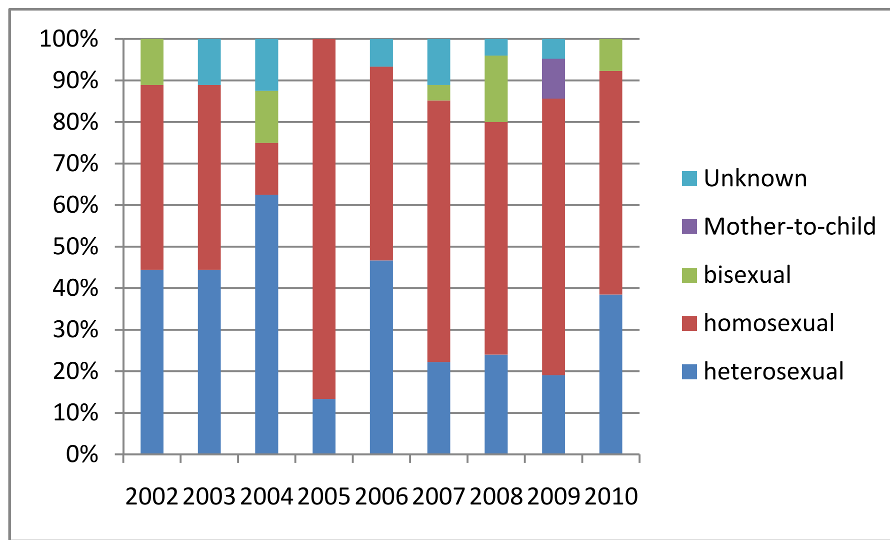
- When only pooling the ethnicities other than Chinese together cumulatively, the top 3 ethnic groups for HIV reported cases were Caucasian (27%), followed by Vietnamese (19%), and Thai (15%).
- Comparatively, in 2009 only, the top 3 ethnic groups for HIV cases remained the same, i.e, Caucasian (21%),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

<u>Risk of transmission among ethnic minorities</u>



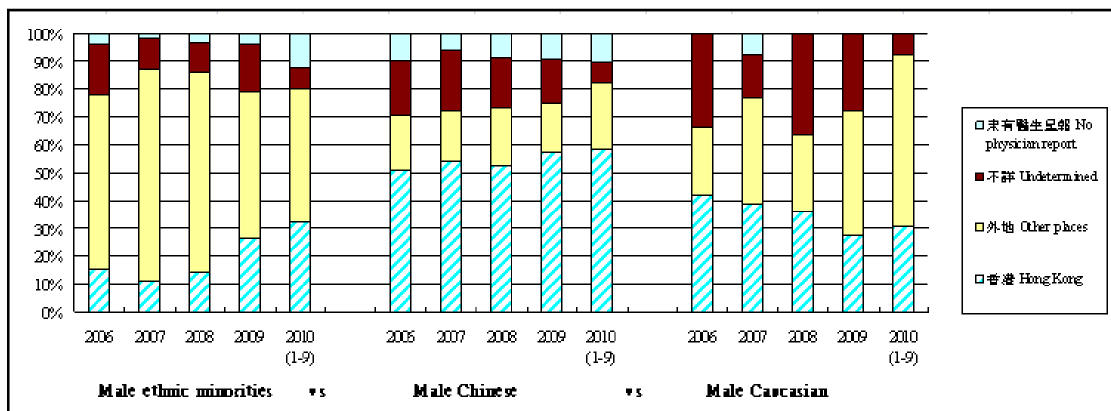
- Heterosexual transmission accounted for over 50% of cases in ethnic minorities in 2008-2010, while homosexual and bisexual accounted for less than 20% of HIV cases in the captioned period.
- Injecting Drug Users (IDU) used to be of higher weighting of transmission route in 2005-2008 among ethnic minorities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

