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

Summary for the Session on Men who Have Sex with Men / Transgender Persons

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 men who have sex with men (MSM) / transgender persons (TG), 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]

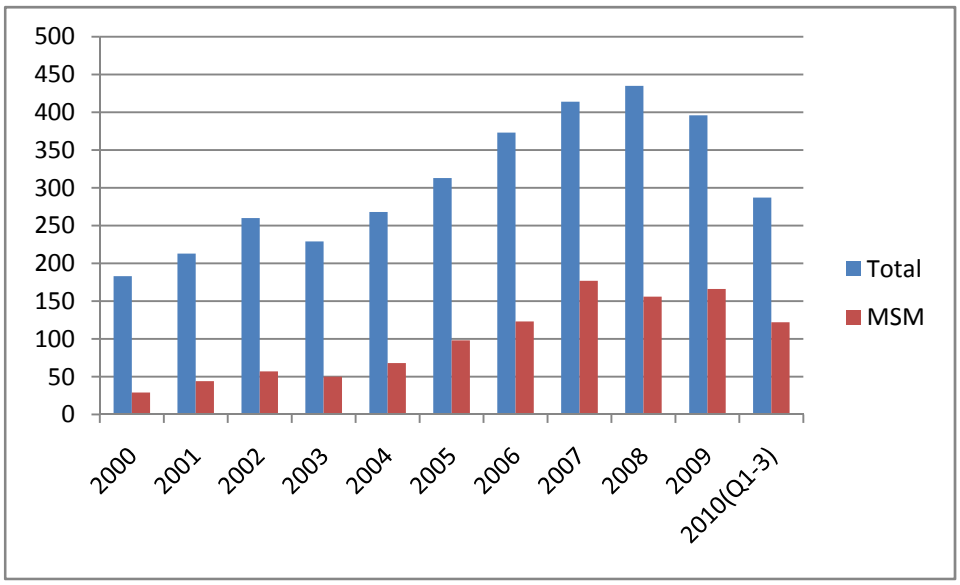
Population size estimation

- A benchmark population based behavioral study in 2001[1], which sampled about 15,000 men aged 18-60 using computer assisted telephone interview, provided an estimation of the size of MSM population at risk for HIV infection. The study showed that 4.5% of the men sampled ever had sex with another men.
- Two percent had sex with another men in the last 6 months (active MSM), 22.3% of them reported to have had anal sex (i.e., 0.45% of all men being interviewed).
- As at end of 2009, the male population aged 18-60 were over 2.1 million [C&SD, 2009], and according to the 2006 by-Census data, 97% of male population aged 18-60 were Chinese.
- Applying the above data, the population size of men who have ever reported to have had sex with men derived for the year of 2009 in Hong Kong would be over 96,000. Such figure would include over 42,000 of active MSM (had sex with another men in the last 6 months) and over 10,000 of MSM with recent anal sex.
- About 6% of the MSM from the AIMSS 2010 study had sex with female partners in the past 6 months.

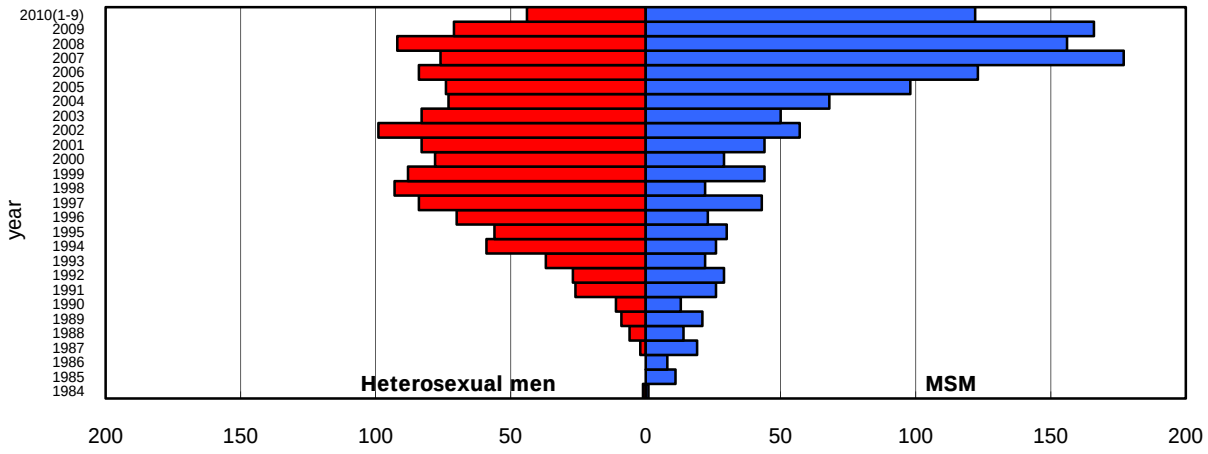
[1] J T F Lau et al. HIV related behaviours and attitudes among Chinese men who have sex with men in Hong Kong: a population based study. Sex Trasm Infect 2004; 80: 459-465.

