Community Stakeholders Consultation Meeting

for

Development of Recommended HIV/AIDS Strategies for Hong Kong 2012-2016

Summary for the Session on

Youth at Risk

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 youth at risk, 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

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

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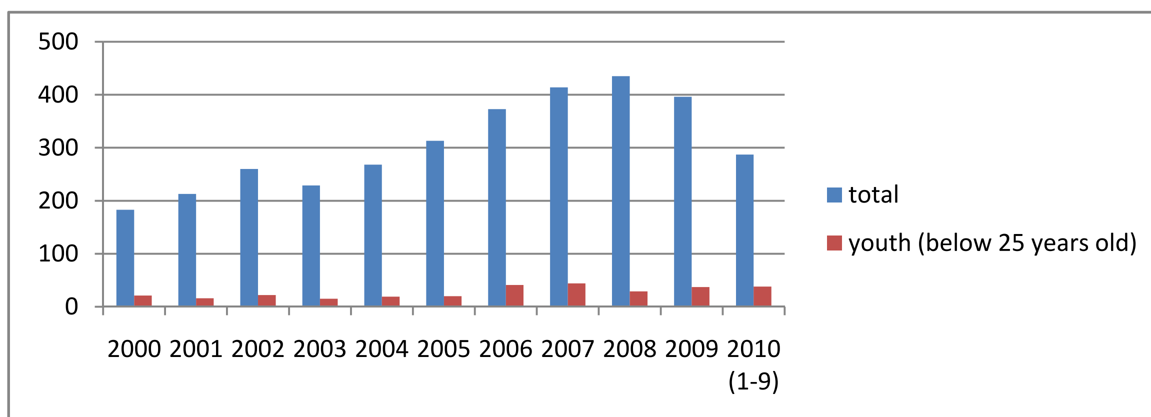
[1] Lau JTF et al. HIV related behaviours and attitudes among Chinese men who have sex with men in Hong Kong: a population based study. Sex Transm Infect 2004;80:459-465.

gave an estimated 14% who had engaged in commercial sex in the past 6 months[2]. Among them about 16% of those aged between 18-30 years old had visited commercial sex worker in the past 6 months. This corresponds to about 90,000 young FSW clients (aged 18-30) in Hong Kong.