Risk of transmission among the Caucasians

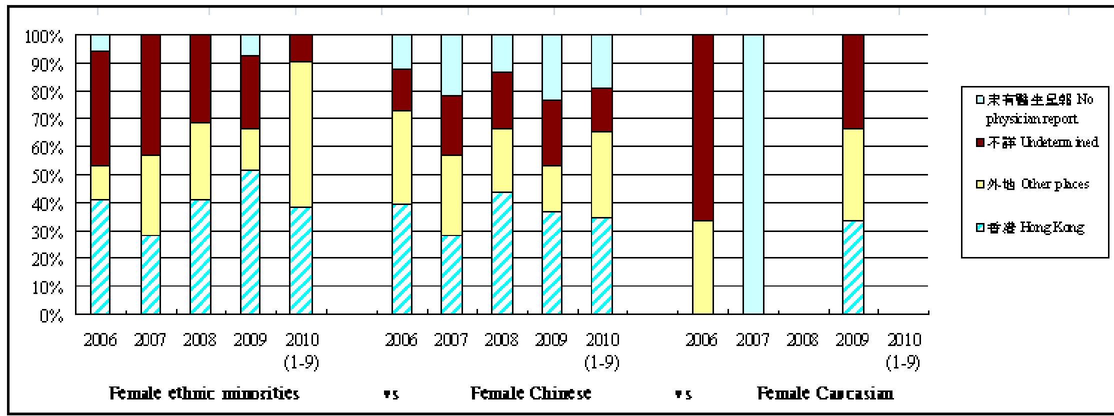


- Homosexual and bisexual transmission were the major route of transmission among the Caucasians, i.e. consistently over 50% since 2007, followed by heterosexual i.e. about 20%-40% in the corresponding period.

Suspected location of infection

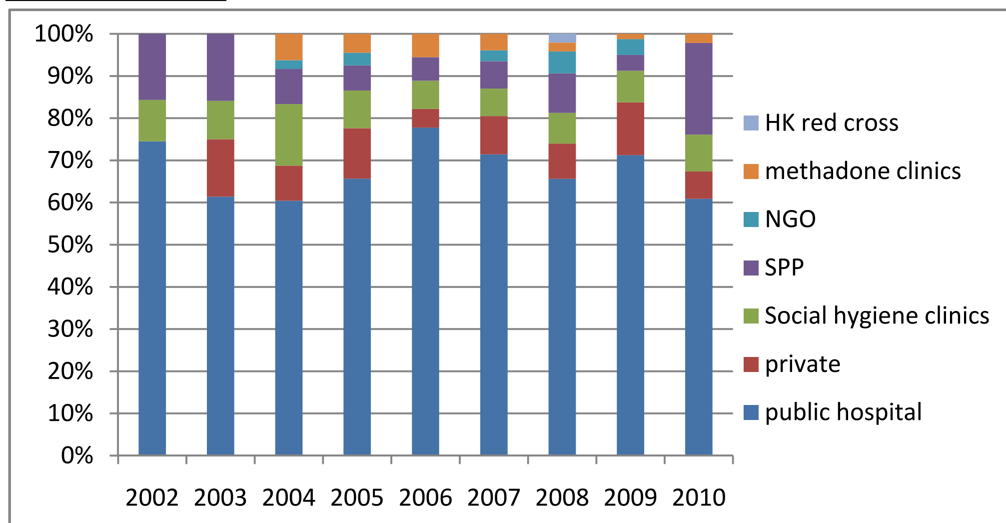


- Compared with Chinese male, male ethnic minorities appeared to acquire the infection in other places rather than in Hong Kong. However, the proportion of local acquisition is catching up in recent years, i.e. from 10% in 2007 to over 30% in 2010 (q1-q3). Caucasian male were more likely to acquire the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



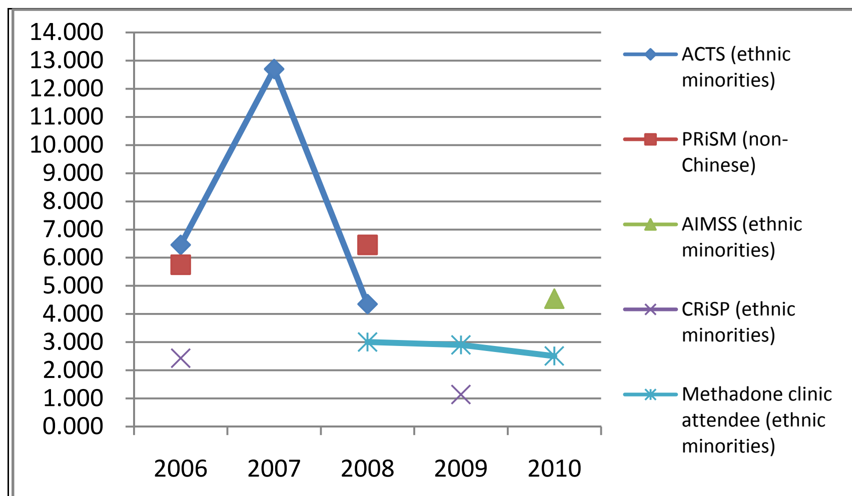
- Pattern for female is more difficult to interpret because of smaller number of cases. In 2010 (q1-q3), more female ethnic minorities appeared to acquire the infection in other places (50%) rather than in Hong Kong (40%).

