

Internal Assessment Report

**A Review of the HIV/AIDS Situation
and the Programmes on its Prevention,
Care and Control in Hong Kong**

April 1998

This Internal Assessment Report is produced by the Secretariat of the Hong Kong Advisory Council on AIDS under the supervision of the Review Steering Committee. The research and preliminary drafts were made between January and March 1998 by a research team composing of Dr SS Lee, Dr Teresa MY Choi, Dr KH Wong, Dr Kenny CW Chan and Dr Tinny TY Ho, with the support of Secretariat staff based in Red Ribbon Centre. The synthesis and final editing were undertaken by Dr SS Lee and Dr Teresa MY Choi. The research team acknowledges the support of all Government units/departments and non-governmental organizations for their input in the forms of advice, information and participation in the survey described.

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Hong Kong Advisory Council on AIDS**

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April 1998

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A Review on the HIV/AIDS Situation and the Programmes on its Prevention, Care and Control in Hong Kong - the Internal Assessment Report

Amendments:

Executive Summary

1. Page 9, Para 31 line 1 should read:

“The Hong Kong Community spent HK\$72.946 million in the year 1997 ...”

I. HIV/AIDS Surveillance & Situation

1. Page 13, (a) sexual transmission, para 2 line 2 should read:

“This corresponds to a new case detection rate of 0.7 per 1000 tests..”

2. Page 30, (b) Main routes of HIV spread, line 8 should read:

“The HIV prevalence in methadone users is less than 0.04%.”

VI. Finance

1. Page 23, 6.6.2 (a) Growth in programme costs line 1 should read:

“The Hong Kong Community spent HK\$72.946 million in the year 1997 ...”

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Internal Assessment Report

**A review on the HIV/AIDS situation and the programmes
on its prevention, care and control in Hong Kong**

Executive Summary

Advisory Council on AIDS 1998

Internal Assessment Report
of
***A Review of the HIV/AIDS Situation and the Programmes on
its Prevention, Care and Control in Hong Kong***

EXECUTIVE SUMMARY

Introduction

1. This *Internal Assessment Report* documents the HIV/AIDS situation and the programmes on its prevention, care and control in Hong Kong. It has been compiled as a research document by the Advisory Council on AIDS as part of the review to assess the current situation and programmes, identify indicators for systematic evaluation, and to recommend on the future strategic direction of the local programmes. A final report will be published following assessment by a team of external consultants in the second part of the Review.
2. In preparing this report, data have been collected through the conduction of a questionnaire survey, results of which are supplemented by an examination of other reports, research articles, in-house papers and other publications. Under the supervision of a Steering Committee appointed by the Council, consultations had been held, and visits made to organisations, amidst numerous research meetings organised for the required studies. The Internal Assessment was conducted from January to March 1998.
3. Assessment is made centering on two main objectives of the local programmes: preventing spread of HIV infection, and reducing the negative impacts of the infection on individuals and society. It begins with an evaluation of the surveillance system, which leads to an assessment of our current understanding of the situation and trends. Three following chapters present the core programmes – on HIV prevention, clinical and support services and the promotion of a supportive environment. The last two

chapters review the programme structures and the financial support to the programmes.

HIV/AIDS Surveillance and Situations (Chapter I)

4. Our understanding of the HIV/AIDS situations hinges on the operation of a surveillance system composing of voluntary reporting, serosurveillance studies, and disease registries. Maintained by the Department of Health AIDS Unit, the system has, in recent years, grown to incorporate data on STD surveillance, plus the input of a number of research initiatives on socio-behavioural factors, modelling, and the monitoring HIV/AIDS control.

5. AIDS (acquired immune deficiency syndrome) represents the late stage of HIV infection. AIDS surveillance data portray the size of clinical load required in our society, and reflects the HIV patterns in the last five to ten years. The cumulative number of reported AIDS cases stands at 309 as of the end of 1997. *Pneumocystis carinii* (30.6%) remains the commonest AIDS defining illness. *Penicillium marneffeii* (9%) infection is a unique condition demanding the attention of local clinicians.

6. An understanding of the HIV situation is crucial in the design of relevant prevention programmes and the provision of services to those infected. A modelling study had suggested a prevalence of 1000 - 1500. Sexual transmission, notably heterosexual contacts, is the commonest mode of HIV spread. Transfusion of contaminated blood/blood products was an important route of HIV transmission before 1985 when safer alternatives were not available. Infection through needle-sharing in injecting drug users has been rare. The risk of perinatal infection is genuine but small. So far only four babies have been known to have contracted HIV from their mothers.

7. Behavioural risk factors are important in predicting the future trends of the epidemic. STD data form also one useful set of information in assessing the level of high risk sexual behaviours. There have been a rising incidence of STD, including syphilis, in the last years. A varying rate of not using condoms is reported in STD

patients (20%-30%), commercial sex workers (50% with non-paying partners), marginal youth (28%), and cross Hong Kong-Mainland border travellers (about one third). The use of commercial sex in cross-border travellers has been documented in various studies. The needle-sharing rate in injecting drug users is low.

8. Other means of monitoring HIV/AIDS control are being explored in the last years. Based on the results of a pilot study, a sentinel risk behavioural surveillance system is under development. Benchmark studies on awareness and attitudes have been conducted by researchers, on the general public and selected communities. The possibility of establishment programme effectiveness indicators has been studied by the advisory Council on AIDS. The objectives are to utilise information generated from surveillance and research to facilitate public health HIV/AIDS programme development.

HIV Prevention and Health Promotion (Chapter II)

9. HIV prevention and health promotion were initiated by the Government, followed by their development by community organisations in the recent years. These programmes generally cover both the contexts of preventing HIV spread and promoting acceptance towards those infected. The latter echoes the objective of minimising the negative impacts of HIV/AIDS. Five major programme foci are identified: (a) enhancing AIDS awareness, (b) prevention of HIV transmission, (c) reducing blood-borne transmission of HIV, (d) reducing perinatal transmission, and (e) promoting acceptance towards people with HIV/AIDS. Four other settings which traverse the five programme foci have received attention: women, prison inmates, mobile populations and young people.

10. Of the five programme foci, much emphases have been placed in arousing public awareness and reducing sexual transmission. The promotion of acceptance of people with HIV/AIDS has come as a natural extension of existing AIDS education programmes. Over the years, a multimodality approach has been adopted by the Government and the community in their organisation of activities. There is wide

community participation involving government units, NGOs, academics, professionals and community leaders.

11. A large majority of activities have utilised population-based or group-targeted approaches. Public awareness campaigns have been commonly staged by the Government and NGOs in numerous forms – media campaigns with, for example, TV APIs (announcements of public interest), publicity events, competitions and exhibitions. While awareness has improved, negative attitudes and misconceptions still prevail. Group-targeted programmes have been organised, but the approach is limited by its relevance in people who can be organised in a group setting. The commonest formats are workshops, training courses and group talks. There has been little development of individual basis intervention to target people practising high risk behaviours. While individual counselling is offered mostly in clinic settings, very little outreach activities have so far been organised in the community. Examples are outreaching activities for homosexual men and commercial sex workers.

12. Two different but overlapping pathways of the organisation of AIDS education have gradually evolved in the last years. One pathway centers on the work of the Committee on Education and Publicity on AIDS, the other through the efforts of individual NGO or the collaboration of NGOs.

13. AIDS prevention and education have also been integrated in other programme areas, notably sex education, education on drug use and harm reduction, womens' s health, and STD prevention. Their development is at a slower pace than that of other more focused AIDS education activities. AIDS programme for injecting drug users is maintained as a small component of the pre-existing mechanisms of harm reduction and drug rehabilitation.

Clinical and Support Services (Chapter III)

14. With the diagnosis of HIV and AIDS, new specialised services have become established, alongside mobilisation of pre-existing services to care for those infected. HIV/AIDS care programme is now made up of three core components: (a) clinical

services, including designated services and non-designated services, (b) laboratory facilities, and (c) support services. The services are supported by a source mechanism of voluntary HIV testing, and two parallel systems – one for upholding the standard of care and the other on the practice of infection control. Over the years, a small core of expertise has been developed in the provision of HIV/AIDS care in Hong Kong.

15. The Department of Health AIDS Unit and Queen Elizabeth Hospital each operates a designated clinical service, now with a total active caseload of about 400. Other non-designated services of public hospitals are largely responsible for the provision of acute care and hospital admissions. Preliminary data suggested that inpatient workload has reached a plateau in the last two years, while the need for specialised outpatient services has increased rapidly. Private sector is taking care of a very small number of patients. Laboratory tests for HIV diagnosis and CD4 monitoring are largely provided in the public sector, with the Department of Health Virus Unit responsible for a majority of HIV antibody tests.

16. Combination antiretroviral therapy is provided largely through the two designated clinical services, and is now regularly prescribed to patients indicated for the therapy. Antiretroviral treatment is also provided to HIV infected pregnant women to reduce their chance of transmitting HIV to their babies, and following significant exposure in needle-stick injuries. The scale of its applications in the latter circumstances is small.

17. Voluntary anonymous HIV testing is provided through AIDS Unit and Hong Kong AIDS Foundation, using the same laboratory support of the Department of Health Virus Unit. Free HIV testing is also provided to all clients of Social Hygiene Service (STD clinics), which looks after 20% of all STD patients in Hong Kong. HIV tests are also available through the private sector, but detailed statistics are not available. Overall, 22% of HIV diagnoses reported to the Department of Health originate in the private sector.

18. Three forms of support services can be distinguished – (a) home-based, (b) centre-based, and (c) institution-based. Designated AIDS NGOs are responsible for running a significant proportion of these services. Hospice services provided by

Society for AIDS Care's LookOut project, Haven of Hope Hospital and Our Lady of Maryknoll Hospital form the main activities of institution-based support services. The effort of medical social workers is involved in the mobilisation of community resources for people with HIV/AIDS, among their provision of direct services.

19. Preparation and promulgation of management guidelines have been one important role of Scientific Committee on AIDS and Department of Health in upholding the standard of service provision. Training of health professionals at undergraduate and postgraduate levels are developed but a systematic approach is lacking. The input of the two designated clinical services is often involved. Academic institutions have so far not assumed a leadership role in the development of training and conduction of research.

Promotion of a Supportive Environment (Chapter IV)

20. A supportive environment is necessary in the development of effective AIDS prevention, care and control programmes. Three major components of a supportive environment are identified: (a) access to information and services, (b) support for acquisition of protective behaviours, and (c) respect for human rights. The mechanisms of promoting a supportive environment are examined, they are: policy development, legal provision and community action.

21. Policy development follows a process involving trigger, deliberation, generation and promulgation. Legislative Council plays a key role in the debate of issues relating to AIDS. Advisory Council provides policy advice, while the Government promulgates the policies either centrally or through the respective bureaus or departments. A majority of the policies on AIDS have been activities-driven and often in response to crises.

22. AIDS was first brought up as a policy issue at an Adjournment Debate of the Legislative Council in February 1993. In concluding, the then Secretary for Health and Welfare summed up the theme of the Government's policy, which encompasses a multisectoral approach, cultivation of a supportive environment, provision of

prevention and care. More specific policies have been laid down as they relate to prevention and control of HIV/AIDS, and in addressing the needs of those infected. Apart from those established in health care setting (which the Advisory Council on AIDS has promulgated), a majority of these policies have been promulgated through circulars or other documents with limited circulation.

23. Positive impacts have been created on the social environment through legislation. Four important ones are: the Undesirable Medical Advertisement Ordinance, which was amended to include the prohibition of advertisement on AIDS treatment; the Crimes (Amendment) Ordinance which decriminalised homosexuality; Consumer Goods Safety Ordinance which covers the quality of condoms, and Disability Discrimination Ordinance which specifically includes HIV/AIDS as one form of disability under protection.

24. The main thrust of community action has been the advocacy for the rights of people with HIV/AIDS. Community action were initiated by people living with HIV/AIDS and their service providers. Apart from advocacy, there have also been education efforts to foster a positive attitude and lobbying to cause policy changes.

25. Despite the efforts of the community, and through policy development, negative factors still prevail in the social environment. HIV/AIDS carries a strong social stigma – infected people and those at risk are reluctant to present for diagnosis/treatment. There were examples of health and social service professionals who were unwilling to take care of people with HIV/AIDS, and objections by some members of public to the provision of HIV care in their vicinity.

Programme Structure, Operating and Monitoring Mechanisms (Chapter V)

26. Programme structures have been set up in Hong Kong over the past years as the base for bringing about HIV prevention and health promotion, provision of clinical and support service, and creation of a supportive environment. Increasing emphasis is being given to a multisectoral approach, especially in creating a

supportive environment. The scope of the programme has also been extended beyond AIDS to general health. Both the Government and NGOs have contributed towards the development of the current local model, which has evolved over years from a response of the medical community to a system with wide community participation.

27. The Government's response is featured by the setting up of special committees to advise on strategies, establishment of designated programme units, and the facilitation of community participation. The Advisory Council on AIDS plays a central role in the Government's response through both the provision of policy advice, and direct involvement in operations via its three committees. The Department of Health provides secretarial, technical and operational support to the Council. Its pegging with the Department of Health has often confused the public as regards its independent status.

28. Increasing community involvement has become evident in the last few years. The first AIDS NGO was set up in 1990. There are now three types of AIDS NGOs – (a) those with broad range of activities - AIDS Foundation and AIDS Concern, (b) those with focussed activity profile - HIV Information and Drop in Centre, TeenAIDS, AIDS Memorial Quilt Project, Society for AIDS Care, and (c) those playing supporting role to other organisations. The AIDS project of Hong Kong Council of Social Service is the only example in the last group.

29. There are three forms of support mechanisms for the effective operation of AIDS programmes – through technical assistance, funding and advice. The establishment of the AIDS Trust Fund has played a facilitating role in the set-up and functioning of AIDS NGOs, as well as development of community-based projects. Coordination of the community's efforts has been developed through formal and informal channels. Provision of mutual support is considered an important common strategy in coordinating the various community organisations working on AIDS.

Finance (Chapter VI)

30. In Hong Kong, the community provides resources through a number of financing means to AIDS service providers. The latter then use the funding to deliver the three main forms of output discussed above – HIV prevention, provision of services for those infected, and surveillance and research. A financial review is conducted through focussing on the direct monetary support for AIDS programmes in Hong Kong.

31. The Hong Kong community spent HK\$72.346 million in the year 1997 to support the AIDS programmes, with expenditures on clinical and support services to HIV prevention in a ratio of 2:1. The two accounted for the main bulk of the programme costs, while surveillance and research consumed only 2.6% of the total. There has been parallel growth in pace in expenditures on prevention and service in the last four years.

32. The public sector is the main service provider in terms of costs incurred. This is particularly so in the provision of clinical and support services. As regards HIV prevention, the ratio of Governmental to non-governmental expenditure has fallen over the years, which stands now at 1:1. About 50% of the manpower cost of AIDS Unit on HIV prevention go to the provision of support to the Advisory Council on AIDS and its committees.

33. Whereas clinical and support services for people with HIV/AIDS account for the largest proportion (61.2%) of the total programme expenditure, inpatient treatment cost has fallen in 1997, while the costs of designated outpatient services have risen, with drug expenditure increasing by over five-fold between 1994 and 1997.

34. Four financing means are evaluated: (a) Government or public revenue, (b) community funds, (c) private sector, and (d) out-of-pocket charges. The public sector contributes the greatest proportion of the programme's finance. The Government recurrent expenditure and AIDS Trust Fund together have supported 80% of the total income in the past four years. During the same period, a four-fold increase (from

HK\$5 million to HK\$20 million per year) in the nominal amount of additional resources from outside the Government had been channeled to the AIDS programme.

35. The Government's AIDS Trust Fund constitutes one major financing means of Hong Kong's AIDS programmes, especially in the support of community-based activities. While support is granted on project basis, there is currently little monitoring or evaluation on the project outputs, nor is there clearly established review criteria before approval. An absence of an overall output evaluation makes decision for future resource allocation difficult, and may adversely affect support from the community.

Internal Assessment Report

A review on the HIV/AIDS situation and the programmes on its prevention,
care and control in Hong Kong

Introduction

Advisory Council on AIDS 1998

INTRODUCTION

0.1 Background

0.2 Methodology

0.2.1 Data collection

0.2.2 Consultation

0.2.3 Collation

0.3 Layout of the Report

0.3.1 Core contents

0.3.2 The supplements

0.4 How to Use this Report

INTRODUCTION

0.1 Background

The purpose of preparing this *Internal Assessment Report* is twofold: to document the HIV/AIDS situation in Hong Kong and the programmes on its prevention, care and control from 1984 to 1997; and to provide background data to facilitate the conduction of the second part of the review commissioned by the Advisory Council on AIDS. Recommendations would be made by external consultants in the second phase for guiding future programme development.

Why does the Advisory Council on AIDS consider a review necessary? Prior to this review, there had been publication of a number of documents reviewing individual parts of the programmes and HIV/AIDS situation (Box 0.1). AIDS has always been treated in two ways: both as a communicable disease not unlike that caused by other microbes, and

as an issue with far-reaching social implications. The reconciliation of patients' rights with the collective rights of the public is often a subject of debates. With AIDS programmes in place for over a decade, there have been concerns, on one hand, of how effective the collective efforts of the Government and the

Documents reviewing the HIV/AIDS situation and individual programme

Advisory Council on AIDS (ACA). Strategies for AIDS prevention, care and control in Hong Kong. Hong Kong: ACA; 1994.

Chin J. Estimation and projection of HIV infection and AIDS cases in Hong Kong. Hong Kong: ASSR project; 1994.

AIDS Services Development Committee. A review of services provided to people with HIV/AIDS in Hong Kong. Hong Kong: ACA; 1994.

Hong Kong AIDS Foundation (HKAF). The knowledge, attitude, behaviour and practice survey on AIDS in Hong Kong 1992. Hong Kong: HKAF; 1996.

UNDP-HK Polytechnic University (HKPU) Collaborative Centre. Enhancing government-NGO collaboration in HIV/AIDS policy and service – the case of Hong Kong. Hong Kong: HKPU; 1996.

Box 0.1

community have been, and what strategies are needed to prepare Hong Kong for the new challenges ahead. On the other hand, AIDS programmes have created impacts on the way public health issues are handled in other settings. These have led, in fall 1996, to the decision of conducting a comprehensive review on the HIV/AIDS situation and programmes. After further discussion, debates and

consultations, options were examined and plans proposed. The final plan was adopted in mid-1997 which was subsequently endorsed in January 1998. In the review, the term “programmes” is taken to include all operations and activities relating to the prevention, care and control in Hong Kong, and therefore implies the efforts of *both* the Government and the community. The objectives of the review is in Box 0.2.

This report forms the first part of the review exercise. As directed by the Advisory Council on AIDS, the Secretariat undertook an internal assessment to document the situation and programmes on AIDS in Hong Kong. By internal, it means the examination by and for people working on the programmes. The report would be examined by a team of external consultants in the second phase of the review. The consultants would have never been involved in Hong Kong’s programmes. Together with subsequent investigations as directed by the consultants, a final report will be composed for submission to the Council.

Box 0.2

Objectives of the Review of the AIDS Situation and Programme in Hong Kong 1998

1. To undertake a thorough assessment of Hong Kong’s HIV/AIDS situation, policies, and the programmes developed for its prevention, care and control;
2. To identify indicators for systemic evaluation of the local AIDS programmes; and
3. To recommend on the future direction of strategy, programme development and the operating structures at the government level and the community.

This Introduction chapter outlines the background and methodology of the internal assessment, and provides a layout for readers in their examination of the core content of the report.

0.2 Methodology

The internal assessment part of the review was supervised by a steering committee composing of Advisory Council members and advisers (Box 0.3). The study was technically carried out from January to March 1998 by a research team set

up under the Secretariat of the Advisory Council on AIDS. The objectives of the internal assessment are to (1) examine available documents and reports on HIV/AIDS situation, policies and programmes, (2) consult relevant personnel and organisations to supplement necessary information, (3) conduct survey for systematic collection of programme data, (4) collate collected information for presentation in a report¹. The following sections outline the processes of data collection, consultation

0.2.1 Data collection

Data collection was performed through three channels: (a) conduction of a questionnaire survey, (b) examination of annual reports, situation papers and other documents, (c) requisition of supplementary information through personal contacts.

(a) Questionnaires survey

A special questionnaire was designed and distributed to AIDS NGOs, community organisations, and government units to collect information and views on various aspects of the programmes. The same form had also been delivered to members of the Advisory Council on AIDS and its committees, subcommittees and task forces. A total of 129 copies had been sent out to 41 organizations and 88 individuals. As of the end of March 1998, 40 returned had been received – 36 from organisations and 4 from individuals.

The questionnaire is divided in two main parts. The first part deals the details of the organisation or individual's participation in the AIDS programme (Box 0.3), while the second part collects opinions about the programmes.

Box 0.3

Steering Committee

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Dr Homer Tso, *JP*
Ms Carlye Tsui, *JP*
Professor YL Lau

TECHNICAL ADVISER

Dr Patrick Li

ADVISERS

Professor S H Lee, *JP*
Dr C H Leong, *JP*

¹ The review objectives were endorsed at the 24th meeting of the Advisory Council on AIDS on 6 January 1998.

(b) Examination of reports and documents

Government units and community organisations were asked to submit their annual reports or other relevant documents for examination. Data collected have been used for analysis or verification of other data collected. Additional information were retrieved from documents and reports shelved in Red Ribbon Centre².

(c) Supplementary information

Followup visits and phone calls were made to collect supplementary information of the various programme areas covered in the review. During the process of internal assessment, two NGOs had been visited as well as a research group.

Box 0.3

The first part of the questionnaire survey collected the following information from organisations:

- The organisation's structure, functions, scope of service and targets.
- Manpower support
- HIV prevention functions
- Clinical and laboratory services
- Support services
- Training
- Research
- Financial situation
- Other areas and future tense.

0.2.2 Consultation

There were two levels of consultation, public and internal. Press advertisements were placed in two Chinese and one English newspapers in February to collect views from members of the public on all aspects of AIDS prevention, care and control. Press releases had been issued. The review was also publicised through internet, and comments were welcomed either through fax, email and/or letters. The response had, so far, not been enthusiastic.

Two internal consultation meetings were held for members of the Advisory Council on AIDS, its committees and task forces. NGOs and others working on AIDS were also invited. The first meeting was held on 13 February 1998 to collect views on the methodology of the review. A second consultation meeting was held on 8 April. At this second meeting, the framework and contexts of the review were presented, together with some

² Red Ribbon Centre is an AIDS education, research and resource centre in Hong Kong.

preliminary data on the cost and patterns of the development of the local AIDS programme. About twenty persons were present at each of the meetings.

0.2.3 Collation

The third phase of the internal assessment involves collation of data into readable format. This has been made through repeated discussion within the research group, and through consulting the Steering Committee. The Steering Committee had met formally three times, and informally on numerous occasions to carve out the strategy for presenting results of the internal assessment.

0.3 Layout of the Report

The *Internal Assessment Report* is organised into two main parts plus a preamble. The preamble is made up of an introductory chapter and an executive summary. The main text is composed of a core of six chapters, and a supplement.

0.3.1 Structure

The core content is organised in six chapters (Box 0.4) covering all possible areas of HIV/AIDS situation and programmes. Each chapter is presented in a similar way with

(a) an introduction with notes on historical development; (b) description of the programmes or situation, illustrated with flow charts, graphs and tables as appropriate; and (c) documentation of characteristics and constraints identified in the

Box 0.4

Core content

1. HIV/AIDS situation in Hong Kong
2. HIV prevention and health promotion
3. Clinical and support services
4. Public policy, laws and environmental changes
5. Programme structure, operating and monitoring mechanism
6. Finance

review. Boxes, tables and appendices are used to highlight key issues or selected areas requiring elaboration.

0.3.2 Core content (Appendix 0.1)

The content is presented in such a way to portray the overall HIV/AIDS situation in Hong Kong, and to reflect how Hong Kong has been doing to meet the main objectives of an effective AIDS programme – preventing the spread of the infection, and reducing the negative impact of HIV/AIDS on the individuals and society.

The report begins with a description of the HIV/AIDS surveillance activities in Hong Kong (Chapter One). They refer to the system in place to collect, analyse and disseminate data pertinent to the planning, implementation and evaluation of disease control activities. Using this broad definition, surveillance has included not only serological data and disease reporting, but an examination of the underlying risk factors in the community. Research activities which have contributed to our understanding of the epidemiological and behavioural aspects of HIV/AIDS are covered.

Chapter Two leads us to an assessment of Hong Kong's work on HIV prevention. The chapter covers HIV prevention and health promotion activities relating to the control of the spread of HIV infection and the fostering of positive attitude towards people living with HIV/AIDS. Major programme foci of the Government and NGOs were identified, and the delivery modalities presented.

Chapter Three and Four examine our work in reducing the negative impacts of HIV/AIDS. Chapter Three describes the provision of HIV/AIDS services. These services have been organised to help people with HIV/AIDS to reduce the physical and psychological stress of the disease, so as to aim at leading a healthier life. There are two broad groups of services – clinical service, which is supported by laboratory activities, and support services. HIV testing is considered as a mechanism to help channel HIV positive patients

into the management system. The Chapter also examines the issues of management standards and the practice of infection control, the cornerstone of quality HIV/AIDS services. Chapter Four focuses on the development a supportive environment to ensure that prevention, care and control of HIV/AIDS can be implemented. The mechanisms behind such an environment are policy formulation, legal provision and community action. The impacts of these mechanisms on the environment are examined, in context of the access to information and service, support for acquisition of protective behaviours, and respects for human rights.

Chapter Five and Six present the support behind the entire programmes, with Chapter Five addressing the programme structure, while Chapter Six looked at its financial aspect. The programme structure refers to the collective system developed by both the Government's and the community. Their inter-relationship and that with the international community are addressed. Chapter Six makes up the financial review of the local programmes. Resources are mobilised from the community and delivered to the community in need. Two broad areas are covered, they are the programme costs and the financing. The mechanism of funding and their monitoring are presented.

0.3.3 The supplements

The supplement is a report of the questionnaire survey. There are two main parts, the first part covers data provided by individual organisation on their involvement in the AIDS programmes. The second part is a list of areas of concern collected through the review exercise.

0.4 How to use this Report

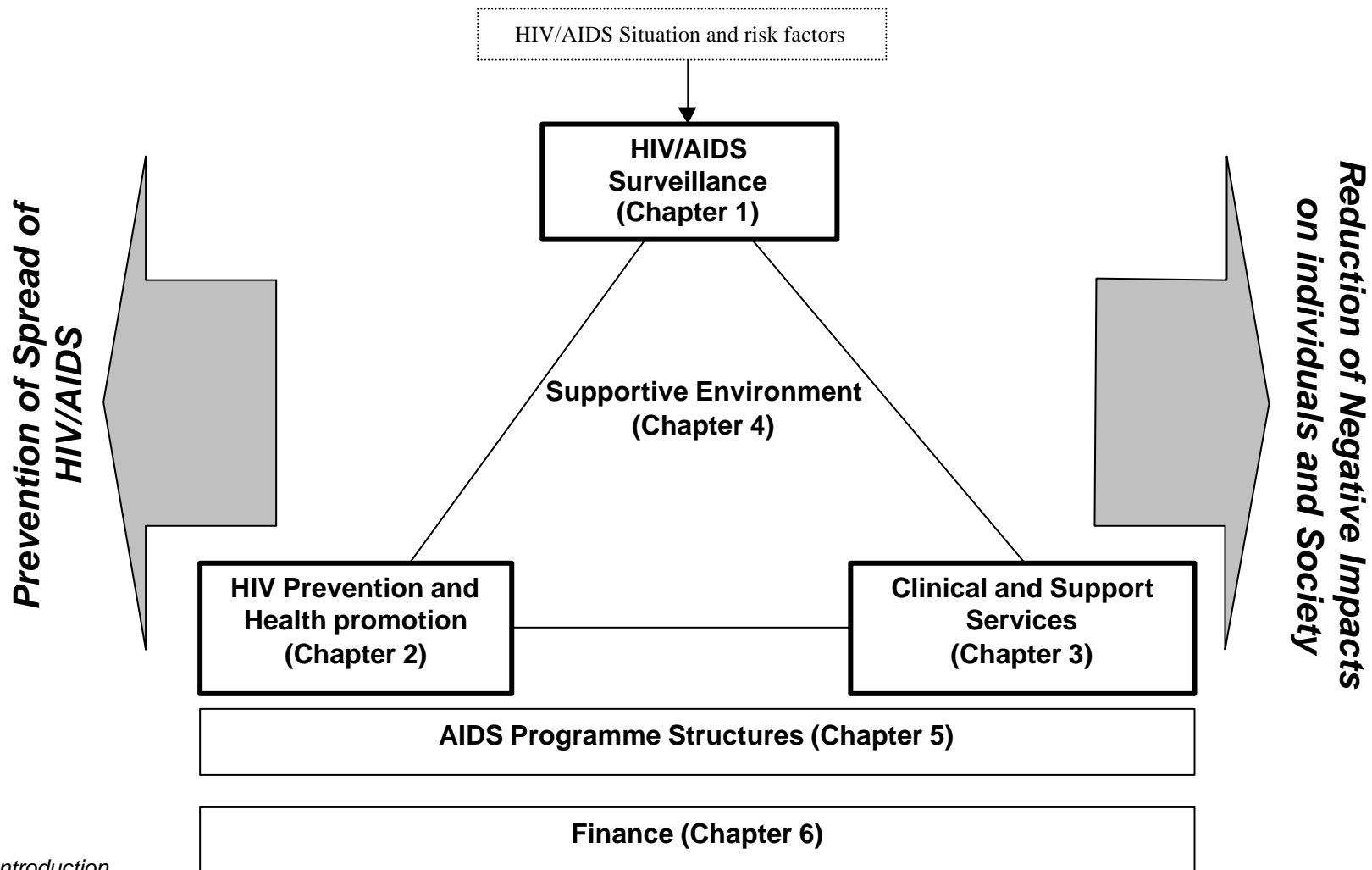
This *Internal Assessment Report* is meant to be a factual account of the HIV/AIDS situation and the programmes in place in Hong Kong. It serves as a brief for external consultants in their study of the Hong Kong HIV/AIDS scenario, policies,

programmes and activities. The core contents (Chapter 1-6) can be read in any order. Each subject is individually presented though cross referencing is needed in some areas if further elaboration is needed. The Executive Summary is the simplest version of the Report for those who want to have a quick glimpse of the contents. In each Chapter, the final section presents the major characteristics of the programmes or situation, with emphasis on constraints identified in the course of the assessment.

The Steering Committee and the research team acknowledges the limitation of the report, which is not meant to be all-inclusive, nor is it possible to be exhaustive in data collection. In understanding the programmes and the concerns of individual organisation, readers are advised to refer to the supplements, or to the original questionnaire forms kept at the Red Ribbon Centre.

Appendix 0.1:

Core Contents of Internal Assessment Report and their Inter-relationship



Internal Assessment Report

A review on the HIV/AIDS situation and the programmes on its prevention, care and control in Hong Kong

Chapter I :

HIV/AIDS Surveillance and Situation

Advisory Council on AIDS 1998

I. HIV/AIDS Surveillance and Situation

1.1 Introduction

1.2 Surveillance and research on HIV/AIDS in Hong Kong

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- 1.2.2 Current set-up of HIV/AIDS surveillance and the components
- 1.2.3 The research network

1.3 HIV/AIDS Epidemiology

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- 1.3.2. HIV situation
- 1.3.3. STD epidemiology
- 1.3.4. HIV and pregnancy
- 1.3.5. Tuberculosis and HIV infection
- 1.3.6. Modelling and scenario construction

1.4 The Social and Behavioural factors

- 1.4.1 Sex behaviours
- 1.4.2 Illicit drug use
- 1.4.3 Commercial sex industry
- 1.4.4 Human mobility
- 1.4.5 Adolescence

1.5 Program Evaluation and Monitoring

- 1.5.1 Awareness and attitudes
- 1.5.2 Sentinel risk behavioural monitoring
- 1.5.3 Programme effectiveness indicators

1.6 Situation Overview

- 1.6.1 Characteristics of the surveillance mechanisms
- 1.6.2 Main features of the HIV/AIDS situation

Appendix I.1 Surveillance & Research and public health programming

Appendix I.2 Epidemiological Data from Voluntary HIV/AIDS Reporting 1984-1997 (charts)

I. HIV/AIDS Surveillance and Situation

1.1 Introduction

The conduct of public health programmes in disease control embraces a series of logical steps of identifying problems, evaluating the determinants and implementing interventions to achieve prevention. Surveillance serves the very first step to detect the scale and changes in the magnitude of the disease. A sensitive surveillance system regularly generates relevant data for useful programming purposes. On HIV/AIDS, a surveillance system is maintained by the Hong Kong Department of Health to depict the trends of HIV/AIDS, and the related conditions.

In order to implement effective HIV/AIDS public health programmes, acquisition of HIV/AIDS data alone is insufficient. An understanding of the underlying factors pertinent to public health control is crucial. These factors may be epidemiological, social, and/or behavioural. For this purpose, ongoing collection of information about the infected needs to be supplemented by data generated from additional studies on related factors. For maximum benefit, these information should lead to a development of intervention strategies, which could be conceptualised, experimented and implemented with relevant evaluation procedures. The surveillance system is assessed, therefore, also in context of its provision of information on related risk factors and the impacts of HIV/AIDS.

All public health activities have to, ultimately, meet the objectives of HIV/AIDS control and impact encapsulation. Clearly, regular monitoring of the outcomes has to be in place. For many diseases, surveillance alone may be adequate to monitor the outcomes in terms of change in incidence and prevalence. For HIV/AIDS, additional evaluation mechanisms must be constructed as timely modifications in response to HIV/AIDS trends is impossible given the lag time of intervention. These processes of using information generated from surveillance and research to facilitate public health HIV/AIDS programme development are illustrated in Appendix I.1.

In this Chapter, we first introduce the HIV surveillance system, which has

been monitoring the local situations, and the relevant research mechanisms. It is followed by an examination of the HIV/AIDS situation, and the patterns of related conditions in the local community, in context of the need for effective programming as described above.

1.2 Surveillance and Research on HIV/AIDS in Hong Kong

The historical development of the HIV/AIDS surveillance system is introduced in this section, in context of its response to the needs of the local community. The current set-up of the surveillance system is presented, together with an examination of the research network which has enriched our understanding of the local HIV/AIDS epidemiology and the related factors.