HIV/AIDS reporting system

Trend



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

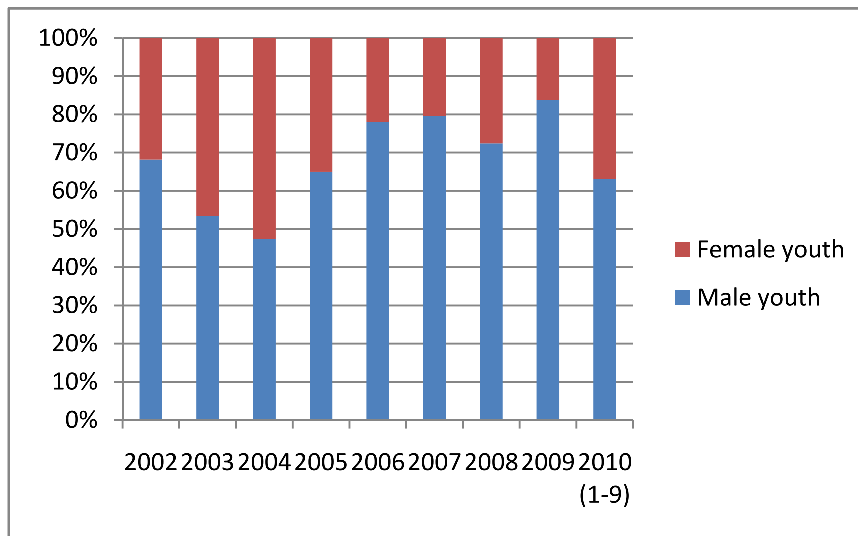
Ethnicity

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

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

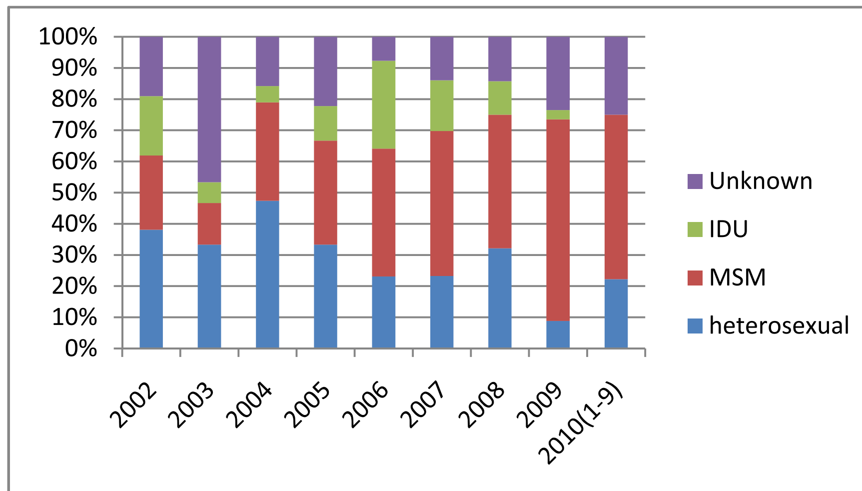
[2] Lau JTF et al. Behavioural surveillance of sexually-related risk behaviours of the Chinese male general population in Hong Kong: a benchmark study. AIDS Care (2001;13(2):221-232.

Gender



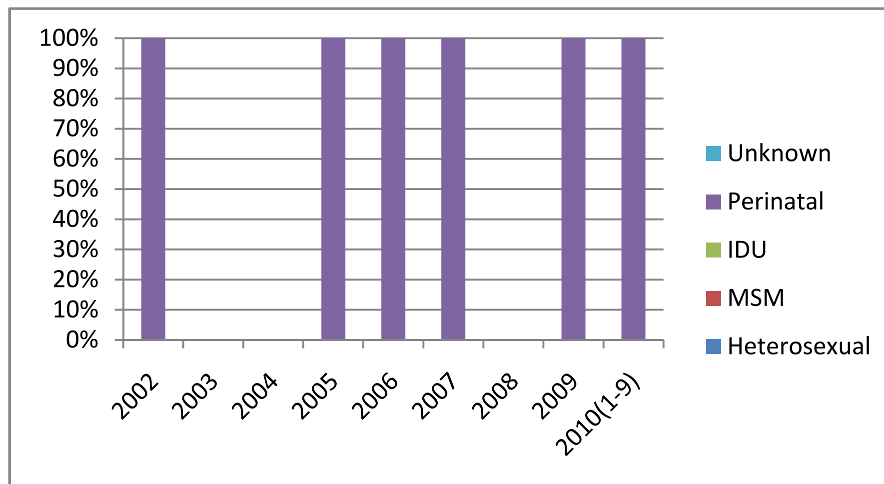
- Consistently over 60% of the youth HIV cases were attributed by male in the years of 2005-2010(q1-q3).

Risk of transmission (aged 14-24 years old)



