香港防治愛滋病策略
摘要

Strategies for AIDS Prevention, Care & Control in Hong Kong

an executive summary

香港愛滋病顧問委員會
Advisory Council on AIDS
Hong Kong
1994

目錄 Contents

頁數 page

前言

自從香港發現首宗感染愛滋病毒的個案後，轉眼已過了十年。為應付這個不斷蔓延的疫症，本地已逐漸發展了一套預防、治理及控制愛滋病的綜合計劃。在這方面，香港總督於 1990 年委任愛滋病顧問委員會，成為本地發展愛滋病計劃的背後推動力。1994 年 7 月，委員會制定了一份名為「香港防治愛滋策略」的文件，以反映對愛滋病的整體政策。這份摘要是該份文件的節錄本，供市民參閱。

這份摘要共有 45 段，列明了顧問委員會對和愛滋病直接或間接有關的各種問題的建議策略。由於愛滋病關乎每一個人，因此本摘要定有某些部份與香港每個階層有關。在有需要時，應參考該份文件的原文。

愛滋病顧問委員會秘書處
1994 年 10 月

香港防治愛滋病策略
摘要

1. 愛滋病又稱「後天免疫力缺乏症」，是指受愛滋病毒感染後，人體免疫系統呈現衰竭的後期現象。自 1981 年在美國發現首宗愛滋病個案後，愛滋病已在全球每個角落迅速蔓延。估計目前已有一千七百萬人受愛滋病毒感染，其中四百萬人已成為愛滋病患者。香港衞生署共接獲近五百宗受愛滋病毒感染的個案，但真正的數字大概是數千人。

2. 在世界各地，愛滋病毒主要是透過性接觸傳染。由於這個問題的複雜性及對社會的影響性，一套綜合的預防、治理及控制計劃是明顯必須的。在 1986 年，世界衞生組織成立了「愛滋病全球規劃署」，負責在國家及國際層面推動、支持及協調有關愛滋病的防治工作。

3. 在香港，愛滋病計劃的發展經歷了三個階段：在第一個階段 (1984 至 1986 年)，醫務衞生署成立了一個專家委員會，重點在於保障血液供應的安全。而設於伊利沙伯醫院的輔導診所亦同時開始運作，向懷疑受愛滋病毒感染的人士提供輔導及臨床服務。第二階段 (1987 至 1989 年)，當局加強了宣傳和教育活動，並製作了電視宣傳短片。自 1990 年開始，一個中央愛滋病顧問委員會被委任後，愛滋病計劃的統籌工作便透過該顧問委員會進行。過去數年，社會人士的參與大大增加。1993 年 4 月，愛滋病信託基金成立，並得到政府一筆三億五千萬元的款項，用作向於 1985 年之前因輸入受感染血液/血液製品而感染愛滋病毒的人提供恩恤金，及支持在香港推行有關愛滋病的教育及服務計劃。

4. 自 1984 年於香港發現首宗感染愛滋病毒的個案後的十年期間，香港發展的防治愛滋病計劃與世界衞生組織及國際社會的策略是一致的，且顧及了本地環境的獨特因素。

目標、先決條件及原則

5. 香港愛滋病防治計劃是基於世界衞生組織及全球愛滋病政策聯盟的目標制定，目標如下：

- 防止愛滋病毒感染
- 減低愛滋病對受影響人士及社會造成的負面影響
- 減低社會對愛滋病患者的歧視及提倡保障人權和人類的尊嚴
- 發展及加強世界各地的聯繫，對抗愛滋病毒感染及愛滋病，從而促進人類的健康

6. 要實施有效的愛滋病防治計劃需要三個先決條件，包括 (一) 足夠的資訊及教育發展；(二) 臨床及支援服務及 (三) 積極及鼓勵性的社會風氣。該等先決條件是建基於以下的主要原則：

- 不歧視的態度
- 負責當局在政策制定及推行上的承擔
- 將計劃納入現行的醫療及社會體制
- 持續的努力
- 社會人士的團結精神

愛滋病防治策略概述

7. 香港的愛滋病防治策略包括四個基本的部份 (一) 防止愛滋病毒的傳播 (二) 對受愛滋病毒感染 / 愛滋病患者提供服務 (三) 監測和控制及 (四) 促進在預防及治理愛滋病毒感染 / 愛滋病方面所需的夥伴關係。

8. 我們的預防策略針對傳染愛滋病毒的三個主要途徑：透過性接觸傳染；血液傳染及母嬰傳染。毫無疑問預防透過性接觸傳染愛滋是整體預防策略中最重要的部份。預防策略包括：提供資訊及教育，以達致行為上的改變；及早診斷愛滋病毒感染和愛滋病；治療透過性接觸傳染的疾病；及發展針對社會各階層的愛滋病教育計劃。預防婦女透過性接觸感染愛滋病毒是減低母嬰傳染的一個最重要方法。

9. 愛滋病毒可能在以下情況透過血液傳染：(一) 吸毒者之間共用注射器；(二) 輸入受感染的血液或血液製品；及 (三) 在醫療程序中意外受傷。這三者之中，透過共用注射器傳染愛滋毒的潛在危險顯然最大。長遠目標應在於減低對精神科藥物的需求，中期目標是減少以注射方式吸毒，並須輔以一個即時目標，即減低因注射而感染愛滋病毒的危險。