HIV/AIDS reporting system

Trend

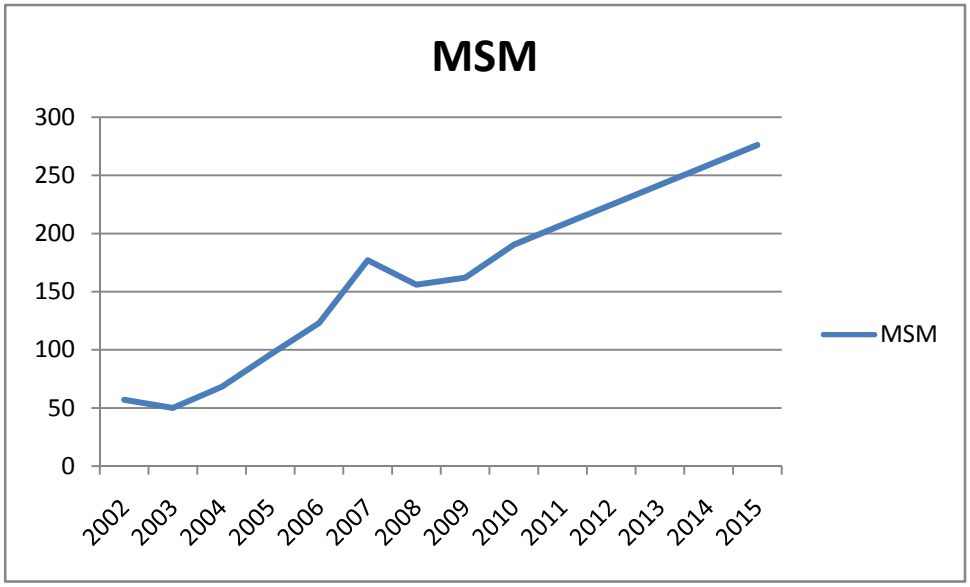


- Number of HIV reported cases from the MSM population rose from the last decade to its peak in 2007-08, and then appeared to be leveling off.
- About 150 MSM HIV cases are being reported annually. About 40% of all HIV reported cases are accountable by MSM since 2007.



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

Projection



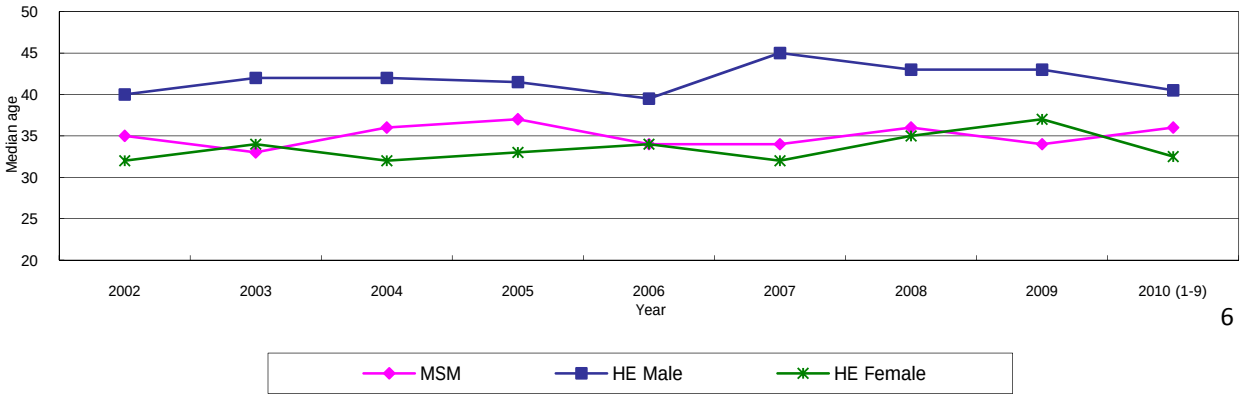
- It is projected that the number of MSM HIV reported cases will continue to increase gradually, based on regression method using past 10 year's data.

Ethnicity

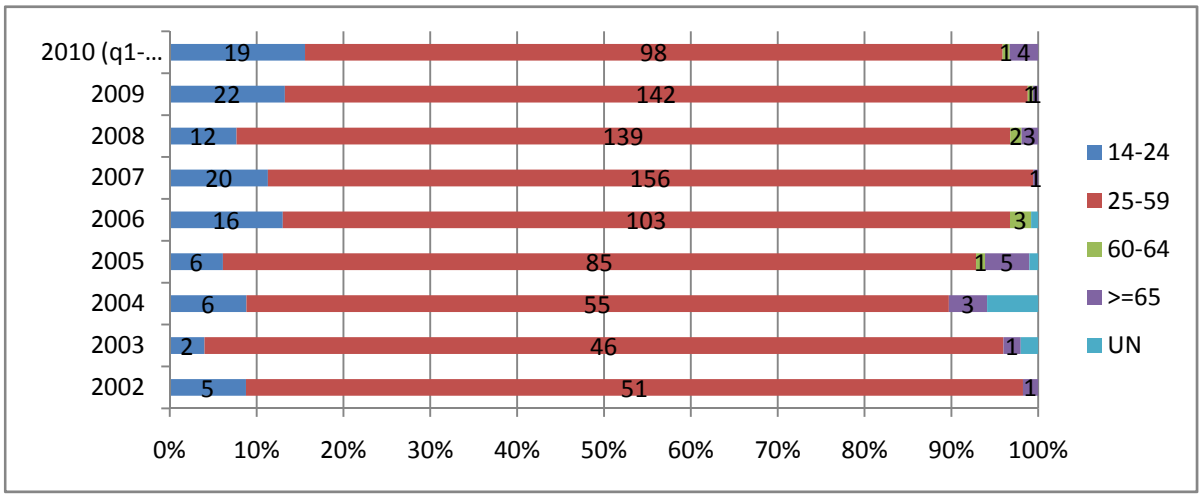
Year	Chinese	Asian	Caucasian	African	Unknown	% Chinese
2002	48	4	5	0	0	84%
2003	43	2	4	1	0	86%
2004	63	3	2	0	0	93%
2005	78	5	13	0	2	80%
2006	113	1	7	1	1	92%
2007	155	4	18	0	0	88%
2008	133	5	18	0	0	85%
2009	137	13	14	0	2	83%
2010 (q1-3)	107	6	8	1	0	88%