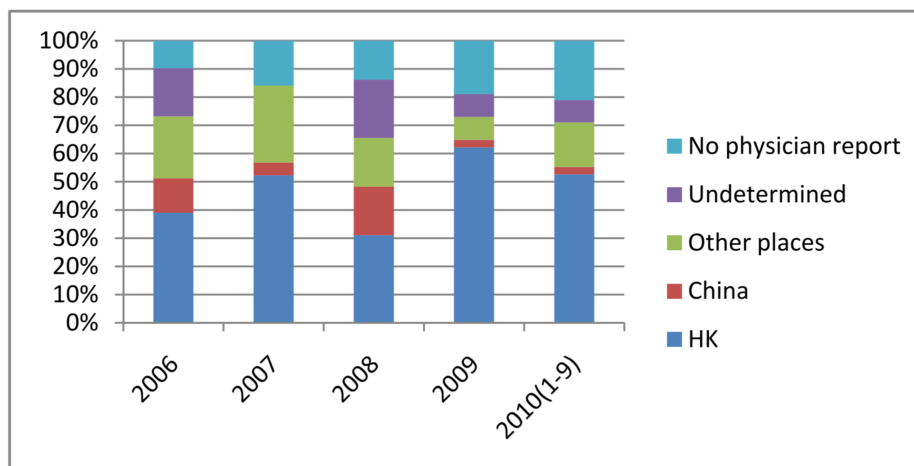
- Over 50% of youth HIV cases reported to be in the recent 2 years, there 10%-20% of youth HIV cases reported to be heterosexual.

Risk of transmission (aged below 14 years old)



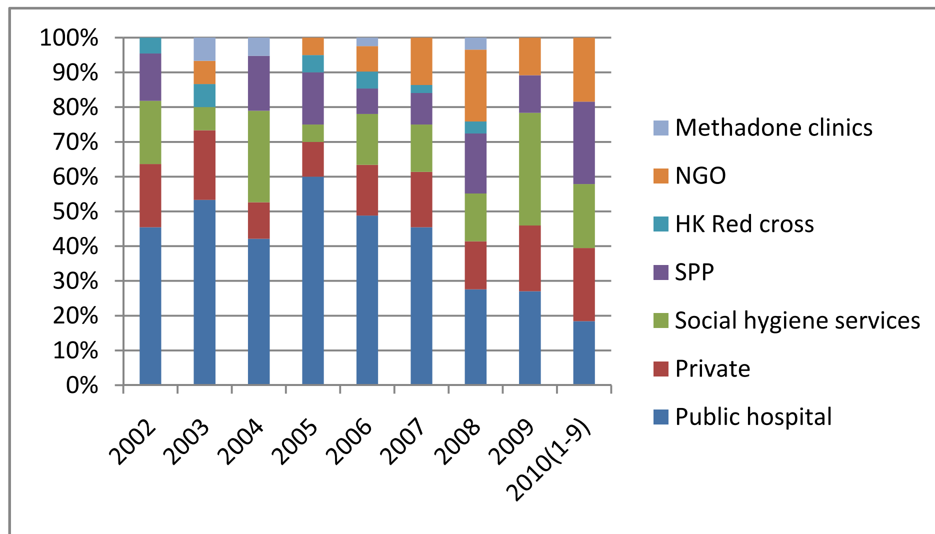
- For those cases aged below 14 years old upon HIV diagnosis, all of them reported to have acquired the infection via perinatal transmission.

Suspected location



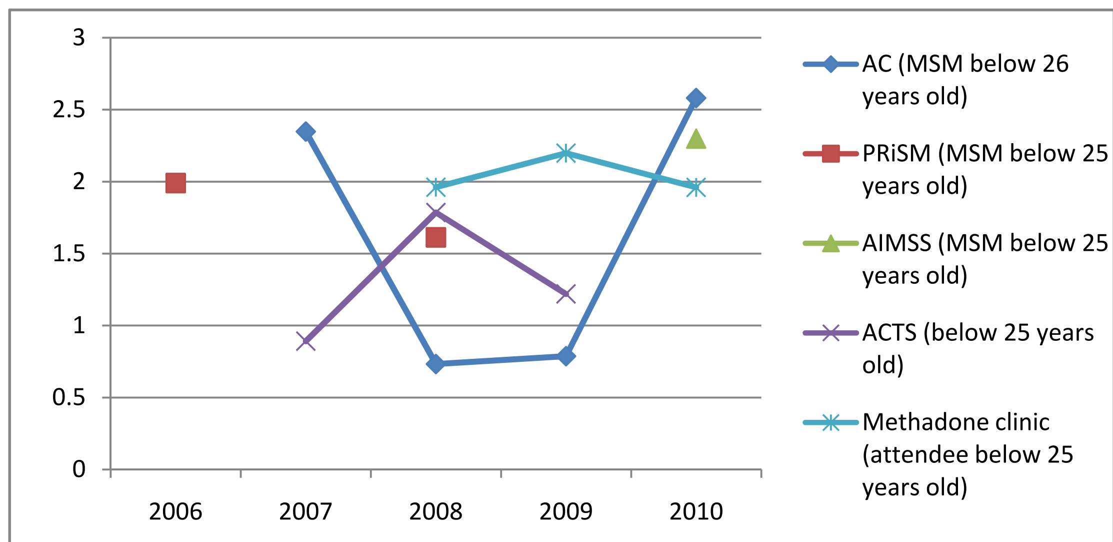
- About 53%-62% of the youth HIV cases reported to have acquired HIV locally in 2009-2010.
- Not more than 5% of the youth HIV cases reported to have acquired from Mainland China.
- Not more than 20% of the youth HIV cases reported to have acquired outside of Hong Kong, but other than places from Mainland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