10. 社會對受愛滋病毒感染/愛滋病患者需要提供照顧，以減輕身體上及心理上的痛苦。愛滋病毒/愛滋病的預防及治理活動須同步進行，以收相輔相承之效。由於愛滋毒感染是一種不能治癒的慢性疾病，並被很多社會人士視作恥辱，因此必須發展適當的臨床及支援服務。這些服務必須是在愛滋病毒感染/愛滋病患者的能力負擔範圍之內，並能容易索取，持續供應，更須切合他們的需求。

11. 為能更清楚了解愛滋病毒感染/愛滋病的各方面影響，進行流行病學監測是必須的。愛滋病毒感染監測是一項流行病學的工作。監測的方法應以取得準確分佈情況為目標，及需盡量減少對個人或社會造成不良的後果。不論在任何情況下，香港均不應推行強制或例行性的愛滋病毒檢驗。為了加強保密，目前有關愛滋病毒感染/愛滋病的呈報是透過自願方式進行。將來香港並會推行行為上的監測作為輔助計劃，以協助預測愛滋病毒感染在香港蔓延的情況。

12. 最後，顆伴關係是整體愛滋病策略的另一個重要部份。為達致一個互相協調的防治計劃，社會人士的參與和國際間的合作均是必須的。特別值得一提的是：由愛滋病毒感染/愛滋病患者成立或為該等人士設立的機構所作的貢獻已取得普遍的承認。

照顧受愛滋病毒感染/愛滋病患者的需要

13. 受愛滋病毒感染的人，約 50%會在十年後患上愛滋病。一如其它疾病，豫後將視乎當地有否提供足夠醫療服務以及病人是否容易獲得該等服務而定。

14. 在香港，愛滋病毒感染/愛滋病問題和其他地方一樣均面對以下的情況：它對處於工作年齡的年青人造成重大的衝擊；它被社會人士視為恥辱，這反映了保密方面的重要性。目前，約半數已呈報的愛滋病毒感染個案 (包括約 80-90%的愛滋病個案) 均使用公共機構所提供的服務。雖然目前的數目仍小，但在未來數年對該等服務的需求將會逐漸增加。

15. 我們必須為受愛滋病毒感染者發展一套有各方面互相配合的聯繫制度，而此制度應在公共服務中獲得優先處理。我們必須確保醫院/診所(不論是公營或私營)不會將受愛滋病毒感染/愛滋病患者拒諸門外。在向受愛滋病毒感染/愛滋病患者提供切合他們需要的綜合服務方面，必須持之以恆，並採用一個以社區為本，有各專科人士參予的模式進行。

16. 我們須為受愛滋病毒感染者提供門診、住院、社會支援、輔導、轉介以及協調等各項服務。提供服務的系統需輔以職員培訓計劃及制定不同方案，以處理各項與愛滋病有關的問題。此外，若假定愛滋病仍會繼續蔓延，則受愛滋病毒感染/愛滋病患者的人數將會迅速增長，而該系統亦須具備靈活性，以應付有關的需求。

愛滋病的社會政策

17. 愛滋病毒感染 – 本身作為一種疾病，直接影響受感染者，而由於與愛滋病有關的行為、態度及政策的問題廣泛，更會間接地影響社會上每一個人。因此，預先採取行動，為香港社會作好準備，應付愛滋病毒感染/愛滋病帶來的衝擊是必須的。一個有意義的愛滋病社會計劃目標在於防止愛滋病毒的傳播，及培養社會人士對受愛滋病毒感染/愛滋病患者採取支持及關懷的態度。

18. 愛滋病毒感染/愛滋病與行為有密切關係。一個積極的社會環境，能幫助及支持社會人士的行為轉變。這樣的社會環境，包括：

- 社會和同輩群體均認同安全性行為的重要性。
- 消除一切社會障礙，廣泛宣傳採用安全性行為的信息(包括推廣安全套的使用)
- 社會上各階層包括「邊緣人士」均獲得資訊/教育及健康服務。
- 社會(包括政府及市民)對愛滋病教育計劃的堅定支持。

19. 對於大眾所關注的問題(如愛滋病)，傳播媒界具備很大的影響力，而傳媒工作應與為社會上不同人士舉辦的健康教育計劃互相配合。政府將繼續承擔策劃宣傳活動，以提高市民對愛滋病的關注及促進愛滋病教育的推行。

20. 當局應向處於性活躍年齡的青少年提供有關的資訊/教育，以預防他們感染經由性接觸傳染的疾病。該等計劃及其它關於性及行為問題(包括濫用藥物問題)的計劃應在學校提供，並合併於其它青少年活動計劃之中。

21. 愛滋病毒不會透過一般的日常接觸傳播，故此受感染的學生、教師或僱員都不會在學校或工作場所對他人構成威脅，而學校及工作場所都是提高一般人對愛滋病的認識及培養他們支持受感染人士的理想環境。另外，按世界衞生組織的建議制定一套不歧視政策亦是十分重要的，尤其不應規定僱員在受聘前及在職時接受例行愛滋病毒測試。