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

Age

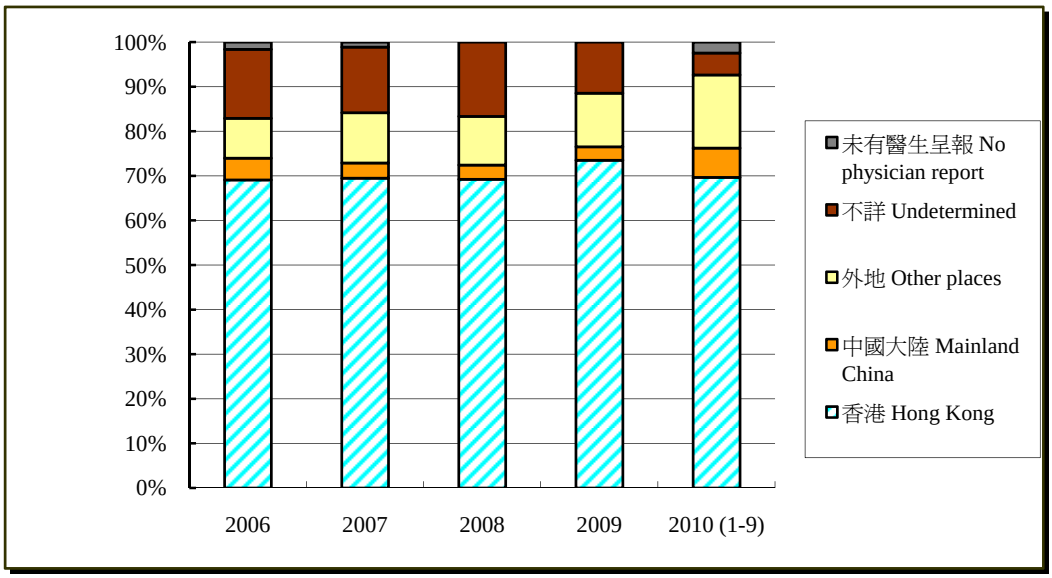


- Since 2002, median age is stabilized at around 35 years old upon HIV diagnosis on the whole.



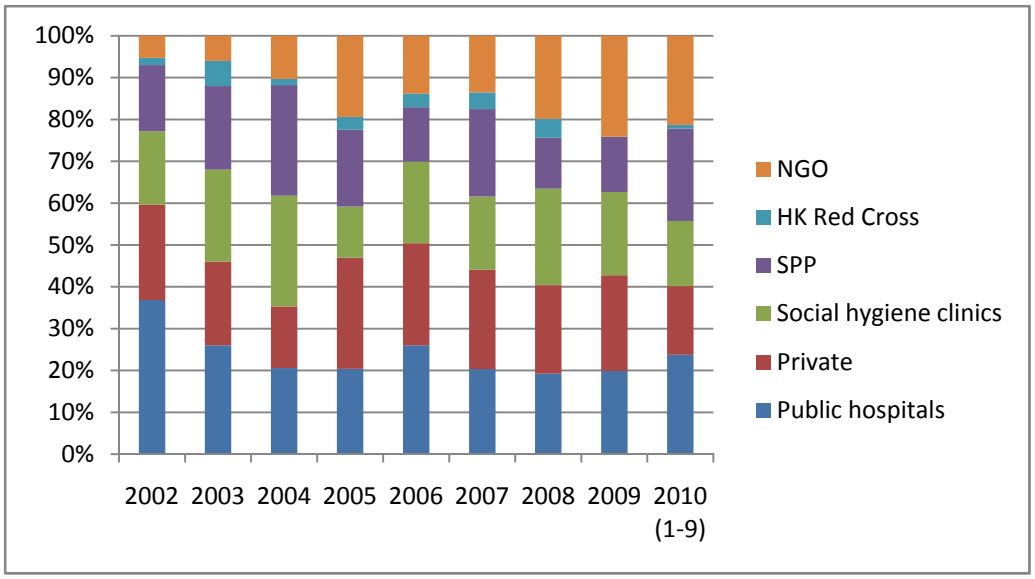
- Since 2002, the 14-24 age group accounted for 10%-15% of all MSM HIV reported cases.
- Since 2002, the >60 age group accounted for <5% of MSM HIV reported cases.