Reporting source



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

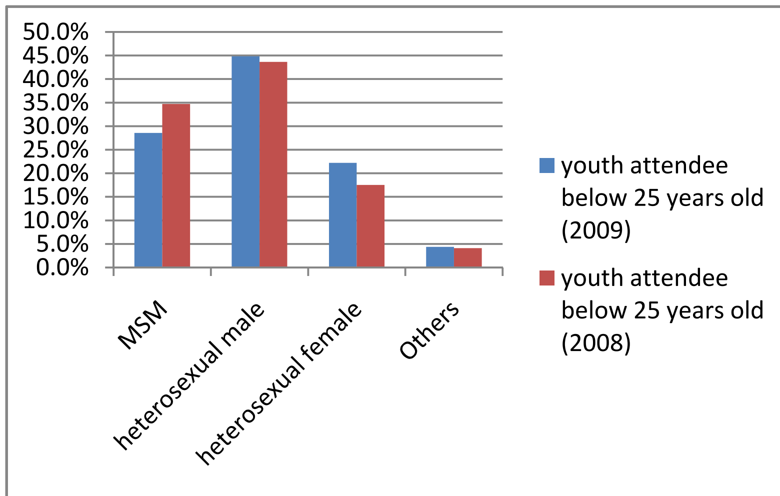
HIV prevalence



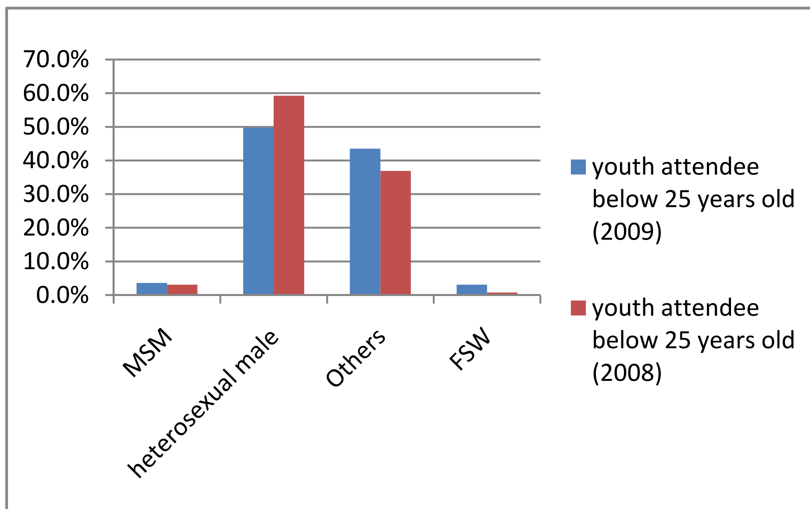
- In the year of 2006-2010, surveillance studies (including PRiSM and AIMSS) and testing services (such as service from AIDS Concern) revealed HIV prevalence of 0.7%-2.6% among MSM youth, while young attendees at ACTS had HIV prevalence of 0.9%-1.8%, and young methadone clinic attendees had HIV prevalence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