22. 女性受愛滋病毒感染的情況受到關注，不論在社會因素或生理方面，女性都較容易受到感染，故此應該為女性提供有關愛滋病毒感染/愛滋病的教育，並用女性可接受的形式推行，以確保她們可以獲得這些知識。在產前檢查中，加入例行的愛滋病毒抗體檢驗是不適宜的。而所有在愛滋病毒抗體測試中呈陽性反應的母親，應該在準備懷孕之前獲得輔導，使她們知道自己可能會將愛滋病毒傳播給下一代(機會率為百分之十五至四十)。最後的決定應該以母親的選擇作為依歸。

23. 另外，兒童亦是社會上會受感染的一群。兒童受愛滋病毒感染的問題應該從健康、家庭及社會等各方面加以正視。有關不歧視及保密的一般原則同時適用於兒童及成人，而由於所涉及的臨床、心理及社會問題獨特，故此需要一群包括多個專家的工作隊伍，以便能夠有效率地提供優良服務。

24. 同性戀者曾被視作有較大機會受愛滋病毒感染的一群。科學及流行病學方面的研究證實，受愛滋病毒感染的機會是與高危險行為有關，而並非是同性戀本身。有關不歧視的一般原則同樣適用於同性戀者，而且同樣須為他/她們提供適當的教育。

25. 受愛滋病毒感染的情況並非局限於某個國家或種族。就愛滋病毒傳播方面，人口遷移(包括移民、旅客及難民)本身雖然涉及各個愛滋病毒感染率不同的國家，但在醫學上並無證據顯示這是直接傳播愛滋病毒的途徑。不過，遷移的人士應該獲得有關愛滋病毒感染/愛滋病的資料，以及獲告知那些行為可能會導致其受愛滋病毒感染。至於限制外遊、簽發證書(證明有關人士並無受愛滋病毒感染)及替旅客進行例行檢驗等措施，由於不能預防愛滋病毒傳播，故此不應實施。

26. 個別人士並不會因為參與體育活動而受愛滋病毒感染。無論在醫學或公眾衞生方面，都沒有足夠理由證明須規定有關人士在參與體育活動之前接受愛滋病毒檢驗。在預防由血液引起的疾病(包括愛滋病毒傳染)，採取一般性的衞生措施已經足夠。

27. 血友病患者受愛滋病毒感染是一項特殊的情況，不論在生理、社交或心理方面對他們都造成重大影響。有關方面應該為患者及其家人提供適當的醫療及支援服務，以及確保他們得以使用該些服務。另外亦須確保所供應的血液製品符合安全標準，以防止同類悲劇重演。

28. 在世界各地，相對於性接觸，愛滋病毒在醫療程序中傳播的機會極微。在這一方面，最有效的預防方法，是採用「一般性」(universal precaution) 的措施，即視所有人的血液及體液都有傳染性，採用同樣的處理方法。

29. 如果醫護人員懷疑自己受到感染，應該接受輔導及愛滋病毒抗體測試。較諸強制測試，自願接受測試是鼓勵可能受感染人士尋求輔導及適當治療的最佳方法。一般來說，醫護人員無須向病人/僱主說明其受愛滋病毒感染。如果須表明情況，必須是按需要而定，而且須獲有關的醫護人員同意。

30. 負責診治受愛滋病毒感染的醫護人員的主診醫生，應該就治理問題及是否須更改有關醫護人員的工作範圍等事宜，徵詢由衞生署署長成立的專家小組的意見。如果主診醫生就工作範圍變更事宜向受愛滋病毒感染的同事作輔導後，知道有關同事並沒有遵行其意見，致令病人受到威脅，便有責任通知有關的專業組織(醫務委員會/牙醫管理委員會)，以便採取適當行動。

31. 在 1985 年 8 月之前，香港尚未引入愛滋病毒測試，輸入受愛滋病毒污染的血液是當時的其中一種傳播途徑。為減少這種傳播機會，當局現時向市民推廣自願捐血的同時，並教育高危人士自行放棄捐血；並對捐獻血液進行精確檢驗；以及只會在絕對有需要才替病人輸血/血製品。當局亦勸籲市民切勿為測試血液是否含有愛滋病毒而捐血，因為如果捐血人士受到感染，但處於「空窗期」(window period)，則血液測試會顯示假陰性反應，在不知情的情況下，輸入其血液的人士亦有機會受到感染。「空窗期」是指受愛滋病毒感染後，身體未形成足夠被檢驗出來的愛滋病毒抗體之前的一段時間，通常不超過三個月。

針對高危行為人士的政策

32. 毒品使用人士共用注射器作靜脈注射，是愛滋病毒在世界各地傳播的主要途徑之一。根據本港毒品使用者自願接受測試及以非聯繫不記名檢查*方式進行的研究結果顯示，受愛滋病毒感染的情況在香港毒品使用人士中並不普遍。預防愛滋病毒在毒品注射人士之間傳播的最佳措施，是提供有關知識及教育/輔導，使其瞭解如何能夠減少受感染的機會。