Suspected location



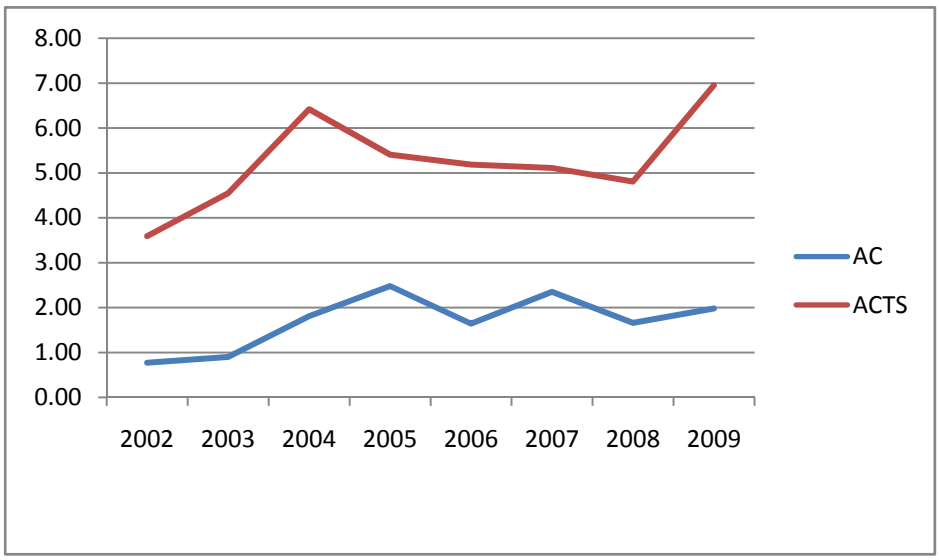
- Since 2006, about 70% of MSM HIV reported cases reported to have acquired HIV locally.
- Since 2006, less than 5% of MSM HIV reported cases reported to have acquired HIV from Mainland China.
- Since 2006, less than 20% of MSM HIV reported cases reported to have acquired HIV from places outside of Hong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

Reporting source



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

HIV prevalence



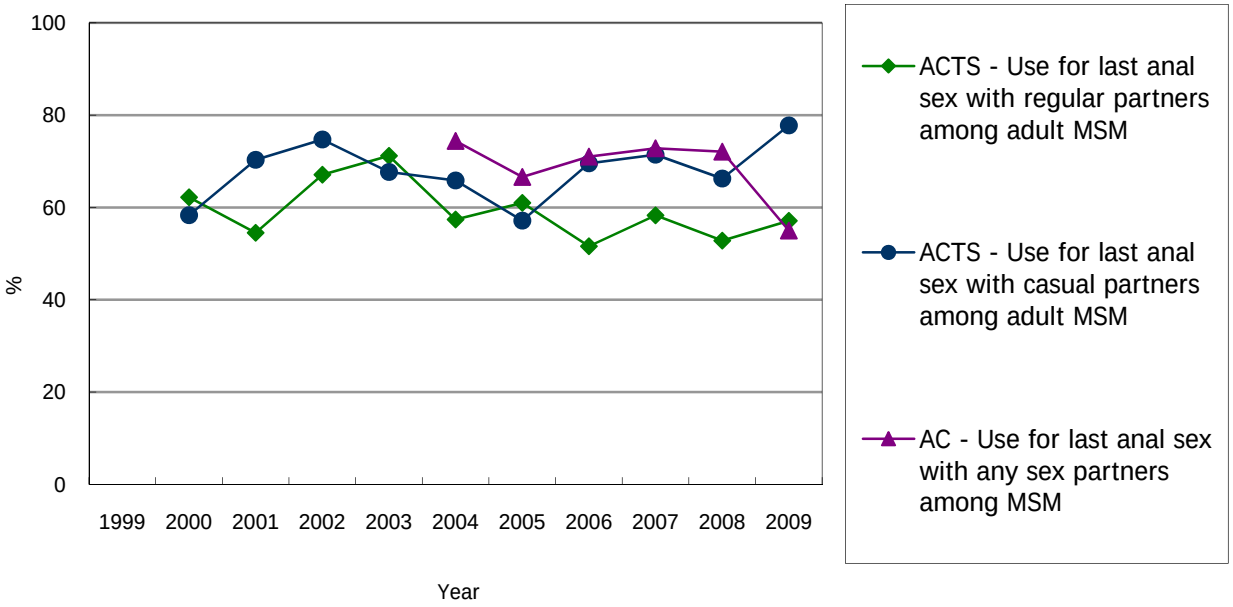
- Sentinel surveillance revealed a gradually rising prevalence from the NGO sentinel point at about 2% of prevalence rate, while there observes a wider fluctuation in prevalence from ACTS due to smaller number of test, at an average of 5% prevalence rate over the years.
- PRiSM studies revealed prevalences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