Risk behaviours

Youth using ACTS



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



Youth using at SHS

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

Youth using methadone clinic

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

Sexual exposure in past year (Source: ACTS)

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

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

Consistent condom use

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

- There is a generally lower consistent condom usage among youth when having sex with RSP, when comparing to having sex with CoSP or CaSP.
- In 2007-2009, the level of consistent condom use increased, and the increase was more obvious when having sex with CoSP or CaSP, than with RSP.
- In 2009 alone, 33%-51% consistent condom use was reported among youth (including heterosexual male youth and MSM) when having sex with their RSP.
- Overall, youth had higher level of consistent condom use with their CoSP, at about 87%.
- However, MSM youth seem to have a lower consistent condom use with their causal sex partner at about 50% in 2009.

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

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

HIV testing history

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

Sexually Transmitted Infections (STI) consultation

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

Current Response in HIV Prevention

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

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

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

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

1. Outreach activities
2. Internet outreach and online intervention
3. Peer education projects
4. Education workshops
5. Voluntary counseling and testing (VCT) service (both HIV and STI tests)
6. Condom and health promotion material distribution
7. Drop-in service
8. Public AIDS Counselling and Testing Service (ACTS)
9. Public HIV clinics and STI clinics

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

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

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

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

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

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

9. SPP provided centre-based VCT service and hotline counseling service free to all people through its AIDS Counselling and Testing Service (ACTS) centre. Among those attending the centre, approximately one quarter to one-fifth claimed that they were aged 15-24 (25.3% in 2007; 21.6% in 2008; 19.1% in 2009). Public HIV testing service is also provided at the Social Hygiene Clinics under the Department of Health, which provide treatment of sexually transmitted infections (STI) for the eligible persons[3] (holder of HK Identity Card and children aged below 11 years who are HK residents) free of charge in Hong Kong.

[3] 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

Discussion Summary

1. Current needs of the youth at risk community

1.1. Prevention

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

1.1.2. Improve access to condoms.

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

1.2. Treatment

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

1.3. Care and support

1.3.1. Increase number of peer counselors and their training.

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

1.4. Enabling environment

1.4.1. Provide sex and AIDS education for ethnic minorities.

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

1.4.3. Nurture a supportive environment e.g. in school, so that it is easier for youth to talk about their needs.

1.4.4. Sex education should focus on concepts and values, not just on safer sex. Funding for sex education should be sustainable. Make use of mass media (including internet) to deliver sex education (with correct messages).

1.4.5. Youth at risk should not be stigmatized (Note: e.g. police would post messages on the internet that contain moral judgment on compensated dating. Such messages may drive the girls to underground and therefore less accessible by service providers.).

1.4.6. Regard Youth as a "stand alone" population, but not to incorporate into other at-risk communities. It is because youth requires different sets of intervention skills.

1.4.7. There are service gaps for youth in general. More comprehensive efforts are needed, e.g. to address their values, developmental stages, drugs, relationships education, social life, perception on health and empowerment. They should be cultural sensitive. Include parents/family in the process.

1.4.8. More professional training is needed to empower professionals (e.g. social workers, teachers, health care workers) to deal with youth issues directly and equip them with necessary skills.

1.4.9. Sustainable funding for NGO work.

1.4.10. Increase support to parents.

2. Visions in 5 years time

2.1. Sex education to have a focus on "relationship." Besides, sex education should be compulsory, promote positive values, include negotiation skills and discuss different issues such as sex work. Sex education topics should match the needs of youth.

2.2. Surveillance which collects data on youth-centric risky behavior (including sex and drug). Youth-related policy should respond to the special needs of youth.

2.3. Youth workers and educators have increased their skills in sex education.

2.4. A youth hotline to deal with different sexual health issues, such as compensation dating.

2.5. Society, including welfare and education sector, should encourage and support a more open atmosphere. Provide training to encourage the public to listen to young people.