33. 本港提供不同形式的藥物治療及康復服務，以應付所有有意參加戒毒計劃的人士的需求。長遠來說，應該在運作及政策制定層面，將戒毒計劃及愛滋病教育配合推行，另外，亦應該致力消除導致新的/清潔的注射器供應不足的障礙，以免助長共用注射器的情況出現。強制毒品使用人士接受愛滋病毒測試是不適當的。

34. 賣淫活動與愛滋病是否有關連，與多項因素有關，包括，有關人士是否有性病、濫用藥物或進行安全性行為，以及社會經濟狀況、性行為和性工作的形式等。事實上，賣淫是遍及全球的現象，香港也不例外。有關方面在作出干預時，應該將焦點集中在減少娼妓(從事性工作以營生的人士)及其顧客在健康上所受到的威脅(包括愛滋病毒感染)，而且應該確保他/她們能夠得到有關的教育資料及服務。

35. 強制娼妓及其顧客接受愛滋病毒抗體測試，以及發給證書證明持有人沒有受感染都是沒有效用的做法。有關方面應向娼妓及顧客致力推廣提供使用安全套。另外亦應將愛滋病教育、支援和預防服務擴展，及合併入這些人士會接觸到的醫療設施中。在這方面，亦應鼓勵非政府機構的參與。

36. 愛滋病毒感染/愛滋病與性病的傳播途徑十分相似，而且兩者都是與高危行為有關。在香港，各項有關性病及愛滋病的工作，必須在治療、預防及控制等方面互相配合，以便提高整體效益、達致彼此在員工訓練及資源發展方面的協調，促使早日研定控制這兩類疾病的新策略。

37. 一旦染上性病或愛滋病毒，患者的名聲往往因而受損，故此應該致力將這種情況消除，以及協助受影響人士獲取有關的知識及使用各項臨床服務。

38. 愛滋病毒感染與被囚禁在監獄有以下兩種關連：(一)囚犯在入獄之前可能曾進行高危行為，(二)而有些囚犯亦會在監獄內進行這類行為(一些海外國家曾接獲這樣的報告)。在香港，囚犯及其他被囚人士享有接受醫療護理的權利，包括預防愛滋病毒傳播的措施。他們不應受到任何形式的歧視。

39. 強制進行愛滋病毒測試是不道德的，而且收效不大，故此應該禁止在監獄實施。另外亦不應因為個別人士受愛滋病毒感染而將其隔離，而有關感染的個人資料亦應該加以保密。

40. 監獄環境是傳達有關愛滋病的資料及教育知識的良機。監獄職員須接受訓練，以便向囚犯及同事灌輸有關愛滋病毒感染/愛滋病的知識。

41. 香港並無特別針對愛滋病毒感染及愛滋病的成文法例。不良醫藥廣告管制條例則列有條文，管制有關宣傳醫療服務的廣告，其中包括了愛滋病。

42. 香港法例第 141 章防止傳染病蔓延(修訂)規例列有條文，規定如果某幾種指定的傳染病在香港出現，便須向當局呈報，但愛滋病毒感染/愛滋病並非該法例附表所列的情況之一。由於愛滋病毒感染/愛滋病的傳播方式不多，而且可能會引起歧視及須鼓勵有關人士自願接受測試及改變其行為，故此傳統的公眾衞生措施未必最為適用。現時，香港已經設有一套自願呈報制度，以便收集有關愛滋病毒感染/愛滋病的流行情況資料。

43. 在香港，如果一個受愛滋病毒感染的人士將愛滋病毒傳染或企圖將病毒傳染給另一個人，或令另一個人有受到感染的機會，現時由於沒有成文法例規範，遇到這種情況，便須根據普通法就個別案件作審判。

44. 保障某人受愛滋病毒感染事得以保密是非常重要的。根據香港人權法案條例第 14 條的規定，任何人之私生活 ……不得受到無理或非法侵擾。香港各國專業團體亦已實施專業道德守則及有關政策，以嚴格遵守有關保密的規定。

45. 至於反歧視方面，當局現正考慮立法，以便令基於別人身體殘障而產生的歧視構成罪行。如有關法例獲得通過，受愛滋病毒感染的人士會在職業、教育、居住地方等方面受到保護。如果沒有這樣的法例而社會上又存有歧視，則須考慮採取所需的行政/法律措施。不過，在糾正人們的歧見方面，公民教育很明顯是擔當著同樣重要的角色。

* 非聯繫不記名檢查(unlinked anonymous screening)是將每個樣本一切可資識別的個人資料刪除(非聯繫)，然後才測試該樣本有否呈現受病毒感染的特徵。世界衞生組織於 1989 年就非聯繫不記名檢查製定國際指引，以監測愛滋病毒感染方面的公眾衞生情況。自 1990 年開始，香港一直採用這項制度。

附錄 I：
愛滋病顧問委員會

香港總督於 1990 年委任愛滋病顧問委員會。該委員會的主席由衞生署署長出任，其職權範圍如下：

1. 關注愛滋病毒感染及愛滋病在本地及海外的趨勢及發展；
2. 就下述事宜向政府提供意見：推行有效的計劃以預防愛滋病、為受愛滋病毒感染的人士提供支援服務，以及進一步就愛滋病防治發展一套全面策略。

愛滋病顧問委員會由三個委員會加以輔助：

(i) 愛滋病教育及宣傳委員會
(ii) 愛滋病科技委員會
(iii) 愛滋病服務發展委員會

以下是愛滋病顧問委員會 1994 至 96 年度的成員名單：

主席：

陳馮富珍醫生，J.P.