Risk behaviours

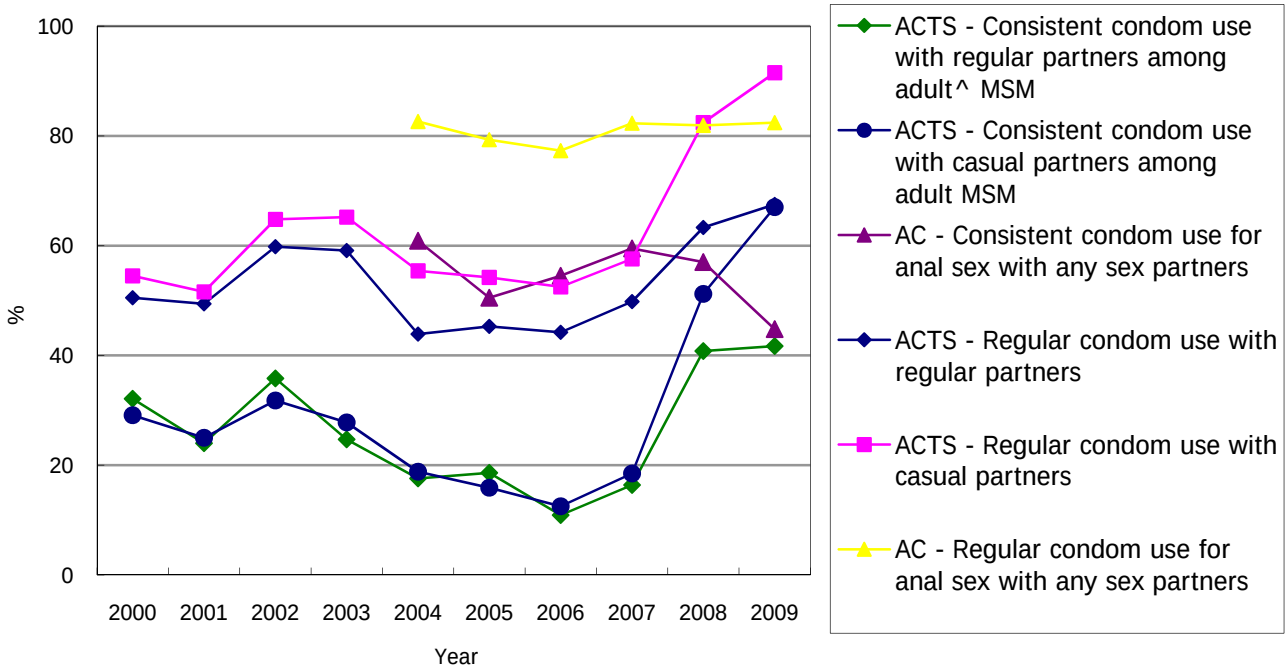
Multiple sex partnership

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

Condom usage



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



- ACTS (2009): Consistent (always) condom usage with regular and non regular sex

partner increased from <20% for both categories pre-2007 to respectively 42% and 67%.

- PRiSM (2006): Consistent condom usage with RSP 41% and NRSP 73%
- PRiSM (2008): Consistent condom usage with RSP 45% and NRSP 75%
- AIMSS (2010): Consistent condom usage with RSP 35% and NRSP 54%

HIV testing history

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

Sexually transmitted infection (STI) consultation

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

Current Response in HIV Prevention

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

<u>Local responses from 2007 onwards</u>

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

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

1. Outreach or centre-based peer counseling and education projects for MSM
2. VCT service for MSM
3. Condom and lubricant distribution to MSM
4. Outreach internet intervention at gay websites and health promotion via internet
5. HIV prevention campaigns targeting MSM
6. Public AIDS Counselling and Testing Service (ACTS)
7. Public HIV clinics and STI clinics
8. HIV-related researches targeting MSM

3. Strengthened community involvement and partnership, and close collaboration among the Government and other stakeholders such as non-governmental organizations (NGOs) are key components in the response to the epidemic. The number of NGOs with projects targeting MSM has increased markedly to ten. ATF is the main funding body for most of the projects carried out by NGOs, with the rest being supported by other funding sources or through self-raised funds (such as charity events or donations). Coordination and collaboration among NGOs has resulted in community-based projects of diverse nature, covering various aspects of HIV prevention work. These projects target various sub-groups of the MSM community, such as youth, MSM living with HIV, those who abuse psychotropic drugs, attendees of private sex parties, and commercial male sex workers and their clients.

Prevention activities such as promoting HIV awareness and safer sex, peer counselling and education, and voluntary counselling and testing (VCT) services are delivered via various settings and media, such as venue-based social functions or activities, saunas, bars, gay events and dance parties, private sex parties, and the internet platform.

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

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

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

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

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

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

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

10. SPP provide centre-based VCT service and hotline counseling service free to all people through its AIDS Counselling and Testing Service (ACTS) centre. Among those attending the centre, about 25% of them claim homosexual/bisexual as the suspected route of transmission. In total, about 500 MSM received VCT service provided by SPP each year between year 2007 and 2009. The designated hotline for gay men registered an annual average of over 500 calls during the period from 2007 to 2010. Free HIV testing service is also provided at the Social Hygiene Service under the Department of Health for the eligible persons[2] (holder of HK Identity Card and children aged below 11 years who are HK residents).