1.2.1 Historical development

(a) HIV/AIDS surveillance system

In Hong Kong, AIDS surveillance was started in 1984 in response to the practical need of medical practitioners to understand the clinical pattern of the disease in the local setting. Collaborated by physicians of major hospitals and microbiologists of the public laboratories in Hong Kong, a registry, which collected detailed clinical information about the infected, was maintained. The then Medical and Health Department, recognising the need to disseminate the information appropriately, began organising the demographic data and the patterns of transmission routes. Regular reporting was thereafter made to the public through press conferences. Such data collection and dissemination process has since been formalised to become the backbone of an emerging HIV/AIDS information system. HIV seroprevalence surveys were also started in 1985 when HIV antibody diagnostic kits became commercially available. In 1990, unlinked anonymous screening was introduced in accordance with guidelines issued by the World Health Organisation. In 1994, the AIDS Unit initiated a project to review the existing surveillance mechanisms, critically analyse the data for scenario construction and projections, and experiment on an HIV-risk behavioural surveillance system. In 1995, STD surveillance was

incorporated into the HIV/AIDS risk factor surveillance. With the increasing number of cases and a need to assess the expanding strain on health care deliveries and support services, disease registries on HIV pregnancies, HIV and tuberculosis infections, and other related clinical conditions relevant to HIV/AIDS, became established.

(b) Research

AIDS related researches in Hong Kong have been receiving greater attention only in the past few years. To date a number of research groups and researchers are working on the various aspects of AIDS (Box 1.1)

Box 1.1

Researchers and research groups on AIDS in Hong Kong

AIDS Scenario and Surveillance Research (ASSR)

ASSR is an epidemiological research project established jointly by the Department of Microbiology of the Hong Kong University and the AIDS Unit of the Department of Health. Housed in the office space of the AIDS Unit, the project is supported by manpower and facilities of the Unit. ASSR consists of a number of research components primarily on epidemiology, surveillance systems, modeling, and risk behaviours evaluation. ASSR is funded by the AIDS Trust Fund in mid 1994.

Community Research Programme on AIDS (CRPA)

The CRPA has been the first university-based AIDS research programme in Hong Kong. Established in March 1994, the programme has been housed in the Centre for Clinical Trials and Epidemiological Research of the Chinese University of Hong Kong. Funded by the AIDS Trust Fund, CRPA is devoted to AIDS prevention researches and studies on the awareness, attitudes and risk behaviours in the community.

Other groups

Apart from the above designated programmes, there are other researchers contributing to AIDS research in various forms. Some research projects are commissioned by specific organisations, and research institutes may also conduct researches covering aspects of AIDS. In the former, research objectives and methodology may be governed by the commissioning organisations or the researchers/ research groups or both. These studies are primarily conducted to meet the needs of the research organisations yet some of the collected information may reveal important data related to AIDS. Some examples are: the *Youth Sexuality Survey* commissioned by the Family Planning Association to the Department of Community of Medicine of Hong Kong University, *Enhancing Government-NGO collaboration in HIV/AIDS policy and service* commissioned by the United Nations Development Programme to a group based at the Hong Kong Polytechnic University headed by Professor Diana Mak (Box 1.5), and *Study of the Marginal Youth* commissioned by the Commissioner on Youth to Mr Billy Ho of City University.

A study of the AIDS Services Development Committee revealed that by the end of 1995, 62 articles, 67 abstracts, and 19 books, reports or monographs on AIDS had been published. These did not include the in-house

studies carried out by the AIDS Unit or other organisations. Although the first local AIDS related articles were published in 1985, it was since 1992 that rapid increase in AIDS research was noted. The first territory-wide household survey on knowledge, attitude, behaviour and practice on AIDS in Hong Kong was conducted in 1992. In 1994, two designated research programmes on HIV/AIDS were set up. There has been active participation of the local researchers in the following international and other AIDS conferences. In 1996, the Advisory Council on AIDS organised the first Hong Kong AIDS Conference in November, providing a forum for researchers from different disciplines to meet and exchange ideas.

1.2.2 Current set-up of HIV/AIDS surveillance and the components

The AIDS Unit is responsible for the compilation and processing of incoming data from various sources; it interprets the results and produces output in an easily used format. Since 1993, the Scientific Committee of the Advisory Council on AIDS (and the Scientific Working Group on AIDS between 1985 and 1993) has taken on the role to coordinate local scientists in the field to consolidate inputs and monitor the operations outputs of the surveillance system.

Currently, there are five components of data input. They are: (1) voluntary HIV/AIDS reporting, (2) seroprevalence studies, (3) unlinked anonymous screening, (4) STD surveillance, and (5) disease registries.

(a) Voluntary HIV/AIDS Reporting

Reporting of individual HIV/AIDS cases has been channeled through two sources, voluntary reporting of doctors and laboratory reporting. This voluntary reporting system is unique as compared with that for many other diseases with public health significance. (Box 1.2) The reported HIV/AIDS statistics are constructed from two sources, supplementing each other.

Under the reporting system, medical doctors are encouraged to supply

information of newly diagnosed HIV infections and/or AIDS to the AIDS Unit of the Department of Health. A standard form ¹ is used to systematically collect details such as the demographic characteristics, suspected routes of transmission, clinical status, and AIDS defining illnesses of the infected. Surveillance definition of AIDS is recommended by the Scientific Committee on AIDS (Box 1.3) Each reported case is assigned a unique code to facilitate subsequent follow up of complications. Anonymity and confidentiality are preserved in this system.

Box 1.2

Disease reporting mechanisms:

Notification system: The infectious diseases listed under the Prevention of Spread of Infections Diseases Regulation are required to be notified.

Voluntary reporting: HIV/AIDS reporting. Clinicians and laboratories are encouraged to report.

Public sector reporting: Private sector not involved. Sexually transmitted diseases in Hong Kong are monitored in this way.

No reporting: Most diseases.

The second source of data is that obtained through laboratory reporting, which has been started since 1985. The laboratories that provide confirmatory HIV antibody tests on voluntary basis submit reports of the infected. At present all three confirmatory laboratories in the public sector but none from the private sector report regularly. The three participating are the virus units of the Department of Health, Queen Elizabeth Hospital, and the Prince of Wales Hospital. Between 80-90% of all HIV screening antibody tests in the territory are done by the Department of Health Virus Unit, which also provides free confirmation tests for specimens positive upon two screenings. Annually, approximate 200 specimens are submitted under this condition from private sector. Concerning the reported data of the infected individuals, generally the sex and age are provided, and occasionally the suspected route of transmission.

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Box 1.3

Surveillance case definition for HIV and AIDS in Hong Kong

In the current system, both HIV and AIDS are reportable. Surveillance case definitions for HIV infection in Hong Kong require the confirmation of HIV positive sero-status in a recognized laboratory in Hong Kong. Since 1985, all reported HIV positive cases could be traced to a confirmation test done in Hong Kong except those diagnosed by overseas laboratories before the availability of commercial screening testing kits in Hong Kong.

For AIDS, the surveillance definition is modified from the 1993 CDC classification² (refer to Chapter III Clinical and Support Services). Serological evidence of HIV antibody positivity is necessary. Penicilliosis has been considered as an AIDS defining condition since 1990. Three cases were diagnosed in 90, 91, and 93, and an annual incidence of 4 to 6 cases was noted since 1994. The Scientific Committee of Advisory Council on AIDS discussed a paper on the case definition on AIDS at its sixth meeting on June 9, 1995. The Committee concluded that the CDC 1993 AIDS case definition should be adopted with the provision of: (1) penicilliosis should be included as an AIDS defining condition, (2) pulmonary or cervical lymph node tuberculosis is regarded as AIDS defining ONLY IF CD4 count is less than 200/~~mm~~³. In addition, no case should be defined solely based on a low CD4 count.

(b) HIV prevalence studies

The HIV positive rates in three population subgroups constitute the database for HIV seroprevalence studies since 1985. They are clients attending the Social Hygiene Services (the government STD clinics), drug users participating in the outpatient methadone drug treatment programmes, and blood donors. The former two groups are the results of voluntary testing. As for blood donors, while the donation of blood is voluntary and non-paid, HIV screening is universal to all collected blood units. The uptake rate in the STD clinics is high in view of its being universally offered to all clients.

(c) Unlinked anonymous screening studies³

Unlinked anonymous screening was started in 1990 in line with WHO recommendation endorsed by the Scientific Working Group on AIDS. Population subgroups having been tested are: neonates (Box 1.4), methadone clinics attendees, tuberculosis patients, male government recruits, correctional institute inmates.

² Scientific Committee on AIDS (SCA). Classification system for HIV infection and surveillance case definition for AIDS in adolescents and adults in Hong Kong. Hong Kong: SCA of Advisory Council on AIDS; July 1995.

³ Scientific Committee on AIDS (SCA). Unlinked anonymous screening for HIV surveillance in Hong Kong 1990-1996. Hong Kong: SCA of Advisory Council on AIDS; June 1997.

Box 1.4

Unlinked anonymous screening using neonatal cord blood

In Hong Kong, all babies delivered in both public and private sectors have 3-5 ml cord blood saved for neonatal G6PD and hypothyroidism screening. In 1990, residual neonatal cord blood was collected for a trial round of UAS. The advantages of using neonatal cord blood for unlinked anonymous screening are the minimal participation bias, high utility (no blood taking from babies or mothers) and low additional cost. The prevalence results provide both estimations of perinatal risks in the local community and also the prevalence in reproductive age women. The generalisability of the results is, however, limited to women giving births in hospitals (which are in fact, the vast majority of the deliveries in Hong Kong) but not to all women population, and has not included the terminated pregnancies.

In view of the low HIV prevalence in this subgroup (less than 1 in 4000), there has been debate at SCA on whether UAS on neonates should be continued, and if yes, at what frequency. It was resolved that the previous monitoring did provide significant negatives in reassuring a low HIV prevalence in women giving births and supportive evidence to the low incidence of perinatal infection. With the rising heterosexual transmission and increasing women infections, it is considered beneficial to continue such monitoring on an annual basis.

(d) STD surveillance

Currently, none of the STDs is notifiable nor reportable in Hong Kong. However, as the government has been operating a network of STD clinics which provide freely accessible services, STD surveillance could be carried out to monitor the disease incidence in those attending these clinics. In this public clinic surveillance, STDs are reported basing on their etiological diagnoses. A study in 1997 estimated that approximately 20% of all STDs presented to health care facilities of the public sector. Since 1995, the findings of this STD surveillance system, in terms of number of cases for each diagnosis, is also compiled together with HIV surveillance results, and disseminated at a quarterly basis.⁴

(e) Disease registries

Disease registries are maintained by the AIDS Unit to track the impact of HIV/AIDS in the community. They include the HIV complications and HIV related pregnancies. Data is primarily collected through the network of clinicians known to be taking care of HIV patients.

⁴ STD and AIDS quarterly statistics are reported and disseminated to medical practitioners, public health workers and other interested personnel through the quarterly surveillance publication *STD/AIDS Update* of AIDS Unit and Social Hygiene Service.

(f) Dissemination of information

Timely dissemination of processed data is crucial. There are three ways. First, the reported HIV/AIDS quarterly epidemiological data are released, with situation highlights, at a press conference, usually held within four weeks after the end of the previous quarter. A press release is issued. Second, the summary data, with charts, tables, editorials and feature articles, are published in an in-house, but official publication⁴, called *STD/AIDS Surveillance Update*. As an in-house production of AIDS Unit, the *Update* enjoys great flexibility in the printing and design process and is generally ready for distribution within 4-6 weeks after the end of each quarter for circulation to 900 readers. Third, the press release, highlights, and the *Update* could be viewed and/or downloaded from the AIDS Unit website (<http://www.info.gov.hk/aids>), since it was established in 1996. An average of 1000 visitors hit on the page each month. In addition to these regular productions, the Unit also publishes, or presents, analysis and studies on specific situation at both local and international fora.

1.2.3 The Research Network

Not all research work on AIDS contribute directly to the ultimate purposes of HIV/AIDS control, yet some may provide good basis for future elaboration. The research network is, unlike the surveillance system, a virtual system for programme workers to gather the research outputs and to build up collaborative relationships for advancing our understanding of the HIV/AIDS situations..

The current research activities relating to AIDS are mostly epidemiological, social-behavioural and evaluation studies. While epidemiological studies aims at supplementing or improving the health data collected through the surveillance system, socio-behavioural and evaluation research have strong bearing on the design and implementation of HIV prevention programmes. Contribution has been observed from CRPA and a number of other researchers who may or may not be represented at the ACA and its committees.

As for the coordination among the researchers/research groups, the first attempt could be traced back to 1990 when the Working Group on Research and Evaluation was formed to report to the interdepartmental Committee on Education and Publicity on AIDS. Represented by a handful of academics and medical staff, the group had also proposed the KABP study (which was subsequently commissioned by the Hong Kong AIDS Foundation) and evaluation of activities to monitor the conduct of prevention programme. The researchers in this Group were responsible for the conduct of the researches. The Group was replaced by the Planning and Evaluation Subcommittee in 1993. Currently, research outputs are channelled to the HIV/AIDS control mechanisms through one or more of the following pathways.

(a) Committees of the Advisory Council on AIDS

Each of the three committees under the Council has examined or been involved in research work in its own arena. The Scientific Committee on AIDS has been overseeing the surveillance system, HIV screening quality control studies, and the AIDS Scenario and Surveillance Research project. As for Committee on Education and Publicity on AIDS (CEPAIDS), the Planning and Evaluation Subcommittee has been set up with an intention to coordinate and consider carrying out evaluation research for HIV prevention programmes. Recently, CEPAIDS has also become a forum to report studies relevant to HIV prevention. The AIDS Services and Development Committee has conducted a review on services provided to people with HIV/AIDS⁵, and examined other relevant research work that may help to promote service provision (Box 1.5).

(b) AIDS Discussion Group

Attempts were made in late 1997 to establish a network among AIDS researchers. A meeting attended by epidemiologists, social scientists, nurses, and public health researchers was held. There was no resolution to any

⁵ AIDS Services Development Committee (ASDC). A review of services provided to people with HIV/AIDS in Hong Kong. Hong Kong: ASDC of Advisory Council on AIDS; 1994.

specific mechanism to coordinate AIDS researches although a group-email network was constructed.

Box 1.5

Enhancing Government-NGO collaboration in HIV/AIDS Policy and Services – The case of Hong Kong

Commissioned by an international agency, the United Nations Development Programme, to the Hong Kong Polytechnic University Research Group made the first attempt to examine the situation and needs of all the “non-governmental organisations” as a group in relation to the government. It has analysed the roles of NGO, discussed the disputes and problems of each NGO, and proposed agenda for enhancing NGO capacity.

Recommended “agenda for dialogue” to enhance NGO capacity

1. NGO technical support mechanism
2. NGO forum
3. The Government-led policy-making structure
4. Funding source
5. Funding mechanism
6. Service delivery models
7. Human capacity enhancement

Afterwards ...

The researchers presented the recommendations at the AIDS Services Development Committee on July 2, 1996. Several further remarks were made⁶: (1) NGOs should be self-reliant in terms of providing mutual technical support and sharing of skills and experience, with or without the support of an additional centre. (2) Long term government support could not last and NGOs should continue looking for other funding sources: (3) Duplication among the NGO services may be reduced through a self-regulatory mechanism without government intervention. There had not been any overt actions observed following this research. The acceptance and support of this action research in the community was not certain.

(c) Presentation and documentation

Presentation of researches and open discussion constitute another means of coordination, adding value to the work of the researchers. These have taken place at local and international conferences. In 1996, Hong Kong organised the first ever local AIDS conference in November. More than 100 researchers attended the 2-day conference and 78 presentations⁷ were made.

Not all local studies were published or presented. To overcome this setback and to enhance collaboration, the Red Ribbon Centre Resource Library has been establishing a comprehensive collection of AIDS related

⁶ Minutes of the Tenth Meeting of the AIDS Services Development Committee held on 2 July 1996. Agenda Item 3.

⁷ Proceedings of Hong Kong AIDS Conference 1996. Hong Kong Advisory Council on AIDS; 1997.

work produced by the local community. They may be in the form of published articles, abstracts/conference proceedings, thesis, or in-house reports. To date, there are more than 200 pieces of such work. From late 1997, all reports returned from the project applicants to AIDS Trust Fund are also collected in the Library for public's reference.

1.3 HIV/AIDS Epidemiology

In the next paragraphs, we examine the HIV/AIDS situation in the context of how they can be relayed to the design of appropriate HIV prevention programmes and service provision. Epidemiology of AIDS and clinical complications, for example tuberculosis, provides us with a broad view of the necessary services required for people living with HIV/AIDS. HIV and STD epidemiology directs programme workers to develop parallel intervention strategy. Modelling and scenarios are invaluable in programme planning on a societal perspective.

1.3.1 AIDS Epidemiology

The demographic characteristics and modes of transmission of the reported AIDS provide information about the transmission pattern of HIV five or more years ago. However, the pattern of presented cases is more important in alerting policy makers and service providers of the burden on the clinical and support services required.

The reporting system provides us with the essential information about AIDS epidemiology. The first AIDS cases were reported in 1985 among homosexuals. There were only few cases in the subsequent four years, until after 1989 when the new case detection rate became more noticeable. Rapid rise was, however, evident from 1994 onwards. The highest number of cases has been recorded in the past two years (1996 and 1997).

Overall, male is much more commonly affected although more women

have been diagnosed with AIDS recently. In 1997, the male to female ratio is 4.8 to one. A majority (80%) of the cases presented between the age bracket of 20 to 49, with a mean age between 35 to 40 for the annual summaries⁸. Heterosexual contact is the most important route of transmission, accounting for 70-80% of the reported cases in the past three years. The number of infections attributable to homosexual or bisexual contacts has been stable in absolute number.

The pattern of clinical presentation carries some bearing on the service needs of those infected. In the past two years, the three most commonly reported primary AIDS defining conditions are: (1) *Pneumocystis carinii* pneumonia (30.6%); (2) Tuberculosis (28.4%); and (3) *Penicillium marneffeii* (9%). Only 5.57% of all cases presented with Kaposi's sarcoma, majority in homosexuals or bisexuals.

Despite the insensitivity of existing voluntary reporting system in detecting deaths due to AIDS, information gathered by AIDS Unit could provide some useful hints. Among the 309 AIDS cases notified to the surveillance system, death has been reported in 48%. Sixty percent of those diagnosed before 1996 were dead whereas for those reported afterwards, only 32% had died. Among the reported cases, the number of people living with AIDS could lie close to 90 and much less than 160. In other words, about one-third to half of the reported are still alive. A retrospective study reported a median survival of 15 months for AIDS cases diagnosed in 1990-91. The impact of the new antiretroviral treatment is still under evaluation.

1.3.2 HIV Situation

It is difficult to know the precise HIV incidence in any community primarily because of the long clinical incubation period and the precise date of acquiring the infection could hardly be identified. Still, HIV reporting system maintained at the Department of Health contributes important information on

⁸ Hong Kong STD/AIDS Update. Vol 4, No. 1, Jan 1998.

the more recently infected ones and gears the direction of HIV prevention programmes. The seroprevalence studies and unlinked anonymous screening provide indications on the burden of the infection.

(a) Sexual transmission

In Hong Kong, the single most important route of HIV transmission is sexual contact. To examine the more recent trend, we examine the HIV infections reported to Department of Health in the past four years. Among the 541 HIV infections reported between 1994 and 1997, 90% reported to be sexually acquired, and 75% of these were heterosexuals. A greater proportion of homosexuals have been detected through at voluntary HIV testing services, for example, Department of Health (Chapter III), and private sector. The heterosexuals, on the other hand, are more often detected at Social Hygiene Service's clinics when they present with STD, and other services in public sector.

The Social Hygiene Service has contributed 18% of all reported cases. This corresponds to a new case detection rate of 0.07 per 1000 tests (Box 1.6). This estimation may be lower than the prevalence because of three reasons. First, some patients who have recovered from STDs, especially the ex-commercial sex workers, may continue to be followed at these clinics for regular assessment. Second, the known positives are generally not tested. Third, those HIV negative ones who revisit with a repeated episode of STD may get tested again.

As for the homosexuals and bisexuals, there has not been any prevalence studies conducted.

(b) Injecting drug use

There has not been evidence of extensive HIV spread in injecting drug users. To date, a total of 16 HIV infections have been reported to be in drug users, some of whom have probably contracted the infection via sexual contact. The HIV prevalence rates in methadone clinic attendees estimated using unlinked anonymous studies had been low, in the range of 0.02-0.04% from

1994-1996, with upper bound of the 95% confidence intervals not more than 0.2%. No positive was detected in 1997. While approximately 60% of drug users reported to the Central Registry of Drug Abusers are from methadone clinics, little seroprevalence information on the other groups of drug users is available.

Box 1.6

Limitations of HIV prevalence estimates in STD patients

What is the limitation of extrapolating from the HIV data collected at the Social Hygiene Service? STD clinics, as a public service, has been estimated to cover 22.3% of all STD patients in the community.⁹ Health services provided include: medical consultation, STD diagnosis and treatment, universal individual counseling on safer sex precaution, HIV testing, and advice on partner notification. The venereal disease control teams also perform outreach work to actively contact commercial sex workers in the nearby regions, advising them to receive regular examination in the STD clinics. Some, but not all, of these commercial sex workers become regular visitors of the clinics. Another behavioural study at the clinics reported that approximately 85% of attendees are aged between 15-49¹⁰.

Despite the absence of any formal study, it is believed that the uptake rate of HIV testing among the STD patients is high because of the (1) provision of universal counseling for HIV testing; and (2) the presence of STD may serve as a trigger to receive HIV testing. Some patients may get tested more than once in a year if they have additional episodes of STDs. As those who are known to be HIV positives do not usually accept testing, only the new case detection rate (instead of the HIV prevalence) per total sample tested is available.

(c) Recipients of blood and blood products

Between 1984 and 1986, recipients of blood and blood products constitute a significant proportion of reported HIV infection. So far 67 persons have been known to have contracted HIV through contaminated blood or blood products. As for the haemophiliacs, 63 out of the 251 tested at Department of Health were found to be HIV positive (25%). This has covered a majority of the known haemophiliacs in Hong Kong.

(d) General public

The infection in the general public is less well elucidated. In adult males, an unlinked anonymous study in 1553 male government recruits in 1992 who were tested for VDRL as part of the regular recruitment

⁹ Epidemiology of STD/HIV in Hong Kong – 1997 Questionnaire survey. SCA Discussion Paper D-10/96-99. Thirteenth meeting of the Scientific Committee on AIDS. 5th March 1998.

¹⁰ Risk behavioural study in STD clinic clients (unpublished). ASSR. 1997.

examination demonstrated a prevalence of 0.064% (95% confidence interval: 0.002% to 0.359%). Unfortunately there has been no further similar estimates for males as the system was abandoned subsequently. As for women, unlinked anonymous screening using neonatal cord blood has in fact measured the prevalence in their mothers. The prevalence rates had been below 1 in four to five thousand until the first positive sample detected in 1995. The prevalence estimates in 1996 was 0.025% (95% confidence interval: 0.009% to 0.140%). No positive was detected in 1997. The limitation of this study for female prevalence is that those who have successfully avoided pregnancies or have their pregnancies terminated before term have not been included.

The blood donor's HIV prevalence is below 0.1%. In 1997, the HIV positive rate was 7 in 187753 blood units tested, or 0.004% (95% confidence interval: 0.002% to 0.008%). This is, however, an underestimation of the prevalence in the general population as the Hong Kong Red Cross Blood Transfusion Service has been discouraging the HIV positives, and those at risk of infection, to donate blood.

1.3.3 STD and HIV epidemiology

STD epidemiology is examined in the context of HIV/AIDS situation assessment in that (1) having sexually transmitted diseases, especially the ulcerative ones, poses greater risk of HIV infection, and (2) incidence of STDs in the community reflects the intensity and prevalence of high risk sex behaviours.

The Social Hygiene Service has been seeing approximately 20,000 new cases each year and a rising trend has been noted recently. In 1997, the Service had diagnosed 228 new primary syphilis, 2412 gonorrhoea, 9754 non-gonococcal infections, 3124 warts and 1113 genital herpes cases. The rise in incidence is obvious in primary syphilis (44 in 1995 and 151 in 1996) and genital herpes (796 in 1995 and 997 in 1996). The male to female incidence was 1.74 in 1996 & 1.81 in 1997.

Of all HIV infections reported, 28% were from the private sector, which has been attending to an estimated 78% of all symptomatic STD cases. The disease pattern, according to symptomatic classification, is similar to that in public services. The former refers basically to primary syphilis and genital herpes while the latter the gonococcus and chlamydial infections. Herpes antibody seroprevalence studies could provide unbiased estimates of the STD prevalence. A study involving sera from general population, STD clinic attendees, and commercial sex workers in 1995¹¹ confirmed that (1) none of those under 15 had antibodies against herpes simplex type II (HSVII); (2) 18.2% of those above 24 had previous infection, (3) HSVII antibody titres in STD clinic attendants are higher, 24.3% in males, and 35.5% in females, and (4) 77.5% of commercial sex workers are HSVII antibody positive.

1.3.4 HIV and pregnancy

Concurrent HIV infection and pregnancy alerts public health practitioners of several issues: First, HIV infection in pregnant women may lead to vertical transmission; two thirds of which may be preventable with prompt prophylactic treatment. Second, early diagnosis of HIV infection may also alter the decision of whether to continue the pregnancy.

Under the AIDS Unit's registry, a total of 22 pregnancies in 17 HIV positive women have been recorded since 1991. A total of 12 babies were born, while 8 ended in termination of pregnancy, one spontaneous abortion, and one loss to follow up. Four of these babies were HIV positive while three of the mothers learnt of the diagnosis of HIV infection within the first one year or so after the delivery. Three babies had confirmed not infected while the remaining five babies were too young to be concluded on their HIV status, or had been lost to follow up. Twelve out of the 17 HIV infected women had infection diagnosed during the pregnancy. Five proceeded to delivery with antiretroviral (zidovudine) prophylaxis.

¹¹ Lo JCY, Lim WL, Ho DWT, Field PR, Cunningham AL. Types-specific seroepidemiology of herpes simplex virus in Hong Kong. Hong Kong Society for Infectious Diseases Second Annual Scientific Meeting. March 1998.

The annual HIV positive pregnancy rate is estimated to be 0.025%, derived from results of the unlinked anonymous screening using neonatal cord blood samples. The confidence range is, however, wide.

1.3.5 Tuberculosis and HIV infection

HIV infection has been noted to worsen the tuberculosis control in some countries. In Hong Kong, tuberculosis control has long been high in the public health agenda. The TB and Chest Service of the Department of Health operates 17 outpatient clinics providing free screening and, for the infected, Directly Observed Treatment (DOT)¹². Universal BCG vaccination is also provided free to all newborns. The coverage rate has been estimated to be near 100%.

The preliminary local data have not shown any association between history of tuberculosis and reactivation of the disease after HIV infection. Two features have been noted. First, the presentation of tuberculosis in HIV infected is different from the non-infected. The median age of tuberculosis in HIV infected is 36.7 years (range 7 – 66 years) while the notified tuberculosis showed a bimodal presentation, with peaks in early twenties and after 60. Second, while most of notified tuberculosis have respiratory involvement, a greater proportion of HIV infected present with extra-pulmonary diseases. In 1995, a total of 11026 respiratory (4605 active infection) and 475 non-respiratory tuberculosis cases were seen at the government TB and Chest Services. On the other hand, among the 309 cumulative AIDS cases, 59 had been reported with tuberculosis as the primary AIDS defining illness (with 28 of them presenting as pulmonary tuberculosis). Lately, pulmonary PCP and tuberculosis co-infection had been reported. Drug resistance is area of concern. There have been, so far, three confirmed resistant cases, two to Isoniazid and one to multi-drug Isoniazid, Rifampicin, and Streptomycin. All

¹² DOT: supervised thrice weekly medication provided free at the TB and Chest Services. For the non-HIV cases, usual treatment regimen consists of Streptomycin and Pyrazinamide for two months and Isoniazid and Rifampicin for six months.

three were primary drug resistance.

The HIV prevalence rate of tuberculosis patients was 0.2% in 1997 (95% confidence interval 0.02% to 0.7%) from unlinked anonymous screening. Voluntary HIV testing is also available for tuberculosis patients.

1.3.6 Modelling and scenario construction

The ASSR researchers (Box 1.1) has conducted a modelling study which constructed the HIV/AIDS scenarios using a back calculation method basing on estimated AIDS incidence. The study suggested that a sharp but limited burst of HIV spread had occurred in the homosexual and bisexual population in early eighties while the bulk of heterosexual spread did not start until after the mid-eighties. It provided an estimate of cumulative 3000 infections and 250 AIDS cases in 1994¹³. A follow up estimation and modeling in 1997 produced a revised estimate of HIV prevalence 1000-1500. The limitations of this modelling method is (1) it relies on assumptions of the natural history in the pre-protease inhibitor era; and (2) it assumes the reported cases are largely local.

This study has created major epidemiological and policy implications. As a scientific research, new perspective was adopted through a re-examination of surveillance and other epidemiological studies. These first scientific estimations have subsequently become the official estimates of Hong Kong and published in the World Health Organisation publications (World Epidemiological Records). On the policy side, the analysis and the results had directive influence on the emphasis of programmes in terms of preventive campaign priority and planning of services.

¹³ Chin J. Estimation and projection of HIV infection and AIDS cases in Hong Kong. Hong Kong: ASSR Project; 1994.

1.4 The Social and Behavioural Factors

In infectious disease epidemiology, the three factors that contribute its spread in any population are: (a) presence of susceptible hosts, (b) presence of agents, and (c) the conditions that allow the transmission to occur. In the context of HIV/AIDS, the latter is largely tied to a number of social-behavioural situations. In this section, we examine the available information on the HIV related risk behaviours in terms of sex and transmission via drug taking. Special social and behavioural factors that increase the risks of commercial sex industry and mobile population are also discussed. We also assess the situation in adolescents, as, from the public health control point of view, they are the vulnerable group that are joining the sexually active majority of the community.

1.4.1 Sex behaviours

For sexual transmission, the high risk behaviours are having multiple sex partners and inconsistent or failure to use condoms in those with more than one sex partner. On a population basis, the proportion that uses commercial sex workers constitutes the group who are most likely to contract HIV infection and the other sexually transmitted diseases.

(a) Sex behaviours in the community at large

Systematic collection of AIDS related risk behaviours in the general population has been uncommon. So far, there was one general household KABP survey on AIDS in 1992 commissioned by the Hong Kong AIDS Foundation. Among the approximately 500 male respondents, 3.2% had one or more non-regular sex partner. The condom use rate was not measured because of the small size of this subgroup. The percentage seems to be low when compared to the 11% detected from the Youth Sexuality Survey in 1991 in young adults 18-27.(see 1.4.5 on adolescents)

(b) People with STDs

Available information on risk behaviours of STD patients has largely

been obtained at the Social Hygiene Service. Behavioural assessment in 1996 showed that more than half of the last sex contact with non-regular partners had been in Mainland China in the male attendees, and more than half had not used condoms in that contact. Thirty percent of male clients reported never used condoms with non-regular sex partners.

There has not been any behavioural information of those attended private practises.

(c) Homosexuals

There have been minimal published data documenting the behavioural factors of the homosexuals and/or bisexuals as they relate to HIV and STD. A majority of the local research on homosexuality centres on the sociological context. Behavioural studies at the Department of Health HIV Testing Service recorded that approximately 15% of the clients were homosexuals. Half of them reported having had more than 3 partners in the previous 12 months. Paid sex had been relatively uncommon. Half reported never used condom in the last intercourse, whereas 49% and 26.5% never used condom with non-regular partners in 1996 and 1997 respectively.

1.4.2 Illicit drug use

The government's Central Registry of Drug Abusers reported that the new drug user incidence had remained relatively constant at 4000 from 1993 onwards, whereas the prevalence was around 20000. In 1996, a total of 19626 were reported and 4281 were new to the Registry. There has, however, not been any official estimate on the real size of the problem. A previous analysis has shown that 60% of the reports were submitted via the methadone clinics. There has not been any official estimation of the total number of drug abusers in Hong Kong.

Behavioural surveillance in methadone clinic users provides the database for understanding the behavioural risk factors involved. Since 1990 1000 to 1600 cases have been interviewed each year. It revealed the

proportion of injecting drug users varied between 20-30%. Among them, about 10% had shared needles. The same monitoring has also been in place in a large inpatient drug treatment centre for males with more than 2000 cases interviewed each year. The proportion of injecting drug users among the newly admitted stayed at 77% in the past four years, the proportion who had ever shared needles decreased from 22% in 1991 to 4% in 1996. Drug addicts on the street were interviewed by a group of ex-addicts on AIDS related behaviours¹⁴. In the studies conducted from 1993 to 1996, 20% of the respondents were injecting drug users who had been sharing needles in the last three months, 25% to 30% had ceased needle-sharing. The overall needle-sharing rates were higher than those of methadone clinic clients. As regard sexual behaviours, 16.3% of the respondents in 1996 reported never used condoms, compared with about one-third in 1993.

The latter study demonstrated that 95% of those interviewed had registered with the methadone clinics, whereas 75% of male and 50% of females had been previously admitted to an inpatient rehabilitation centre.

1.4.3 Commercial sex industry

Commercial sex workers, as an occupation, face much higher risks of sexually transmitted diseases through their work. Use of condoms offers one effective means in stopping HIV transmission while this is apparently difficult in view of the economic and social pressures. A qualitative study in 1992 first estimated that half of the clients of the female commercial sex workers used condoms¹⁵. In 1994, 190 female commercial sex workers attending Social Hygiene Clinics were interviewed¹⁶ and 38% reported always used condoms with their clients and 55.3% never or seldom used a condom with their non-paying partners. Women over the age of 30 were less likely to use condoms.

¹⁴ Chien J. Summary findings of street addict's surveys on AIDS AWARENESS 1992-1996. Report submitted to the Committee on Education and Publicity on AIDS, 26 February 1997.

¹⁵ Li PCK et al. A qualitative survey on female commercial sex workers in Hong Kong. [Abstract PO-D-5636] Proceedings from the VIIIth International Conference on AIDS. Amsterdam, July 1992.

¹⁶ Wong KH et al. Condom use among female commercial sex workers and male clients in Hong Kong. *Int J of STD & AIDS* 1994;5:287-9.

As for the male clients attending STD clinics, 22.8% never or seldom used a condom during commercial sex. The reasons for not using a condom included: the belief that their partners were reliable, condoms reducing sexual pleasure, and condoms not available when they had sex.

In 1994, Foy recruited a sample of 45 female commercial sex workers from private nightclubs in addition to 132 recruited from the government STD clinics¹⁷. Fifty percent of the workers reported always used condoms when at work but only 13% always did in private. While only 4% never used condoms at work, 49% never did so in private. Reasons for not using a condom at work included pressure from clients, and not feeling risky; and 16% did not use a condom because of the higher pay in return, and some indicated that not using one with regular clients. This study also provided data about the sex trade among the indirect sex workers, those who were not working full time in commercial sex.