會員：

林鉅成醫生，J.P.
吳文瀚教授
徐尉玲女士，J.P.
狄志遠議員
陳黃穗女士，J.P.
關淑華醫生
梁鄧素晶醫生，J.P.
馮志麗女士
夏永豪議員，M.B.E.，J.P.
陳家樂先生
葉蒨文女士
麥潔妮修女
阮文賓醫生
方津生醫生，J.P.
左偉國醫生
羅志強先生
賴福明醫生
劉李麗娟女士
李瑞山醫生

秘書：

郭榮安先生

附錄 II：
查詢電話及地址

1. **衞生署愛滋病熱線** **電話：**780 2211
諮詢及輔導

2. **衞生署愛滋病服務組** **電話：**780 8622
九龍油麻地砲台街 145 **號** **電傳：**780 9580
油麻地賽馬會診所六樓

3. **愛滋病顧問委員會秘書處** **電話：**961 8550
香港灣仔皇后大道東 213 **號** **電傳：**836 0071
胡忠大廈 21 **樓**

4. **非政府機構**

香港愛滋病基金會 **電話：**560 8528
電傳：560 4154

關懷愛滋 **電話：**898 4411
電傳：505 1682

P r e f a c e

A decade has elapsed since the diagnosis of the first case of HIV infection in Hong Kong. In coping with the growing epidemic, a comprehensive AIDS prevention, care and control programme has gradually become established locally. In this context, the Advisory Council on AIDS, since its first appointment by the Governor of Hong Kong in 1990, is the driving force behind development of the local programme. In July 1994, a document titled ***"Strategies for AIDS prevention, care and control in Hong Kong"*** was prepared to reflect the Council' s overall AIDS policy. The *executive summary*, which is the abridged version of the document, is presented here for the reference of the public.

The *executive summary* contains a total of 45 paragraphs, outlining the Council' s recommended strategy in a broad range of issues relating directly or indirectly to AIDS. As AIDS concerns everyone, there are certainly aspects of the summary which are relevant to each community sector in Hong Kong. The mother document should, however, be referred to whenever necessary.

Secretariat
Advisory Council on AIDS

October 1994

Strategies for AIDS prevention, Care & Control in Hong Kong

- an executive summary

1. AIDS stands for Acquired Immunodeficiency Syndrome. It represents the late stage of human immunodeficiency virus (HIV) infection which causes progressive depletion of a person's defence system. Since the diagnosis of the first AIDS cases in the U.S.A. in 1981, there has been a remarkably rapid growth of the epidemic in every inhabited corner of the world. To date, an estimated 17 million people have been infected with the virus, of which three million have progressed to AIDS. In Hong Kong, nearly 500 cases of HIV infection have been reported to the Department of Health, but the actual number is probably a few thousand.

2. On a global scale, the majority of the HIV infections have been contracted through sexual contacts. Because of its complexities and social implications, a comprehensive prevention, care and control programme was clearly needed. In 1986, the World Health Organization (WHO) established the Global Programme on AIDS to initiate, support and coordinate AIDS work at national and international levels.

3. In Hong Kong, development of our AIDS programme has gone through three phases: The initial phase (1984-1986) saw the establishment of an expert committee within the Medical and Health Department with the emphasis placed on safeguarding blood supplies. A counselling clinic based at Queen Elizabeth Hospital started operation and HIV tests became available to people at risk of infection. In the second phase (1987-1989), intensified publicity and education programmes were launched and Television Spots (APIs) were produced. From 1990 onward, the programme was consolidated through the appointment of a central Advisory Council on AIDS. Community participation has become substantially increased in the last few years. In April 1993, the AIDS Trust Fund was established with HK$350 million given by the government to provide ex-gratia payment to people infected with HIV through transfusion of contaminated blood/blood products before August 1985, and to support HIV/AIDS education and service projects in Hong Kong.

4. In the ten year period since HIV infection was first diagnosed in Hong Kong in 1984, strategies on its prevention, care and control were developed in line with those established by WHO and the international community, taking into consideration factors unique in the local context.

Objectives, Pre-requisites and Principles

5. The objectives of Hong Kong's AIDS programme, adapted from WHO and the Global AIDS Policy Coalition, are:

- to prevent HIV infection
- to reduce the negative impacts of the disease on affected individuals and society
- to reduce societal discrimination and promote respect for human rights and dignity
- to develop and strengthen global solidarity against HIV/AIDS, thereby advancing the health of all people

6. The pre-requisites for an effective AIDS programme are (a) information and education; (b) clinical and support services and (c) a supportive environment. These are built on the following key principles:-

- non-discrimination
- commitment at operational and policy levels
- integration into existing health and social structures
- sustained effort
- solidarity

An Overview of the AIDS Strategy

7. There are four basic components to Hong Kong's AIDS strategy (a) prevention of HIV transmission (b) care of people with HIV/AIDS (c) surveillance and control and (d) partnership in HIV/AIDS prevention and care.