11. Specialized HIV management for those infected is provided by three HIV clinics, namely the Kowloon Bay Integrated Treatment Centre (KBITC) of SPP and the two clinics located at Queen Elizabeth Hospital (QEH) and Princess Margaret Hospital (PMH) run by the Hospital

[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

Authority. About 60% of those infected are catered for by the service provided at KBITC. In 2006, the number of active MSM clients (attending KBITC during the year of 2006) was about 380 and there were a total of about 440 new MSM cases since then (as of the end of 2010). KBITC have also organized three safer sex campaigns targeting MSM clients living with HIV.

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

Table 1. Summarized Responses from the Government

Health promotion and prevention
● 3 venue-based campaigns by RRC
■ 80 gay venues (e.g. bars, saunas) and gay magazines, websites
● 1 internet-based viral campaign by RRC
● 450,000 condom and lubricant packs distributed by RRC
VCT and hotline service by ACTS
● VCT for about 500 MSM clients per year
● 500 calls received via 2117 1069 per year
HIV treatment
● Kowloon Bay Integrated Treatment Centre of SPP (60% of patients)
■ 380 active MSM clients in 2006 (attending KBITC in 2006)
■ 440 new MSM cases since 2006 (as of end of 2010)
● Queen Elizabeth Hospital and Princess Margaret Hospital (40% of patients)
Research
● 8 MSM-related studies e.g. PRiSM studies

Table 2 Summarized Responses from the Non-governmental Sector

Number of NGOs with MSM projects: 10 NGOs

Projects:

- More than 62 projects (48 ATF-funded and 14 non ATF-funded)
- 48 ATF-funded projects
  - 33 with prevention activities and support services
    - 19 at fixed venues e.g. bars, saunas, pubs, massage parlours
    - 18 with centre-based activities e.g. VCT, hotline, workshops
    - 4 with non-fixed venues e.g. private sex parties, circuit dance parties
    - 10 with internet-based outreach activities
  - 15 research projects
- 14 non ATF-funded projects
  - 7 with prevention activities and support services
  - 7 research projects

Type of Intervention	**No. of NGOs**	**Coverage**	**Funding source**
Voluntary Counseling and Testing (VCT)	7	15 ATF projects ● 10 with centre-based VCT ● 11 with outreach VCT 1 non ATF-funded projects 2,700 HIV tests per year	15 ATF-funded 1 non ATF-funded
Distribution of Condom and Lubricant packs	6	16 ATF projects 1 non ATF-funded project 268,000 packs distributed per year	15 ATF-funded 1 non ATF-funded
Distribution of Health Promotion Material	6	16 ATF projects 1 non ATF-funded project 31,000 hit counts per year 5,800 units distributed per year 2,000 calls to hotlines per year	15 ATF-funded 1 non ATF-funded
Internet Outreach	6	10 projects 10,500 attendances per year	All ATF-funded
Community Outreach	6	19 projects 66,000 attendances by community outreach per year 930 attendances by counseling per year 600 attendances by groups or workshops per year 260 attendances by training of peer educators per year	All ATF-funded

Discussion Summary

1. Current needs of the MSM / TG communities

1.1. Prevention

1.1.1. Halt HIV transmission in the community.

1.1.2. Programmes should address the needs of different sub-populations, e.g. MSM who are newly come out, drug use, closeted MSM and transgender persons etc. Use of multi-media to ensure messages could reach out to them. Collaborations within government are required.

1.1.3. Interventions to deal with cross border issues need to be strengthened.

1.1.4. Improve access to services by expanding geographical coverage.

1.1.5. Implement and strengthen in-depth interventions, e.g. behavioral change, gender and sexual orientation identity and negotiation skills. Identify methods in reaching out to MSM through the Internet so that they could accept and access to health promotion message and services.

1.1.6. More HIV/STI rapid testing spots, e.g. saunas, and to increase incentives to encourage testing. Allocate additional resources.

1.1.7. HIV prevention publicity to deliver knowledge on HIV and the needs of MSM. However, when targeting the general public, they should understand that "MSM≠HIV".

1.1.8. Installation of condom vending machines.

1.2. Care, support and treatment

1.2.1. More emotional and counseling support to MSM who use VCT, and extend the support to their partners/friends. More counseling services are needed in general.

1.2.2. MSM are empowered through services to build their self efficacy to counter stigma from the society.

1.2.3. Put more concerns on TG. Identify different methods to reach out to TG. Regard TG as an individual community but not attached to MSM.

1.2.4. More support to HIV infected MSM is needed. Reduce stigma within the MSM community against HIV infected MSM.

1.2.5. Set up a comprehensive sexual health centre for MSM.

1.2.6. Increase choices in medical practices, e.g. traditional Chinese medicine should be provided and encouraged for MSM. Besides, more information is needed for PLHIV on access to medical care.

1.2.7. Multi-sectoral collaboration: education department, health care and parents can have more collaboration.

1.2.8. Services (e.g. counseling hotline) to support young and newly come out MSM for accepting their self identities.

1.3. Enabling environment

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

1.3.2. Elimination of discrimination through sex and HIV education in primary and secondary schools. This education to be led by neutral groups, i.e. non religious groups. Education messages should be explicit, proper and positive. Make use of [community] spokesperson for health promotion message. Provide public spaces for better communications between the community and general public.