As regards the sex trade, a qualitative study under ASSR documented the pattern of sex establishments in Hong Kong in 1996¹⁸. It reported that the total number of *known* establishments had exceeded 1100 in 1995. Although there were more premises providing direct commercial sex workers than those for indirect ones, the total number of indirect commercial sex workers were greater.

Almost all published data on commercial sex have so far been focussed on female workers. The pattern and factors associated with male commercial sex workers are not exactly known.

1.4.4 Human mobility and risk behaviours

While travel itself is not a risk factor for HIV infection, concerns have

¹⁷ Foy RWS, Li Y, Kaldor JM, Hedley AJ. Factors associated with sexually transmissible diseases/human immunodeficiency virus infection and condom use amongst female sex workers in Hong Kong. Proceedings. Hong Kong AIDS Conference 1996. Hong Kong. Nov 1996. Pp. 24-36.

¹⁸ Commercial sex industry in Hong Kong. Report of a preliminary study. AIDS Scenario and Surveillance Research. October 1995.

been raised on the pattern of risk behaviours among those who travel frequently. CRPA (Box 1.1) reported the findings of Hong Kong-China Travellers Sexual Behaviour Study conducted in March 1997. They reported a lower AIDS awareness and knowledge as compared to the general public and a high level of risk behaviours. Among the 1200 respondents interviewed when they crossed the border at Lo Wu Check Point to Mainland China, 11% reported having contacts with commercial sex workers while 18.3% had sex with non-regular partners. One third of those who contacted commercial sex workers in this trip and 32% making the contact in the previous 6 months failed to use condoms. While married men were not less likely to contact commercial sex workers, 74.5% said they would not use condoms with their wives afterwards.

There have been other studies on frequent travellers. In 1995, for example, a preliminary study was conducted under ASSR to document the commercial sex establishments along the routes of the Hong Kong-Mainland truck drivers and explore the associated social factors.

In another study on travellers departing for other countries¹⁹ (mainly China, USA, Singapore, Thailand, Taiwan, and the Philippines), 44% reported having sex with “strangers”, of which 38% had used condoms during sex.

1.4.5 Adolescents

Adolescents have been broadly referred as the group moving from childhood to a sexually active period. The mid-1996 estimates of the population aged between 15-24 were 869,511 (14% of total 6.12 million). Adolescents are examined on the rationale that while entering the sexually active age, their behaviours may have an indication on the future trend, from the public health point of view. Variables used in this particular group have

¹⁹ Abdullah ASM, Hedley AJ, Fielding R. How much do Hong Kong and Asia Pacific travellers understand about HIV/AIDS risk? The need for effective for effective intervention. Proceedings of Hong Kong AIDS Conference [abstract D11]; November 1996.

been the age of onset of sex behaviours and the occurrence of premarital sex. Teenage pregnancy rates provide indirect indication of the prevalence of unprotected sex.

The Family Planning Association's 5-yearly youth sexuality surveys (Box 1.7) have provided some insight into the risks in adolescents. For the respondents selected through household sampling, the proportion of those aged between 18 to 27 who had ever used commercial sex workers was 16% in 1986 and 11% in 1991.

In the same survey, the proportion of those having had sex remained at about one third. The proportion is lower in the in-school survey, which only targeted F.3 to F.7 students. Six percent of boys and 4% of girls had sex experience. The street youth survey revealed that condoms have been the most commonly used method for contraception : 84% in 1991 compared to 64.5% in 1986 in boys whereas 76.5% in 1991 and 50.6% in 1986 in girls.²⁰

Box 1. 7

Research on Youth Behaviours

Youth Sexuality Survey

The Youth Sexuality Survey of HKFPA provides some indication of the trends of risk behaviours in both school and out-of-school youth, while the study on the marginal youth measured those of the active clients of the outreach social worker teams.

Study on the Knowledge of and Attitude towards AIDS-related issues among marginal youth

This study reported that, among 800 clients of outreach social workers, that 40% had had sex experience, 17% of them being constant condom users. These youngsters knew that AIDS was a killer disease but other knowledge about the natural history was not satisfactory. The researchers had defined marginal youth as those aged between 13-18 belonging to one of the following: members of natural group at street, unattached youth, potential run-away from home, and potential drop-outs. (There were 6000 such active cases (contact on regular basis) in Hong Kong. However, it was reckoned that marginal youth is a heterogeneous group each having its sub-culture.

²⁰ Data and tables 1991 and before are abstracted from the Youth Sexuality Survey 1991. In-school and Out-of-school. The Family Planning Association. The 1996 results were taken from data discussed at Scientific Committee on AIDS and correspondence from Dr Susan Fan, Chief Executive of FPA.

In another study on marginal youth (Box 1.7) ²¹, forty percent of the youngsters aged between 13 to 18, both sexes, contacted by the outreach social workers admitted that they had had sex experience before. The mean age of first sex intercourse was 14-15, with a range of 11 to 21. Forty percent of them had more than one sex partner in the year before. Most (92%) had sex activities unplanned. As for condom use, 41% had used condoms in the last sex intercourse, 28% reported they had never used condoms. Most reported condom use for pregnancy prevention (86%) while more than half also for prevention of STD or AIDS. The most popular source of condoms was convenience stores.

About drug use, nearly 40% had tried at least one of common illicit drugs. The mean age of onset of drug use was 13.8 years ranged from 8 to 19. The most popular drug administration routes were oral and inhalation. Only a few had tried injection.

1.5 Programme Evaluation and Monitoring

In the conventional public health programmes, especially those on infectious diseases, outcomes of disease control are usually assessed through the surveillance on disease incidence and prevalence. For HIV/AIDS control, this approach is, however, not sensitive enough, and is also by itself insufficient for purpose of programme planning. Data are needed to facilitate programme people to develop appropriate intervention strategies in the areas described in Chapters II, III and IV, that is, HIV prevention and health promotion, provision of clinical and support services, and the promotion of a supportive environment. Attempts have therefore been made to supplement the surveillance through (1) regular awareness and attitude surveys, and (2) sentinel behavioural surveillance. Finally, the potential of developing programme indicators has been explored by the Advisory Council on AIDS in late 1997. All

²¹ HoBCO, Pun SH, The knowledge of and attitude towards AIDS related issues among marginal youth in Hong Kong. Hong Kong : City Consultants Ltd. ; 1997

these new initiatives are contributing towards a better understanding of the HIV/AIDS situation instead of the narrower meaning of surveillance in conventional public health programmes.

1.5.1 Awareness and attitudes

A telephone survey has been started under the auspices of CRPA to assess and monitor AIDS awareness and acceptance of the public towards people living with HIV/AIDS. The sample sizes varied between 1000 and 1600. Emphasis had been put on whether the public was aware of AIDS, understood that the disease can be transmitted in an apparently healthy individuals, and their level of misconceptions. Conducted as an annual survey from 1994 to 1996, the study revealed a high level of awareness towards HIV/AIDS, with between 80% to 90% giving correct answers to questions on transmission routes, and the asymptomatic nature of HIV infection. There were however reported negative attitudes towards those infected, with 31.2% - 37.6% expressing avoidance, 22.1% to 24.8% objecting to normal schooling for HIV positive students. Perceived risk of infection had been low, with 5% - 8% of women and 8% - 9% of men perceiving an average/high risk of infection.

Other similar studies, with slightly different focus, have been conducted in the last years to assess the attitude and awareness of specific occupations, including social service personnel, health professionals, workplace personnel. In a study conducted in 1995 (Box 1.8), training needs was one major area pursued by researchers, which carry strong implications to the development of HIV prevention and management programmes in health profession. Most studies have provided useful information as baseline in assessing the societal factors behind HIV prevention and control. Repeat studies have also been conducted in some cases allowing trends to be assessed.

Box 1.8: Training needs of intermediaries (Research)

Research: Assessment of training needs of intermediaries – the health care workers and the social services personnel

The training needs of health care workers was examined in 1995-96 in a large scale mailed questionnaire survey to all medical and nursing personnel, laboratory technicians, occupational therapists, radiographers, physiotherapists and optometrists, with an assessment of their knowledge about the natural history of HIV infection, clinical management and infection control measures. This study provided an important benchmark on the areas where HIV training should need to be strengthened or developed not only in medical and nursing and the paramedical professions. The results were presented at a meeting of SCA.

As for the social services personnel, their knowledge on AIDS and the perceived needs of training was assessed in 1994 and 1997 through mailed questionnaires²² (1885 questionnaires in 1994 and 3301 in 1997, with response rates of 58.5% and 41.6% respectively). Targets were the home helpers, outreach worker, children and youth services workers, drug rehabilitation services and family services. This study was commissioned by the Hong Kong Council for Social Services in line with its training programmes for social services personnel.

1.5.2 Sentinel Risk Behavioural Surveillance

Sentinel risk behavioural risk surveillance has been started as a pilot project under the ASSR programme (Box 1.1). This has involved experimentation to identify a sustainable mechanism to monitor AIDS related high risk behaviours for two main purposes. One is to improve the sensitivity of the surveillance system to detect pre-epidemic changes, and two, to contribute to the measurement of evaluative indicators for the AIDS programme in the society as a whole. Several potential sentinel sites had been tested: (1) public STD clinics, (2) outpatient methadone clinics, (3) inpatient drug treatment centres, and (4) correctional institutes.

The studies have been organised not only to conduct behavioural surveys, but also to establish a sustainable surveillance mechanism. In some cases, for examples in the assessment of drug-taking behaviours, the surveys have been incorporated in the regular consultation conducted by health professionals. Some trends can be deduced, which have been described under

²² Report of the follow up survey on AIDS related knowledge and attitude among the social welfare personnel in Hong Kong (1994-1997). Submitted

1.4.2. In other settings, sentinel sites have been placed at clinics or other places where long term support could be ensured. This has resulted in limiting the scope to recruiting samples from selected community groups, instead of establishing as a monitoring mechanism for the general public.

1.5.3 Programme effectiveness indicators

Whereas HIV/AIDS surveillance portrays the end-stage of HIV spread, risk factors surveillance assesses the potential for HIV to disseminate in the community. It is clear also that a mechanism is needed to inform policy-makers, service-providers, and the community how the programmes in place have been contributing to the overall control of the infection and the risk factors. The concept of setting up sentinel systems that contribute to continuously evaluating aggregate programme performance in the community has been discussed at the Advisory Council on AIDS²³. By extending the concept to the non-institutionalised and non-clinic based groups, the programme indicators would constitute another level (after HIV/AIDS, attitude/awareness and risk factors surveillance) of the HIV/AIDS information system. The establishment of programme indicators has also been advocated by WHO and UNAIDS. The mechanism is yet to be set up, while there is not yet any commonly agreed indicators for the programme.

1.6 Situation Overview

As the concluding part of the Chapter, this section deals with the characteristics of the surveillance mechanisms with emphasis on their constraints. Despite these drawbacks, a picture of the current HIV/AIDS situation is painted towards the end, based on information collected over the years, and through summarising from the descriptions under 1.3, 1.4 and 1.5.

²³ To develop programme indicators ... ACA discussion paper.

1.6.1 Characteristics of the surveillance mechanisms

Over the years, the local surveillance programme has evolved from a disease reporting system to one encompassing both conventional surveillance activities as well as initiatives developed to understand and evaluate the situation. HIV/AIDS situation now carries broader meaning than merely HIV prevalence/incidence, but also socio-behavioural factors, and indicators for tracking the infection and its control. In this connection, data have also been collected in a multitude of ways to construct and verify the trends. Apart from the AIDS Unit that provides technical input, the role of the Scientific Committee on AIDS and the various research initiatives have been most significant.

A number of constraints have been identified in the course of examining the surveillance mechanisms:

(a) Sampling in surveillance activities

Close inspection of the various groups under surveillance demonstrated a predominance of clinic based samples, which cannot be directly extrapolated to that in the community. Analysis is influenced by the choice of methodology and sampling frames. There is the bias towards underestimation in assessing the HIV situation in women when, for example, HIV prevalence is inferred from the results obtained in the unlinked anonymous screening of neonates. (1.3.3 and 1.3.4)

(c) Seroprevalence estimates

With relatively low HIV positive rates, the existing sero-prevalence studies are providing unstable estimates with wide confidence intervals. These add uncertainty to the problem definition process.

(d) Research types and outputs

Current research efforts have been concentrated on epidemiology, social and behavioural, and evaluation studies. Other types, such as intervention trials are less popular. These would have impacts on the

development of long term and specific strategies in the future. Basic science research is also less developed. Not all research outputs fit into the programme development cycles. Some areas may be repeatedly dealt with while the others might not have been touched whatsoever.

(e) Impact and outcome monitoring

A regular monitoring mechanism on the programme impacts and control has not yet been available. The current provision in the tracking of socio-behavioural factors is not sufficiently institutionalised to provide useful data to AIDS programme operators.

1.6.2 Main features of the HIV/AIDS situation

Despite the constraints identified in the last section, the local surveillance system has been able to provide some key information on the current situation of HIV/AIDS, which can be summarised as follows:

(a) A low HIV prevalence in the general public

Serosurveillance studies have revealed a prevalence of lower than 0.1% in the adults. One study estimated that the prevalence now stands at between 1000 and 1500.

(b) Main routes of HIV spread

Sexual transmission is the commonest mode of HIV spread. This phenomenon is observed from the reported data as well as the diagnosis of HIV infection in STD patients. A majority of the sexually acquired infections are heterosexual men. Except for the infection of haemophiliacs in the mid-1980s, blood contact has not been a significant factor in causing HIV spread in Hong Kong. On the other hand, infection through needle-sharing in injecting drug users has been rare. A total of only 16 drug users have been reported to be HIV infected. The HIV prevalence in methadone users is 0.X%.. The risk of perinatal infection is genuine but small. So far only four babies have been known to have contracted HIV from their mothers.

(c) The pattern of AIDS

A total of 309 AIDS cases have been reported as of the end of 1997, the highest number being recorded in the last two years. *Pneumocystis carinii* pneumonia accounted for 30.6% of all primary AIDS defining illnesses. *Penicillium marneffeii* (9%) is a unique condition as an AIDS-defining illness because of its endemicity in South east Asia. Overall about one-third to half of the reported cases are alive. With the use of effective antiretroviral treatment, its impacts on AIDS would need to be evaluated.

(d) Risk of sexual transmission

The practice of high risk behaviours can be inferred from (1) a rising incidence of STD, including syphilis, (2) a higher rate of herpes simplex type II antibodies in STD patients and commercial sex workers than the general public, (3) varying rates of not using condom in STD patients (20%-30%), commercial sex workers (50% with non-paying partners), marginal youth (28%), cross border travellers (about one-third), and (4) the use of commercial sex in cross border travellers (11% in the last trip), youth aged 18-27 (11% in 1991).

(e) Risk of injecting drug use

History of injection was higher in those attending inpatient drug rehabilitation treatment, compared with methadone users. The rates of drug injection and needlesharing varied from one sample to the other, depending also on the definition adopted in each study. The needle-sharing rates were generally low, particularly in those reported in institutions, viz. methadone users (10%), and those on inpatient treatment (4%), but was higher in those interviewed on the streets (20%)

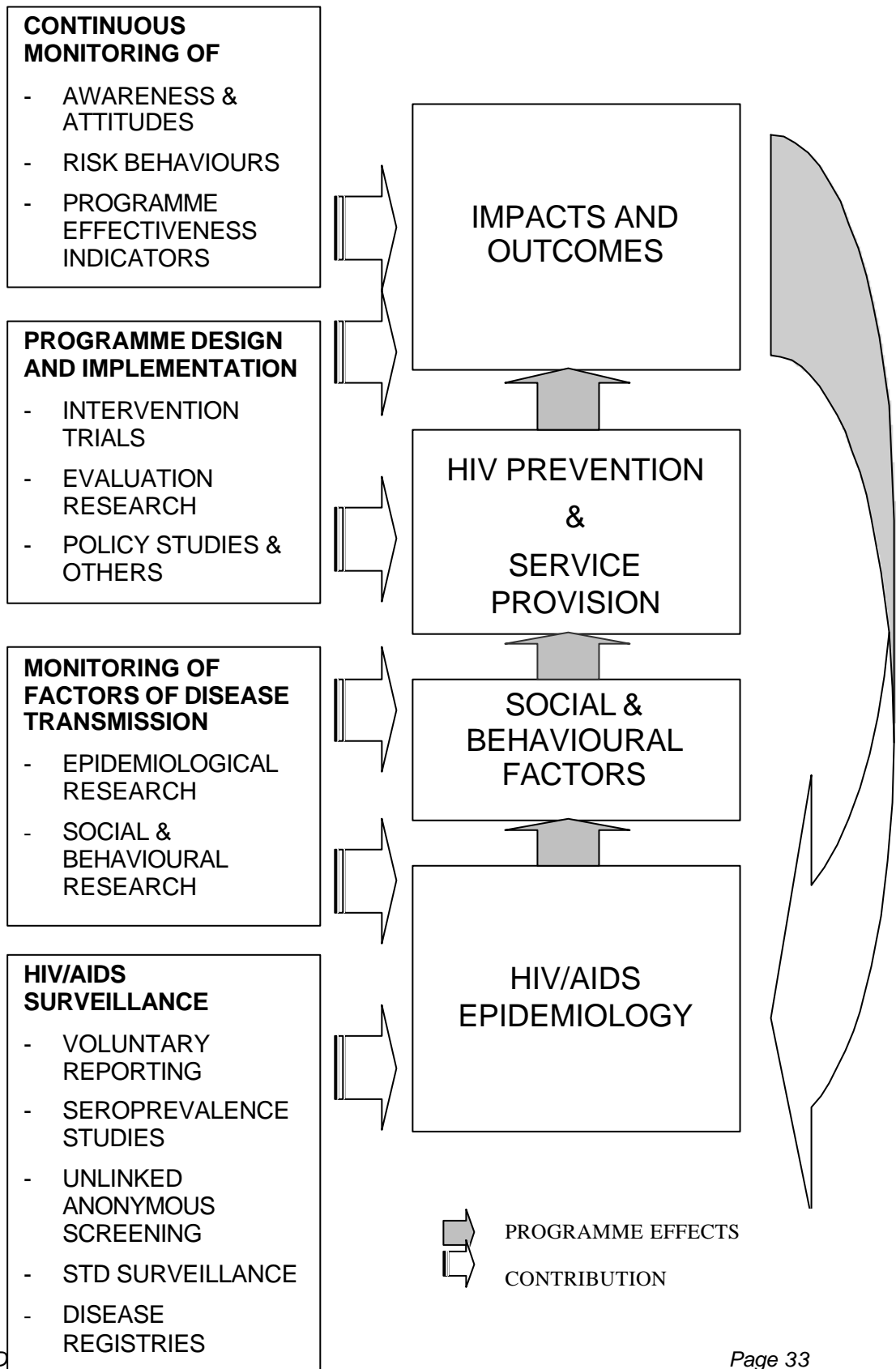
(f) Attitudes and awareness

A relatively high level of public awareness has been reported in the surveys conducted over the last for years, in terms of one' s knowledge about transmission routes and common misconception. Negative attitude was, however, held by a substantial proportion of members of the public against people living with HIV/AIDS.

Appendix I.1 Surveillance, Research and Public Health Programming

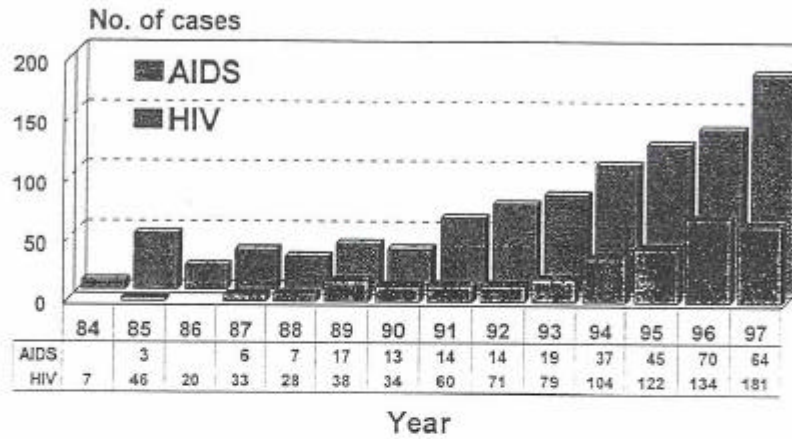
MECHANISMS/METHODS

INFORMATION



Annual Reported HIV/AIDS

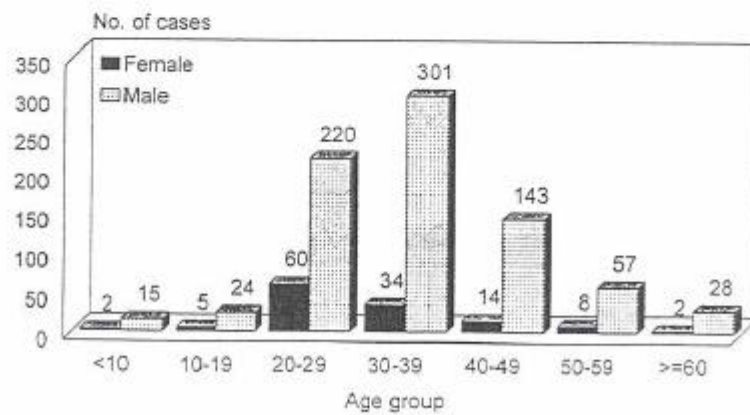
1984 - 1997, Hong Kong (N=957)



spp/hivsurveillance Mar 98

Age distribution of reported HIV infection

1984 - 1997, Hong Kong (N=957)

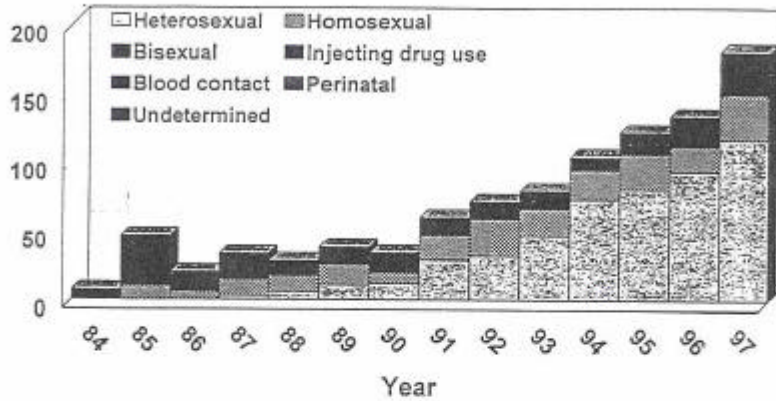


spp/hivsurveillance Mar 98

Note: 3 women & 41 men are of unknown age

Route of transmission of HIV infection

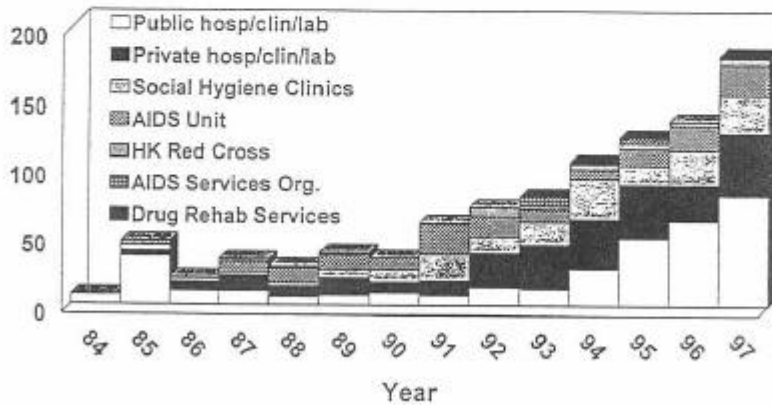
1984 - 1997, Hong Kong (N=957)



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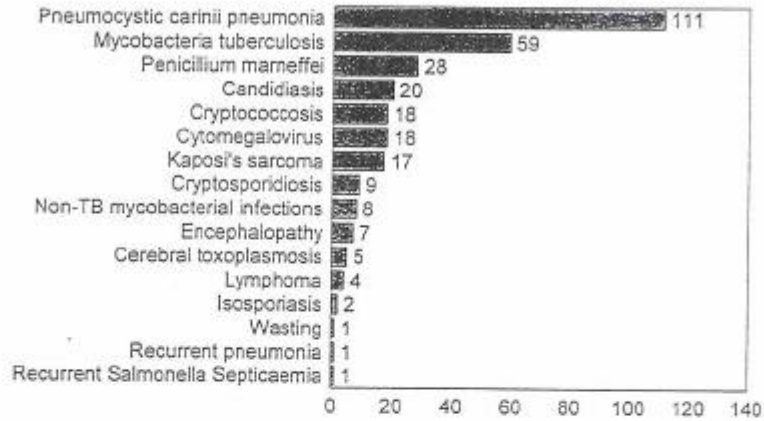
Source of referral of HIV infection

1984 - 1997, Hong Kong (N=957)



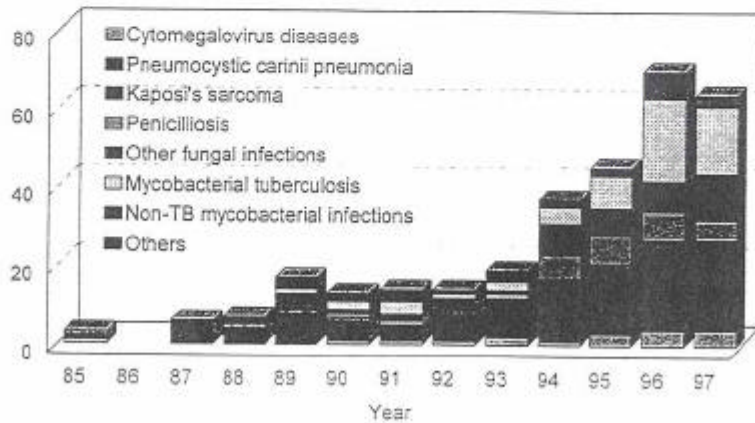
spp/hivsurveillance Mar 98

Primary AIDS-defining Conditions Hong Kong 1985 - 1997 (N=309)



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Primary AIDS-defining Conditions 1985 - 1997, Hong Kong (N=309)



spp/hivsurveillance Mar 98

Internal Assessment Report

A review on the HIV/AIDS situation and the programmes on its prevention, care and control in Hong Kong

Chapter II:

HIV Prevention and Health Promotion

Advisory Council on AIDS 1998

II. HIV Prevention and Health Promotion

2.1 Introduction

2.2 Programme Foci

- 2.2.1 Enhancing AIDS awareness
- 2.2.2 Prevention of sexual transmission
- 2.2.3 Reducing blood-borne transmission of HIV
- 2.2.4 Reducing perinatal transmission
- 2.2.5 Promoting acceptance towards people with HIV/AIDS

2.3 HIV Prevention in Special Settings or Groups

- 2.3.1 Correctional institutions
- 2.3.2 Travelers, migrant workers, and other mobile population
- 2.3.3 Youth
- 2.3.4 Women

2.4 Programme Organisation and Delivery Modalities

- 2.4.1 Programme organisation
- 2.4.2 Delivery modalities

2.5 Characteristics of the Local Programmes

Appendix II.1 Television Announcements of Public Interest (APIs) on AIDS

Appendix II.2 Programme Foci and Target Groups/Settings

II. HIV Prevention and Health Promotion

2.1 Introduction

The “Strategies for AIDS Prevention, Care and Control in Hong Kong”, published by ACA in 1994, set out the three pre-requisites for an effective AIDS programme¹, which should include (1) information and education; (2) clinical and support services; and (3) supportive environment. As a medical disease, preventive strategies have been developed to control HIV/AIDS in community. Conventional concepts of disease prevention have, however, changed over the years to reflect a broad perspective of health promotion. The latter includes not only preventive measures, but a whole range of activities to improve the quality of life of the community as well as those infected. A multisectoral approach is the cornerstone to this new strategy. Promotion of a supportive environment constitutes also one aspect of an effective health promotion programme. In Hong Kong, a good range of activities have been organised, and the scope of the programmes has also extended beyond AIDS to related social and health areas. For this Chapter, discussion on HIV prevention and health promotion is limited to the direct forms of activities and programmes developed to address AIDS, while the creation of a supportive environment is covered in Chapter IV.

In the past decade, both population based and target oriented approaches have been utilized in HIV prevention and health promotion activities in Hong Kong. While the former aims at disseminating preventive information to people of all ages and gender, the latter stresses on designing and implementing programmes tailored to meet the needs of specific groups. However, no matter what approaches or forms they have adopted, major programme foci could be identified in common to all. In this chapter, we examine the five major foci of the HIV prevention programmes in Hong Kong. There are special settings or groups which traverse conventional programme foci. Interventions in the commonly adopted settings or groups are evaluated. Selected policies and intervention strategies that aim at modifying the social environment are highlighted only in context of meeting the objectives of HIV

¹ Strategies for AIDS Prevention, Care and Control in Hong Kong. Advisory Council on AIDS. 1994. Government Printer. Ch. 2.2 pp11.

prevention and promoting health of the population. The details are further elaborated in Chapter IV. The delivery modalities are reviewed, which finally leads to an identification of characteristics of the local programmes. Activities of both the Government and NGOs are considered together.

2.2 Programme Foci

Most of the HIV prevention and health promotion programmes or interventions in the territory could be classified under one or more of the following foci. (Appendix II.2). They are: (a) enhancement of AIDS awareness, (b) prevention of sexual transmission, (c) reducing blood-borne transmission, which includes preventing transmission through blood and blood products, and that in drug users, (d) prevention of perinatal transmission, and (e) promotion of acceptance towards people living with HIV/AIDS. The emphases of the different foci have evolved over the year. (Box 2.1)

Box: 2.1

Evolution of HIV prevention programme foci

HIV prevention has always been an emphasis in Hong Kong's AIDS programmes. In the early eighties, AIDS was perceived as a disease of foreigners, and most of the early responses were to alleviate people's anxiety. The Government's hotline for those who suspected themselves at risk was almost the only source of information. The public learnt about the transmission modes primarily through press reports released by medical professionals, translated medical and health news from overseas literatures, or feature articles presented by a small number of interested individuals.

The first ever planned publicity to disseminate information relating to HIV prevention in Hong Kong was organised in 1986. The key step taken by the government was the set-up of an inter-departmental education and publicity committee to initiate population targeted media campaign. TV spots (Announcements of public interest – appendix II.1) on AIDS, together with radio versions, were first produced, to warn the public against the infection. Like any other diseases, risk factors and preventive measures identified by the Western countries constituted the focus of these media campaigns. At the same time, targeted education programmes were also initiated in the government networks of sexually transmitted disease clinics and methadone clinics.

It was soon recognized, almost simultaneously in most developed countries, that people with HIV/AIDS were not well accepted because of their association with marginalized populations, such as injecting drug users and commercial sex workers. Concern was raised on how this rejection might be a hindrance for at-risk population to access relevant information especially on effective preventive measures. Building up a supportive environment in terms of both physical and social-cultural support was recognized to be an essential component of effective disease prevention strategies. In Hong Kong, it was translated into a series of actions to promote acceptance towards, not only the disease prevention approaches but also people with HIV/AIDS. Steps taken include misconception clarification, portraying AIDS patient as one suffering from a disease, the concept of anti-discrimination, and the rights of the infected.

2.1.1 Enhancing AIDS awareness

Enhancing awareness has been regarded as the main objective of most population-based campaigns or functions. Mostly media functions, formats used include TV spots or Announcements of Public Interest (Appendix II.1) and radio announcements, as well as other television programmes which reach a wide audience². There have also been public events such as exhibitions, fun fair, red ribbon sale, variety shows, and concerts. More recently, fundraising activities have been organised by community organisations, which also serve the function of reminding the public about AIDS. Many public events are accompanied by distribution of information leaflets and publicity materials. These activities are often participated by large crowds of mixed background. Simple messages are disseminated, for example, “AIDS is fatal and incurable” in the early days whereas the more recent public functions stressed on “showing care and concern to those living with HIV/AIDS”.

The annual World AIDS Day/Campaign’s main functions mostly fall under this category. Between 1988 and 1991, World AIDS Day activities were strictly Government activities, through the coordination of the Committee on Education and Publicity on AIDS. Subsequently it has become a focus for activities participated by both the Government and NGOs. Whereas the World Health Organisation (and Joint United Nations Programme on HIV/AIDS since 1996) has been giving a new theme to each year’s World AIDS Day, this has not caused much change to the tone of the campaign – that of arousing general awareness. The specific themes have not been found to be always applicable in the local setting. Though often a one-off project, a 5-metre high bronze sculpture was erected in the city on World AIDS Day 1997 with an attempt to increase the sustainability of the impacts.

² Committee on Education and Publicity on AIDS (CEPAIDS) Discussion Paper presented at the XXVIIIth meeting on 9 February, 1998. Media communication on AIDS; 1998.

Effectiveness of public awareness campaigns is difficult to be evaluated. The aggregate impacts of these activities have been monitored regularly by the annual Community Awareness Survey of the CRPA (see Chapter I: HIV situations in Hong Kong) between 1994 and 1996. In the 1996 survey, it was demonstrated that 60% of the respondents were interested in AIDS and 30% in AIDS related activities. Close to 90% believed that Hong Kong people commonly used commercial sex in Mainland China. While 80% considered the chance of contracting HIV high in Mainland, only 60% thought so in Hong Kong. Approximately 20% considered condom use not very effective. As for general knowledge on AIDS, 80% knew that HIV could be transmitted by asymptomatic carriers while 30-40% still misconceived that HIV could be transmitted through toilet seats and coughing.

Box 2.2

World AIDS Day/Campaign Main Functions in Hong Kong 1988 – 1997

1988	<i>First World AIDS Day</i>	Public Exhibition at Hong Kong Bank Plaza
1989	<i>Our Lives, Our World – Let's take care of each other</i>	Youth Concert at Kowloon Park Piazza
1990	<i>Women and AIDS</i>	Youth Concert at Victoria Park
1991	<i>Sharing the challenge</i>	Public Exhibition at City Hall
1992	<i>AIDS- A Community Commitment</i>	Public Exhibition
1993	<i>Time to Act</i>	AIDS Week 93 – AIDS Awareness Day
1994	<i>AIDS and the Family</i>	AIDS Fortnight – AIDS Awareness Day
1995	<i>Shared rights, shared responsibilities</i>	Ten years of AIDS in pictures – Hong Kong Bank Plaza
1996	<i>One World One Hope</i>	Premiere of Television API on AIDS
1997	<i>Children living in a world with AIDS</i>	Erection of “Ribbon” – a twin-ribbon Sculpture

Apart from media campaigns, other group education activities also carry the major theme of enhancing general awareness on the subject of HIV/AIDS. These include activities for women (2.3.4), youth (2.3.3), the setting of schools, and families. Hong Kong AIDS Foundation has adopted “Family” as its theme for the years 1994-1996, coinciding with the theme of World AIDS Day 1994. Activities include a good range of advertising techniques with production of TV APIs, posters for public venues, bus

advertisements etc. As for schools, AIDS education is organised either independently (Box 2.3) or as a component of sex education (2.2.2(c)).