8. Our prevention strategy targets the 3 major routes of HIV transmission: sexual transmission, blood-borne transmission and perinatal transmission. Prevention of sexual transmission is indisputably the most important component of the overall prevention strategy. There should be provision of information and education to bring about behavioural modification, provision for early detection and treatment of sexually transmitted diseases, and opportunities for developing educational programmes tailored to meet the needs of various sectors of the community. Prevention of sexual transmission of HIV in women is primarily the single most important tool in reducing the risk of perinatal transmission.

9. Blood-borne transmission of HIV may occur through (a) needle-sharing among intravenous drug users, (b) transfusion of contaminated blood or blood products and (c) accidental injury in health care settings. Of the three, the potential for HIV to spread through needle-sharing is by far the highest. The long term goal should be the reduction of demand for psycho-active drugs. Our intermediate goal is set to reduce drug injection, which is backed up by an immediate goal of reducing the risk of injection.

10. AIDS care programmes involve the relief of physical and psychological suffering. It is necessary for HIV/AIDS prevention and care activities to be conducted simultaneously - the effectiveness of one usually enhances the other. Since HIV infection is a chronic illness with no cure and yet which carries significant social stigma, clinical and support services must be developed appropriately. Such services should be affordable, accessible, continuous and responsive to the needs of people living with HIV/AIDS.

11. To better understand the dimension and impact of HIV/AIDS, epidemiological surveillance activities are essential. HIV surveillance is an **epidemiological** exercise. The design of HIV surveillance methodology should maximize the likelihood of obtaining useful and accurate epidemiological information about the distribution of HIV/AIDS in the community and minimize the emergence of adverse individual or community consequences. In this context, under no circumstances should mandatory or compulsory HIV tests be performed in Hong Kong. Reporting of HIV/AIDS is conducted in a voluntary system to better preserve confidentiality. In the future, behavioural surveillance will become a supplementary programme to help predict the trend of HIV progression in Hong Kong.

12. Finally, partnership is another key component in the overall AIDS strategy. Community participation and international cooperation are essential in bringing about a coherent prevention and care programme. In particular, the credibility of associations formed by or for persons with HIV/AIDS is acknowledged.

Meeting the Needs of People with HIV/AIDS

13. AIDS originated as a clinical problem. We know that about 50% of the HIV-infected persons will develop AIDS after a period of ten years. Like any disease the clinical outcome is dependent on the availability and accessibility of health services in the locality.

14. In Hong Kong, as is the case elsewhere, HIV/AIDS is characterized by its impact on young people in the working age range, its associated social stigma, and the importance of preserving confidentiality. To date, about half of all reported cases of HIV infection (including some 80-90% of AIDS cases) have used the services provided in the public sector. Although numbers are small at present, demands for such services will increase steadily in the years to come.

15. Development of a coordinated HIV management system should be prioritized in the public service. We need to ensure that no hospitals/clinics (public or private) would turn HIV/AIDS patients away. Continuity of care is essential, and a multi-disciplinary, community-based approach should be adopted in the delivery of comprehensive care in responding to the needs of people living with HIV/AIDS.

16. HIV management encompasses out-patient treatment, in-patient treatment, social and support services, counselling, referrals for specialists' advice, and coordination of all available services. The system is backed up by appropriate staff training programmes and establishment of protocols for specific issues relating to HIV management. The system should have the built in flexibility of accommodating a rapid increase in the number of people with HIV/AIDS on the assumption that the epidemic will continue to grow.

AIDS Policy in the Community

17. HIV infection affects everyone in the society - either directly as a disease, or indirectly on AIDS-related behaviour, attitudes, and policy. An anticipatory approach is therefore crucial to prepare the community in Hong Kong for HIV/AIDS and its impact. The objectives of a meaningful community AIDS programme are to prevent HIV transmission and to foster a supportive and caring attitude towards those infected.

18. HIV/AIDS is closely related to behaviour. Behavioural modification is encouraged if the environment is supportive of such change. A supportive environment means :

- Perception of safer sexual practice as the norm in the peer group or in the community.
- Absence of barriers to the dissemination and adoption of safer sex messages, including condom promotion.
- Accessibility of information/education and health services to all in the community, including ' marginalized' people.
- Firm public support for AIDS educational programmes

19. The mass media can be influential in setting the agenda for public issues like AIDS. Media initiatives should be supplemented by more targeted health educational programmes for individual community group. The government remains committed to organizing media campaigns, the themes/strategies of which shall provide a strong impact in arousing awareness and creating a climate for educational intervention to operate.

20. Adolescents and youth approaching a sexually active and conscious age require information/education to protect them from exposure to sexually transmitted diseases. Such programmes, together with others centering on sexuality and behavioural issues (including drug use), should be provided in schools and integrated in youth initiatives in the wider perspective.

21. HIV is not spread by casual, everyday contact. Infected students, teachers or staff/employees do not pose a risk to others in the school and work place settings. Both the school and the workplace are good fora for promoting understanding of HIV/AIDS and in fostering a supportive attitude to those infected. The development of a non-discriminatory policy is crucial, as recommended by the WHO. In particular, pre-employment and in-service routine HIV tests should not be introduced.