1.3.3. Law reform to protect the rights of LGBT couples, e.g. right to donate organ, property handling. Currently gay couples are not allowed to donate organ(s) to their partner.

1.3.4. Promote image and acceptance of condoms in the society.

1.3.5. Comprehensive sex education needs to be implemented. More education on HIV prevention to the general public.

1.3.6. Educate family members of MSM on HIV and MSM needs and issues. Besides, acceptance and support from family are important.

1.3.7. Training is needed for health care professionals, social workers, psychologists and teachers etc, on working with PLHIV and MSM. Positive attitudes of healthcare professionals when working with MSM/TG.

1.3.8. Reduced discrimination against MSM & PLHIV.

1.3.9. Legalization of gay marriage.

1.3.10. More activities provide and led by NGOs. Diversify services for MSM, e.g. MSM elderly home, gay churches, cafes etc, so that MSM can mingle and live normal social life.

1.3.11. Enhance and strengthen community ownership and responsibility of HIV prevention, e.g. more involvement of sauna owners.

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

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

1.4. Strategic information

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

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

1.4.3. Research in MSM and drug use issues.

1.5. Strategy/policy

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

2. <u>Visions in 5 years</u>

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

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

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

2.4. Community to provide normal activities in order to enhance normal development of MSM, e.g. religious groups, organized activities.

2.5. Safer sex promotion with focus on normalization of condom use. Image of condom use become more positive.

2.6. Educated public, e.g. cashiers in convenient stores to sell condoms to those who are “underage.”

2.7. Keep the HIV prevalence low in MSM community.

2.8. Increased interventions provided by professionals, e.g. healthcare, social workers and teachers. More training for these professionals so that they are supportive to the MSM community.

2.9. Sex education included in primary school and in general study, which facilitate the normalization of different sexual orientations. Besides, the focus of sex education is not about suppressing sexual desire.

2.10. Healthcare workers in SHC are gay friendly. More gay friendly medical services (both in-patient and out-patient). A list of gay friendly doctors is available for reference.

2.11. More HIV clinics (in HA hospitals). A gay (HIV) clinic is established.

2.12. VCT coverage goes up to more than 80% and regular condom use (regular and causal partners) is more than 80%.

2.13. A comprehensive understanding to the needs of TG in terms of HIV-related service in order to reflect the situation. More NGOs provide support to TG.

2.14. HIV testing become universal and easily accessible, e.g. in community centres.

2.15. De-stigmatize MSM so that people do not associate MSM with HIV and label them as high risk group.

2.16. Integration of MSM service to the mainstream so that people with different background or orientation can use the same service.

2.17. Effective HIV treatments are available. A cure (treatment/vaccine) is found.

2.18. Access to earlier HIV treatment with better psychological and social support.

2.19. Healthcare workers who serve PLHIV had an increased understanding of MSM.

2.20. HIV infected MSM experience less pressure and has peer support group.

2.21. Increase APIs during TV prime time slot. Monitor the situation of discrimination in the mass media.

2.22. Society allows (tolerates) more diversified discussions on the [MSM] issue.

2.23. Better surveillance system through more regular research.

2.24. Provide information and support to bisexual women.

2.25. Working Group for HIV Prevention in MSM (in Red Ribbon Centre) has representatives / participation from various government departments.

2.26. The government new Community Care Fund will support HIV/AIDS programmes and services.

2.27. Information of MSM in other countries is available.

2.28. There is support for homosexuals from religious groups.

2.29. Better support Younger MSM (at school) by social workers.

2.30. Better support of MSM from their families.

2.31. Care and support services are available in different geographical locations.

2.32. A comprehensive one stop service for MSM and/PLHIV, e.g. testing, treatment and follow up etc. Service for PLHIV should facilitate a better quality of life.

2.33. Orientation information on the Internet for gay men who have just came out.

2.34. A conducive environment for safer sex, e.g. condoms are available in saunas, family size lubricants, condoms in different sizes. Condom packaging should be more attractive to young people.

2.35. Coming out of PLHIV who are also public figures to share their experiences.

2.36. Publicity of HIV/AIDS should be more proper and explicit.

2.37. More HIV prevention work on the Internet. Programmes need to cover private sex parties.

2.38. Generalized training on HIV for health care workers, teachers, social workers and parents etc, and for other government departments such as police.

2.39. All MSM are self responsible for safer sex and HIV prevention, they possess HIV knowledge and know how to refuse requests for unsafe sex.

2.40. More research about outcome/impact of HIV preventive measures.

3. Strategies which need to be continued or in place

3.1. Prevention

3.1.1. Strengthen interventions including peer education, internet outreach, support middle aged and older gay people, counseling, support to family/parents (for gay children to come out).

3.1.2. More outreach activities in internet and bars etc, and condom distribution. More education work should target younger MSM. Internet outreach should be more interactive such as live chat.

3.1.3. Provide mobile VCT services e.g. testing service in van. Ensure testing service coverage and quality, and encourage regular testing.