Box 2.3

AIDS education in schools

AIDS education is promoted in schools through its integration in sex education, and the organisation of other activities focusing on AIDS. In the latter context, emphasis is put not only on routes of transmission but the fostering of supportive attitude towards those infected, as well as the concept of universal precaution in the handling of wound and blood. School talks are organised for students. Other activities organised by the Government and/or NGOs include: quiz, essay competition, poster design competition, surveys, fun fairs, exhibitions. In 1993, a Telematch featuring games and quiz was organised with the support of AIDS Trust Fund. The function was subsequently broadcasted on TV.

2.2.2 Prevention of sexual transmission

There are three main themes, one often leading to the other, to prevent sexual transmission of HIV. They are: safer sex promotion, STD prevention and sex education. While the first two targetted sexually active and/or those known to have been practising high risk sex behaviours, sex education is more for those who are moving into the sexually active age, especially adolescents and young adults. The three themes are applicable to heterosexuals as well as homosexuals or other sexual inclination.

(a) Safer sex promotion

Safer sex incorporates the strategies of reducing the number of sex partners, engagement in sexual activities without exchange of body fluids, and the use of condom. Of these, the use of a male condom is one most important preventive measure against sexual transmission of HIV infection (Box 2.4). While ensuring good supply and acceptance to condoms are of primary importance in safer sex promotion, encouraging proper and consistent use plays an equally crucial role. Approaches taken include dissemination of messages on proper use of condoms to general public or people practising high risk behaviour, encouraging safer sex practice in public functions and

individual counselling (see 2.4.2(c)), and empowering women to initiate safer sex (see 2.3.4).

Condom promotion has been undertaken at two levels – one reaching the general public, and the other targeting people practising high risk behaviours. On the general level, the use of the media is important. Of the 28 television APIs produced by the Government Information Service, 7 had advised the public to “take precautions” in sexual activities, 3 had talked about “using a condom”, and only 1 had shown a condom explicitly. The message has also been publicized in other public functions organised by the Government or NGOs, for example, through such activities as concerts, exhibitions and safer sex kit distribution campaigns. Computerised hotlines with recorded messages constituted another means of disseminating the safer sex message (Box 2.5).

Box 2.4

Nurturing a Condom Friendly Environment

Condom sales in Hong Kong have largely been determined by self-regulation of the market. However, there has been evidence to show increasing in demand in all three main sectors: the government clinics, Family Planning Association, and private sector. It was estimated that the total condom supply in the territory has been more than 38 millions per year in the past 2 years.

Safety of condoms is controlled through legislative means. In the third round of condom safety testing in 1993, the Consumer Council reported significant unsatisfactory quality control. This report, and a series of governmental and public actions, had finally led to the inclusion of condom as a ‘consumer item’ under the newly enacted Consumer Goods Safety Ordinance in October 1995. Currently the manufacturers, importers and suppliers all share the responsibility to ensure the safety standards of condoms. (Chapter IV, Box 4.9)

As for peripheral availability, condoms could be available in a number of outlets. Four main sources are identified. They are: (1) condom sale at supermarkets and convenience stores, at a range of prices; (2) free distribution of condoms at government STD clinics, HIV clinic and methadone clinics – totalling over 35000 per month.; (3) distribution at the Family Planning Association or government Family Health Services as a contraceptive tool; (4) free distribution at some commercial sex establishments. Condom vending machine is not yet popular in both public and private facilities. The Urban Council has started a trial of installing vending machines in some public toilets, which also supply tissue papers.

Free distribution of condoms with safer sex messages at the streets or Hong Kong-China borders has become one popular publicity functions carried out by NGOs and CEPAIDS in recent years. While the contribution to the total number of circulating condoms is relatively small, these public functions may have a more important roles in modifying the social environment to promote the acceptance of condom use and to desensitize the public about AIDS.

As for people practising high risk sex behaviours, the Government's Social Hygiene Service (STD clinics) and HIV clinics operate clinic-based service to provide counseling for attending clients through trained nurses. HIV tests are offered at these services, and also through the Hong Kong AIDS Foundation, an AIDS NGO (see Chapter III). Outreach programmes have been operated by AIDS Concern and Action for REACH OUT. AIDS Concern has been focusing on promoting safer sex in homosexuals through their gay outreach programme. Volunteer participation is a key feature of the programme. AIDS Concern has a team of about 200 volunteers. Action for REACHOUT operates a drop-in centre for commercial sex workers in Yaumatei district, which receives about 30 clients per month.

Box 2.5

Hotlines with recorded messages on safer sex

In 1993, Department of Health launched its computerised AIDS hotline with both recorded messages and access to counsellors (27802211). The interactive voice response system is used. Currently about 7000 callers use the service monthly. The most popular message so far is "how to use a condom". In 1996, AIDS Unit joined hands with Hong Kong Sex Education Association to introduce its Dr Sex Hotline (23372121). The new Hotline also provides messages of all aspects of sex, including the practice of safer sex. About 12000 callers use the service monthly.

(b) STD prevention

STD prevention has seldom stood out as an isolated programme in the local community. The governmental Social Hygiene Service under the Department of Health operates 11 (8 of which are part-time) Social Hygiene Clinics (STD clinics), and manages 20000 cases of STD per year. The Service supports basically secondary prevention through the provision of treatment for STD patients, offering face-to-face counseling, and advising on safer sex. Its clients include also commercial sex workers. Its Anti-Venereal Disease Office staff are responsible for reaching out to commercial sex establishments to disseminate information, publicize the services and advise commercial sex workers on health checks. In 1995, an STD-AIDS working group was formed between the Social Hygiene Services and AIDS Unit to plan and implement primary STD-AIDS prevention in a more systematic manner (Box 2.6).

Box 2.6

Accomplishments of the STD-AIDS Working Group of Department of Health

1995

Production of STD-AIDS prevention exhibition boards
Incorporation of STD messages in AIDS Hotline (27802211)
World AIDS Campaign STD/HIV exhibition at Social Hygiene Clinics

1996

Establishment of the Dr Sex Hotline (jointly with the Hong Kong Sex Education Association)

1997

Public Estates Roving Exhibition on STD/HIV awareness
Establishment of STD Hotline

Ongoing activities:

Joint surveillance monitoring and epidemiology studies
Resource materials production – pamphlets, posters and others
In-service staff training, such as marital counseling

Substantial proportion of the community's input in STD prevention have been based at the Social Hygiene Clinics. Some examples are the STD education workshops for STD staff organized by non-governmental organisations, for example, AIDS Concern; and the study on commercial sex workers by some independent researchers. Exhibitions are occasionally held in schools, public housing estates or other centres on STD prevention with resource materials produced by the joint working group of the Department of Health. Adopting the similar approach to include STD prevention, AIDS Concern has also produced special pamphlets and posters to target homosexuals and STD patients in the past few years. There has been little information regarding STD prevention, both primary and secondary, in the private sector, despite the fact that 80% of STD cases have presented to private clinics. This estimation does not include those who self-administer using over-the-counter prescriptions and those visit traditional medical practitioners.

(c) Sex education

Sex education lays the groundwork for sustaining HIV prevention in adolescents. Attempts have been made in two approaches: (1) development

and promotion of an integrated sex and AIDS education programme in the formal school curriculum (Box 2.7); and (2) community based programmes.

(1) *Curriculum in School* - There has not been any compulsory curriculum on sex or AIDS education although the guidelines developed in 1998 by the Curriculum Development Committee on Sex Education for kindergarten, primary and secondary schools had included AIDS. In 1996, Education Department reported on its integrated approach on sex and AIDS education in a paper submitted to ACA³. It recommended a “cross-curricular approach” to primary and secondary schools. To support the approach, the Education Department has organized 67 sessions of seminars and training courses for school principals and teachers since 1987, with a total attendance of more than 7000. Teaching kits and other education materials have been produced and supplied either directly to school or at the two *Sex Education Resource Centres*. Productions of the Department include: *Guidelines on the Prevention of Blood-borne Diseases in School* in 1994 (supported by the Department of Health), and “AIDS” (1988), “Learning Pack on AIDS” (1992), and “Teaching Kit on AIDS for Primary Schools” (1994).

As for promulgation, a survey conducted by the Education Department⁴ in 1994 reported that 40% of all schools had an overall policy on sex education (59% in Girls’ Schools and 32% in Boys’ Schools) and about 10% of the schools designed school-based curricula on sex education. Among the topics included, 58% of schools had covered AIDS while only 29% covered sexually transmitted diseases. The other popular topics were puberty changes, dating, self-image, love and infatuation etc. As for school teachers’ training, 49% of the schools had 1-3 teacher attended sex education

³ ACA Information Paper I-4/96. Sex and AIDS Education in Schools.. Education Department. January 1997.

⁴ Report of the Survey on the Implementation of Sex Education in Secondary Schools 1993/94. Education Department. Hong Kong.

training while another 25% more than 3 trained teachers. The most commonly quoted difficulties in the implementation of sex education in schools is lack of teaching time, lack of trained teachers/professional advice, and teachers feeling uncomfortable or embarrassed.

Box 2.7

Sex and AIDS Education in Schools

... A cross curricular approach is recommended to schools for the implementation of sex and AIDS education. At the primary level, elements of sex and AIDS education have been substantially integrated into syllabus of the subject General Studies ... Elements of sex and AIDS education has been integrated in syllabus of relevant secondary school subjects such as Social Studies, Integrated Science, Biology, Human Biology, Home Economics, Religious/Ethical Studies and Liberal Studies ... The Education Department runs regular sex education courses for serving primary and secondary school teachers ...

(Abstracted from ACA Information Paper I-4/96)

(2) *Community projects on sex education* – Community organisations participate in promoting sex education in schools. Some examples of community projects developed lately on integrated sex and AIDS education are: Dr Sex Hotline established jointly by the Hong Kong Sex Education Association and the Department of Health funded by the Health Care and Promotion Fund and AIDS Trust Fund, Sex Education drama series of Radio Television Hong Kong partially supported by the AIDS Trust Fund, and the Hong Kong Sex and AIDS Education Expo organised by the CEPAIDS. TeenAIDS is an NGO that provides also sex education.

(d) The context of homosexuality

Even the same principle of safer sex applies to homosexual community, its context is considered separately in the development of programmes appropriate to their unique setting. Homosexuals are sometimes considered a marginalised community. The perceived linkage of homosexuality and HIV/AIDS by some people creates a barrier in developing effective programmes. Safer sex programmes have been organised at two levels: Firstly, with the establishment of a rising number of homosexual groups (male and female ones), some have become involved in AIDS education and safer sex

promotion. Means of promoting AIDS awareness and safer sex are: delivery of messages at group activities, production and distribution of publicity materials, through letters, and the conduction of

Box 2.8

Gay Outreach Programme of AIDS Concern

Established since 1994, the programme encompasses preventive education workshops to gay groups; outreach work; production of AIDS information materials targeting gay men, and organising AIDS awareness events. There are currently weekly visits to gay bars, night clubs and Karaoke. The outreach programmes are provided by volunteers. There are about 40 volunteers in the team. In 1996-1997, 30000 sets of safer sex cards were distributed. They also displayed and distributed materials at gay theatre productions, and solicited the participation of local gay groups in safer sex awareness events.

seminars and workshop. A complete list and breakdown of these activities is not available. Secondly, AIDS NGOs, notably AIDS Concern, have been playing an important part in reaching out to the homosexual community, and in delivering safer sex messages. This is done using a more personal approach with their Gay Outreach programme (Box 2.8).

2.2.3 Reducing blood-borne transmission of HIV

Blood-borne transmission of HIV refers to the contracting of the virus through (a) transfusion of contaminated blood or blood products, and (b) the practice of needle-sharing in injecting drug users. While HIV transmission may also occur in health care setting, the risk is much smaller. The latter includes HIV transmission through needle-stick injuries, mucosal contacts and procedures such as transplantation. HIV transmission in health care setting is covered in Chapter III, its prevention forms part of the infection control policies of individual institution.

(a) Safeguarding blood and blood products

The Hong Kong Red Cross Blood Transfusion Service (HKRCBTS), as the sole agent in the territory responsible for collection and supply of blood units to hospitals, takes up the responsibility of safeguarding blood and blood products. This set-up allows a centralized approach to safeguard the blood supply. A four-level safeguarding mechanism is in place at the HKRCBTS. First, only voluntary blood donation is accepted. Second, an initial screening

of the risk factors is conducted using a self-administered questionnaire and those with relevant risk factors are advised against donation. Third, all blood units are screened for HIV antibodies. Fourth, a green card system has been in place, allowing some blood donors to call back to withhold their blood unit from being used after donation.

Blood products safety is monitored under the same mechanism as for other pharmaceutical products. In 1997, Advisory Council on AIDS recommended the setting up of a committee to better monitor blood/blood product safety. In the middle of the same year, the first case of HIV infection acquired through blood transfusion during the window period was reported, despite the 4-level mechanisms being in place. The incident has prompted the establishment of an Expert Panel later the same year. Operative under the Red Cross, this Panel is responsible primarily for upholding the safety standard of blood and blood products supplied to hospitals in Hong Kong.

(b) Prevention of HIV transmission among injecting drug users

Programmes on preventing HIV through drug injection have been organised to injecting drug users as well as members of the public. In Hong Kong, the pre-existing methadone clinics for injecting drug users has provided good contact points for personal level HIV prevention to be delivered promptly, since the beginning of the AIDS era in early eighties. There are at present 21 methadone clinics opening daily including Sunday and public holidays. Total registered methadone users now amount to more than 10,000, half of all those reported to Central Registry of Drug Abuse, while average daily attendance is approximately 7000.

In targeting drug users, the principle of harm reduction is applied in preventing HIV transmission, which essentially means do not share needles or syringes (Box 2.9). The alternative, that of cleaning used injecting equipment with bleach, has also been promoted. The latter strategy has not gained popularity in Hong Kong, probably as a result of easy access of syringes. Almost all work on preventing HIV transmission in drug users have been coordinated by the Task Force on Drug Abuse and AIDS of the CEPAIDS.

Represented by Government units and voluntary agencies working on drug rehabilitation, the Task Force has been organizing regular training programmes for rehabilitation staff and volunteers, community projects to clean some areas of abandoned needles, and to disseminate safer drug use messages. Many of these programmes are also based at the methadone clinics, with the technical support of AIDS Unit. The Group also conducts an annual survey on the drug-taking behaviours of street addicts. Individual counseling is provided at methadone clinics and on admission to voluntary inpatient drug rehabilitation centres. Prisoners on discharge are advised on HIV prevention through the distribution of a special pre-exit kit, and with the support of the Society for Rehabilitation of Offenders after discharge.

Box: 2.9

Needle supply, needle exchange, and needle disposal in Hong Kong

While needles and syringes could be legally obtained through pharmacies without prescription at a low cost, possession of syringes with drug may be considered as circumstantial evidences of drug trafficking. Therefore local injecting drug users face the problem more on disposal of used needles, rather than the inaccessibility to clean needles. Needle-exchange programmes have not received much attention in Hong Kong. Small-scale experimental rounds of needle-exchange had been organised by MSF at Pillar Point refugee camp in 1996. Boxes which could hold used needles were distributed by Department of Health as a experimental project in 1996.

Since 1994, the Task Force on Drug Abuse and AIDS has been organising the “clean the needles” exercises. Volunteers, mostly ex-drug addicts, are coordinated by an anti-drug NGO, SARDA to collect abandoned used needles mostly near government methadone clinics. Apart from the direct effect of removing the risks of used needles, this project also serves educational purposes to the public, drug abusers, and the volunteers.

As for the general population, one announcement had been made through the media (television and radio) to warn against HIV infection via sharing of needles and syringes. Attempts have been made to incorporate HIV prevention messages to anti-drug programmes in schools, social work setting, outreach teams and population based campaigns. However, most programmes were on an ad hoc basis while no long-term commitment has been noticed.

(c) Infection control in non-health-care settings

To address the fear of getting infected via wound or blood contacts, the concept of universal precaution has been simplified, consolidated and

introduced to non-health care settings such as schools, youth centres, workplace, social services and correctional service settings. Guidelines have also been developed, following the same principle of universal precaution (Chapter III) as that adopted in health care settings (Box 2.10).

Box 2.10

Guidelines or documents on universal precautions in non-health care settings
➤ Prevention of blood-borne diseases in schools (Education Department, 1987)
➤ Blood precaution for service workers - posters/leaflets (Department of Health, 1992)
➤ Guidelines on prevention of blood-borne diseases in schools (Education Department, 1994)
➤ General infection control precautions for social welfare personnel. In <i>Manual on HIV/AIDS for Social Welfare Personnel pp.131-133</i> . (AIDS Services Development Committee, Advisory Council on AIDS, 1995)
➤ Guidelines for institutional settings and home care givers. In <i>Manual on HIV/AIDS for Social Welfare Personnel pp.134-137</i> . (AIDS Services Development Committee, Advisory Council on AIDS, 1995)
➤ HIV/AIDS for Correctional Services Department staff. - Information sheet 1995.

The basic principles of universal precaution are (1) wear a pair of disposable gloves while handling wounds or blood contaminated substances; (2) wash hands with soap if contaminated with blood or other body fluids; (3) dress wounds properly. Demonstration of wound management and promotion of “first aid box with gloves” are frequently incorporated in AIDS education activities. There is, after all, no evaluation on the impacts of these activities.

2.2.4 Reducing perinatal HIV transmission

Prevention of perinatal HIV transmission is a relatively young programme and only formally came up the local agenda in 1994. Two events prompted such movement. First, the first HIV infected baby was diagnosed and reported in mid 1994. Second, the confirmed efficacy of zidovudine in reducing the risks of vertical HIV transmission by two thirds was released by CDC in 1995. As far as the strategy is concerned, these developments were not foreseen during the preparation of the 1994 strategy document. New initiatives developed subsequently have been to ensure (1) access of information to pregnant and pre-pregnant women; (2) accessibility of HIV screening testings; (3) informed decision of the couples about the fate of the pregnancies; and (4) accessibility of subsequent clinical and support services

as decided by the couples. The latter include: termination of pregnancy, prophylactic antiretroviral treatment, appropriate obstetric care, and paediatric follow-ups. A definitive mechanism to bring out the benefits of antenatal HIV testing is not available yet.

The Department of Health has been responsible for most part of this programme, which currently composes essentially of staff training and information dissemination. Annual workshops specifically for nursing staff working in the government Family Health Service (which looks after 40% of antenatal women) and hospital obstetrics and gynaecology units were started since September 1996. Special resource materials, posters and leaflets have been produced to facilitate information dissemination. An exploratory survey conducted among the participants of the most recent training workshop in 1998 suggested 80% accepted group or individual counseling and universal testing for antenatal women.

Currently, HIV counseling and testing are still on a selective basis – only those with explicit risks are advised strongly for testing. There are, however, not any organized data on the accessibility of such services in any sector. The issue on furthering prevention through setting antenatal HIV testing policies was debated at the Scientific Committee on AIDS meetings on 5 March 1998. The subject would be further deliberated by the Advisory Council.

2.2.5 Promoting acceptance towards people with HIV/AIDS

Over the years, the number of HIV/AIDS patients in Hong Kong had been relatively small, especially in the initial few years. In those years, the major themes of HIV education activities were largely geared towards HIV prevention. With the diagnosis of more people with HIV/AIDS, their problems began to unfold. Because of the stigma attached, discrimination has become the most difficult problem faced by people living with HIV/AIDS. In the course of conducting AIDS education activities, it became natural to incorporate messages of “acceptance” and “non-discrimination” into pre-

existing activities on AIDS like health talks and public events. In 1995 and 1996, for example, TV APIs featured an AIDS patient and a radio host respectively to appeal for public support to people living with HIV/AIDS. In 1997, Hong Kong AIDS Foundation screened another API focussing on discrimination and AIDS. More specifically, workplace AIDS education programmes put forward by the Government and the community had focused on promoting acceptance in the community. The Charter is a special programme on this front. (Box 2.11 and 2.12)

Approaches taken to promote acceptance of people with HIV/AIDS include information dissemination on

Box 2.11

Workplace Programmes

Workplace offers a unique setting for promoting acceptance of people living with HIV/AIDS. Hong Kong AIDS Foundation has set its theme as “AIDS and the Workplace” in their business plan for the years 1996-1998. Activities in the plan include: development of training packages, policy manuals. In 1996 to 1997, nine workshops had been conducted for five companies/organisations.

clarification of misconceptions, advocacy, policy intervention in schools, workplace and health care settings, and legislation to ensure rights of the infected are protected. These are dealt with separately in Chapter IV. The rights of people with HIV/AIDS are protected under the law. The Equal Opportunities Commission is charged with the responsibility to promote equal opportunity for people living with disabilities, of which HIV/AIDS has been defined as one, under the Disability Discrimination ordinance. The Commission also runs education activities, including seminars and publication/distribution of leaflets, and AIDS has been included in their activity profile.

Box 2.12

Community Charter on AIDS

The Hong Kong Community Charter on AIDS, jointly initiated by the Lions Clubs International District 303 and Department of Health, is a unique project that promotes acceptance of people with HIV/AIDS in the workplace. By signing the Charter, the organisations or employers pledge to (a) openly support the Charter, (b) conduct AIDS education and (c) establish a non-discriminatory workplace policy. Since it was launched in December 1994, a total of 79 organisations have become the Charter's signatories, the total number of employees amounting to 270,000. These organizations fall under one of the three categories: (1) Business community, (2) community organisations and (3) Public bodies, including municipal councils. Community organisations outnumbered business companies by a ratio of about 6:1.

2.3 HIV Prevention in Special Settings or Groups

In the previous section, HIV prevention efforts are considered according to the five major themes identified in Hong Kong's HIV prevention and health promotion programmes. Normally, a specific setting or group is approached in context of one of these programme foci. There are, however, a number of community groups and settings which do not fit into just one of the foci (Appendix II.2). Instead, they need to be approached by adopting a cross-focus strategy, through identification of the social and behavioural factors unique to the own settings or groups. Special treatment has been given in the design of HIV prevention interventions, not because of the level of risk but a multitude of sociobehavioural factors implicated. Four such settings or groups are considered here, namely, correctional institutions, mobile population, women and youth. HIV prevention in the health care setting is another setting which is covered under Chapter III: Clinical and Support Services.

2.3.1 Correctional institutions

Correctional institutions constitute one setting in the local HIV prevention and health promotion programme for a number of reasons: Firstly, a significant proportion of the inmates are ex-addicts, making the institutions an ideal channel for imparting AIDS knowledge in a group setting. Secondly, there is a separate system of health care provision, which requires attention as in other health care facilities in the community. Thirdly, HIV prevention

efforts would minimise the chance of HIV spread within a closed environment, where the pattern of risk behaviours cannot be easily ascertained.

There are 23 correctional institutions accommodating 12,000 inmates in Hong Kong under the Correctional Services Department (CSD). HIV related matters was advised by the *Standing Committee on Special Health Care*, whose membership comprised CSD administrators and medical personnel, established in 1992. The main task of this committee was to examine and develop guidelines in the management and prevention of HIV infections in prison setting. In 1997, this standing committee was dissolved while the tasks amalgamated into the Medical Service Committee, which reports to the Assistant Commissioner of CSD, and is responsible for all medical services in the prison setting. HIV prevention and health promotion programmes are organised for CSD staff as well as for inmates.

(a) Prison inmates

Messages on HIV/AIDS prevention have been delivered to prison inmates largely through the institutions' health care system (hospitals and clinics). Education programmes are organised for inmates on their admission. A small booklet for inmates has also had message of AIDS included. Since 1996, pre-exit kits that contain pamphlets on AIDS prevention and condoms are distributed to prisoners upon discharge.

(b) CSD Staff

Lectures and workshops have been regularly conducted, with the assistance of the Department of Health, for CSD staff. These training activities covered general awareness on AIDS, universal precaution, and non-discrimination, as well as the management of positive cases. A resource centre was established in 1995 at CSD for use of staff. Infection control and management guidelines have been drawn up.

2.3.2 Travelers, migrant workers and other mobile population

Mobile population constitutes a heterogeneous group of people who either move from Hong Kong to other countries or vice versa. There is no clearly defined level or pattern of risk behaviours. Two settings are considered here: people travelling out of Hong Kong, and those coming into Hong Kong. In both settings, safer sex promotion has been an important focus in the programmes, though general awareness and information on access to services are also important themes.

(a) People coming into Hong Kong

There are three broad groups of people coming to Hong Kong: (1) tourists, (2) migrant workers, and (3) refugees or boat people. For tourists, the Central Health Education Unit of the Department of Health has been issuing a leaflet which is distributed at the airport. The leaflet emphasises on healthy travelling and has covered briefly the subject of AIDS. Migrant workers from the Philippines, Thailand, Indonesia and Nepal form a sizable population in Hong Kong. Most are females working as domestic helpers. Education leaflets produced in the languages of these workers are produced by Department of Health (the general leaflet on AIDS is available in 10 languages). Separate ones have also been produced by AIDS Concern, Action for REACHOUT, St John's Cathedral HIV Information and Drop-in Centre. AIDS Unit also operates an AIDS Infoline in Thai, Tagalog and Vietnamese. The total number of calls is now very small at less than 50/month. AIDS Concern had operated an Asian Migrant Workers Outreach Programme in 1996-97, but was halted because of lack of fund. As for refugees, Vietnamese constitutes a big group but the number remaining in Hong Kong now is very small (Box 2.13) One study revealed that a significant proportion of the male inmates had a history of drug taking ⁵.

⁵ Medicins Sans Frontier. Evaluation report – HARP (Harm Reduction Programme) for the Vietnamese drug users in Pillar Point refugee camp, 1997.

Box 2.13

Vietnamese boat people and refugees

HIV infection among Vietnamese boat people and refugees detained in Hong Kong has been perceived as a potential problem relating to injecting drug use. From 1992 to 1996, a Working Group on AIDS Control for Vietnamese Institutions was set up by Department of Health, with both governmental and non-governmental inputs. Education activities were organised in refugee camp and detention centres, and the Group saw that policies established in other communities were equally applicable to Vietnamese in Hong Kong. The Group was suspended subsequently when Vietnamese were gradually being repatriated. Being monitored by United Nations, there were a number of international agencies participating in the HIV prevention activities in these institutions. Examples were Save the Children, International Organisation of Migration, UNICEF, Medicins Sans Frontier. Some of the projects were: road show to desensitise condoms, condom distribution, and a pilot needle-exchange scheme at Pillar point.

(b) People leaving Hong Kong

There are tourists who leave Hong Kong for leisure, with some of the trips being linked with high risk sexual activities. In the last two years, there have been public concern that many local men are crossing the border to Mainland where high risk sexual activities are practised. The Social Hygiene Service had documented that some two-thirds of the STDs were contracted outside Hong Kong ⁶. Another study ⁷ conducted at Lo Wu border reported that some 18.3% of the men interviewed have had intercourse with either a commercial sex worker or a casual partner in the Mainland. Among those who visited commercial sex workers in the last 6 months, a third did not use condoms.

AIDS education activities for people leaving Hong Kong began with the screening of an API on AIDS and travelling in 1990. In 1993 and 1995 CEPAIDS' s participation in two travelling exhibitions, where safer trip messages were distributed to several thousands potential travelers attending the functions. In 1995 distribution of leaflets and condoms to cross-border lorry drivers was planned. The project was subsequently taken up by AIDS

⁶ Scientific Committee on AIDS paper D-11/96-99. Update in pattern of STDs in Social Hygiene Service (1997) presented on 5 March 1998.

⁷ Lau J. Hong Kong – China travellers sexual behaviour survey – executive summary. Hong Kong: Community research programme on AIDS; 1997.

Concern. In February 1998, CEPAIDS resolved that a task force be established to develop an overall strategy for carrying out AIDS prevention education among travellers leaving Hong Kong.

2.3.3 Youth

The main emphasis in youth or adolescent HIV prevention is to build up sustainable mechanism that deliver AIDS education in the formal curriculum and the consolidation by informal curriculum and extra-curricular activities. The formal curriculum has been covered in 2.2.2; here we examine the informal curriculum and out-of-school settings. The objectives of these activities cross the major programme foci. The activities promote general awareness, instill knowledge and skills against high risk behaviours, and foster acceptance towards people living with HIV/AIDS.

(a) Programmes for youth

Informal curriculum refers to the form teacher period, special sessions in school, and extra-curricular activities. Some schools may provide policy support to sex education while others depend on the enthusiasm of the teachers involved. They may also obtain support from external sources such as Department of Health or non-governmental organisations. Young people may also be involved in AIDS education in community facilities mostly at youth centres. At present, at least three groups/organization operated programmes or activities directly target youngsters. They are: (1) “Youth Action on AIDS” funding scheme of the Committee on Education and Publicity on AIDS; (2) “Healthy Young Ambassadors” of the Hong Kong AIDS Foundation, started since 199X; and (3) activities of TeenAIDS, a non-governmental organisation which promotes AIDS awareness through performance art.

The “Youth Action on AIDS” is a ongoing project developed by the Task Force on Youth of CEPAIDS. Both financial and technical support are provided to encourage youngsters to initiate their own peer group AIDS prevention activities.

The Hong Kong AIDS Foundation utilizes a different approach by recruiting and training volunteers from schools and mobilizing them in involvement in AIDS related public programmes. Named “Healthy Young Ambassadors”, 20-30 youngsters have been trained annually by the Foundation since 1993. There are now 30-40 active members. As for TeenAIDS, the most widely known approach is through group activities, and performing art to disseminate AIDS related messages. There has not been any other published study on the impacts of the extra-curricular activities

Box: 2:14

“Youth Action on AIDS” funding scheme

This is the only programme that provides funding specifically for AIDS activities in youth. Since its inception in 1991, a total of 104 projects have been supported with a total amount of HK\$473,000. An estimated 16,000 people have been reached through the project.

While the direct funding support comes from the Department of Health, there have been important involvement of the community youth workers. Initially set up as a project under the Youth Working Group of the Committee on Education and Publicity on AIDS, the scheme was promoted and operated by youth workers in the Group and supported technically by the AIDS Unit. Twice a year, extensive promotion was made to schools and youth centres to encourage participation. All project applicants needed to attend a group interview which was preceded by an introductory seminar on AIDS. An award ceremony, with sharing sessions and prize presentations, was held each year (usually in late February) for encouragement and networking.

In 1996, the Working Group published an album to document projects undertaken in the last years.

(b) Marginal youth

Marginal youth is a loose term referring to young people engaging in risk behaviours, and who are beyond the network maintained by schools or other community facilities. Regular AIDS education has been provided to those in Boys’ and Girls’ Home through group talks delivered by nurses from the Department of Health. As for the street ones, the approach taken was to encourage the outreach social workers in delivering integrated sex, drug and AIDS education programmes. The Task Force on Youth of the CEPAIDS edited a safer sex pack which include a number of games to facilitate group work. “Networking Voice”, a 4-monthly bulletin, serves as the link between the Task Force on Youth and the other youth workers. In 1997, the Commission on Youth published a report on *Study on the Knowledge of and*

Attitude towards AIDS-related Issues among Marginal Youth in Hong Kong.

The report called for targeted education, creation of innovative channels, training and skill-building to equip workers on AIDS prevention and health promotion.

2.3.4 Women

Women are often considered to constitute one special target in the HIV prevention and health promotion programme in view of (a) their biological vulnerability to STD and HIV, and (b) the difficulty in negotiating safer sex, often as a result of their perceived inferior position in the society. The increase in heterosexual transmission of the virus alerts Government and NGOs to focus their programme on women. While the major themes on awareness and risk behaviours apply to men as well as women, the issue of negotiating for safer sex is often brought up in programmes packaged for women. The recent advances in reducing perinatal HIV infection adds yet another dimension to the themes of HIV prevention activities. Three levels of HIV prevention and health promotion programmes which can be documented for women in Hong Kong: Firstly, programmes organised specifically on AIDS for women; secondly, programmes organised for women in other settings but incorporating the subject of AIDS; and thirdly, the instillation of the gender issue in AIDS activities organised for the public or other setting. For this chapter, the concern of migrant workers and commercial sex worker is dealt with separately under their respective headings.

In Hong Kong, specific programme on women was not organised until December 1990 when a seminar was conducted by the Committee on Education and Publicity on AIDS, in line with the theme of the World AIDS Day for that year. Titled *Prevention of AIDS – a Women’s Mission*, the seminar featured presentation by health, education and social welfare professional, with the input of the community. A seminar bearing similar theme was organised by AIDS Foundation in 1993. In 1992, an API targeting women was screened. Subsequently, AIDS Unit had produced publicity leaflets and exhibition boards addressing the needs of women. In 1995, Zonta

Club sponsored a radio programme addressing the concerns of women in HIV transmission.

While specific programmes targeting women have not been commonly organised, AIDS has been included in other local activities for women. The characteristics of these activities are that they are not organised by designated AIDS services or NGOs, but often have their input. Family planning programmes and maternal and child health services are two such examples whereby AIDS has been included as one of the subjects in workshops and health talks. The depth of such activities and their impacts have not, however, been evaluated. The focusing on perinatal infection has recently facilitated the development of training activities for health care personnel who worked with women. Other women's groups, though still small in number, have sought collaboration with AIDS NGOs and the Government to design relevant programme for their clients.

A majority of HIV prevention and health promotion programmes do not primarily target women. The concern of women has, however, been incorporated in the examination of AIDS in context of the family, the theme which was adopted by AIDS Foundation in its activities for 1994 to 1996. What's more important is that programme organisers have become more gender-sensitive in their development of HIV prevention activities. How this approach has affected the overall strategy and the output is not specifically known.

2.4 Programme Organisation and Delivery modalities

2.4.1 Programme organisation

There are three broad groups of organisations working on HIV prevention and health promotion: (a) designated Government unit, for example, AIDS Unit of Department of Health, (b) non-designated Government units, for

example, Methadone Clinics, Social Hygiene Service, Correctional Services Department etc.; (c) AIDS NGOs, and (d) community organisations not working specifically on AIDS. There are generally two pathways of organising the programmes in Hong Kong, both involving the direct participation of designated Government services and/or AIDS NGOs. The first pathway centres on the Committee on Education and Publicity on AIDS, and the second involving AIDS NGOs predominantly.

(a) Pathway centering on CEPAIDS

The Committee on Education and Publicity on AIDS, has been initiating activities on HIV prevention and health promotion in collaboration with Government departments, and with the technical support of AIDS Unit, Department of Health. Operationally, these programmes have been executed either through the Committee's working groups, task forces, or the assigned Government departments/units. Community organisations not working specifically on AIDS were also involved. Some examples have been the promotion of training through the Working Group on training of intermediaries between 1990 and 1993, and the planning and monitoring media campaign by the Task Force on Media and Publicity (formerly Publicity Working Group). This pathway of routing through the Committee was common between 1987 and 1991 when the Government had been assuming the role of providing AIDS education in the community, and when no other NGOs have yet been established. In the recent years, the Committee has been taking on more a coordinating role in local AIDS education efforts. The coordination of each year's World AIDS Day activities and the launching of the highlight programme have become the Committee's major work. Gradually, specific programmes are being operated by NGOs or Government units. The number of task forces/ working groups has decreased from 7 to 4 by late 1997.