2.6. More involvement of peer educators as they are more influential on their peers; and messages from peers may be more positively perceived and accepted.

2.7. Employ EM staff to implement programmes and services in their communities. More drug treatment centre for EM, and to include HIV treatment and education in the centre.

2.8. A community-based sexual health youth (testing) centre is set up.

2.9. Parents/relatives are educated on sex education.

2.10. Youth can develop ability and skills to make well rounded decisions.

2.11. Nomenclature of the session on “Youth at risk” should preferably be modified to simply “Youth” for the sake of avoiding unnecessary stigma and participation of community members.

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

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

3. Strategies which need to be sustained or in place

3.1. Prevention

3.1.1. Keep STI prevalence low in the youth population.

3.1.2. Strengthen effective HIV knowledge delivery to youth.

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

3.1.4. Increase outreach efforts in the internet.

3.2. Care and support

3.2.1. Provide more help to non-Chinese youth.

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

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

3.3. Enabling environment

3.3.1. Make sex education compulsory in school. Sex education should be age-specific and target the diverse background of young people, such as those who engage in sex work.

3.3.2. Multi-level sex education – sex education should be more in-depth, interactive and conducted in small groups. It should take into account of the identities and background of target audience: universal sex education as well as targeted sex education for those who started risky behavior at early age. Educate parents as well.

3.3.3. Establish youth-friendly sexual health environment, resources are needed to support youth's significant others.

3.3.4. University should educate health care workers on sex education and social workers providing services are youth friendly.

3.3.5. More effective use in data to promote law reform, e.g. decriminalization of sex work.

3.3.6. Use of mainstream media and the internet for promotion/publicity, and health promotion messages should be delivered on a systematic and regular basis. Make use of peak hours for wider dissemination, and make use of different languages to meet individual needs such as ethnic minorities.

3.3.7. Provide more funding to NGOs for at risk youth progamme. Besides, additional resources are needed so that NGOs can carry out sex education in schools.

3.3.8. Anti-stigma (against LGBT, sex workers).

3.3.9. Increase EM participations. More HIV centres for EM including staff members who are EM.

3.3.10. Anti-discrimination campaign for sex workers for the general public.

3.4. Strategic information

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

3.5. Strategy/policy

3.5.1. A strategy to promote regular HIV testing.

3.5.2. Increase youth participation in policy development.

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

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

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

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

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

4. Prioritized recommendations

The following recommendations were compiled based on the above discussions, agreed and prioritized by participants:
(Note: Additional post-Meeting remarks on the recommendations can be found in Annex 13 of the full report, namely Report of Community Stakeholders Consultation Meeting for Development of Recommended HIV/AIDS Strategies for Hong Kong 2012-2016.

High priorities

4.1. Sex education should be multi-level and comprehensive, taking into account of various factors such as age, culture, ethnicity and background (sex workers/drug use/identity); adopt suitable approaches (such as not based on fear, conduct in small group, interactive and bottom up rather than a one-way lecture, updated); sex education to be compulsory in school (i.e. part of the school curriculum). The content should go beyond HIV education and also cover relationship/values education.

4.2. Supportive environment: anti-stigma (sex worker/MSM/against labeling those schools/children homes/ youth centers who are active in conducting sex education to be institutes compiling of so-called "at-risk" youth); reduce taboo to talk about sex; strengthen data collection as a tool to advocate for law reform for decriminalization of sex work.

4.3. Training & information provision to health care workers, social workers, peer educators, counsellors, teachers & parents so as to reduce psychological barriers among young people when expressing their needs.

4.4. Comprehensive sexual health clinic/centre: provide testing service to different ages and racial background etc. Such service should be youth friendly and youth focused. Engage staff members who have diversified backgrounds.

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

Medium priorities

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

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

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

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

Lower priorities

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

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

4.12. Advocate regular HIV testing.

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