3.1.4. Peer education approach in prevention efforts, e.g. in the internet.

3.1.5. Use of new technology to promote new services and information on gay venues e.g. new massage parlour, bars, gym so as to facilitate HIV prevention and intervention activities.

3.1.6. More vision in planning and the use of health promotion approach in prevention.

3.1.7. Accessible condom vending machines.

3.1.8. Use of technology such as iphone for promotion/education.

3.2. Treatment

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

3.2.2. Add more HAART with fewer side effects to the Drug Formulary. Keep low charges for the use of medical services.

3.2.3. Post-exposure prophylaxis (PEP) should be more accessible.

3.2.4. Set up a designated SHS for MSM and TG.

3.3. Care and support

3.3.1. Provide peer counseling service to MSM. Other forms of peer support and activities are needed. Include general public in service provision in order to increase their understanding on MSM and related issues.

3.3.2. Involvement of professional in interventions, e.g. social worker to provide counseling.

3.3.3. Provide information to gay men who just come out. Besides, gay/PLHIV who are out publicly will help encourage more people to come out.

3.3.4. MSM to increase their support to (MSM who are) PLHIV.

3.3.5. Segment service to address the needs of MSM with different backgrounds.

3.3.6. More support to family members of MSM PLHIV. More support to older and younger MSM.

3.3.7. Liaison is needed to bridge the communication between the community and government.

3.3.8. Provide more resources for follow up and counseling services after VCT.

3.3.9. Create PLHIV (who are MSM) social platform for their networking and education purpose.

3.3.10. Encourage acceptance by family.

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

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

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

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

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

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

3.4. Enabling environment

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

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

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

3.4.4. MSM are being stigmatized as having mental illness by the mass media and therefore, monitoring messages that are homo/LGBT-phobic behavior disseminated through the mass media is needed.

3.4.5. Programmes to promotion of harm reduction, at risk behavior and drug information should be addressed.

3.4.6. Change the Chinese name of "AIDS" into a less scary one.

3.4.7. Continue to disseminate (HIV) information on regular basis.

3.4.8. Include MSM and HIV topics in schools e.g. through assembly.

3.4.9. Mainstream NGO workers are not aware of MSM services and therefore communication needs to be improved, e.g. memo to circulate to the workers to keep them informed about the services. More mainstream NGOs to provide services to MSM.

3.4.10. Comprehensive sex education in primary and secondary schools. Issues such as HIV and sexuality should be discussed with open and positive attitude.

Organize sex education carnivals and educate families on the issue. Provide workshops and publicities targeting parents.

3.4.11. Training to media workers, social workers and teachers etc on HIV and MSM issues. Produce a standard guideline for media to enhance reporting on MSM issues.

3.4.12. Legalization of same sex marriage.

3.4.13. More promotion of HIV/AIDS knowledge in the media. Use TV to advertise related promotion to MSM.

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

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

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

3.5. Strategic information

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

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

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

3.5.4. Continual collaborations with NGOs.

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

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

3.6. Strategy/Policy

3.6.1. Sustainable strategy and funding to support comprehensive MSM and TG work/service, with an aim to improve their quality of life and not just focus on condom use rate or number of VCT.

3.6.2. A strategy to address hard-to-reach MSM, e.g. young MSM, those living in remote areas etc.

3.6.3. Better support to NGOs.

3.6.4. Government takes the lead to coordinate the efforts in local responses, e.g. development of MSM strategy.

3.6.5. Cross departments and NGO collaborations for HIV prevention. Increase communications and liaison among community, NGOs and government.

3.6.6. A policy of anti-discrimination and sexual orientation.

4. Prioritized recommendations

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

High priorities

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

4.2. Legislation of sexual orientation discrimination ordinance.

4.3. Education: sex and sexuality education in primary/secondary schools, training to service providers, use of multi-media for dissemination, promotion of positive image of MSM/TG and PLHIV, foster open and positive discussion about sex.

4.4. Comprehensive and diversified services that go beyond condom promotion and current outreach activities, such as longer term counseling & follow up, peer counseling, support for family and partners, self/identity acceptance.

4.5. Advocate a long term and visionary LGBT policy (same sex/TG marriage). This policy should be Government-led.

4.6. MSM/TG representative in ACA.

Medium priorities

4.7. Initiates research and provide services for TG.

4.8. Services are tailor-made to different market segments e.g. ages, PLHIV, those who are newly come out, TG, drug users and cross border travelers etc.

4.9. Adopt health promotion approach and go beyond HIV prevention.

4.10. Specialization of MSM/TG services, e.g. gay/TG service centre.

4.11. More concerns to MSM/TG who are PLHIV: anti-stigma efforts within MSM community, establish HIV infected MSM groups. Efforts should be comprehensive.

4.12. Increase VCT service coverage through, e.g. mobile service, and make testing regular.

Lower Priorities

4.13. Expand services in different geographical locations.

4.14. Sexual orientation mainstreaming of services with an ultimate goal of achieving equality.

4.15. Multi-sectoral/departments collaborations.

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

4.17. Increase research initiatives and behavioral surveillance that go beyond existing research agenda, e.g. reasons of (no) condom use and quality of life.