(c) Pathway involving NGOs

As from 1990, AIDS NGOs have begun to play a key role in the conduction of AIDS education in the local community. Each AIDS NGO initiates its own activity, often through the efforts of staff, volunteers,

members, and with the input of advisory and/or executive boards. Collaboration among NGOs is common, particularly in the organisation of population based campaigns and target based programmes involving the participation of a larger number of workers, or when expertise sharing is required. Individual basis intervention, for example outreach activities, continue to be operative within the individual organisation.

2.4.2 Delivery modalities

Three different delivery modalities of HIV prevention and health promotion programmes are presented in this section. They are: (a) population based campaigns, (b) group targeted programmes and (c) individual basis intervention. Other means of effecting HIV prevention are covered elsewhere, they are: policy development to safeguard blood and blood products (2.2.3 and Chapter IV), and advocacy (Chapter IV)

(a) Population based campaigns

Population-based campaigns are those without a specific target audience. The commonest theme is often arousing awareness. The message is therefore always general and simple, which has a potential of reaching many people in the community. Some public functions do consider special targets in addition to the general audience. For example, the organisation of concerts (by CEPAIDS and also NGOs) was intended to reach any member of the public, but young people were often targeted. Setting up a publicity stall at Repulse Bay (CEPAIDS, 1993) could qualify as a population-based campaign but targeting largely young people. In other cases population-based campaigns are organised to appeal to communities which would otherwise be difficult to reach in conventional group-targeted programmes, for example drug users, and people practising high risk sexual behaviours. Four major forms are listed below.

*i. Media campaigns*²- APIs are the most conventional form of media communication instrument for population based campaigns. From 1987 to 1997, the government Information Services Department

produced 28 television announcements under the auspices of the CEPAIDS while the Hong Kong AIDS Foundation has another six. (refer to appendix II.1 for the list of APIs). An evaluation study was conducted in 1995⁸ and showed that an API advising women to request partners to use condoms featured by Do Do Cheng won the highest recall rate of 23.8% among the about 600 respondents. Death Pyramid came the second with 21.7% recall and Stuntmen by Jackie Chan the third with 6%. Other means of involving the media are: (1) joint programme with TV or radio stations e.g. “Enjoy Yourself Tonight” variety show (Government, 1993), telematch (Education Department 1994), drama series on sex/AIDS education (RTHK, since 1991); (2) radio phone-in programmes. The latter has actually assumed an important position as a means of interacting with the audience, who may be concerned with the risk of infection. Phone-ins relating to the subject of AIDS were often staged at night. Some were initiatives of the radio stations inviting the participation of Government and NGOs, others had been developed by community groups, for example Zonta in 1995.

ii. Publicity events - These can be taken a variety of forms. Some have been organised to specifically address to AIDS - Safer Sex Kit/Condom Distribution, Red Ribbon Sale/Distribution/Parade, and Candle Light Vigil. While the former promotes safer sex directly the latter two contributed more towards promoting acceptance to people with HIV/AIDS. The AIDS Memorial Quilt Project has organized Quilt Display, as part of their quilt production activities. AIDS non-governmental organisations have organized major publicity functions for fundraising purposes. The annual ball of the Hong Kong AIDS Foundation, and Charity Walk and Fashion Show of AIDS Concern contributed towards enhancing awareness, promoting acceptance, and fundraising. (refer to Chapter VI. Finance). AIDS NGOs and

⁸ Report on Evaluation of TV APIs on AIDS. J Lau. Centre for Clinical Trials and Epidemiological Research (CRPA). March 1996.

designated Government services have also participated in other functions to bring out the AIDS messages – Chinese New Year Fair, Health Education Carnival of the Urban Council, travel exhibition organised by travel agencies.

iii. Competitions - Poster, photo, and card competitions have been popular programmes especially in earlier days of HIV prevention work. More recent ones are drama competition (organised by TeenAIDS) and Media Awards for Print Coverage of HIV/AIDS (joint NGO event with the Hong Kong Journalist Association).

iv. Exhibitions - Again, exhibitions on knowledge of AIDS are also popular delivery modalities. Gradual changes have been noted in the local community in terms of the modes of exhibitions from a major and grandiose AIDS knowledge exhibition in the eighties at the City Hall, to the more recently organised exhibitions of photos, posters or materials of interest in public areas. Systemic evaluation of these activities has seldom taken place.

(b) Group targeted programmes

A target group or setting is identified followed by the organisation of a programme addressing the needs of the specific audience. People in the group often come from a similar background, and should theoretically benefit from participating in activities tailored to their common needs. One drawback of this approach is that it is relevant only for those who could be organised in a group. Broadly we include all group education such as workshops, seminars, training courses etc in this category. Most commonly one or several speakers are invited to deliver lectures or presentations on some selected areas. The number of participants may vary from twenties to a few hundreds. In some, the attendees may be required to participate more actively in role plays, games or other interactive programmes. In other cases, the target may become involved in the organisation of additional programmes, adding value to the original activity, for example, volunteers training by NGOs, and Youth

Funding Scheme on AIDS of Committee on Education and Publicity on AIDS. Organizers of group programmes frequently build in immediate impacts assessment. While many have shown improve in knowledge and/or a shift to a more favorable attitude, the effects on behaviour change and the long term impacts have seldom been evaluated.

(c) Individual basis intervention

Individual basis programmes are those organised on a person-to-person level. These include the counseling services provided either through hotline or direct face-to-face setting (Box 2.15). Mostly they are found in clinics or other health care setting. Non-governmental organizations, for example AIDS Foundation and AIDS Concern, also operate a number of hotlines supported by programme staff and their volunteers.

Box 2.15

Individual counselling

Individual counselling has played an important part in HIV/AIDS education and prevention ever since the mid-1980s. The Department of Health offers telephone and face-to-face counselling to those who feel themselves at risk of infection. The programme is organised together with the HIV testing service (Chapter III; section 3.6.1). Over 1000 phone counselling sessions per month were conducted in 1997. AIDS Foundation and AIDS Concern also run their own helpline, with about 200 and 60 calls per month received.

Outreach programmes actively seek their intended target, the commonest being those with a certain behavioural risks. On-site counseling or other educational processes are provided right away. AIDS Concern operates a number of outreach programs such as MSM (men have sex with men) Bar, and Sauna Outreach Programmes, Sex Industry programme to female commercial sex workers, and one for Asian migrant workers which was terminated in 1997. Action for REACHOUT works with commercial sex workers on the street. The Pui Hong Self-Help Association operates another outreach programme, under which ex-addicts serve as voluneers to provide peer counselling to addicts on the street. A yearly survey has also been implemented in the last five years.,

2.5 Characteristics of the Local Programmes

HIV prevention and health promotion activities have evolved through the years, from a Government-led programme to the one that features the participation of the community and involvement of different partners. A number of characteristics can be identified in the course of reviewing the work in Hong Kong.

- (a) A multimodality approach – A good variety of delivery modalities have been used to provide AIDS education to the public. These modalities range from population based approaches to individual approaches. A different modality is often adopted in response to the unique needs of the clients, as well as feasibility of the system, and with regards to the perceived effectiveness of the programme.
- (b) Community participation – To date there is wide community participation of the local AIDS education programme, in terms of the range of sectors involved in the planning, coordination and implementation of the activities. Programmes are basically led by designated Government units, AIDS NGOs, coordinated by CEPAIDS and other NGO mechanisms, and with the participation of community organisations which are not working specifically on AIDS. Different levels of personnel participate in the programmes – health professionals, social welfare professionals, volunteers, community leaders, researchers, and the business community.
- (c) Major programme foci – Of all foci identified, two have been most commonly addressed in the programmes in Hong Kong. These are (1) prevention of sexual transmission, and (2) arousing public awareness. The promotion of acceptance of people with HIV/AIDS has recently come as a natural extension of the AIDS education programme.
- (d) High risk behaviours - A large majority of activities use population-based or group-targeted approaches in their conduction of AIDS education activities. There has been little development of individual basis intervention to target people practising high risk behaviours. The focus of injecting drug use is largely an

integral part of the pre-existing mechanism of harm reduction and drug rehabilitation. As for high risk sexual behaviour, the focus is largely limited to STD patients, plus limited development of outreach activities developed by some NGOs.

- (e) Limitation of groups and settings – Programmes have been limited by those targeting conventional target groups and settings, for example students, STD patients, media events. Little attention has been placed on groups/settings which are less well-defined, for example homosexuals, commercial sex workers.

- (f) Progress of integration – Integration of AIDS prevention and education in other programme areas is underway, but the desired depth of such integration, and their effectiveness in implementation have yet to be determined. One key programme which integration is crucial is that of sex education. Others include: programmes for marginal youth, harm reduction in drug users, women's health, STD prevention and management.

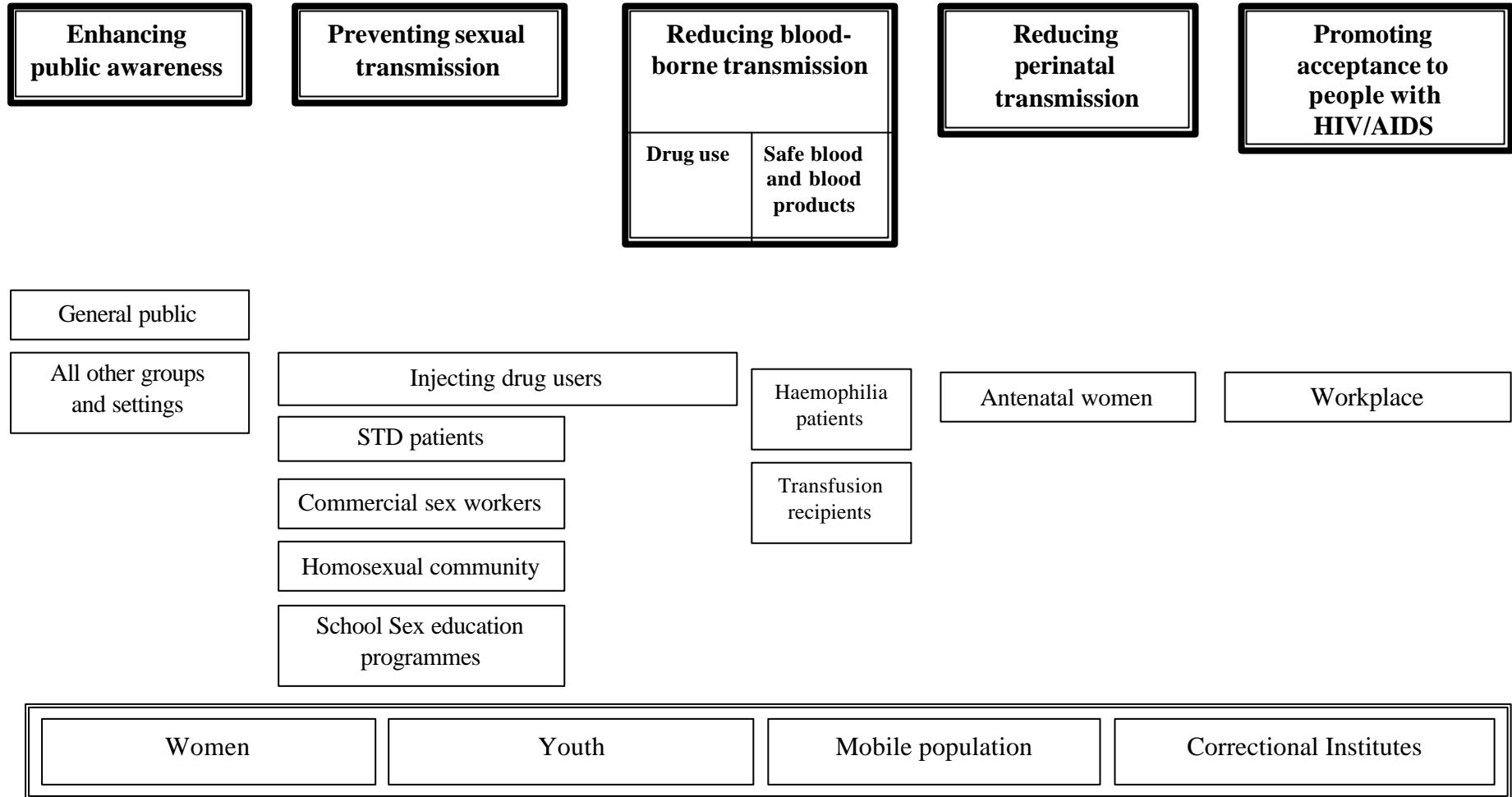
- (g) Feedback mechanism - The current provision of the programmes is activities driven. Programmes conducted are not research based, nor is a monitoring mechanism in place to evaluate their effectiveness.

Appendix II.1: Television Announcements of Public Interest (APIs) on AIDS

<u>Title</u>	<u>Format</u>	<u>Duration</u>	<u>Language</u>	<u>Launching Date</u>
AIDS counselling hotline	S	20/30	C/E	
Pyramid	V	30/30	C/E	
High risk group	VT	30/30	C/E	15/04/87 on wards
AIDS counselling service	S	20/20	C/E	
Condom	VT	30/30	C/E	01/07/87
Prevention-High Risk Group (Bar)	VT	30/30	C/E	
AIDS Counselling Hotline	S	20/30	C/E	
Parents' and Children's Guide Book	S	20/20	C/E	09/05/88
Youth and Prostitution	VT	30/30	C/E	01/12/88
Infection of Ordinary People	VT	30/30	C/E	01/12/88
Aids Exhibition	S	15/15	C/E	Mid-Nov. to 10/12/88
Homosexuals	VT	30/30	C/E	01/12/88
Sharing Needle	VT	30/30	C/E	01/12/89
Safer Sex/Condom	VT	30/30	C/E	01/01/90
AIDS Exhibition '90 (City Hall)	S	20/-	C	23/11/90-02/12/90
AIDS Exhibition '90(Cultural Centre)	S	20/-	C	03/12/90-10/12/90(am)
AIDS & Travellers	VT	30/30	C/E	01/12/90
Misconception (I)	VT	15/15	C/E	10/11/91
Misconception (II)	VT	15/15	C/E	10/11/91
Misconception (III)	VT	15/15	C/E	10/11/91
Stuntman	VT	30/30	C/E	01/02/92
The Use of Condoms		37.5/37.5	C/E	
The Use of Condoms	V	38/38	C/E	01/06/92
HIV Test Booklet	S	15/15	C/E	10/08/92 onwards
Women Protection	VT	30/30	C/E	05/12/92 onwards
Husband	VT	30/30	C/E	01/08/93
Girl	VT	30/30	C/E	01/08/93
Three Women (Salon)	VT	30/30	C/E	23/06/94 onwards
Talk About AIDS (Mouth)	VT	30/30	C/E	23/06/94 onwards
The story of J.J.	VT	60/60	C/E	05/06/95 onwards
Prevention	VT	30/30	C/E	01/08/95 onwards
Attitudes	VT	30/30	C/E	01/09/95 onwards
10 Years of AIDS in Posters	S	30/30	C/E	25/03-07/04/96
Appeal by Pamela Pak	VT	30/30	C/E	02/12/96 onwards
Appeal by Paul Tse	VT	30/30	C/E	02/12/96 onwards
Appeal by Li Pik Sum	VT	30/30	C/E	02/12/96 onwards
Misconception I (Revised 96)	VT	15/15	C/E	22/07/96 onwards
Misconception II (Revised 96)	VT	15/15	C/E	22/07/96 onwards
Misconception III (Revised 96)	VT	15/15	C/E	22/07/96 onwards
Misconception I (Second Rev 96)	VT	15/15	C/E	16/09/96 onwards
Misconception II (Second Rev 96)	VT	15/15	C/E	16/09/96 onwards
Misconception III (Second Rev 96)	VT	15/15	C/E	16/09/96 onwards
Appeal by Hung Chiu Fung	VT	30/30	C/E	02/12/96 onwards
Appeal by Gary Ngan	VT	30/30	C/E	02/12/96 onwards
Appeal by Li Pik Sum (Revised)	VT	30/30	C/E	02/12/96 onwards

Key: S= slide, C=Chinese, E=English

Appendix II.2 Programme foci  and target groups / settings 



Internal Assessment Report

A review on the HIV/AIDS situation and the programmes on its prevention, care and control in Hong Kong

Chapter III:

Clinical and Support Services

Advisory Council on AIDS 1998

III. Clinical and Support Services

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- Appendix III.1** The network of service providers for people living with HIV/AIDS
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III. Clinical and Support Services

3.1 Introduction

One unique feature of HIV/AIDS is that infected people suffer not just from the medical illness, but also the accompanying psychological trauma and social stigma attached to the infection. Clinically, an infected person may be asymptomatic until the body's immune defence becomes compromised to an extent that complications arise. Generally, about 50% of the infected persons develop AIDS or acquired immune deficiency syndrome (with complications) after ten years. With the advances in medical therapy, the prognosis of HIV/AIDS patients have improved. The psychosocial aspects of HIV/AIDS, on the other hand, need to be addressed not only from the angle of those infected, but that of the society. The latter aspect is dealt with in Chapter IV and partly in Chapter II. This Chapter deals with direct services provided to people living with HIV/AIDS in Hong Kong. This is divided into two main parts – clinical service and support service. The two form the cornerstone of the management programme.

Box 3.1

Health care in Hong Kong

The health care system in Hong Kong is a 2-tier structure that comprises a private and a public sector. The public sector of health care delivery is the responsibility of the Government and is available to every resident of Hong Kong at a minimal fee. This can be waived in the event of economic hardship. The public sector not only provides a comprehensive range of out- and in-patient service but constitutes the bulk of the medical infrastructure in Hong Kong. It is the sector where all medical and most nursing training take place. Whereas the private sector is responsible for 70% of the primary care services, the public sector accounts for 90% of the secondary and tertiary care. The public sector underwent an administrative restructuring in 1989 when the then Medical and Health Department was split to become the Department of Health and the Hospital Authority, the latter formally inaugurated in 1991. The Hospital Authority is a statutory body outside the civil service which is charged with the management of all public hospitals, the total number now stands at 41, accounting for 85.4% of all hospital beds. There are currently 12 private hospitals in Hong Kong. Overall, Hong Kong has a bed-population ratio of 4.7 beds per thousand population. On the other hand, provision of primary health care and public health services fall under the Department of Health. Clients are charged a nominal fee of HK\$37 (US\$1 = HK\$7.8) per outpatient visit at the general outpatient (primary care) clinics run by the Department of Health. They are charged HK\$44 for each consultation at the specialist clinics of. For inpatient care, a fee of HK\$68 is charged for each day's stay in a public hospital. The charge covers everything inclusive of medicines and operations irrespective of the specialty. In the public service, HIV/AIDS has been managed as any other diseases. The fee described above therefore applies to people with HIV/AIDS as regards specialist outpatient as well as inpatient treatment.

Like other medical services in Hong Kong, clinical HIV/AIDS treatment is provided largely through the public sector. HIV/AIDS treatment provided through designated clinical services are organised like that of other specialist medical services. Support services, on the other hand, fall within the boundary of both the public service and community organisations. The latter includes pre-existing agencies as well as those set up in response to the AIDS problem. In this Chapter, the current provision of AIDS services is examined, in context of how they are delivered, how each component is related to another, and how their standards are being maintained.

3.2 Overview of HIV/AIDS Service Provision

3.2.1 Historical development

The first diagnosis of HIV infection in Hong Kong was made in 1984. The first few AIDS patients were initially managed at Princess Margaret Hospital, the only hospital in Hong Kong that was equipped with an Infectious Disease team and isolation wards. In 1985, a *Counselling Service* was set up at Queen Elizabeth Hospital. This setup quickly evolved to become a de facto HIV clinic staffed by physicians of the hospital and nurses specifically recruited to provide counselling support. In 1987, the counselling service extended its hotline service to 12 hours a day from Monday to Friday. With the establishment of the Department of Health, an AIDS Unit, now based in Yaumatei, was constituted which continued to provide outpatient based clinical and counselling service in Hong Kong. A clinical AIDS service is operated separately by the Queen Elizabeth Hospital. The close relationship between Queen Elizabeth Hospital and the AIDS Unit (the HIV Clinic) continues.

Community-based services were introduced subsequently. The process was hastened through the efforts of AIDS NGOs, especially after the setting up of the AIDS Trust Fund by the Government in 1993, the latter providing financial support to service projects for people living with HIV/AIDS. In the same year, the Government-appointed Advisory Council on AIDS (which advises on Hong Kong's AIDS policies) formed a new committee to examine service development. This committee, the AIDS Services Development Committee, published its *Review of Services provided to People with HIV/AIDS in Hong Kong* in 1994. The Review had incorporated a simple study on assessing the needs of people with HIV/AIDS.

3.2.2 Current layout of HIV/AIDS services (Appendix III.1)

In response to AIDS, new specialised services have emerged in Hong Kong, alongside mobilisation of existing services. In broad terms, the HIV/AIDS care programme is made up of the following core components: (a) clinical services – including specialised designated services and non-designated but participating clinical services (section 3.3), (b) laboratory services providing diagnosis and facilitating management (section 3.4), and (c) support services (section 3.7). The contribution of each form of service varies with patient populations. The needs of, for example, HIV infected health care workers and haemophilia are unique and are dealt with separately (section 3.2.3). AIDS services are supported by a source mechanism which identifies HIV infected people through the provision of HIV testing and counselling (section 3.6).

In support of the direct services, two other systems provide the backup support for effective management of the patients: firstly, standard infection control practice to safeguard health care workers and clients, and to ensure a non-discriminatory setting (section 3.9); and secondly, mechanisms to uphold the standard of the services, through training of health care professionals and the promulgation of management guidelines (section 3.5 and 3.8).

3.2.3 Clients with special needs

Haemophilia patients and HIV infected health care workers deserve special attention. Both are HIV infection acquired in or related to health care settings. With the use of safer blood products and universal blood screening, the problem of HIV infection through blood/products has become minimal, though the infection during window period is small but genuine.

(a) Haemophiliacs with HIV

In Hong Kong, some haemophilia patients acquired the infection by using blood products prior to 1985 before heat-treated alternatives were available. Medical treatment and support services are provided in the same way as for other HIV infected patients. In 1993, the AIDS Trust Fund was formed by the Government, primarily for providing special ex-gratia payments to patients who acquired the infection through the use of blood and blood products prior to 1985. (Box 3.2 and 5.4) Most of those patients who survived into adulthood are

now under the care of the Department of Health's HIV Clinic and hospital haematologists.. There had been no HIV infection through this route until 1997, when one was infected through the transfusion of blood during the window period.

Box 3.2 Exgratia payment

Schedule of ex-gratia payment for those infected with HIV through transfusion of blood or blood products in Hong Kong prior to August 1985:	
<u>For those infected</u>	
(i) married with dependent children	HK\$1,000,000
(ii) married without dependent children	HK\$ 750,000
(iii) single	HK\$ 600,000
<u>For an infected spouse or children of the above</u>	HK\$ 300,000
<u>For the family of a victim who has died and not eligible for any of the above</u>	HK\$ 300,000
*HK\$100million of the \$350 million Fund is for providing exgratia payment, the remaining for education and service project, US\$1 = HK\$7.8	

(b) HIV-infection in health care workers

The issue of the HIV-infected health care worker is a delicate one. There are the controversies as regards the size of transmission risk to patients, the definition of exposure-prone procedure, balance between confidentiality and public interest, and possible discrimination in the workplace. In 1992, an HIV antibody positive dentist openly declared his HIV status (Box 3.3). In the following year, the Advisory Council on AIDS convened a special panel to address this issue. A set of guidelines was published in 1994¹, and with it, a panel has been appointed by the Director of Health to advise on management of individual cases of HIV infected health care workers. The guidelines emphasise on the practice of universal precaution and advise against mandatory testing. So far, no case has been referred to the Panel.

¹ Advisory Council on AIDS. HIV infection and health care workers – recommended guidelines. Hong Kong: Advisory Council on AIDS; 1994.

Box 3.3

Dr Mike Sinclair

In 1992, Dr Mike Sinclair, a dentist, made public his HIV status. This was unprecedented and the story had drawn wide publicity in the media. One ripple from this publicity, however, was the concern in the community about the risk of transmission from a health care worker to a patient. This was understandable, as the dramatic incident of the Florida dentist infecting 6 of his patients had been widely covered in the media. Dr Sinclair subsequently became an education officer of the Hong Kong AIDS Foundation, a local NGO. He was also an adviser to the Hong Kong Community Charter on AIDS which has been involved in the promotion of AIDS education in the workplace. He died in 1995.

3.3 Provision of Clinical Service

3.3.1 An overview

Clinical services for people with HIV/AIDS are provided largely through the public sector. Here an arbitrary distinction can be made between designated and nondesignated services. Designated clinical services are those specially run for people with HIV/AIDS, whereas non-designated services are those for other specialties which also take in HIV/AIDS patients. In Hong Kong, there are two designated AIDS services - one is operative under the Department of Health, whereas the other under the Hospital Authority.

The designated clinical services have since become the main centres for the delivery of HIV care. It is at these services that antiretroviral treatment is provided and referral made to other services (including support services) as necessary. Other activities of the designated AIDS services include clinical assessment, antimicrobial prophylaxis, clinical/laboratory monitoring, referral for cross-specialty consultation and treatment of superimposed complications. With the advances in HIV treatment, designated clinical services are becoming more specialised and outpatient based. Non-designated services take up the role of acute hospital management, and patients are often referred to the designated services for long term followup.

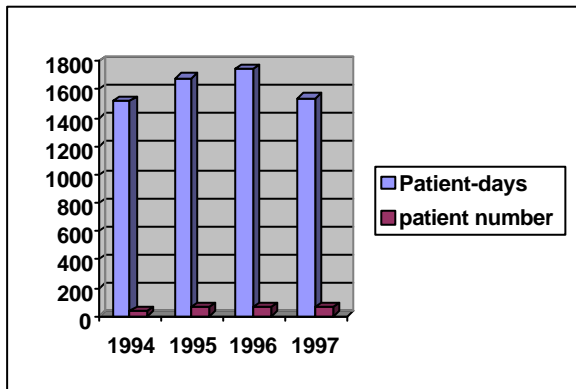
3.3.2 Designated services

(a) Department of Health's HIV Clinic

Over the years, the HIV Clinic has developed itself into an outpatient management centre. The number of new cases seen at the service was 52, 64 and 90 in 1995, 1996 and 1997 respectively. Its active caseload now stands at about 210. There is a daily clinic session attended by approximately 10-15 clients. The Clinic also provides on-the-phone consultation with other practitioners and, if necessary, hospital/clinic visits. For example, the Clinic attended to 34 patients of 12 hospitals/institutions between 1995 and 1997, in a total of 47 visits arranged with the respective hospitals. A patients' helpline is available. Five doctors and nine nurses participate, aside public health activities, in the clinical programme. The training background of the five clinicians are: internal medicine (2, plus 1 trainee), public health (1), dermatology /venerology (1, trainee). Major referral sources of clients of the HIV Clinic are the Social Hygiene Service (the Department of Health's STD clinics), the Hong Kong Red Cross Blood Transfusion Service, some private and public hospitals.

(b) AIDS Service based in Queen Elizabeth Hospital

Box 3.4



The role of Queen Elizabeth Hospital in the hospital care of HIV/AIDS has been preeminent. Historically it was the first major centre for admissions of HIV/AIDS. HIV/AIDS patients are admitted into the general medical wards of the Hospital. There are no isolation wards, nor are there

designated cubicles. Two doctors (both of them in internal medicine), one nurse specialist and one nursing officer constitute the core of the team that provides consultation and followup care to HIV/AIDS patients. Day-to-day inpatient management is the responsibility of ward clinicians. The number of inpatient admissions were 39, 60, 67, and 67 for the years 1994 to 1997 respectively (Box 3.4). This has remained stable at about 1500 patient-days in 1997, with an average stay of 13.2 days per admission. In 1997, between 10-15 discharges were recorded per month. There are now regularly 3-6 patients in the hospital

on an average day. The active caseload is about 160, and there are 3 to 4 clinic sessions per week, each taking care of 10-20 clients. The main referrals are from acute hospital admissions, other public and private hospitals, and AIDS Unit of the Department of Health.

3.3.3 Non-designated services

The official policy of both the Advisory Council on AIDS and Hospital Authority is that inpatient management should not be limited to one specific hospital, but rather determined by such factors as patients' wishes and geographic proximity. In practice, hospitals other than Queen Elizabeth Hospital take in acute cases predominantly, while referral is often made to the designated services if long term followup or chronic care is required. In late 1997, Princess Margaret Hospital had started to provide followup clinical service for a small number of HIV/AIDS patients. About 30 admissions were made in 1997 by these hospitals, amounting to 850 patient-days.

The situation is quite different in the care of HIV-infected children. Historically, the burden of care of HIV infected haemophiliacs had fallen on the paediatric service of the hospitals which managed their haematological condition. Almost all major public hospitals had had some limited experience with paediatric HIV/AIDS. As heterosexual infection became prevalent, it also posed the threat of perinatal infection. So far, four incidents of perinatal infection have been documented, while another four are being monitored for more definitive outcome. As of the end of December 1997, the AIDS Unit, under a separate registry, has recorded a total of 21 pregnancies in HIV infected mothers. These were taken care of by different obstetricians in the territory. At Queen Elizabeth Hospital where a substantial proportion of HIV/AIDS are being followed, 6 HIV+ mothers (5 with HIV antibody negative babies, 1 with a positive baby) are on regular followup. There being a limited number of patients, no designated HIV service in paediatrics similar to those for adult patients has been established.

Dental service assumes a special position in the provision of HIV/AIDS care. Public dental care is not generally available to all members of the public, while the private sector has not been actively involved in the care of people known to be HIV infected. Special arrangement, through consultation, has been made in the last years for known HIV infected patients to receive dental service

in case of needs (Box 3.5).

Box 3.5

Dentistry and HIV in Hong Kong

Infection control – The self-disclosure of the HIV status of a local dentist has alerted the dental profession of the need to uphold the standard of infection control. Issues such as the wearing of gloves, sterilisation of equipments, and the concept of universal precaution have received much attention. Training courses were conducted, education materials produced and guidelines promulgated centering on the same theme.

Patient care – There have been concerns when some dentists reportedly refused to take care of HIV infected patients and those at risk of infection.

Protecting patients – The incident of the Florida dentist and the story of Dr Mike Sinclair have caused the dental and health profession to re-examine how patients could be best managed with due regards for confidentiality, safety and the complexity of ‘rights to know’ ..

Another form of clinical service is hospice. Traditionally, hospice represents one form of clinical service often linked with terminal illnesses like cancers. Earlier on, there have been difficulties in persuading existing hospices to take in AIDS patients because of (a) the stigma, (b) concern for competition with other terminal patients, (c) the perceived difference in the needs of AIDS patients, which probably demands a different expertise. Currently there are 2 hospices in the public sector that have admitted AIDS patients, but the number of clients has been very small so far. As the current concept of hospice is extending beyond that of traditional terminal care, this would be elaborated under section 3.6 under support services.

3.3.4 Private sector

About 60% of the registered doctors worked in private sector. There are only a few private practitioners who take care of clients with HIV/AIDS. It is estimated that, currently, the total number of patients regularly under the care of the private sector is less than 10. In 1994, a questionnaire survey was conducted in 13 private hospitals, with 10 returns. It was found that six (60%) of hospitals had had managed patients with HIV/AIDS. All except two would refer patients with HIV/AIDS to the public sector upon discharge rather than continue to follow them up (Box 3.6). To date, it is believed that all private hospitals had

taken care of HIV/AIDS patients, though often just for acute management.

Though the private sector has not been actively involved in HIV management, private practitioners do play an important role in the diagnosis of the infection. Overall, 22% of all HIV diagnoses reported to the Department of Health originate in the private sector. Some of these might have been incidental findings when clients present for HIV testing while, say, applying for an insurance policy. It is noted also that some 80% of the STD patients are taken care of in the private sector².

Box 3.6

Difficulties cited by private hospitals in the care of HIV/AIDS

- (a) insufficient experience of health care staff
- (b) concern of poor acceptance by other patients
- (c) infection control practice
- (d) medical costs generally not covered by insurance
- (e) reluctance on the part of the health care staff to care for such patients
- (f) the presence of AIDS in the hospital stigmatizing their image

3.4 Provision of Laboratory Services

Laboratory services form the major support to the clinical programmes. This section deals with a number of tests important in the management of HIV infection in Hong Kong. The HIV antibody test represents the first step towards a diagnosis, which is available in both the private and public sector. The CD4 cell count and viral load tests are now essential investigations for managing HIV infection. CD4 tests have been available in the public sector since over 10 years ago, whereas the viral load tests have only been introduced lately, in the last two years.

3.4.1 HIV antibody tests

A two-step approach has been adopted in the public service in the diagnosis of HIV infection in Hong Kong. Screening for both HIV-1 and HIV-2 by ELISA is followed by Western Blot testing for positive specimens. While ELISA testing is widely available in the public and private sectors, there are

² Scientific Committee on AIDS paper (XIIIth meeting on 5 March 1998): Survey on epidemiology of STD/HIV in Hong Kong 1997; 1998.

only 3 services in the public sector regularly providing Western Blot confirmation: the Department of Health Virus Unit, Prince of Wales Hospital, and Queen Elizabeth Hospital. The total number of private laboratories performing confirmatory tests is not exactly known, but is unlikely to be significant. The Government's Virus Unit handles the biggest number of tests, averaging 3800 HIV antibody tests (including voluntary testing and serosurveillance studies) per month in 1997. Western Blot confirmation is provided free of charge for positive ELISA tests detected in the private sector. At a standard charge, it also performs testing requests of private practitioners. Currently the monthly number of tests performed by either Prince of Wales Hospital or Queen Elizabeth Hospital is about 150. In 1993, the Department of Health's Virus Unit set up the External Quality Assessment Programme under the auspices of the Hong Kong Medical Technology Association. A total of 16 (public and private) laboratories participated.

3.4.2 CD4+ cell count

Since 1985, the Pathology Institute (PI) of the Department of Health has been providing CD4+ cell count on a routine basis for the public sector, covering HIV/AIDS patients of both Queen Elizabeth Hospital and the Department of Health's AIDS Unit. In general CD4 cell enumeration for people living with HIV/AIDS is done every three to four months. At a fee, it also provides the service for private practitioners. The manual method has been replaced by flow cytometry since 1992. In 1997, 1376 CD4 tests (399 in 1994) were performed by the laboratory now based in Sai Ying Pun Pathology Institute.