22. HIV infection in women is a matter for concern because of women's general vulnerability both socially and biologically. HIV/AIDS education should be available and accessible to women and presented in a way that is acceptable to the female population. Antenatal HIV screening is not recommended as a routine investigation. All HIV positive mothers should be counselled on the risk of vertical transmission of HIV to their babies (15%-40%) before embarking on pregnancy. The mother's decision is overriding.

23. Children, too, are vulnerable members of the society. The issue of paediatric HIV infection should be viewed in health, family and social contexts. The general principles of non-discrimination and preservation of confidentiality apply to children as well as adults. Because of the unique clinical, psychological and social problems involved, the concerted efforts of a multi-disciplinary team is needed for effective and quality services to be delivered.

24. The homosexual community has erroneously been labelled as being at higher risk of HIV infection. Scientific and epidemiological research has confirmed that the risk is linked with the practice of high risk activities rather than of homosexuality itself. The general principle of non-discrimination and the need for providing targeted education applies equally to the homosexual community.

25. HIV infection is not restricted to certain nations or ethnic groups. Human mobility (involving migrants, travellers, refugees) by itself, involving countries with different HIV prevalences, has no medical consequences as far as HIV transmission is concerned. The migrant populations, however, should be informed about HIV/AIDS and the behaviour that puts them at risk of HIV transmission. Travel restrictions, the requirement for HIV negative certificates, and screening of travellers have no prevention effect on the spread of the virus and thus are not introduced.

26. Participation in sport by itself does not put individuals at risk of HIV transmission. There is no medical or public health justification for HIV screening prior to participation in sport activities. General hygienic practices on blood precaution is sufficient in preventing possible transmission of blood-borne pathogens (including HIV) in sport settings.

27. HIV infection in a haemophiliac patient is a unique circumstance carrying great physical, social and psychological implications. It demands that the appropriate medical and support services be available and accessible to those affected and their families. The supply of safe blood products should be ensured to prevent similar tragedies from happening again in the future.

28. The risk of HIV transmission in the health care setting is minimal compared with the dimension of sexual transmission on a global scale. The most effective measures of preventing such transmission from occurring is through adherence to universal precaution.

29. Health care workers should receive counselling and HIV antibody testing if they have reason to suspect that they have been infected. Voluntary rather than mandatory testing is the best way of encouraging at risk individuals to seek counselling and appropriate treatment. It is generally not required to disclose a health care worker' s HIV status to patients/employers. Disclosure, if any, should be made on a need-to-know basis and with consent of the worker.

30. The attending doctor of an HIV-infected health care worker should seek the advice of an expert panel formed by the Director of Health on areas of management and possible need for job modification. The doctor who has counselled an HIV-infected colleague on job modification and who is aware that the advice is not being followed and patients are put at risk, has a duty to inform the professional body(Medical/Dental Council) for appropriate action.

31. Transfusion of HIV contaminated blood was a known route of transmission of the virus before HIV screening became available in Hong Kong in August 1985. To reduce such risk, there is the promotion of voluntary donation with a mechanism for self-exclusion of those with risk of infection, effective blood screening, and the policy of administering blood/blood products only when they are absolutely necessary. The public is advised against giving blood for the purpose of blood testing for HIV because of the slight risk of infecting recipients if infected but serologically HIV negative blood is obtained during a ' window period' – the time (usually less than three months) before an HIV – infected person develops detectable HIV antibody in the blood.

Policy for Communities Practising High Risk Behaviours

32. The sharing of injection equipment by intravenous drug users constitutes a major route of HIV transmission on a global scale. In Hong Kong HIV seroprevalence has been low in studies involving voluntary testing and unlinked anonymous screening* of local drug users. Information and education/counselling on risk reduction are the best measures of preventing HIV transmission among drug injectors.

33. Different modalities of drug treatment and rehabilitation services are available to meet the demand of all who wish to enter into the programme. Better integration of drug rehabilitation and the AIDS programme should be developed in the long term on the operational and policy levels. Barriers which limit the availability of new/clean injection equipment and thus encourage sharing should be removed. Mandatory HIV testing is not warranted for drug users.

34. The relationship between prostitution and HIV hinges on a range of factors including the incidence of sexually transmitted diseases, drug abuse, practice of safer sex, socio-economic conditions, sexual behaviour and forms of sex work. Prostitution occurs virtually worldwide and Hong Kong is no exception. Intervention should be focused on decreasing health risks (including risk of HIV) to prostitutes (commercial sex workers) and their clients, and that access to information and services should be ensured.

35. Mandatory HIV testing of commercial sex workers (and clients) is not practised because of its ineffectiveness. The same is true for the issuing of HIV-free certificates., The proper use of condoms and their availability to commercial sex workers and clients should be promoted without restriction. HIV education, support and prevention services should be provided, expanded and integrated into the overall health care system for commercial sex workers and clients. Participation of non-governmental organizations is encouraged.

36. HIV/AIDS and sexually transmitted diseases(STD) bear remarkable similarity in their route of transmission and their link to high risk sexual behaviour. Coordination of STD and AIDS programmes in Hong Kong is crucial. This should cover not only treatment but prevention and control. Such coordination should enhance the overall effectiveness of programme implementation, serve the common goal of staff training and resource development, and promote the development of innovative strategies for control of the two diseases.