<u>Reporting source</u>



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

HIV prevalence



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

Risk behaviours

Consistent condom use

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

- AIMSS (2010): Consistent condom usage among MSM ethnic minorities was 17% with their regular sex partner (RSP), and 59% with their casual sex partner (Ca SP) in the past 6 months.

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

<u>HIV testing history</u>

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

Current Response in HIV Prevention

Local responses from 2007 onwards

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

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

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

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

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

promotion materials and condoms are distributed during outreach and peer educational sessions. Individuals (IDU or FSW) who are identified to have high risk behaviours are referred for additional intervention and testing for HIV.

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

5. Highly subsidized specialist HIV management is provided by the three major public HIV clinics run by DH (Kowloon Bay Integrated Treatment Centre) and Hospital Authority (Queen Elizabeth Hospital and Princess Margaret Hospital) for eligible persons[2] (holder of HK Identity Card and children aged below 11 years who are HK residents), who also enjoy free medical consultation and treatment on sexually transmitted illnesses provided by Social Hygiene Service of DH. About 20% and 13.8% of patients seen in DH HIV clinic are non-Chinese and non-Chinese Asians (mainly Thai, Vietnamese, Nepalese, Filipino and Indian) respectively. One NGO runs an integrated sexual health clinic which provides FSW with accessible, affordable and non-stigmatising sexual health services, with special focus on marginalized groups such as non-Chinese and non-Hong Kong residents who are

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

difficult to access or not eligible to receive free medical service in Hong Kong.

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

7. Various activities are taking place to track HIV situation in Hong Kong for improving prevention and control of HIV infection. In addition to the voluntary HIV reporting system, HIV prevalence among those who join the universal testing programme in methadone clinics can be analyzed by ethnicity groups. Tracking of risk behavioral trend including Central Registry of Drug Abuse maintained by Security Bureau, admission/ readmission survey at methadone clinics, prisons and drug treatment and rehabilitation centres and ACTS also capture data on ethnicity.

Discussion Summary

1. <u>Current needs of the EM community</u>

1.1. Prevention

1.1.1. More NGOs and manpower provide service for (hidden) EM groups, especially female sex workers and their EM clients.

1.1.2. Mainstream NGOs can provide sex education and knowledge on HIV/STIs, and increase their efforts in raising awareness on safer sex in the EM community.

1.1.3. Increase EM access to free (or low cost) condoms since female sex workers find condoms too expensive. For domestic helpers, they worry about bringing condom back home as their bosses may scold them. Educate sex workers' clients who are EM on condom use.

1.1.4. Provide 24 hours access to free syringes.

1.1.5. Conduct drug and HIV education programme at the street level.

1.1.6. Although most Nepalese in Hong Kong know about HIV/AIDS, they have problems in accessing syringes at night time.

1.1.7. Vietnamese, both in Hong Kong and in Vietnam, know little about HIV testing and treatment and do not know how to get information. Language is a barrier in accessing local services.

1.1.8. Hotline cards are not produced in languages that EM are familiar with.

1.1.9. Domestic helpers need more information on sexual health. They worry that their bosses would terminate their contracts if they are infected with STI.

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

1.2. Treatment

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

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

1.3. Enabling environment

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

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

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

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

1.3.5. Education progammes should be gender and religion sensitive.

1.3.6. Lack of translation services. Train more EM to become translators.

1.3.7. More support for integration of EM into the society.

1.3.8. Increase gender sensitive services by separating services for females and males.

1.3.9. Promotion that suits cultural context in reducing taboo related to condom use.

1.3.10. More resources for building network between the EM community and NGOs for long term partnership.

1.3.11. Sex education targeting young EM with materials and information that are sensitive to their cultures.

1.3.12. Provide service for EM who lives in temporary shelters.

1.4. Strategic information

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

2. Visions in 5 years time

2.1. EM youth are more educated on sex education. EM adults are more open to talk about sex and HIV.

2.2. Increased education to parents – it is viewed that literacy of EM women is low, which is a barrier for them to access to HIV and STI information.

2.3. Racial equality is achieved. Since currently, EM do not see the opportunities for them to further develop in the existing social atmosphere and system. Little hope for good prospect means not caring for oneself, including sexual health and safer sex. Equal opportunity for all ethnicities to increase access to services and education.

2.4. HIV infection will be kept at a low level.

2.5. Tailor made treatment, drug treatment centre and after care services for EM drug users, with provision of food and accommodation that suits their cultures, and operated by EM staff.