The Immunology laboratory of Queen Mary Hospital also performs CD4+ cell count. The service is limited largely to the same hospital's patients, some public hospitals, and private practitioners through special arrangement. Between 50 to 100 tests were performed yearly between 1994 and 1997, a significant proportion of which were for non-HIV patients.

3.4.3 HIV viral load

HIV viral load testing is a useful tool in modern day management of HIV infection, in diagnosis, monitoring, treatment and prognosis. In early 1996, the Department of Health's Virus Unit and the Microbiology Department of Queen

Elizabeth Hospital began performing the test on a trial basis, by the Roche RT-PCR and Chiron bDNA methods respectively. The former provides service to patients of Queen Elizabeth whereas the latter serves the Department of Health's AIDS Unit. The total number of tests performed by the two laboratories per year is about 700.

3.4.4 Other tests

General tests not specific to the care of HIV are readily available across major laboratory facilities of the Department of Health and Hospital Authority. More specific tests requested include that for *Pneumocystis carinii*, mycobacterial culture by BACTEC, CMV antigen, and other microbiological tests for diagnostic purpose.

3.5 Practice of Clinical Management

3.5.1 The application of antiretroviral therapy

Antiretroviral drugs are prescribed (a) for the management of HIV infection and (b) in the prevention of infection in certain settings, particularly in the prevention of perinatal infection and in post-exposure prophylaxis in health care settings.

(a) Antiretroviral treatment in HIV/AIDS patients

Antiretroviral treatment is now regularly prescribed to people with HIV/AIDS in Hong Kong. Its use is largely through the two designated AIDS clinical services. Their prescription in non-designated services and private sector is minimal.

As with the rest of the world, the use of zidovudine (ZDV) as the sole therapeutic agent against HIV has been widespread until relatively recently. The drug has been available in Hong Kong since 1987. ddI and ddC followed suit in 1992 and 1993 respectively. An avalanche of new medications began in 1996. In late 1997, all nucleoside reverse transcriptase inhibitors and protease inhibitors (PI) but nelfinavir registered by the United States Food and Drug Administration (FDA) were available in Hong Kong (Box 3.7).

In the wake of scientific findings and new guidelines³ published elsewhere, combination treatment gradually became the standard. Double treatment was introduced in mid 1996 in the public service. Since late 1996, triple therapy involving the use of two nucleoside reverse transcriptase inhibitors and a protease inhibitor has become gradually available. In Jan 1997 the Scientific Committee on AIDS issued a consensus statement in support of its use in Hong Kong. The statement was revised in March 1998, incorporating the new element of drug adherence, and concluded that monotherapy should no longer be the standard. Each designated clinical service has established its own protocol in the use of antiretroviral drugs, following the principles laid down by the Scientific Committee as well as guidelines published elsewhere. As of the end of 1997, about 30-50% of the active cases at the two designated services are receiving triple therapy including at least one protease inhibitors. The indication of combination treatment is either (a) clinical AIDS or symptomatic disease, and/or (b) patients with low CD4 and/or high viral load. The absolute level of CD4 for initiating treatment is similar to that in western countries, though it has been reported that the normal range does have variation⁴.

Box 3.7 Registration of antiretrovirals in Hong Kong

Antiretroviral	registration	First use in
Zidovudine (AZT, Retrovir)	6/1987	1987
Didanosine (ddI, Videx)	3/1992	7/1992
Zalcitabine (ddC, Hivid)	8/1993	3/1994
Stavudine (d4T, Zerit)	9/1996	10/1995
Lamivudine (3TC, Epivir)	5/1997	5/1996
Saquinavir (Invirase)	11/1997	8/1996
Ritonavir (Norvir)	9/1996	8/1996
Indinavir (Crixivan)	1997	1/1997
Nelfinavir (Viracept)	1998*	1998*
Nevirapine (Viramune)	1998*	1998*
Delavirdine (Rescriptor)	1998*	1998*

*expected date

(b) Antiretroviral prophylaxis

Effectiveness of ZDV to prevent mother-to-infant transmission was demonstrated by the results of ACTG 076⁵. To date, a total of 22 pregnancies of 17 HIV-infected mother had been recorded by the AIDS Unit. 12 of these

³ International AIDS Society – USA Antiretroviral Therapy for HIV Infection in 1996, recommendations of an International Panel *JAMA* 1996: Vol 276 (2) 146-154

⁴ Kam KM, Leung WL, Kwok MY, Hung MY, Lee SS, Mak WP. Lymphocyte subpopulation reference ranges for monitoring human immunodeficiency virus-infected Chinese adults. *Clin Diagn Lab Immunol* Vol 3 No.3 326-330 May 1996

⁵ Conner EM, Sperling RS, Gelbert R, et al. Reduction of maternal-infant transmission of human immunodeficiency virus type 1 with zidovudine treatment. *N Eng J Med* 333: 1173-1180, 1994

pregnancies went on to birth. After 1994, all pregnancies of known HIV infected mothers in the public service were given ZDV in some form, but not all managed to receive the full course as recommended in ACTG 076⁵, the main reason being the often late diagnosis of maternal HIV infection in the course of pregnancy. Current antenatal care in Hong Kong does not include routine screening for HIV infection. Health talks are given periodically to antenatal mothers attending the Department of Health's Maternal and Child Health Centres (MCHs), which look after 40% of all pregnancies in Hong Kong. Referral for HIV tests are made on a case-by-case basis.

Post-exposure prophylaxis is an area of concern in health care setting. In recognition that ZDV was effective in post-exposure prophylaxis, the Scientific Committee on AIDS revised its guidelines (originally formulated in 1992, revised in 1995) in 1997 (Appendix III.3) accordingly. The guidelines call for the use of combination therapy in high-risk exposures. Management protocol is developed by individual hospitals' Accident and Emergency Departments, Infection Control Teams and the designated AIDS services. Problems in effectively implementing the programme are (a) lack of expertise to provide on-the-spot counselling and prophylaxis regimens, and (b) the mechanism for long term followup; and (c) access to drugs.

3.5.2 Management and prophylaxis of complications

While management of AIDS-associated complications largely follows the lead of Western countries, local circumstances sometimes dictate a different approach. Tuberculosis, *Pneumocystis carinii* pneumonia, CMV retinitis, Kaposi's sarcoma, penicillosis are some of the more unique clinical problems associated with HIV infection in Hong Kong. A summary of how they are managed is at Appendix III.4.

Prophylaxis of opportunistic infections has been an important part of the clinical management programme. Criteria followed by the designated AIDS services in the use of prophylaxis are generally in line with those recommended by the USPHS⁶. The nadir of the CD4+ cell count is used for guidance.

⁶ 1997 USPHS/IDSA Guidelines for the Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus *MMWR* 1997;46(RR-12)

However, In this context, it is interesting to note that the average CD4+ count of healthy Chinese is probably lower than that of Caucasians⁶. Currently, routine immunization for adults with influenza, hepatitis B or pneumovax vaccine is not practised.

3.6 HIV Testing Services

Three forms of HIV testing services are available in Hong Kong. Firstly there are designated HIV testing services which provide anonymous and confidential testing in context of counselling. The AIDS Unit is now the Government's operation in providing the service, which is available free. The service operates through a designated AIDS Hotline. A similar service, but in a smaller scale, is also available through AIDS Foundation, an AIDS NGO. Secondly, voluntary HIV tests are available as part and parcel of the pre-existing service, for example, in STD clinics and drug rehabilitation services. Thirdly, private laboratories are also providing HIV tests as referred by private doctors. Such tests could be initiated by the client and/or in consultation with the doctor.

3.6.1 Anonymous and confidential HIV testings

The HIV antibody test as offered at the AIDS Unit since 1985 is complete with pre- and post-test counselling by nurses-counsellors. On average, about 1000-1300 HIV tests are performed yearly. In 1997, a total of 1101 screening tests were done. Overall, the clinic contributed 22% of all HIV diagnoses reported to the Department of Health. Blood taking and counselling are carried out in the same facilities. Appointment is made through the AIDS Hotline.

Since March 1993, the Hong Kong AIDS Foundation, an AIDS NGO, has maintained a telephone helpline that offered voluntary HIV testing for concerned individuals. This service is operated by volunteers in its premise located in the Shaukeiwan Jockey Club Clinic. Pre- and post-test counselling are provided. Blood samples are sent to the Government's Virus Unit for assays

⁶ 1997 USPHS/IDSA Guidelines for the Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus *MMWR 1997;46(RR-12)*

that are provided free. Referrals are then made for HIV-infected individuals to attend services of the private or public sector. About 200 tests are done annually.

3.6.2 HIV tests in other services

Free HIV testing is provided to all clients of the Government's Social Hygiene Service, which is responsible for the care of about 20% of all STD patients in Hong Kong. The total attendance (6 male and 6 female clinics) was about 140,000 annually in the last 5 years. Currently, they form the biggest proportion of all voluntary HIV testing undertaken by the Virus Unit, accounting for 3000-3500 tests per month. Approximately one-fifth (19%) of all reported infection to date have originated from the Social Hygiene service.

HIV tests are also offered to patients of public hospitals and clinics for a clinical indication. These are performed either by the same hospital or referred to one of the three laboratories where confirmatory tests are available. The Department of Health's Virus Unit performs a majority of these tests. The Virus Unit also supports HIV tests performed in other settings, namely, drug rehabilitation facilities under the Society for the Aid and Rehabilitation of Drug Users (SARDA), methadone clinics, and the Family Planning Association which offers as an option in their premarital package service

3.6.3 HIV tests in private sector

Many private laboratories are providing HIV tests to referring private doctors. The number of private laboratory and hospitals capable of HIV testing has greatly increased over the years, while Western Blotting confirmation is still confined to a small number of laboratories, largely in the public service. The Department of Health's Virus Unit provides free confirmatory tests to preliminary positive results by screening. Statistics of HIV tests done in private sector is not available.

3.7 Support Services

Support service supplements clinical services in the management of HIV infection. Many are provided through mobilisation of community resources, making use of informal network as well as collaborating with formal services and facilities. The

objective is to create a supportive care environment so as to retain clients in the community. Current provision of support services is categorised⁷ under (a) home-based services, (b) centre-based care, and (c) institution-based service. These are supported by medical social service which functions both in discharging direct care as well as mobilising community resources for access to people living with HIV/AIDS. (Appendix III.1)

3.7.1 Medical social service

Medical social service is available to hospital patients upon referral and requests. Since January 1994, a medical social worker has been posted by the Social Welfare Department to AIDS Unit to take care of, among other duties, people living with HIV/AIDS. Her activities are two-fold: mobilising community resources and the provision of direct services including counselling, arranging tangible assistance, education and training, and convening patients' support groups. Since 1996, she became full-time involved in AIDS. As of the end of 1997 the cumulative caseload was 197. In 1995, 1996 and 1997, the number of sessions she had conducted amounted to 180, 635 and 435 respectively.

In the public hospitals, referrals to a non-designated medical social worker can be made on a need basis. At Queen Elizabeth Hospital where a majority of in-patient cases are managed, a part-time medical social worker is assigned to take care of people with HIV/AIDS. The number of referrals made to the medical social service was 66, 88 and 44 in the years of 1995, 1996 and 1997 respectively.

3.7.2 Financial and housing support

In Hong Kong, financial subsidy is available from the Government for those individuals with low income (Comprehensive Social Security Assistance, CSSA), with additional allowance given for those with disabling sicknesses. Disability Allowance (DA), as it is known, is payable to a patient who has been certified by an attending physician as 100% disabled. So far 27 of the 210

⁷ AIDS Services Development Committee paper (XXth meeting on 27 March 1998). Consultation on the current provision of community based care for people living with HIV/AIDS; 1998.

clients of the Department of Health's HIV Clinic are currently on CSSA because of HIV-related complications. Patients with genuine and immediate housing need due to personal factors and other specific reasons can apply for compassionate rehousing.

For patients with HIV/AIDS, the Hong Kong AIDS Foundation also maintains the "PWA Support Fund", originally set up in 1992 by an anonymous donation. The Fund aims at helping those whose application for government assistance was pending or who have extraordinary needs that will not be met by government assistance. Successful applicants receive generally up to \$2500 per month for up to three months. So far, a total of 115 applicants have received the money.

3.7.3 Home-based support services

Many support services are community-based activities organised to meet the needs of those partially or completely confined at home. Community nursing provided through the Hospital Authority is one such example, but referrals have rarely been made. Home-care nursing is a new form of services which is more flexible and user-friendly in their provision. Together with inpatient and outpatient care, it constitutes hospice care, which is considered under institution-based services (section 3.6.5). The home-care nursing team of Society for AIDS Care has an active caseload of about 20. Home-based service may also be rendered by volunteers. The AIDS Concern's buddy service has, since 1991, been serving people living with HIV/AIDS. In 1997, there are nearly 30 buddies serving 10 clients.

Home-help service is one form of welfare services which can be available to people with HIV/AIDS. In 1992 there was an incident of an HIV patient being denied service by the local home-help team. The situation has improved (in terms of willingness) following efforts made by, notably Council of Social Service, to train and enlist the support of these teams. There are now 22 welfare agencies operating over 120 home-help services. The need of such service for people with HIV/AIDS is currently minimal. Its utilization has not been evaluated. Other designated services belonging to the same category are: transport service provided to some 40 clients by AIDS Concern in the last year, and soup delivery by the same organisation. On the other hand, family aide service of Social Welfare Department can help clients on home-making. No

case has however been referred yet.

3.7.4 Centre-based service

Centre-based services provide support to those who are mobile and are thus able to maintain their community activities to a great extent. These are primarily supported by AIDS NGOs, especially AIDS Foundation. So far, 60 clients have been referred to the Foundation for evaluation by a social worker, who designed the type of work (e.g. group work) required. Self-help patient support group has also been set up. These are either based in the designated AIDS services or other AIDS-NGOs.

3.7.5 Institution-based service

Under this category, a broad range of services could be available from an institution which clients could stay for a period of time. Service provision includes respite care, rehabilitation, terminal care, and social care. The best examples in Hong Kong are the three hospice services – Tai Po' s Look Out, Haven of Hope Hospital, and Our lady of Maryknoll Hospital. Tai Po' s Lookout is a designated AIDS hospice operated by Society for AIDS Care. Currently, it has 5 beds and is staffed by one doctor and six nurses, supported by a social worker and 50 volunteers. So far, 4 patients have been referred by the two designated AIDS services to Lookout. Opened in September 1997, the number of clients which LookOut has taken care of is on the rise. The other two are hospices for terminal diseases which also take in people with HIV/AIDS. The Haven of Hope Hospital has received 7 clients since September 1996; and Our Lady of Maryknoll Hospital has taken 3 since April 1997.

3.8 Maintenance of Standards

Maintenance of standard in the public health control and clinical management of HIV/AIDS is one most important principle behind training activities organised by and for health professionals. The relatively low prevalence of HIV in Hong Kong poses problems in the provision of training. In fact, HIV medicine had not been formally recognized by any medical specialties until only very recently. This is compounded by the limited training exposure to HIV-related diseases in both undergraduate and postgraduate medical and nursing education, which has arisen because of the small

number of patients and the general desire of many patients to keep their identity confidential adds to the problem.

Despite these shortcomings, two major forms of activities were witnessed in the last years – (1) training programmes targeting professionals at various levels, and (2) development of management guidelines and manuals. A list of guidelines and manuals are at Appendix III.2. These have largely been produced by the Advisory Council on AIDS or its committees, with the technical support of AIDS Unit of Department of Health, which functions as its secretariat. Cooperation and advice were sought from related government agencies in the drafting of these documents. In November 1996, Advisory Council on AIDS organised the first Hong Kong AIDS Conference, providing a forum for advancing knowledge in health care professionals. It was attended by about 400 persons from not just Hong Kong, but also Macau and the Mainland. The following summarises programmes in place to help upkeep the knowledge of health care workers or arouse their interest in HIV/AIDS.

3.8.1. Postgraduate medical training

(a) General training

There is no regular programme of HIV training for general practitioners. From time to time, seminars have been organised by such organizations as Advisory Council on AIDS and other professional medical bodies in forms of lectures and seminars. Other lectures were often presented to tie in with related specialties like infectious disease, respiratory medicine, therapeutics. In 1997, AIDS Unit had presented 31 lectures to various health professionals, with a total attendance of 1828. Of these, doctors' programmes accounted for 12 hours (425 attenders). Similar activities are also undertaken by the AIDS service of Queen Elizabeth Hospital, but to a smaller extent.

(b) Specialised training

So far training have been provided more on the clinical than public health side of HIV/AIDS. HIV medicine forms one part of the specialty training under the Hong Kong College of Physicians (Box 3.8). A majority of the activities have been generated by the two designated AIDS services. The two hold a joint weekly clinical round to discuss management of patients in Queen Elizabeth hospital. A joint clinical meeting was started in 1993 and is now run on a monthly basis. Journal articles are discussed and local studies / clinical cases are presented. Continuing Medical Education (CME) accreditation has

been granted since October 1997. These rounds serve also training purpose. By the same token, the two services also separately hold weekly discussions to address treatment issues, psychosocial or medical, of their own patients. Self-auditing is also done on a regular basis. As from early 1998, AIDS Unit started its monthly journal meeting to cover both clinical and public health side of HIV/AIDS, infectious diseases and clinical immunology. Clinical attachment and part-time in-service training have been provided at both designated AIDS Services.

Some medical staff working in the designated AIDS services have participated in education programmes overseas in the forms of (1) clinical training attachment lasting for over six months, (2) participation in short courses organised by e.g. British Council and World Health Organisation, and (3) attendance in conferences. Whereas short courses and conference often focus on AIDS, clinical training attachment is usually undertaken in context of a more established specialty, e.g. clinical immunology, infectious diseases. One physician has received training in HIV medicine in context of clinical immunology.

Box 3.8

Postgraduate medical training in Hong Kong

The Hong Kong Academy of Medicine carries the role of supervising specialty training, while the Medical Council is responsible for Specialist Registration as required by law. There are 15 specialty colleges under the Academy. Broadly speaking a medical graduate in Hong Kong completes medical specialty training in two stages – general training and higher training. In the case of internal medicine, a graduate has to work in a recognized institution for at least three years and pass an examination of the Hong Kong College of Physicians. The next step involves four years' accredited training - two years of advanced internal medicine training and two years of training in a subspecialty, after which the trainee physician will have to pass an exit assessment before he is conferred the fellowship of the College, and through it, fellowship of Hong Kong Academy of Medicine. He/she can then apply for Specialist registration. As far as HIV medicine is concerned, accreditation is possible towards fulfilling physician training requirements in Infectious Disease, Dermatology/Venereology or Clinical Immunology.

3.8.2 Undergraduate medical education

There are two medical schools in Hong Kong, one with the University of Hong Kong and the other with the Chinese University of Hong Kong. Undergraduate medical education on HIV/AIDS has been provided by individual university departments, depending on the expertise available and the needs as assessed by the medical school. In 1992 the Committee on Education and Publicity on AIDS (CEPAIDS) wrote to the two schools requesting them to strengthen medical education on HIV/AIDS. The University of Hong Kong has, in the last years, included an integrated teaching session of 2 hours in the third year and another 3-hour seminar in the Community Medicine curriculum. Lectures under such subjects as Microbiology, Pathology, Immunology and Medicine are delivered at the two schools.

Clinical teaching, however, has been inadequate in the medical curriculum. The contributing factors are (1) both designated AIDS services are not academic units and are therefore not directly involved in clinical teaching, (2) the small number of patients under the care of hospitals, and (3) reluctance of HIV-infected patients to participate in training activities for medical staff.

3.8.3 Training of nurses

In nursing schools and degree programmes, the subject of AIDS has been included in the curriculum of some but not all institutions. Occasionally professional staff from the two designated AIDS services were invited to deliver lectures at various nursing schools or the University's nursing curriculum. Since 1993, the School of Professional and Continuing Education, (SPACE), University of Hong Kong, and the AIDS Unit have been organizing an annual Introductory Course on HIV/AIDS for Nurses. There are 8 weekly sessions in each course, and the class size varies from 50 to 80. In 1997, the Hospital Authority initiated a training course for nurses working in the hospitals. A course on hospice care was organised in late 1996. The School of Public Health Nursing of the Department of Health is a training institute of its own nurses. Beginning in 1993, every student has had to spend a one-day clerkship with the HIV service. More recently, longer training attachment has been offered by the AIDS Unit to clinical nurses.

For nurses currently working in the two designated services, about a

quarter have attended overseas training courses ranging from a couple of weeks to three months. Conference attendance forms part of the training activities in the recent years, though the number of nurses participating in such events has remained small.

On a general level, lectures are delivered to nurses of public or private hospitals on an as-needed basis. It is noted that the demand for such education programmes rises sporadically when a hospital has recently taken care of patients with HIV/AIDS. Similarly, special didactic lectures or clerkships are also arranged for personnel of institutions preparing for AIDS-related services. The two designated AIDS services entertain requests in this regard.

3.8.4 Training of social workers

The number of medical social workers who have participated in the care of HIV/AIDS patients in the public service is small. An annual one-day symposium on HIV/AIDS including workshops is jointly organized by the Social Welfare Department and the AIDS Unit for social workers in Hong Kong. Each seminar holds about 250-300 workers. The workshops cover subjects of counselling, home care, AIDS education in youth, and family. In addition, the AIDS Services Development Committee published the Manual on HIV/AIDS for Social Welfare Personnel in 1995.

3.8.5 Management guidelines

To promulgate the principles of HIV management, three manuals have been published by the Advisory Council, through the technical input of AIDS Unit: (a) Manual on HIV/AIDS for Social Welfare Personnel, (b) AIDS Manual for Doctors and Dentists (1987, 1992, 1995), and (c) the AIDS Manual for Nurses (1988, 1993, 1998). An information booklet for primary care doctors was published and distributed to all doctors in Hong Kong (1992, 1995, 1997) (Appendix III.2).

Specific guidelines have been published by the Scientific Committee on AIDS, which are brought updated periodically. Some guidelines deal with the subjects of public health control: diagnostic criteria for AIDS, HIV testing, safeguarding blood and blood products, TB/HIV co-infection; others deal with management in the clinical setting: needlestick injuries, reducing perinatal

infection, management in children, principles of antiretroviral therapy

3.9 Infection Control

Standard infection control practice occupies a unique position in the organisation clinical service on HIV/AIDS. Not only is it important in ensuring safety in health care setting, but is itself contributing to non-discrimination towards people living with HIV/AIDS. The threat of HIV has actually brought infection control into the limelight. Today, almost all health care institutions have an infection control team staffed by infection control nurses. In 1993, the Department of Health set up its Infection Control Committee to implement policies on infection control within the Government's service. Back in 1992, the Scientific Working Group of the Advisory Council on AIDS published an infection control document *Prevention of HIV infection in health care setting – guidelines and practice*. It was revised and brought updated in 1994. Universal/ standard precautions are recommended irrespective of the HIV status of clients being taken care of. The guidelines were promulgated, in parallel with the production of training videos and posters. The Department of Health has produced two videos on infection control, one for general clinic setting and the other for dental care. While observed in principle, there exists in actuality a 2-tier system in some institutions - the practice of gloving in procedures involving known HIV-infected patients, scheduling surgery of the HIV-infected to the end of the day, or extra labeling of their specimens.

Needlestick injuries and mucosal exposures constitute an area of concern in health care practices. In 1992, the Scientific Working Group on AIDS, in conjunction with the Department of Health's Scientific Working Group on Viral Hepatitis Prevention published the *Procedures for management of needlestick injuries or mucosal contact with blood or body fluids: recommended guidelines for HIV and hepatitis B prevention*. The subject of hepatitis C was included in the revision made in 1995. The document was brought updated in 1997, taking reference from the provisional recommendations made by USPHS (1996) regarding the use of antiretroviral drugs in post-exposure prophylaxis. Accident and Emergency Departments of hospitals have established protocols to prescribe antiretroviral treatment for high risk exposure on an emergency basis. Follow-up care is largely provided through either one of the designated AIDS services. The total number of health care workers receiving such treatment is small.

3.10 Characteristics and Constraints of AIDS Service Provision

The development of clinical and other support services for HIV/AIDS in Hong Kong is a unique product of its health care system, the hitherto low prevalence of HIV, and the very structure of the government and non-governmental organization. Some characteristics are identified.

(a) Small but comprehensive HIV service

Despite a low local prevalence of HIV and an underexposure of an average medical professional to HIV-related issues, Hong Kong has laid down the infrastructure for the care of patients with HIV/AIDS. This ranges from counselling, medical treatment, to hospice care. In retrospect, all developments in HIV care evolved in synchrony with the need of society.

(b) A core of expertise

Concurrent with the development of clinical services for the HIV-infected has been the emergence of a core of professional expertise. Nurses have been at the forefront of the development. The frontliners of the Government's counselling service were nurses dedicated to developing a locally relevant service for people living with or at risk of HIV/AIDS. The expertise has covered also public health nursing in the development of health promotion in HIV prevention. To date nurses played the key role in not only the two designated AIDS services, but NGOs working on home-care, hospice, and other support services. In parallel there are now a small number of doctors practising HIV medicine in the public service. The input of medical social workers has gradually become substantiated, though size-wise the operation remains minimal.

(c) Standard of care

Health professionals in the two designated AIDS services have tried to set their standard of care according to recommendations in developed countries. However, this is sometimes easier said than done. While a substantial proportion of local patients are receiving combination antiretroviral treatment, the efforts have been limited by factors like availability of laboratory facilities, an inflexible resource allocation mechanism, small expertise base, and limited research initiatives.

(d) A variety of community-based services

The relatively low prevalence of HIV in Hong Kong has not prevented the development of community-based support services. There are NGOs that provide various forms of services that range from counselling to hospice care. The utilisation of

these services have, however, not been thoroughly evaluated.

(e) Integration of clinical and public health functions

In the Government's operation, close collaboration between the public health arm and the clinical service exists, as the core expertise essentially falls under the same unit. Such a system has allowed for a swift response to changes in the epidemic pattern or changing needs of the patient population. The feasibility of this very mechanism may become at risk as the patient population grows.

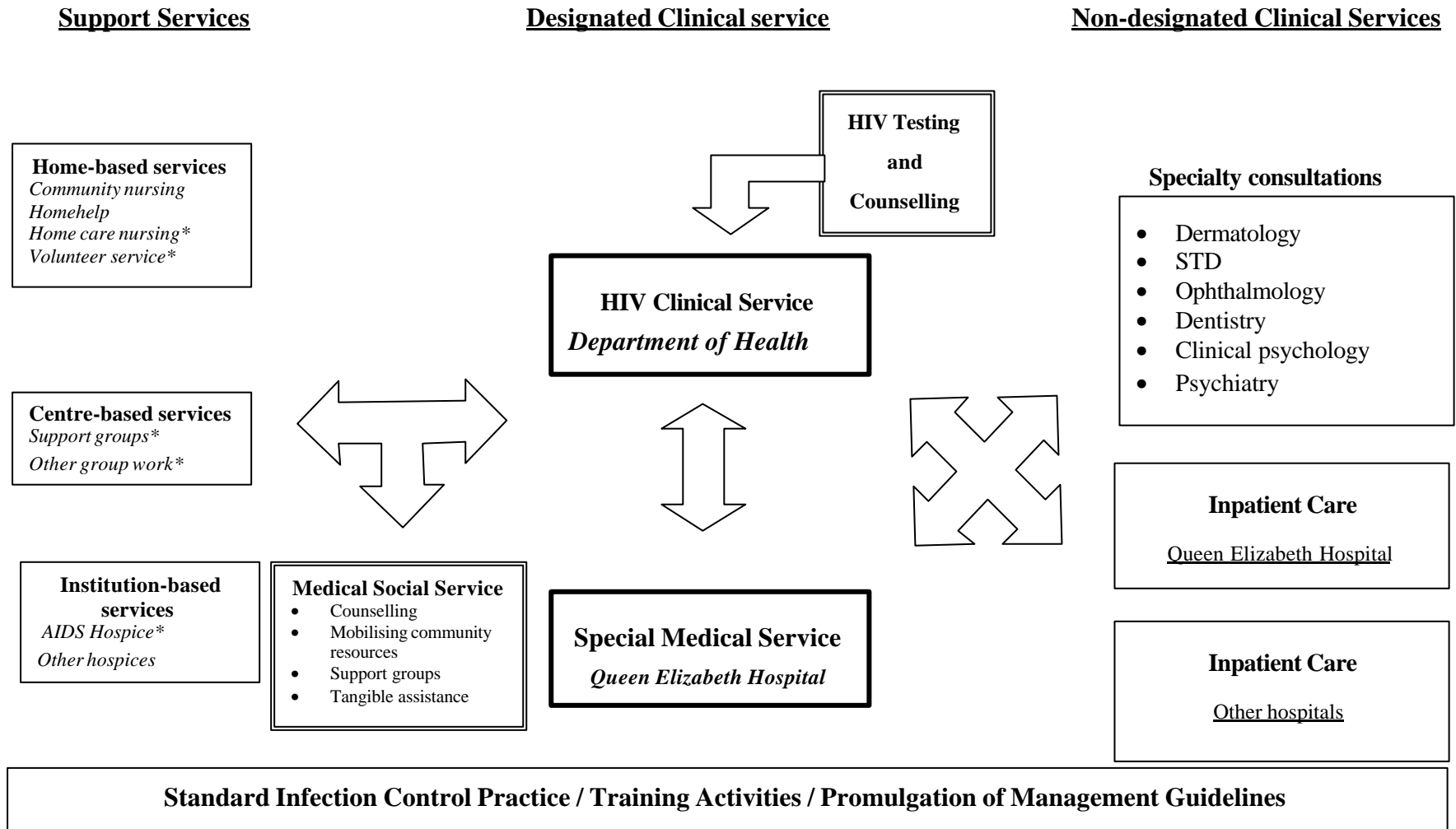
(f) Passive participation of academic institutions

In contrast to development elsewhere, the two medical schools have not assumed a leadership role in providing clinical AIDS services or clinical research. In fact the major teaching hospitals of the two medical schools regularly refer patients to the two designated AIDS services for followup. Such phenomenon has also hindered the development of postgraduate medical training on HIV/AIDS, since the subject has yet to be formally incorporated in the clinical and public health curricula in a systematic manner. There is a general paucity of clinical research on AIDS.

(g) Insufficient assessment of clients' needs

Though service providers have various means of evaluating their own activities, there have not been any systematic assessment of the needs of people living with HIV/AIDS in the local setting. Current service provision have arisen largely (1) in response to perceived needs of clients, (2) adaptation from overseas experience, (3) funding availability. The phenomenon has hindered service development which is research-based and which addresses the genuine needs of those infected.

Appendix III.1 The network of service providers for people living with HIV/AIDS



**Designated community-based services*

Appendix III.2: Publications for health and social welfare professionals

A. List of professional guidelines and protocols established by the Advisory Council on AIDS and its committees/working groups

1. Virus inactivation for clotting factor concentrates – Scientific Working Group on AIDS 1991
2. Disease notification in the context of HIV/AIDS – Scientific Working Group on AIDS 1992
3. Guidelines on Consent for HIV testing – Scientific Working Group on AIDS 1992
4. Procedures for management of needlestick injury or mucosal contact with blood or body fluids: recommended guidelines for HIV and hepatitis B prevention – Scientific Working Group on AIDS and Scientific Working Group on Viral Hepatitis Prevention 1992, revised in 1995 (hepatitis C prevention included) & 1997 (revision, with Chinese version added)
5. Prevention of transmission of HIV in health care settings: guidelines and practices – Scientific Working Group on AIDS 1992, 1995.
6. Recommended guidelines for undertaking unlinked anonymous screening for public health surveillance of HIV infection in Hong Kong – Scientific Working Group on AIDS 1992
7. HIV infection and health care workers: recommended guidelines – Advisory Council on AIDS 1994
8. Guidelines on the prevention of blood-borne diseases in schools – Department of Health and Education Department, 1987, 1994
9. Guidelines on management of HIV infection in children – Scientific Committee on AIDS 1994, 1995
10. HIV antibody testing: recommended measures to generate quality results – Scientific Committee on AIDS 1994
11. The choice of safe clotting factor concentrates for treatment of haemophilia in Hong Kong: recommended guidelines – Scientific Committee on AIDS, 1994
12. Classification system for HIV infection and surveillance case definition for AIDS in adolescents and adults in Hong Kong – Scientific Committee on AIDS 1995
13. Consensus statement on antiretroviral therapy for HIV infection in Hong Kong – Scientific Committee on AIDS 1997, 1998
14. Precautions for Handling and disposal of Dead Bodies – Department of Health, Hospital Authority, Regional Services Department, Urban Services Department, 1994, 1997

List of reports and information papers of the Advisory Council on AIDS

1. Strategies for AIDS prevention, care and control in Hong Kong – Advisory Council on AIDS, July 1994
2. A review of services provided to people with HIV/AIDS in Hong Kong - AIDS Services Development Committee, July 1994
3. Report of the study group on HIV infection of haemophiliacs through blood products in Hong Kong (by an adhoc working group) – May 1993
4. Estimation and projection of HIV infection and AIDS cases in Hong Kong – report of the AIDS Scenario & Surveillance Research Project, initiated and monitored by the Scientific Committee on AIDS, 1994
5. Prevention and management of tuberculosis in HIV-infected patients: an information paper – Scientific Committee on AIDS, 1995
6. Unlinked anonymous screening for HIV surveillance in Hong Kong 1990-1996 – Scientific Committee on AIDS, 1997
7. AIDS and the Law: the Hong Kong Experience – Advisory Council on AIDS 1997

C. Manuals for doctors and nurses published by the Department of Health

1. Information on AIDS for doctors and dentists – Medical & Health Department 1987, Department of Health 1992
2. Information on AIDS for nurses – Medical & Health Department 1988, Department of Health 1993 [Chinese & English]
3. HIV & AIDS: Information for primary care doctors – Committee on Education and Publicity on AIDS 1962, Department of Health 1995, 1997
4. AIDS manual for doctors and dentists – Department of Health 1995
5. AIDS manual for nurse – Department of Health 1997

**Appendix III.3 List of AIDS-defining Illnesses in Hong Kong
(Scientific Committee on AIDS July 95)**

1. Candidiasis of bronchi, trachea, or lungs
2. Candidiasis, esophageal
3. Cervical cancer, invasive
4. Coccidioidomycosis, disseminated or extrapulmonary
5. Cryptococcosis, extrapulmonary
6. Cryptosporidiosis, chronic intestinal
7. Cytomegalovirus retinitis
8. Cytomegalovirus disease (other than liver, spleen or nodes)
9. Encephalopathy, HIV-related
10. Herpes simplex chronic ulcer, bronchitis, pneumonitis or esophagitis
11. Histoplasmosis, disseminated or extrapulmonary
12. Isosporiasis, chronic intestinal
13. Kaposi' s sarcoma
14. Lymphoma, Burkitt' s
15. Lymphoma, immunoblastic
16. Lymphoma, primary of brain
17. Mycobacterium avium complex or kansasii, disseminated or extrapulmonary
18. Mycobacterium tuberculosis, extrapulmonary or pulmonary/cervical lymph node
(only if CD4+<200/ μ l)*
19. Mycobacterium, other species, disseminated or extrapulmonary
20. Penicilliosis, disseminated*
21. Pneumocystis carinii pneumonia
22. Pneumonia, recurrent
23. Progressive multifocal leukoencephalopathy
24. Salmonella septicaemia, recurrent
25. Toxoplasmosis of brain
26. Wasting syndrome due to HIV

* Modification of the CDC 1993 Classification:- (1) Penicilliosis has been added and (2) pulmonary or cervical lymph node TB included only if CD4+<200/ul.