37. Efforts should be made to remove the stigma attached to people with STDs and/or HIV/AIDS, and to facilitate access to education and clinical services.

38. HIV infection and the prison setting are related in two ways: the background of high risk behaviour before incarceration of the prison inmates, and the practice (reported in some countries) of such behaviour in the prison itself. The wider policy adopted in Hong Kong applies equally to inmates of prisons and other institutions: they have the right to health care, including preventive measures against HIV, without discrimination in any form.

39. Compulsory HIV testing is unethical and ineffective, and should be prohibited in prisons. There should not be segregation based on an individual's HIV status, and that confidentiality should be preserved.

40. The prison environment provides unique opportunity for AIDS information and education to be disseminated. Prison staff should be trained to provide HIV/AIDS education to inmates as well as colleagues.

AIDS and the Law

41. In Hong Kong, there is no legislation dealing specifically with HIV infection and AIDS. The Undesirable Medical Advertisement Ordinance provides for the control of advertisements publicizing medical treatment, including that of AIDS.

42. The Prevention of Spread of Infectious Diseases (Amendment) regulation Cap 141 provides for the notification of selected infectious diseases in Hong Kong: HIV/AIDS is not one of the conditions listed in the schedule. Traditional public health measures may not be the best for HIV/AIDS because of its limited modes of transmission, the risk of discrimination and the need to encourage voluntary testing and changes in behaviour. A voluntary reporting system is already in place for the collection of epidemiological data on HIV/AIDS.

43. In Hong Kong, there is no legislation making it an offence for a person with HIV to transmit or attempt to transmit the infection to another, or to expose another to the risk of infection. Should this occur, individual case would have to be judged according to the Common Law.

44. The protection of confidentiality in relation to a person's HIV status is critical. According to Article 14 of the Hong Kong Bill of Rights Ordinance, it provides that no one shall be subjected to arbitrary or unlawful interference with his privacy …… Professional bodies in Hong Kong have also adopted ethical codes of practice and policy enforcing strict compliance with the rule of confidentiality.

45. As regards anti-discrimination, legislation is being considered which would make discrimination on the grounds of disability an offence. People with HIV/AIDS would be protected in areas such as employment, education, accomodation etc. under the legislation. In the absence of such legislation, administrative/legal measures would need to be considered if discriminatory conducts are practised. It is clear, nevertheless, that civic education is equally important in effecting changes to discriminatory practices.

* **Unlinked anonymous screening** is the testing of specimens for markers of infection after elimination (unlinking) of all personal identifying information from each specimen. International guidelines on undertaking unlinked anonymous screening for public health surveillance of HIV infections were established by the World Health Organization in 1989, and the system has been adopted in Hong Kong since 1990.

Appendix I :

The Advisory Council on AIDS

The Advisory Council on AIDS (ACA) was appointed by the Governor of Hong Kong in 1990. It is chaired by the Director of health. The terms of reference of the ACA are:

1. To keep under review local and international trends and development relating to HIV infection and AIDS;

2. To advise Government on effective programmes for prevention of AIDS and support services for HIV infected persons and on further development of a comprehensive strategy on AIDS.

The ACA is underpinned by three committees, namely:

(i) Committee on Education and Publicity on AIDS
(ii) Scientific Committee on AIDS
(iii) AIDS Services Development Committee

The following is a list of members of the ACA for the term August 1994 – July 1996:

Chairman: Dr. Margaret CHAN, *JP*
Members: Dr. the Honourable Conrad LAM Kui-shing, *JP*
Professor NG Mun-hon
Ms. Carlye TSUI Wai-ling, *JP*
The Honourable TIK Chi-yuen
Mrs. Pamela CHAN WONG Shui, *JP*
Dr. Margaret KWAN Shuk-wa
Dr. Susan LEONG, *JP*
Ms. Esther FUNG
The Honourable Timothy HA, MBE, *JP*
Mr. Walter CHAN Kar-lok
Miss Sally YEH
Sister Maureen McGINLEY
Dr. Patrick YUEN Man-bun
Dr. David FANG Jin-sheng, *JP*
Dr. Homer TSO Wei-kwok
Mr. LAW Chi-keung
Dr. Lawrence LAI
Mrs. Shalley LAU
Dr. LEE Shui-shan
Secretary: Mr. Aaron KWOK

Appendix II :

Useful Addresses & Telephone Numbers

1. AIDS Hotline (Department of Health) Tel: 780 2211
information & counselling

2. AIDS Unit, Department of Health Tel: 780 8622
5/F Yaumatei Jockey Club Clinic Fax: 780 9580
145 Battery Street, Yaumatei
Kowloon, Hong Kong

3. Advisory Council on AIDS Secretariat Tel: 961 8550
21/F Wu Chung House Fax: 836 0071
213 Queen's Road East, Wanchai
Hong Kong

4. Non-governmental organizations

Hong Kong AIDS Foundation Tel: 560 8528
Fax: 560 4154

AIDS Concern Tel: 898 4411
Fax: 505 1682