2.6. More EM workers in the field. Sex and equal right educations are provided for EM by EM.

2.7. Government promotions on drug and HIV prevention through mass media are in multi-languages. More mass programmes (on HIV and drug use) in schools and communities are conducted in multi-languages. More harm reduction programmes, and the use of diversified approaches.

2.8. Employ EM as staff in prison setting for more cultural sensitive services.

2.9. Programme on educating on their (patients) rights.

2.10. Use mentorship programme to build positive attitude of drug users.

2.11. Reduced drug use and less crime. Reduced number of homeless EM.

2.12. All programmes and services are cultural and religion sensitive.

2.13. Materials/workshops are in one EM specific language. If not, translation is provided in workshops and other activities to EM. More resources to reach out to EM.

2.14. A range of services including training, job finding, temporary shelter and integration to society available to rehabilitate EM IDU.

2.15. Training for community leaders in different nationalities to become peer educators.

2.16. Zero language barriers. Easily accessible translation/interpretation services. Provide language support to NGOs to facilitate their works for EM. Make use of the internet platform for (HIV) related services that are support by multi-languages.

2.17. 24/7 services, e.g. social hygiene clinic for EM, and low cost/free services.

3. <u>Strategies which need to be continued or in place</u>

3.1. Prevention

3.1.1. Increase outreach efforts and expand to other districts, such as Kowloon City and Wanchai.

3.1.2. Set up outreaching team that stations at border checkpoints and provide information on HIV and sexual health.

3.1.3. Disposable syringe boxes in places where EM congregate.

3.1.4. More education to EM SW and SWC. Promote regular medical check-ups.

3.1.5. Promote safer sex through internet/website. Internet outreach programme for HIV/STI education.

3.1.6. Increase number of EM peer educators, and their training (in appropriate language and addressing cultural differences).

3.1.7. Change the concept of condom use among EM. Improve access to (cheaper) condoms.

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

3.1.9. Provide education workshops to refugees.

3.1.10. More VCT and counseling services for EM.

3.2. Treatment

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

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

3.2.3. Ensure drug free environment in methadone clinics.

3.3. Care and support

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

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

3.3.3. Motivate EM to stay away from drug use.

3.4. Enabling environment

3.4.1. School for EM should provide sex and HIV education in multi-languages. Increase the number of talks, and the quality has to be good.

3.4.2. Access to drug rehabilitation services that are religion free.

3.4.3. NGOs and church groups that work with EM should work on mainstreaming HIV issues into their institutions, such as churches.

3.4.4. More networking between organizations that serve EM and the EM communities.

3.4.5. More long term funding to sustain NGO partnership with EM community. Monitoring should be in place.

3.4.6. User friendly translation service should be provided, e.g. in the hospital to increase accessibility.

3.4.7. Workshops by NGOS to target different EM groups. Increase education for adults in general.

3.4.8. Extensive use of peer educators in EM programmes.

3.4.9. Provide support services to EM who are living in the border areas, e.g, domestic helpers who are in-between contracts.

3.4.10. Provide service/workshops that are for EM females such as, Indians and Nepalese.

3.4.11. Create an EM caring society.

3.4.12. Promote anti-discrimination against PLHIV among different ethnicities.

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

3.5. Strategy/policy

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

4. <u>Prioritized recommendations</u>

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

High priorities

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

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

4.3. Capacity building in the EM community to enable them to become HIV prevention workers, peer educators (in same language) and health care

workers. Provide training for them in different languages (languages of their origins).

4.4. Multi-faceted approach for EM services: Increase outreaching services to different sub-groups (e.g. drug users, sex workers & clients) and in different locations such as Kowloon City, Wanchai. More street level education and the use of peer education approach in delivery. Increase access to condoms.

Medium priorities

4.5. A drug free methadone clinic, cultural sensitive treatment centre and hostels, and provide comprehensive after care service (increase motivation for change). Training programmes for ex-drug users and ex-prison inmates to become peer educators.

4.6. Provision of services should be cultural and gender sensitive. HIV programmes/services should be EM- centric.

4.7. Support groups for EM PLHIV.

4.8. Reduce language barriers through provision of translation. Use of multi-languages in TV/printed media/hotlines, and the internet.

Lower priorities

4.9. Free syringe programme for drug users and sharp boxes in different districts.

4.10. Increase network among organizations that serve EM community and AIDS service organizations.

4.11. Education within EM communities to reduce stigma and discrimination against PLHIV.

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