Appendix III.4 Management of HIV related complications

(a) Tuberculosis

Tuberculosis (TB) is endemic in Hong Kong even well before the advent of HIV. Although there has been in a declining trend in the last four decades (the notification rate dropped from 697 per 100,000 population in 1952 to 101 in 1995), TB as an HIV-associated complication is not uncommon. The high background prevalence rate for TB was one of the reasons why pulmonary TB was not counted as an AIDS-defining disease in Hong Kong (Appendix III.4). In 1995, the Scientific Committee on AIDS published an information paper on Prevention and Management of Tuberculosis in HIV infected Patients in Hong Kong to address the complicated issue of treating concurrent HIV and TB in Hong Kong (Appendix III.1). For various reasons including the endemicity of TB and wide use of BCG vaccination, isoniazid prophylaxis is not routinely given to positive reactors to tuberculin.

The TB and Chest Service of the Department of Health is responsible for the surveillance and treatment of TB in Hong Kong. One of its priorities has been the maintenance of an infrastructure of directly observed treatment (DOT). The treatment defaulter rate is less than 5%. An initial treatment regimen of at least 4 drugs in the HIV-infected patient, namely rifampicin, isoniazid, ethambutol and pyrazinamide is used. Patients with dual HIV and TB infection are either referred to the TB and Chest Service or followed up at the designated AIDS services. In a study conducted jointly by the AIDS Unit and the TB and Chest Service, 95 cases of coinfections have been recorded as of 31 Dec 97. Tuberculosis was the primary AIDS-defining illness in 83.9% - lung involved 48.8%, disseminated 27.5%. Only a small number (5%) developed multidrug resistance. The median CD4 was 81/ul.

The popular use of protease inhibitors often complicates the concurrent use of rifampicin. Although the combination of indinavir and rifabutin is commonly employed in this situation, there is no specific guideline or protocol in this respect. Decisions are made on a case-by-case basis.

(b) *Pneumocystis carinii* pneumonia

Pneumocystis carinii pneumonia is the most common primary AIDS-defining event in Hong Kong, accounting for 36% (111 out of 309) of the cumulated AIDS cases, and 31.2% of those reported in 1997. Treatment is generally by intravenous trimethoprim-sulphamethoxazole (Septrin), although oral therapy is sometimes employed for milder cases. Additional steroid is given for severe cases. As a result of increased experience, the frequency of PCP as the cause of death decreased from 18% to 5.3% from the first hundred AIDS cases to the second. (ref). Overall survival after the diagnosis of AIDS rose from 7.3 months to 11.9 months.

Primary prophylaxis with Septrin against PCP is started when the CD4+ cell count drops below 200/ul. Secondary prophylaxis is given for those who recover from the disease. Inhaled pentamidine is substituted for those who are allergic to Septrin. At the AIDS Unit, for example, 22 patients are receiving inhaled pentamidine as a means of preventing from PCP. So far no breakthrough PCP has occurred with pentamidine.

(c) CMV retinitis

CMV retinitis generally occurs in patients with CD4+ cell count lower than 50/ul. The Hong Kong Eye Hospital, a public hospital under Hospital Authority, performs 3-monthly fundal examination for clients referred from the designated AIDS services. Intravenous ganciclovir is the first line of treatment. Induction is followed by maintenance at home via an indwelling catheter. Foscarnet is substituted for those who fail or who are intolerant of ganciclovir therapy. Maintenance is similar to ganciclovir.

Recurrent CMV retinitis is either treated with combined ganciclovir and Foscarnet or ganciclovir eye implant. Up to 31 Dec 97, five eye implants have been performed. The cost of the implant cannot be covered in the regular hospital budget, and AIDS Trust Fund has become a source of financial support. Oral ganciclovir as maintenance is provided on a trial basis. Cidofovir is not licensed yet in Hong Kong.

(d) Kaposi's sarcoma

Kaposi's sarcoma as a primary AIDS defining illness has been reported in 17 (5.5%) of the total cases. In the 10-year period from Feb 1985 to Dec 1994, 17 (13%) of the 130 AIDS reported to the Department of Health had Kaposi's sarcoma (KS) either as the primary or subsequent AIDS-defining illness. The median CD4+ cell count was 91/ μ l at diagnosis. In the same study, the mean survival after diagnosis of KS was 14.4 months, and there had been no deaths directly related to KS⁸. Management of this condition is mainly provided jointly by the Dermatologists of the Department of Health and the designated AIDS services. Various treatments given included α -interferon, intravenous vinblastine and intralesional vinblastine.

(e) Penicilliosis

Penicillium marneffei infections are an important cause of morbidity and mortality in HIV-infected patients in Southeast Asia, Hong Kong being no exception. It now accounts for 29 (9.4%) of all primary AIDS-defining reported⁹. The classic finding is skin papules with central necrotic umbilication. Systemic dissemination is almost always present. A definitive diagnosis requires culture of the organism from tissue specimens. Treatment is with IV amphotericin B, monitored by measurement of antigen level. Lifelong suppression with itraconazole is given.

⁸ LY Chan, SS Lee, KH Wong, KK Ng, PCK Li. Kaposi's sarcoma in patients with the acquired immunodeficiency syndrome: the Hong Kong experience. *HKMJ Vol 2 No. 2 June 1996*

⁹ Wong KH, Lee SS, Chan KCW, Choi TMY. Redefining AIDS: case exemplified by *Penicillium marneffei* infection in HIV infected people in Hong Kong. *Int J STD & AIDS 1998, in press.*

Internal Assessment Report

A review on the HIV/AIDS situation and the programmes on its prevention, care and control in Hong Kong

Chapter IV: Promotion of a Supportive Environment

IV. Promotion of a Supportive Environment

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IV. Promotion of a Supportive Environment

4.1 Introduction

The main objectives of an effective HIV/AIDS prevention, care and control programme are firstly to prevent the spread of the infection, and secondly to minimise the negative impacts of the disease on individuals and society. The establishment of a surveillance programme (Chapter 1), provision of HIV/AIDS services (Chapter 3) and the conduction of HIV prevention and health promotion activities (Chapter 2) are but means towards the common goals. In parallel there needs to be in place an environment which can support the full range of activities outlined in the previous chapters. To AIDS programme operators, all activities are ineffective if they are not environmentally supported. Intervention strategies could not become materialised if the societal environment does not support their implementation. Service activities could not reach the clients if the environment does not support their access to those in needs. Surveillance and control activities become only bland names if HIV testing and other epidemiological activities cannot be conducted independently with due regards to scientific principles and individual rights.

What are the major components of a supportive environment in effecting AIDS prevention, care and control. There are basically three, which are inter-relating to one another: (a) access to information and services, (b) support for acquisition of protective behaviours, and (c) respect for human rights. The latter includes rights to privacy and non-discrimination.

This chapter examines the development in Hong Kong of a supportive environment for effective HIV prevention, care and control, in context of the above three major components. The mechanisms of promoting a supportive environment are explored. These are: policy development, legal provision, and community action. The impacts of these mechanism are reviewed, followed by an identification of the characteristics and constraints in the local environment.

4.2 Mechanisms towards Promotion of a Supportive Environment

Three mechanisms are examined in this chapter, which are related to one another – policy, laws and community action. Policy and laws are often considered together. For this chapter, the following definition is adopted for policies, which are “those laws, regulations, formal and informal rules and understandings that are adopted on a collective basis to guide individual and collective behaviour”¹. Policy acts through laying down specific steps, either written or not written, to achieve the set purposes. Legislation represents one means of policy formulation, which is more restricted to regulatory functions. Both policy and laws impact significantly on the establishment of a supportive environment. Community actions are those initiated by the community, through individuals or groups. They may affect the environment directly or they may serve as trigger to policy changes.

4.2.1 AIDS Policy development

In Hong Kong, Government policies are developed through a system involving various players and organisational structures (Box 4.1) The Legislative Council is a forum where the subject of AIDS has been debated and policies developed. Laws have been enacted or amended in context of AIDS. The Chief Executive’s policy address has covered AIDS, while individual Government department and policy bureau have, from time to time, issued specific guidelines addressing certain facets of policies on AIDS. On the other hand, the Government-appointed Advisory Council provides a parallel system in recommending policies to the Government through various means (Appendix IV.1).

(a) The role of the Legislative Council

The Legislative Council has participated in the development of AIDS policies in different ways. *Firstly*, questions are raised by Council members

¹ Wallack L. Media advocacy: promoting health through mass communication. In: Glanz K, Lewis FM, Rimer BK, eds. *Health Behaviour and Health Education: Theory Research and Practice*. San Francisco, Calif: Jossey-Bass; 1990: 370-386.

from time to time which the Government has to respond. The Health and Welfare Bureau is often the responsible Government policy bureau. The exercise is done either verbally or in written form. *Secondly*, the Council examines the subject of AIDS during meetings - health panel meetings, finance committee meetings approving the use of public money on AIDS services. *Thirdly*, an adjournment debate has been held on 10 February 1993 covering broader perspective of the subject of AIDS. *Fourthly*, laws are enacted or amended through the debates of the Council, this is dealt with separately.

Box 4.1

Hong Kong Government's policy formulation processes

At the top level, the Chief Executive (or the Governor before 1 July 1997) of the Hong Kong Special Administrative Region (HKSAR) Government is advised by an Executive Council in its policy development. In support of this mechanism, there is a three-tier system of representative government – at central, regional and district levels. The Legislative Council is at the central level, whose functions are to enact laws, control public expenditure and monitor the performance of the Government. On the second level, the municipal councils safeguards environmental hygiene and provides cultural programmes for the community. At the district level, District Boards provide a forum for consultation.

The Government is supported by a network of advisory boards and committees which seek advice to base decision on a whole range of issues. A Central Policy Unit provides a confidential source of advice to the central government. Governmental policies are promulgated through the publication of white papers, or declared in the annual policy address of the Chief Executive. Another means is the enactment of specific legislation, which reflects the standpoint of the Government in mandating a certain policy in the society. The Legislative Council therefore plays a key role in the whole process of policy formulation. Even without law enactment, the Council's deliberation provides a mechanism for understanding the policy of the Government. Once a broad policy principle is in place, Government departments may carry the policy forward through the preparation of more specific guidelines.

(b) Legislation

The major sources of law in Hong Kong are ordinances enacted by the Legislative Council, the common law and rules of equity². Though there have not been a law which deals specifically with AIDS, AIDS has effected the enactment of new laws and led to amendments of others (Box 4.2). Legal cases involving the subject of AIDS are uncommon (Appendix IV.2)

² The legal system. In: Howlett B, eds. Hong Kong 1997. Hong Kong: Information Services Department; 1997: 26-35.

Box 4.2

New or amended laws relating to HIV/AIDS, and their key features

1. Undesirable Medical Advertisement Ordinance – prohibiting advertisements on the treatment of AIDS (amendment) 1988
2. Crimes (Amendment) Ordinance Cap 200– decriminalisation of homosexuality (amendment) 1991
3. Consumer Goods Safety Ordinance – covers quality of condom (new) 1994
4. Disability Discrimination Ordinance – HIV/AIDS is one form of disability (new) 1995

(c) Policy issued by the Government

Each year in October, the Chief Executive (the *Governor* prior to July 1, 1997) delivers his Policy Address at the Legislative Council Chamber. This is published and widely distributed to members of the public. From 1994 on, the content has been expanded to include detailed commitments of the Policy Bureaus, and the Government's yearly report. Though AIDS has not been singled out in the main Address, it has been mentioned in the policy commitments of the Health and Welfare Bureau since 1994. In most instances they involve pledges to new activities on various aspects of AIDS. The Government has published white papers to present its policy on specific issues. This has, however, not been done for AIDS.

Government departments and bureaus have drawn up policy guidelines for more specific areas (Box 4.3). The Education Department, in conjunction with Department of Health) published guidelines on the prevention of blood borne diseases in school settings. Correctional Services Department formulated guidelines on the education and management of inmates. Social Welfare Department provides guidance on the provision of services to people living with HIV/AIDS. Civil Service Bureau published its guidelines on education and non-discrimination in the workplace.

(d) Recommendations of Advisory Council on AIDS

The Advisory Council on AIDS is charged with providing policy advice to the Government. There are two main types of policy: (1) overall policy, e.g. through the publication of Strategies for AIDS prevention, care

and control in Hong Kong in 1994, and (2) policy in health care setting. The latter includes a whole range of professional guidelines which have been drawn up over the years. These have been adopted by the Department of Health and Hospital Authority in their prevention of HIV infection and management of those infected. They are listed in the Appendix of Chapter III Clinical and support services.

Box 4.3

Policy guidelines of Government Departments

Education Department

Prevention of blood-borne diseases in schools 1987

Guidelines on the prevention of blood-borne diseases in schools 1994

Circular: Guidelines on issues relating to HIV+ pupils in schools 1994

Correctional Services Department

General guidelines on management of HIV/AIDS cases in penal institutions 1994, 1997 (rev)

Civil Service Bureau

Circular: AIDS education and policy in civil service 1996

Social Welfare Department

Department policy on AIDS and general guidelines on working with people with HIV/AIDS 1996

(e) Dynamics of policy formulation (Appendix IV.3)

The process of policy formulation is a complex one which can be separated into four phases – the first phase is the trigger that brings out the issue, the second is the deliberation, followed by generation of output. The last phase is promulgation, the process of carrying forward the policy and making it known to the community. In the past, policy formulation has been mostly triggered by crises. The deliberation processes vary from case to case and are dependent on the channels used in policy development.

4.2.2 Community action

Community action constitutes another major group of activities in the promotion of a supportive environment for HIV/AIDS prevention and care. These initiatives come commonly from people living with HIV/AIDS and

their service providers. The impacts of these community action are discussed in a separate section.

(a) People living with HIV/AIDS

The efforts of people living with HIV/AIDS have come in three forms: (a) individual appeal in anonymity, (b) open appeal by individuals, and (c) working in groups. Though there have not been any systematic evaluation on their impacts, their courageous contribution had been generally acknowledged and highly regarded in the community. So far very few persons with HIV/AIDS had made open appeal to the public (Box 4.4).

Since the diagnosis of the first cases of AIDS in the mid-1980s, some people living with HIV/AIDS have participated in newspaper interviews, appearance in radio and television

programmes. One had written a book to tell his story (Box 4.4).

Such appearance has largely been done without disclosing one's identity. The main issues raised at these forums were: transmission other than the sexual route (blood and blood products), dispelling misconception on how

Box 4.4

Three persons with HIV/AIDS

A young haemophilia patient (under the name "Zi Wu") published a Chinese book in 1995 (To touch the untouchable sky – Hong Kong: Breakthrough Ltd) to explain how he struggled through the dual tragedy of HIV and haemophilia. Zi Wu launched a personal crusade to speak for the rights of people living with HIV/AIDS, through appearing in radio interviews, writing for newsletter, and helping in support group activities. He died in 1996 at the age of 23, after which his mother wrote another book to continue the story of his son's plight.

Dr Mike Sinclair, a Caucasian dentist who originally told his story anonymously in an interview with the Window Magazine in 1992. He subsequently openly stated (see III Clinical and Support Service, Box 3.2) his case and had subsequently become an education officer of Hong Kong AIDS Foundation.

JJ, a local Chinese, featured in the Government's API (announcement of public interest, or TV spot) in 1995 to appeal for non-discrimination.

- all 3 had already passed away

HIV infection cannot be transmitted, explaining the stigma attached to AIDS, and appealing to counter discrimination. It was not until 1997 that groups of people living with HIV/AIDS were formed. There are now two: Positive Living Group, and House of Hope. The two had not organised any public appeal. The AIDS Advocacy Alliance was formed in late 1997. With some

members themselves being people with HIV/AIDS, the new group had worked on the rights of patients towards quality care.

(b) Efforts of AIDS service providers

The stigma attached to HIV/AIDS has made public appeal of patients difficult. Service providers, because of their longstanding relationship with HIV/AIDS patients and their understanding of the problems involved, have contributed towards environmental changes. There were three main forms of activities which have been used to affect or influence policy formulation: (a) advocacy, particularly through the media, (b) lobbying Government authorities, (c) setting model policy principles (4.5.3). On the other hand, public education has also served as a means of cultivating a supportive environment by enlisting the support of members of public, and by changing their perception of specific issues on AIDS.

4.3 AIDS Policies and Laws in Hong Kong

4.3.1 Progress of AIDS policy development

An examination of Hong Kong's AIDS policy development reveals that we have gone through two periods. The first period began with the identification of the first cases of HIV/AIDS in 1984/1985. The whole subject of AIDS had been treated basically as a medical problem. Almost all policies formulated were those relating to the surveillance and control of the infection, and its prevention through the efforts of health professionals. Published documents were those on infection control, safeguarding blood and blood products, and hospital care of people living with HIV/AIDS. Though AIDS has drawn a great deal of media attention, its deliberation by the Legislative Council had not been significant.

The second period was ushered by two 'crises' in 1992 – the public declaration of the HIV status of a dentist, and the rejection of an HIV infected haemophilia child from school. The two incidents unveiled the social

dimension of AIDS, and the human face of a disease. Thereafter, the Government has been under pressure to develop policies to address the various aspects of HIV prevention, care and control. Members of the Legislative Council became active in posing questions to the Government, and AIDS was considered when related new laws were being drafted. The reappointment of the Advisory Council on AIDS had also facilitated the changes, through the active roles played by members who also had a seat in the Legislative Council.

In reviewing AIDS policies formulated in the last years, three categories are considered: (1) a unified approach to the problem, (2) policies on prevention and control, and (3) policy addressing the needs of those infected. Putting these three categories in perspective, Hong Kong started off having some policies on prevention and control, often limited to health professionals' guidelines. This was followed by intensified policy formulation in protecting those infected, and in the drawing up policy principle on AIDS in broad terms.

4.3.2 A unified AIDS strategy

The first time AIDS was considered ONE policy issue was at the Adjournment Debate of the Legislative Council on 10 February 1993. The debate was moved by Dr Conrad Lam with the presentation of 9 other Members. The conclusion given by the then Secretary for Health and Welfare (Box 4.5) summed up the theme of the policy of the Government, which encompasses a multisectoral approach, cultivation of a supportive environment, provision of prevention as well as care.

Box 4.5

In concluding the debate on 10 February 1993, Mrs Elizabeth Wong, the then Secretary for Health and Welfare expressed:

“a broad-based multisectoral response by the Government and health care professionals, charitable and voluntary organisations, the media and the private sector.... We need to cultivate a sympathetic social environment which is vital to the effective implementation of AIDS prevention programmes and humane care of affected individuals. We appreciate the critical role of NGOsthat Hong Kong could play a leadership role ..in this part of the world.”

The same principle has been proclaimed in the policy commitment of the Health and Welfare Bureau, under the Governor's Policy Address in 1994, 1995 and 1996 (Box 4.6). The Advisory Council on AIDS, through its publication of its recommended policy *Strategies for AIDS prevention, care and control in Hong Kong* in 1994³, echoed the same themes and expanded on the strategies for the community.

Box 4.6

Policy commitments of Health and Welfare Bureau (Policy Address)

1994 and 1995

We can only keep this danger under control if people are well-informed about the problem and avoid taking risks. We will maintain our campaign of public education and ensure that AIDS patients have access to a full range of government and community-based support services.

1996

We will continue to promote education and research on AIDS and work towards eliminating discrimination against victims of AIDS and HIV infection ...

4.3.3 Prevention and control policies

Policies documented below fall under three areas: (a) preventive education and intervention, (b) surveillance and control, (c) policy in health care settings.

(a) Preventive education and intervention

Though public education has been repeatedly mentioned in the Government's policy commitment, more specific strategies have not been formulated. Education, for example, is mentioned in broad terms in the policy guidelines of Education Department, Social Welfare Department, Civil Service Bureau and Correctional Services Department for school students, social welfare staff/clients, civil servants and correctional institutes

³ Advisory Council on AIDS. *Strategies for AIDS prevention, care and control in Hong Kong*. Hong Kong: Advisory Council on AIDS; 1994.

staff/inmates respectively. The Education Department recommended a “cross-curricular approach”⁴ for undertaking AIDS and sex education in schools. This echoed the Advisory Council on AIDS’ s proposed integration of AIDS education with sex education. The setting up of the AIDS Trust Fund has reflected the Government’ s policy towards supporting community-based education, but its precise definition of such activities is not known. The Advisory Council on AIDS had recommended strategies⁵ on prevention which are categorised according to risk factors and settings. These have not been converted into the Government’ s own policy.

Clear policies on risk behaviours have not been introduced. The Government’ s strategies can only be inferred from its administrative practice and legislation. The *Drug Addicts Treatment and Rehabilitation Ordinance Cap 326* provides for the treatment of drug addicts as ‘ inpatients’ . An extensive methadone programme is operated by the Department of Health as clinic service (clients are charged a nominal HK\$1 per visit) without clearly proclaiming its harm reduction policy. There is no policy governing access to needles, but they can be purchased from pharmacies legally without the need for a prescription.

On sexual risk, the only clear policy from the Government has been the decriminalisation of homosexuality, which came into effect under the *Crimes (Amendment) Ordinance* in 1991. Apart from decriminalising homosexual activity between consenting adults in private, the amendment extended the protection of girls under 16 from unlawful sex and prostitution to boys, and the age of a child whereby indecent conduct is prohibited raised to 16 from 14. Clear policy on safer sex is not available. The Government has not issued any policy on the role of condom. It was reported that the Urban Council had not been supportive of installing condom vendors in public toilets. The importance

⁴Education Department. Sex and AIDS Education in schools – ACA information paper I-4/96. Hong Kong: Advisory Council on AIDS; 1997.

⁵Scientific Committee on AIDS. Prevention of transmission of HIV infection in health care settings – guidelines and practice. Hong Kong : Advisory Council on AIDS; 1992, revised 1994.

of condom quality is, however, acknowledged in its incorporation in the *Consumer Goods Safety Ordinance*. As regards commercial sex, being a commercial sex worker *per se* is not illegal. The law (Crimes Ordinance) prohibited one to live on earnings of prostitution, to keep a vice establishment or let premises for use as vice establishment.

(b) Surveillance and control

There are two laws governing communicable diseases control. The Government had not included HIV/AIDS in either. Firstly, the *Quarantine and Prevention of Disease Ordinance (Cap.141)*, enacted in 1955, provides for the public health control of communicable diseases. Under its *Prevention of the Spread of Infectious Diseases (Amendment) Regulation 1994* the Director may amend the schedule listing diseases notifiable by law. Secondly, the *Venereal Disease Ordinance Cap 275*, provides for the report of suspected sources of sexually transmitted diseases (STD), contact tracing and examination of contacts. The law was subsequently repealed in 1995. Administratively, the Government has allowed a voluntary and anonymous notification system to be introduced by the Department of Health for collecting surveillance data on HIV/AIDS.

On the other hand, the *Undesirable Medical Advertisement Ordinance Cap 231* revised in 1988 provides for the prohibition of advertisement relating to certain diseases. AIDS has been specifically included in Schedule 1 as one form of venereal disease in respect of which advertisement of treatment or prevention is prohibited. The Ordinance serves to protect the public from ineffective means of prevention and control.

(c) Policies in health care settings

This group of policies have largely been drawn up as recommended by the Advisory Council on AIDS and its Scientific Committee. A full list of the policy guidelines is at the Appendix of Section III Clinical and support services. On prevention and control, the following aspects are covered: (1) universal infection control practice is recommended to prevent HIV transmission in health care setting, irrespective of the HIV status of clients or

staff⁵, (2) the use of safe clotting factor concentrates is recommended⁶, (3) unlinked anonymous screening is advocated as a means of collecting seroprevalence data⁷, in accordance with guidelines established by World Health Organisation.

4.3.4 Policies addressing the needs of those infected

With the diagnosis of more patients with HIV/AIDS, the public's attention has been gradually shifted from prevention to how to provide care for those infected. Debates on policies on patients' rights dominated the field of AIDS policy development since the early 1990s, after some of these problems became known to the public. Three major groups of policies can be documented here: (a) HIV testing, (b) human rights, and (c) confidentiality.

(a) HIV testing

Discrimination has arisen because of the perceived linkage between HIV/AIDS and high risk behaviours. HIV testing provides a means for knowing of one's HIV status. It has, therefore, received a great deal of attention because of its liability to lead to discrimination. From documents published by the Government, mandatory HIV testing is prohibited in schools, social welfare settings, prisons, and in the civil service (Box 4.7). The Disability Discrimination Ordinance enacted in 1995 prohibits the requisition of information unrelated to the employee's job requirement. In 1993, in response to a question raised on the issue of HIV-free certificates to travellers crossing the Hong Kong – Mainland border, the Government reiterated that such would not be considered. The Advisory Council had, through its Scientific Working Group on AIDS, recommended that HIV tests, if

⁵ Scientific Committee on AIDS. Prevention of transmission of HIV infection in health care settings – guidelines and practice. Hong Kong: Advisory Council on AIDS; 1992, revised 1994.

⁶ Scientific Working Group on AIDS. Proposed revised specification for clotting factor concentrates. 1993. Hong Kong: Advisory Council on AIDS

⁷ Scientific Working Group on AIDS. Recommended guidelines for undertaking unlinked anonymous screening for public health surveillance of HIV infection in Hong Kong. Hong Kong: Advisory Council on AIDS; 1993.

performed, must be voluntary, with consent, and in context of counselling⁸.

Box 4.7

HIV Testing policies formulated by Government departments

*Blood tests should only be carried out with the consent of the inmates –
Correctional Services Department Guideline 1997*

*We will not undertake screening for HIV/AIDS on serving officers or potential
employees – Civil Service Bureau Circular 1996*

*HIV test should not be regarded as a routine or a pre-requisite of application for
any services – Social Welfare Department 1996*

(b) Human rights

Two pieces of laws enacted to protect human rights could be relevant to people with HIV/AIDS. The *Hong Kong Bill of Rights Ordinance 1991* provides for the incorporation into the law provisions of the International Covenant on Civil and Political Rights as applied to Hong Kong; and for ancillary and connected matters. Though not specifically referring to AIDS. The law underlines the broad principles of entitlement to rights without distinction. The *Disability Discrimination Ordinance, 1995*, is the more recently introduced specific legal instrument which mandates equal opportunities. The key features of the Ordinance are: (i) HIV/AIDS is specified as one form of disability; (ii) discrimination and harassment on the ground of disability is unlawful in areas of housing, education, access to premise, provision of goods, services and facilities; (iii) requests for information for the purpose of discrimination in situation like employment is unlawful. An Equal Opportunities Commission was formed in 1996 to enforce the Ordinance. The Commission also works on education to promulgate the spirit of the non-discriminatory policy. The Commission is represented in the AIDS Services Development Committee of the Advisory Council on AIDS.

More specifically on the levels of Government departments, rights of people with HIV/AIDS have been specified in policy guidance formulated on

⁸ Scientific Working Group on AIDS. Guideline on consent for HIV testing. Hong Kong: Advisory Council on AIDS; 1993.

the subject of AIDS, which had been promulgated through circulars and guidelines (Box 4.8). As regards access to therapy, the single most important principle on medical treatment has been that no patients should be denied service because of lack of means – which health officials have repeatedly stressed in open functions. In response to a written question raised at the Legislative Council by the Honourable LAW Chi Kwong in November 1996 on new HIV treatment (referring to protease inhibitors at that time), the Government expressed “*the introduction of any new drug within the public hospitals and Department of Health’s clinics is governed by established mechanisms whereby assessment has to be made to the risks and benefits, supporting evidence of clinical efficacy and cost effectiveness .?’*”

Box 4.8

Government departments’ policies on protecting the rights of HIV infected individuals:

HIV infected inmates should have equal access to workshops and other areas –
Correctional Service Department

HIV infected pupils, teachers or other staff should be allowed to continue with normal activities, which in the case of pupils, implies normal school. – Education Department

Persons with HIV/AIDS and their families should have equal access to welfare services ... – Social Welfare Department

We will not discriminate against HIV infected staff and accordingly will continue to provide employment ...- Civil Service Bureau

(c) Confidentiality

Policy on the protection of confidentiality has been prepared by various Government departments to guide the handling of one’s HIV status. This policy therefore covers patients in the public service, students, customers of welfare services, prison inmates and government employees. While disclosure is being considered, two principles are laid down, consent of the client and need-to-know. The principle of need-to-know often refers to the situation when the health of the client is implicated, for example, in the course of referral to another service-provider.

On the legal side, the Personal Data (Privacy) Ordinance came into effect in 1996, providing broad coverage on the protection of personal data in

Hong Kong. HIV/AIDS has not been specified in the Ordinance. The Privacy Commission for personal Data was set up to enforce the new law. The relevance of the Ordinance to HIV/AIDS has so far not been reflected in any formal documents.

4.4 Impacts of AIDS Policies

The impacts of AIDS policies on the social environment is considered at three levels: (1) Supports for acquisition of protective behaviour, (2) Access to information and services, and (3) Respect for human rights.

4.4.1 Support for acquisition of protective behaviours

The main routes of HIV transmission are through unsafe sex and the sharing of injection equipments in drug users. The most important protective behaviours, proven in overseas studies, are therefore: (a) the practice of safer sex, including the use of condoms, and (b) the use of clean needles. A supportive environment is essential in ensuring that people practising high risk behaviours could acquire protective behaviours without fear or obstacles.

(a) Promotion of safer sex

The Government has not decreed any guiding policy on safer sex promotion. Some of the related policies have, however, affected the way safer sex education is organised. The amendment of the *Crimes Ordinance* in 1991 provides for the decriminalisation of homosexual activity between consenting adults in private. Since then, homosexual groups have been formed locally, some of which are active in the promotion of safer sex and prevention of HIV/STD. The same *Ordinance* has, however, given rise to some obstacles in the promotion of safer sex in the community. Outreach activities are difficult to be organised in places like saunas as these are public places where sexual activities should not have occurred. Under the same *Ordinance*, working as commercial sex worker *per se* is not illegal. The Ordinance has, however, made it unlawful to live on earnings of prostitution, to keep a vice establishment or let premises for use as vice establishment. Brothels therefore

do not formally exist and many commercial sex workers (CSW) are in ‘solo’ practice, making it difficult for education activities to be organized in groups. In recent years, a substantial proportion of the CSW have come from overseas. Though one may not be arrested because of being a CSW, the *Immigration Ordinance* (Cap 115) could be used to bring to court those who unlawfully remain in Hong Kong or have breached their conditions of stay.

The subject of condom safety has often confused the public. The availability of substandard condoms has led to the public’s conclusion that condoms are ineffective. Safer sex campaigners are always faced with the difficulty of explaining the effectiveness of condoms in HIV prevention. The enactment of the Consumer Goods safety Ordinance has helped somehow in restoring the confidence of the community (Box 4.9)

Box 4.9

Consumer Goods Safety Ordinance.

The Ordinance, enacted on 20 October 1995, imposes a duty on manufacturers, importers and suppliers of certain consumer goods to ensure that the consumer goods they supply are safe and for incidental purposes. As of March 1997, the Customs and Excise Department has conducted 87 investigations and seized 393,623 condoms comprising 25 brands. The condoms were seized following failure of samples to pass the leakage test by the International Standard ISO 4074. The Department has also served 19 Direction Orders on the suppliers of some 5 million condoms, which complied with the safety requirement but did not provide adequate instructions for their proper use.

(b) Harm reduction in drug users

Methadone programme is an important part of the harm reduction strategy, which is also one integral component of an effective HIV prevention programme. In the absence of clear policy on harm reduction, the Government’s operation of methadone ‘clinics’ have often met with fierce criticism of neighbours or even community leaders. It is interesting to note also that the easy accessibility of needles from pharmacist did not start as a deliberate policy, but has contributed towards the very low needle-sharing rates in Hong Kong. One complication, however, is that drug users are liable to be arrested if found in possession of syringes with drugs for injection. This has prompted many drug users to dispose of their syringes on the street immediately after use, causing the hazards of injuries to pedestrians. As

abandoned syringes are often found outside Methadone clinics, this has fuelled the dissatisfaction of the community towards the methadone programme. . A supportive environment for drug users (and particularly methadone users) is still far from ideal.

4.4.2 Access to information and services

(a) Access to information

Public policies on access to HIV/AIDS information are largely those formulated by individual Government department for staff and clients. The Social Welfare Department, Education Department, Correctional Services Department and Civil Service Bureau have all included HIV/AIDS information as one component in their policy circulars or other documents. These papers have impacts on the availability of information, while the whole question of access has not been evaluated. The establishment of the AIDS Trust Fund in 1993 has, on the other hand, reflected the Government's policy of supporting community-based education. In providing financial support to AIDS education projects, information on HIV/AIDS has become more readily available and accessible through NGOs and their activities.

(b) Access of HIV/AIDS patients to services

On clinical treatment, the policy of managing HIV infection as any other chronic medical disease has enabled antiretroviral treatment to be made available very early on within the public service. The establishment of the AIDS Trust Fund and through it, the support of community-based activities, has led to new changes in the provision of services to people living with HIV/AIDS. It has led to the initiation of designated community-based AIDS services, including home-care, hospice and other centre-based activities described in Chapter III.. The dilemma is, however, that the activities of designated services are restricting the exposure of non-designated services to people with HIV/AIDS. So the problem with the overall access of support services remains.

The problem with access to funeral services is a slightly different one. Essentially all funeral homes are privately run. Operators of funeral homes

used to reject families of deceased HIV/AIDS patients if the HIV status is known. This has however improved gradually over the years in parallel with the issue of standard guidelines in the handling of dead bodies (Chapter III). Other factors have also contributed to the improved situation: (1) education activities organised for funeral homes, and (2) more patients have died in recent years, resulting in more exposure of funeral operator to the issue.

4.4.3 Respect for Human Rights

Human rights is a vast subject. For HIV/AIDS, the main foci are confidentiality and non-discrimination. The issue of access to services has been dealt with in the previous section.

Confidentiality is an area of concern for people living with HIV/AIDS. Most preferred to keep their HIV status secret in their daily work or schooling. By not proclaiming HIV as a notifiable disease, service providers are not required to report their clients to the Hong Kong Government. The practice has relieved the anxiety of some patients when they are seeking medical advice. So far a majority of HIV positive individuals are under the care of the health service in the public sector. Laws and public policies are in place to protect the confidentiality of clients receiving services, but their impacts are not known.

With a relatively low HIV prevalence in Hong Kong, many people have not had come into contact with people living with HIV/AIDS. Discriminatory attitude is still held by some local people. The attitude of the public is also liable to be shaped by existing policies. Inconsistency of policy or its interpretation by the authority can easily confuse the public. Recently, two defendants convicted of other crimes have reportedly applied to the court for their sentences to be shortened basing on their HIV status. The judiciary's response, as perceived by the public, was confusing –one case was successful and the other failed. In another case, a judge had openly explained that he would consider HIV infection in his sentencing of a serial rapist. On two other occasions, the judge had ordered HIV tests for the defendants, a practice

which ran contrary to strategies recommended in the community. Though a separate system, the Judiciary's different interpretation of AIDS policies as compared with the 'mainstream' approach could bring unpredictable impacts on attitude of the public.

Legally, HIV/AIDS is specified as one form of disability under the Disability Discrimination Ordinance. Though no case has yet been brought to court, the Ordinance has served to remind the public that discrimination against HIV/AIDS patients is not tolerated. The establishment of the Equal Opportunities Commission has contributed in other ways: (a) through production of education materials to reinforce the perception of the public towards non-discrimination, (b) by becoming a partner in AIDS education programmes, especially those relating to the workplace.

4.5 Impacts of the Community's Action

The impacts of the community's action can be assessed from two perspectives – direct ones and those reflected through the policy-formulation processes.

4.5.1 Direct impacts

Advocacy has been one commonest means used by people with HIV/AIDS and service providers in making known the rights of those infected. Respect for human rights has gradually emerged as one major focus in the community's action, often initiated by AIDS NGOs in Hong Kong since 1992/93. Media advocacy, for example, has served not only in setting agenda, but bringing into focus the human rights aspects of HIV/AIDS. There have been no studies to link the public's attitude with the advocacy movement.

The community's action has also provided support for acquisition of protective behaviours, one notable example being condom promotion. Campaigns centering on condoms serve two purposes. On one hand they target

high risk behaviours and call for behavioural changes. On the other hand, the campaigns are means to desensitise condom, and to normalise its image in the community. By distancing from such negative image as promiscuity, condom has become an acceptable choice for those who may be practising risk behaviours. The growing size of the condom market testifies to the environment which is more supportive of their use.

4.5.3 Impacts on policies

Community action plays a significant role in causing changes to AIDS policies in Hong Kong. Again, respect for human rights has been one most important theme. In 1993 the Government made a policy change in its handling of a subgroup of HIV infected individuals. It set up a fund to provide exgratia payment to HIV infected haemophiliacs. The move had resulted from the efforts of the media and service providers, who publicised the tragedy faced by this special group of individuals. The incident has also instilled sympathy in the public's perception of people living with HIV/AIDS.

Government authorities have been lobbied in their development of AIDS policies in Hong Kong. The reading of the Disability Discrimination Bill by the Legislative Council is one such example.

Box 4.10

Coalition of AIDS organisations against discrimination 1995

The Coalition was formed by

- AIDS Concern
- Hong Kong AIDS Foundation
- Hong Kong AIDS Memorial Quilt Project
- Society for AIDS Care
- St John's Cathedral

NGOs formed a coalition to jointly voice the insufficiency of the Bill under examination in 1995 (Box 4.10). There was also petition to Council members to alert them of the needs of people living with HIV/AIDS. In 1997, the Task Force on Media and Publicity wrote to all Urban Council Members to seek their support of their World AIDS Day Campaign, a symbol that there should be joint efforts towards AIDS prevention and care. When some patients were refused hospice treatment in 1992/93, AIDS service providers lobbied the Hospital Authority to commit to providing the service.

Formulation of AIDS policy is often considered an effective means of creating an optimal environment for AIDS prevention, care and control. Some community efforts have aimed at setting up model policy principles for the reference of the Government. In 1994, the Lions Clubs International launched the Community Charter on AIDS to promote development of non-discriminatory AIDS policy in the workplace. Through signing the Charter, the Government had become obliged to formulate a non-discriminatory policy for the 190,000 strong civil service (section 4.3.3).

4.6 Characteristics and Constraints

4.6.1 How supportive is our environment

Despite the efforts of the community and the progress made in policy development, the promotion of a supportive environment is still a slow and difficult process. There have so far not been any systematic evaluation of the environmental changes as they relate to HIV/AIDS. The following illustrates the negative environmental factors still in place in Hong Kong.

(a) The social stigma

HIV carries a strong social stigma. To date only very few people in Hong Kong have openly acknowledged their HIV status. Dr Mike Sinclair was probably the only named HIV patient in our history. In the Chapter on HIV/AIDS situation (Chapter I), the cumulative HIV incidence has been estimated to be between 1500 to 2000. Only about half of these are being taken care of in health care service. The remainder either are not aware of their HIV status, or are unwilling to present themselves for medical treatment. These figures reflect the resistance of people infected or at risk to be identified with HIV/AIDS. The phenomenon is indicative of the negative social environment relating to access of service, and public support for AIDS services.

(b) Duty of care

Health care professionals are bound by the doctrine of providing quality care to their clients. Clinicians cannot simply reject or refer an HIV infected patient solely because of his or her HIV status. In a survey conducted in 1995⁹, however, it was revealed that 13.1% of registered medical practitioners, if allowed, would choose not to take care of HIV/AIDS patients. The figure was 20.6% if all categories of health care workers were considered. In late 1997, it was reported in MingPao that some dentists were reluctant to provide care to those infected.

In 1994, there were reports of private hospitals rejecting or openly expressing their unwillingness to provide treatment to people with HIV/AIDS. A survey conducted by AIDS Services Development Committee¹⁰ in the same year revealed that four of the 13 private hospitals refused to take in HIV/AIDS patients. The commonest reasons given were lack of expertise, inadequate facilities, and

their perceived advantage of referring to specialists in the public sector. The Committee had subsequently set up a coordination group to lobby the support of private hospitals, leading to the issue of a joint statement which was

Box 4.11

Joint statement on the care of people with HIV/AIDS AIDS Services Development Committee 1996

Having considered the medical and psychosocial implications of HIV infection and AIDS, and the need for avoiding cross infection in the health care setting, we* agree to the following resolutions:

- that people with HIV/AIDS shall be provided with care of the same standard as that for patients with any other illnesses, including those with other forms of immunodeficiency;
- that people with HIV/AIDS shall not be refused access to relevant health care facilities on the ground of their HIV status;
- that efforts shall be made to coordinate services in the public and private sectors in optimising care provided to people with HIV/AIDS;
- that health personnel shall treat patients with HIV/AIDS with care, compassion, dedication and professionalism no differently to any other patients.

⁹Lau JTF, Cheung JCK & Chan MW. Report on the survey of HIV/AIDS training and patient care among health care workers. (submitted to the Scientific Committee of Advisory Council on AIDS in May 1996). Hong Kong: Centre for Clinical Trials and Epidemiological Research (CCTER); 1996.

¹⁰AIDS Services Development Committee. A review of services provided to people with HIV/AIDS. Hong Kong: Government printer, 1994.

published in 1996. The statement was eventually signed by a majority of the private hospitals (Box 4.11).

(c) The public's attitude

Firm public support has been described as an important element of a supportive environment for effective AIDS strategies³ (pp15). The public's attitude has direct impact on the access to AIDS education and services. Starting from 1996, there had been fierce objections from residents when the Department of Health decided to set up a service which included the provision of HIV/AIDS care (Box 4.12). Prior to that, some home-helpers had protested against serving patients with HIV/AIDS. The incident reminds the Government and AIDS NGOs that the community's action is not invariably in line with the concept of a supportive environment. HIV/AIDS is often considered in association with marginalised populations like injecting drug users and commercial sex workers. Such perception has become an obstacle in the development of prevention programmes and service activities for people living with HIV/AIDS.

Box 4.12

The Kowloon Bay incident

From 1995, there had been fierce objections when the Department of Health decided to set up an integrated day treatment centre for STD/skin disease patients which included also HIV/AIDS care. Residents of a nearby housing estate staged protests, petitioned to politicians and debated at District Board meetings. The reason given by these residents had however changed from AIDS to "insufficient consultation". The Commissioner for Administrative Complaints (COMAC) had accepted their complaint, launched an investigation, and concluded in late 1996 that consultation was insufficient.

(d) Condom vendors

A supportive environment for HIV prevention should be free from obstacles in the adoption of safer sex, including the promotion of condom use³. Though condom is becoming better accepted as a means of HIV prevention, its promotion is still met with resistance. A few years ago, there was opposition from Urban Council when the idea of installing condom vendors was raised by the Advisory Council on AIDS. Similar resistance from the

community and organisations is still encountered by NGOs lately when condom promotion is launched.

4.6.1 Characteristics and constraints in AIDS policy development

AIDS policies are important in the promotion of a supportive environment. Some constraints have been identified in the processes of AIDS policy formulation and promulgation. These features, however, are not unique to AIDS, but are common characteristic mechanisms adopted by the local Government in the handling of many social issues:

- (a) Activities-driven – The Government's policy bureaus did not issue policy guidance on HIV/AIDS from the start. Instead, it has allowed operational departments to react to the problem while abiding to their regular principles of practice. The experience gained reflects the contemporary practice which subsequently became the backbone of the Government's policy (appendix IV.1). There are obvious drawbacks: lack of anticipation, late in development, and not being proactive.
- (b) Responsiveness to crises – Over the years, there have been numerous instances which originated as crises but had subsequently become the driving force behind the Government's policy development process. There is therefore not a regular and effective mechanism to provide feedback to the policy development process.
- (c) The role of the Advisory Council – Rather than directly advising on policy formulation, the role of the Council has been a subtler one. By publishing its policy (enshrined in the *Strategies for AIDS Prevention, Care and Control in Hong Kong*) it has set a standard for Government departments and community organisations to follow in their subsequent policy formulation. Over the years, the Council Secretariat, supported by AIDS Unit, has taken on the role of a think tank which raises issues for deliberation, researches on policy, and drafts the relevant papers to facilitate policy development.

- (d) An integrative approach in the legal system – There has been little pressure from whatever sources on the Government to control HIV/AIDS through legislation, the only exception being the strong call for legislation against discrimination. The Disability Discrimination Ordinance was subsequently enacted which had specifically included AIDS as one form of disability. It is evident that the efforts have so far been on refining existing legislation to include AIDS, instead of setting up specific ones.
- (e) Influence of the international community – Unlike other third world countries, Hong Kong's AIDS policies have not been under major influence of international bodies (e.g. World Health Organisation) or donor countries. International influences can be felt but in a more subtle way. Through the various Government committees and participation in international meetings, Hong Kong has been able to benefit from lessons learned overseas, and has taken on salient principles of effective policies in other countries.
- (f) Policy promulgation – The existing mechanism of AIDS policy promulgation is rudimentary. A majority of the Government department's policy guidelines have been promulgated through circulars or documents often limited to certain service-providers. The community may not know whether any policy has already been in place. The discrepancy may, in the long run, create misunderstanding among clients, service providers and the central government.

4.6.3 The dual approaches to AIDS

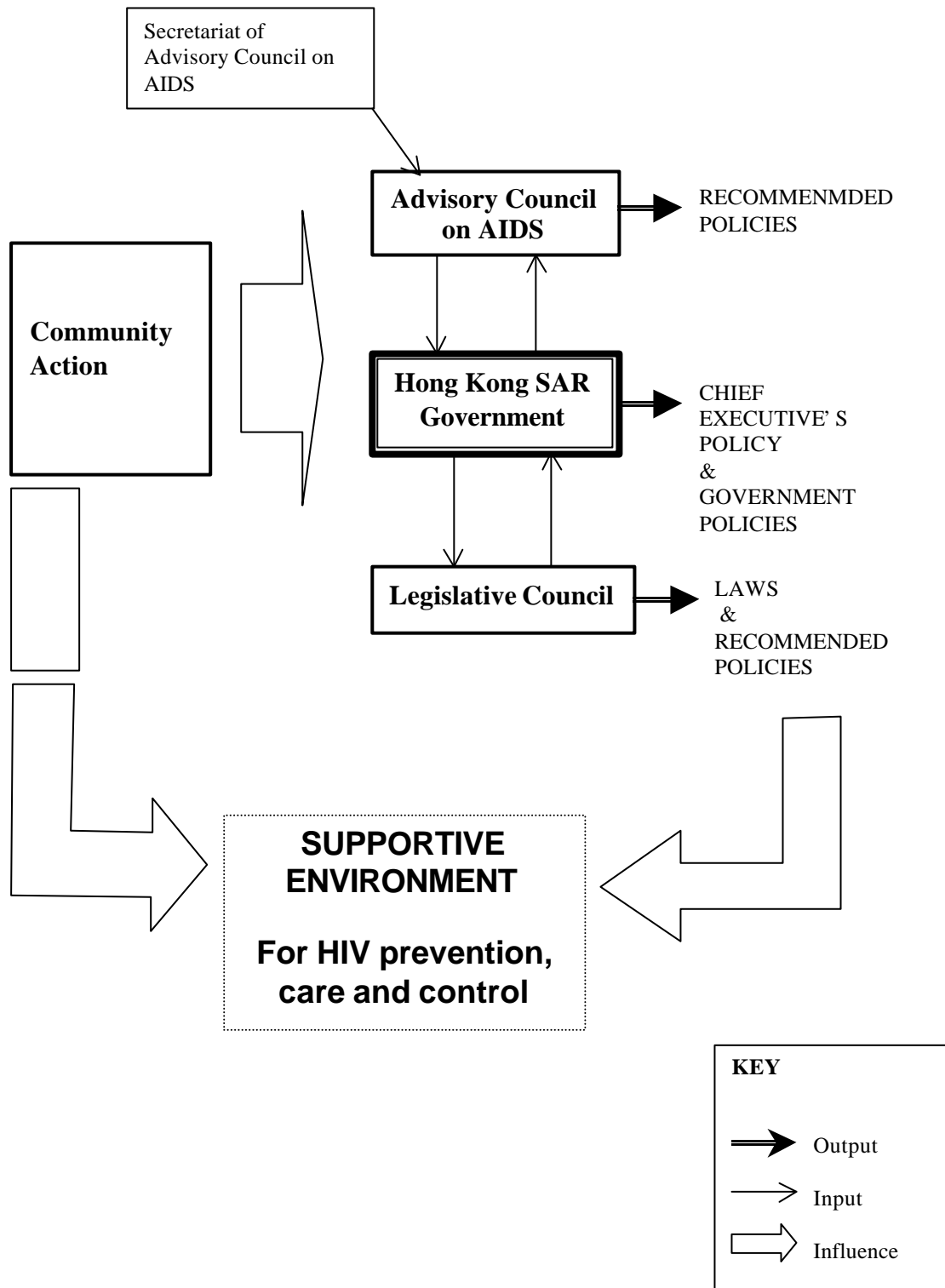
In concluding, a dual approach has been behind Hong Kong's policy response to AIDS in the first decade. On one hand, AIDS has been given special treatment, unlike that for any other public health issue. Parallel to this exceptionalist approach was the inclination to handle HIV/AIDS as just another infectious disease. The exceptionalist approach dominated the early

phase, gradually merging with a more integrative one in recent years. Both approaches are in place in Hong Kong.

Early on, HIV/AIDS was a mystery to scientists and the public. Patients were bluntly discriminated and there was the imminent danger that the whole epidemic would be driven underground. In response, an exceptionalist approach had been taken, similar to that in western countries. Emphasis was placed on special media campaign, with the assumption that everyone was at equal risk. Voluntary and anonymous testing in context of counselling was advocated to both encourage testing and to protect privacy of those infected, who often belonged to the marginalised communities. Unlike other communicable diseases, notification was strictly voluntary. Special committees were set up to provide policy advice on each and every aspect of HIV/AIDS. The exceptionalist approach led to the development of designated services, and the provision of specific guidelines on HIV prevention and management in all related community settings.

The exceptionalist approach could not by itself solve all problems arising from HIV/AIDS. There was the concern that when HIV/AIDS patients were treated differently, more isolation and avoidance resulted. There were calls for HIV/AIDS patients to be treated as for other diseases. HIV management has been portrayed as a primary care issue, and all private and public hospitals were asked to take care of people with HIV/AIDS. Anti-discrimination law was drawn up, not for AIDS, but to include HIV/AIDS as one form of disability. Universal infection control practice was advocated, bringing into focus risky procedures instead of people living with HIV/AIDS. There was the trend to integrate AIDS education with sex education, to combine the public health programmes on AIDS and drug abuse, and to bring together the public health control of HIV/AIDS with that for STD and other communicable diseases. Recent advances in anti-HIV therapy has caused changes to HIV testing strategy, notably in encouraging more people to be tested in view of the advantages now known for providing early treatment.

Appendix IV.1: Creation of a supportive environment



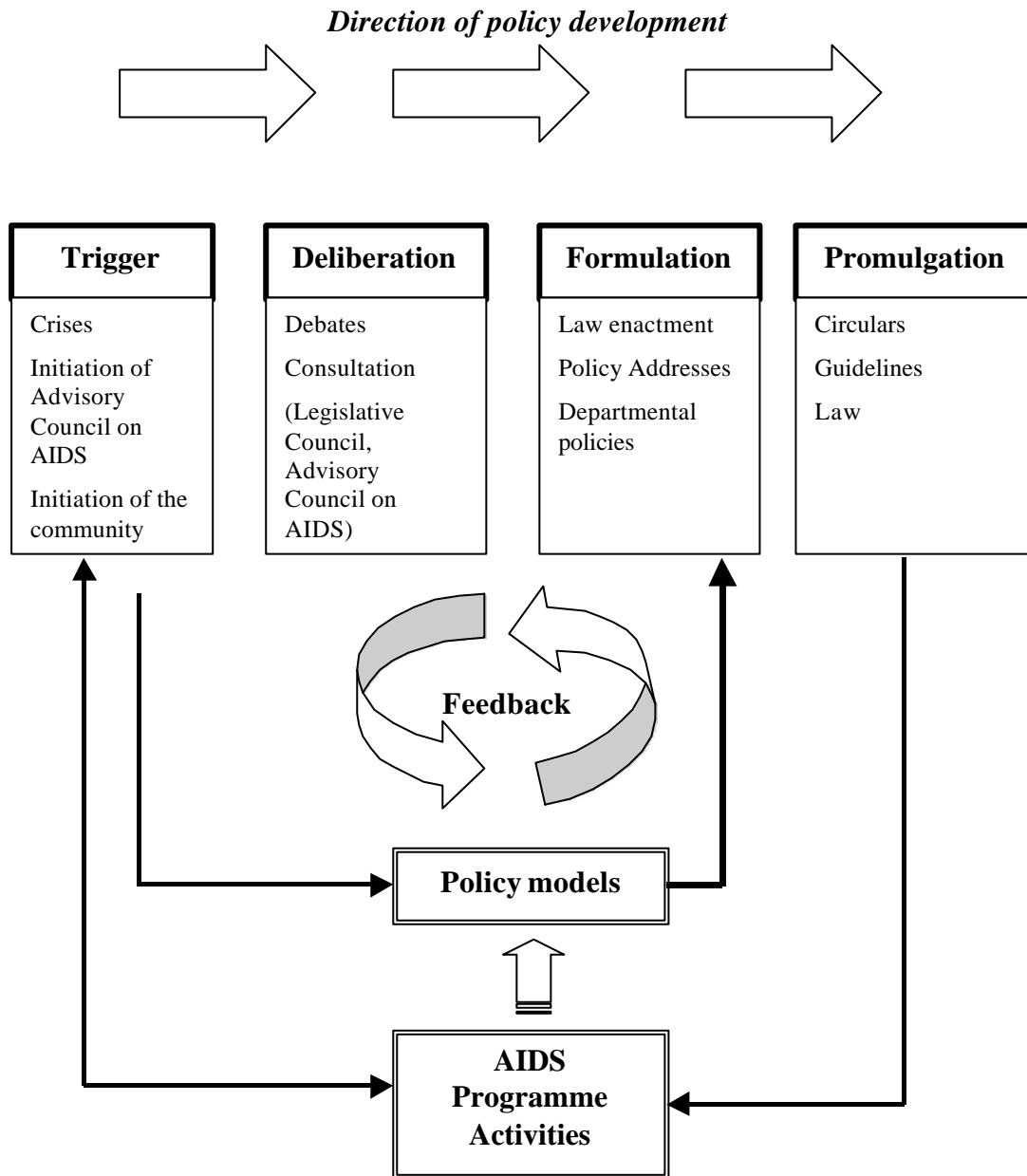
Appendix IV.2: Legal cases touching on HIV/AIDS

In a study of court cases reported in the media between 1992 and 1997, the following had touched on HIV/AIDS:

1. One person was charged under the Undesirable Medical Advertisement Ordinance for publicising an anti-HIV drug *Retrogen*. The defendant was subsequently found to be not guilty.
2. An HIV infected illegal immigrant died in custody, the case was heard in coroner's court.
3. Two prisoners applied to the Court of Appeal to have their sentences reduced because of their HIV status – one succeeded and one failed. Another defendant convicted of burglary asked for a lenient sentence in view of his HIV status, the lawyer of whom feared that his client could face discrimination in prison. He was subsequently sentenced to a 21-month imprisonment.
4. 3 drug users injured or threatened to injure others with blood-filled syringes. Another bit a policeman. All were not HIV infected but claimed to be so.
5. An HIV infected haemophiliac was charged with damaging government properties in hospital.
6. An HIV infected haemophiliac was charged with damaging government properties while in hospital. He was subsequently bound over for six months at \$500.
7. On two occasions, the judges had ordered HIV tests on the defendants, one of which was a commercial sex worker, while the other was one drug user described in (d). In the former case, the client refused, while in the latter case, the doctor initially refused to disclose the test result.
8. A deputy judge openly raised in court that he would consider possible infection by the AIDS virus in sentencing a serial rapist.

The study has not included hearings on cases relating to the Consumer Goods Safety Ordinance. At the time of writing, no case has been brought under the Disability Discrimination Ordinance.

Appendix IV.3 Mechanism of AIDS Policy Development



Appendix IV.3 (continued)

(a) Triggering factors

In a majority of cases, AIDS policy generation has been driven by crises. The following are the most notable crises which have led to policy establishment or policy changes: (1) In 1992 there was public outcry in response to the problems faced by HIV infected haemophilia patients. In addition to the dual tragedy, there were reports of patients being rejected from school. The public demanded a clear policy on how to offer assistance to this special group. (2) An HIV infected dentist proclaimed his HIV status in the same year of 1992. At the beginning the media were outraged because of their concern over possible transmission in health care setting. The public demanded an effective policy to prevent such from happening. This has subsequently given way to debates on the policy of providing HIV/AIDS care. The two incidents, happening at around the same time, have led to debates at Advisory Council on AIDS, Legislative Council, as well as in the media.

Over the years there were other incidents which had stimulated the policy machinery to respond. In 1993, Mainland authorities demanded mandatory HIV testing for Hong Kong people crossing the border. The subject of cross-border collaboration was raised. The concern of substandard condoms, raised by Consumer Council in its studies conducted over years, triggered the Government to examine the strategy of upholding standard of locally available condoms. In 1992, when the news broke out that there were HIV positive inmates in correctional institutes, the Government found itself in need of a policy to deal with the complex issues of clinical management, HIV testing, and preventing infection from occurring.

Occasionally, issues had been raised even when there were no apparent crises. The Advisory Council on AIDS had, over the years, initiated debates on its own. This anticipatory approach was adopted in examining (1) AIDS education in schools in 1994, (2) the need for a comprehensive AIDS policy in 1993, (3) training needs of health care workers in 1996, (4) transplantation and HIV risk in 1997, and (5) collaboration with the mainland in 1997.

(b) Deliberation and policy generation

The Government is the final gatekeeper of policy formulation. Between the trigger and the final policy product, there is lengthy deliberation through seeking of advice, their collection and interpretation. The Advisory Council, government department/bureaus and Legislative Council interact both informally and formally. In the case of legislation, draft bills are read and debated at the Legislative Council. Though the Legislative Council plays a central role in policy deliberation, the interest of Legislative Council members in the subject of AIDS is however minimal. Debates involving the whole Council had been rare. The 1993 adjournment debate was unusual as it followed the two major crises outlined under the previous section. The enthusiasm of the Council had already faded by the time the Director of Health made a presentation in the following week. When Professor Jonathan Mann of Harvard School of Public Health, ex-Director of Global Programme on AIDS, World Health Organisation, addressed the Health Panel on 30 November 1993 (titled: *New AIDS Policy: applying the lessons of the first decade*), only a handful of Members were present.

(c) Policy promulgation

AIDS policies have been promulgated in different ways. One informal means which the Government often uses is expressing open support during public functions, or through the media. The formal and most direct one is the publication of official government documents, documentation in other publications, enactment or amendments of laws. So far, the bulk of the policies are issued by individual government departments in the forms of guidance notes or circulars. Policies in health care setting are the better known ones because they have also been promulgated as Advisory Council on AIDS papers, through wider distribution and their access on internet (The Council and the Department of Health's AIDS Unit maintain a joint HomePage on AIDS, launched since January 1996).

Another means of promulgating policies is through institutionalization of the policy strategy. An example is the setting up of the Council for the AIDS Trust Fund to provide funding on education and HIV service, thus reflecting the original policy of strengthening prevention and care. The setting up of the Equal Opportunities Commission is another example. Though not directly relating to AIDS, it serves to promulgate the Government's policy of fighting discrimination against disabilities, and HIV/AIDS has been specified included.

Internal Assessment Report

A review on the HIV/AIDS situation and the programmes on its prevention, care and control in Hong Kong

Chapter V: Programme Structure, Operating and Monitoring Mechanisms

Advisory Council on AIDS 1998

V. Programme Structure, Operating and Monitoring Mechanisms

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- 5.2.3 Phase III - Consolidation 1990 to 1993
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5.7 Characteristics and Constraints

- 5.7.1 Characteristics of the AIDS programme structure
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V. Programme Structure, Operating and Monitoring Mechanism

5.1 Introduction

AIDS programme structure is taken to mean all operations involved in the prevention, care, and control of HIV/AIDS in Hong Kong. This encompasses both the Government's and non-governmental responses. Over the years, programmes have been set up to bring about HIV prevention and education, provision of clinical and support services, and the creation of a supportive environment. Programme structures form the base for these activities to be implemented. They also constitute a network to enhance mutual support, to promote coordination, and for channelling information from the surveillance mechanisms to programme operators. Increasing emphasis is being given to the development of a multisectoral approach, especially in the creation of a supportive environment. The scope of the programmes and the structures has also been extended beyond AIDS to general health.

This Chapter begins with an introduction of the administration of the Government and its structures as they relate to HIV/AIDS (Box 5.1). The historical development of the programmes is presented. Four phases are described to highlight the main themes of development. This is followed by an account of the programmes of both the Government and the community, their nature, and modes of operation. The interrelationship between programme components is described, in terms of their support, monitoring and coordination. It follows with a documentation of our programme's link with that overseas, especially that of our counterpart in the Mainland. The characteristics of the local programme structure are outlined towards the end of the Chapter. A number of charts are produced to illustrate the relationships between different parts of the programmes.

Box 5.1

The Hong Kong Government and the health and welfare infrastructure

The structure of Hong Kong Special Administrative Region (SAR) Government is organised into bureaus and departments. The bureaus, each headed by a policy secretary, collectively form the government Secretariat. The Secretary for Health and Welfare leads the Health & Welfare Bureau which the Department of Health, Social Welfare Department, and the Hospital Authority report to (Appendix V.1 & V.2). As the name implies, this bureau is responsible for the health care and social welfare of the society, including people with HIV/AIDS.

The public medical and health services had been administered by the Medical and Health Department (M&HD) till 1991, when it was split into the Department of Health (DH), and the Hospital Authority (formerly Hospital Services Department). The Hospital Authority is a statutory body directly funded by the Government. Overall, there are over 9000 medical practitioners in Hong Kong, About 60% of doctors worked in private sector, while 35% and 5% worked in HA and DH respectively. It is equivalent to 1.4 doctors per thousand population.

The Social Welfare Department and non-governmental organisations (including 173 subvented welfare agencies) provide a broad range of welfare services through 2700 service units¹. Services include social security, family and child welfare, medical social work, group and community work, services for young people, services for the elderly, rehabilitation services for the disabled, and probation service and residential training for young offenders. Non-governmental organisations have been playing important roles in Hong Kong's social service provision. In 1947, the Hong Kong Council of Social Services was established to coordinate the voluntary sector in enhancing development of social policies and services, and their necessary manpower, resources and information. It has currently over 255 member agencies. Its main income is from government subvention. As from 1990, AIDS NGOs have become established, adding to the programme on AIDS in Hong Kong.

5.2 Historical Development of Hong Kong AIDS Programme

With the objectives of preventing the spread of HIV and providing services to those suffering from HIV/AIDS, the following four phases have been witnessed over the years in the development of Hong Kong's programme (Appendix V.3). The separation into phases is arbitrary, and has been retrospectively made.

5.2.1 Phase I (1984 to 1986) – Initial Response

In November 1984, an *Expert Committee on AIDS* was set up within the then Medical and Health Department, to "... discuss and review the medical aspects of AIDS and to work out a plan necessary for monitoring and managing the disease when required." Subsequently in 1985, a *Scientific Working Group on AIDS*

(SWG) was formed to initiate and implement medical, surveillance and public health activities in Hong Kong. Key output during this period included: establishing an AIDS counselling clinic and a hotline, ensuring supply of safe heat-treated blood products, safeguarding blood supply through blood-screening by the Hong Kong Red Cross Blood Transfusion Service (HKRCBTS), initiating an HIV/AIDS surveillance system, and providing the HIV antibody tests to people at risk of infection.

5.2.2 Phase II (1987-1989) – Enhanced Public Education

Public education was systemically introduced during the second phase, in line with the strategy of the World Health Organisation (WHO). A committee on education and publicity on AIDS (CEPAIDS) and a publicity working group were formed by the then Medical and Health Department to initiate, implement and coordinate publicity and education programmes. These were put forth through the aid of various government departments as well as community organisations. There were, however, no AIDS non-governmental organisations (NGOs) during this and the previous phase. Media publicity was launched, with television Announcement of Public Interest (API, or TV spots) produced by the Government Information Service, to arouse public awareness. The AIDS Counselling and Health Education Service of the Medical & Health Department was expanded to become an operational arm of the committee, which organised educational activities targeting various community groups.

5.2.3 Phase III (1990 - 1993) - Consolidation

A central Advisory Council on AIDS (ACA), appointed by the governor, was established in March 1990. The Council has been charged with recommending AIDS strategy and streamlining the operations of Hong Kong's AIDS prevention, care and control programme. Community participation was encouraged. Both the Hong Kong AIDS Foundation and the AIDS Concern, the first two AIDS NGOs were formed during this period. In early 1993, the AIDS Trust Fund was set up by

the government to provide ex-gratia payment to HIV-infected haemophiliacs and transfusion recipients, following the public outcry in response to the rejection of an HIV-infected haemophilia boy from school. The same Fund also financed educational and AIDS care projects, The HIV/AIDS surveillance system was strengthened through the conduction of epidemiological serosurveillance, e.g. unlinked anonymous screening (UAS). The original counselling service became the Department of Health's AIDS Unit.

5.2.4 Phase IV (1994 - 1997) - Wide Community Participation

In 1994, the ACA officially published its strategy in a document titled *Strategies for AIDS Prevention, Care & Control in Hong Kong*. Subsequently, more guidelines and documents on HIV/AIDS had been published by the ACA and its committees. There was wider community participation with five more AIDS NGOs established in a couple of years' time, with a substantial funding support from the AIDS Trust Fund. More pre-existing organisations also incorporated AIDS in its conventional activities through new initiatives, e.g. the Community Charter on AIDS by the Lions Club International District 303 Hong Kong and Macau. Education programmes on awareness/prevention were expanded with the participation of more NGOs and the re-organised CEPAIDS. More recently in 1997, a resource centre (Red Ribbon Centre) was set-up by the Department of Health to facilitate and enhance the response in the community.

5.3 The Government's Response

5.3.1 An overview

The Government has responded to the HIV/AIDS epidemics at three levels: Firstly, special committees have been established to advise, supervise and/or coordinate the functioning of the various components of the programmes. The

Advisory Council on AIDS and its committees are some examples. Secondly, designated services are set up, but basically only within the health sector. Other non-designated Government units also participate in collaboration with the designated arm of the programmes. Thirdly, it facilitates the participation of the community. This has been largely through the setting-up of the Council for the AIDS Trust Fund, which has since become the major funding source of AIDS activities in the community. The programme areas of the community is covered in section 5.4 under “Involvement of the community”.

The Governmental response covers four broad areas (Appendix V.4) (a) disease surveillance and control, (b) HIV prevention and health promotion, (c) clinical and support services, and (d) policy. With the establishment of AIDS NGOs since the early 1990s, some of the activities have been supplemented at the community level. It can be noted that the community's input actually began before the setting-up of AIDS NGOs. Community leaders, religious leaders and voluntary agencies (those not working specifically on AIDS) have participated in the Governmental programme since the mid-eighties. These were usually through joining the various committees, or collaborating with the Government in its execution project-based activities. Appendix V.6 illustrates the key organisations, personnel and the programmes involved.

5.3.2 The Advisory Council on AIDS

The Government-appointed Advisory Council on AIDS (ACA) was formed in 1990. The ACA was headed by the Director of Health until the Council's reform in 1996. The Council is now chaired by a non-government official, with a majority of members appointed in their personal capacity except the: *Director of Health (as vice-chairman) and the representatives of Health & Welfare Bureau, Hospital Authority, Education Department and Social Welfare Department*. Its terms of reference are at Box 5.2.

Secretarial and operational supports to the Council are provided by the AIDS Unit of the Department of Health, the consultant of which is serving as the secretary to the Council. The Council now meets on a quarterly basis. It examines issues on various aspects of AIDS. The secretariat is responsible for researching on these issues and providing input to the Council for deliberation. Other activities of the Council include (a) holding an AIDS conference in 1996, (b) meeting with NGOs and other people to improve coordination among key players of the programme, and (c) formulating guidelines and publication of related documents. Two main documents which had far-reaching impact are the *Strategies for AIDS prevention, care and control in Hong Kong* 1994, and *HIV infection and health care workers: recommended guidelines* 1994.

Box 5.2

Advisory Council on AIDS

The current terms of reference are:

- (a) to keep under review local and international trends and development relating to HIV infection and AIDS;
- (b) to advise Government on policy relating to the prevention, care and control of HIV infection and AIDS; and
- (c) to advise on the coordination of programmes on the prevention of HIV infection and provision of services to people with HIV/AIDS in Hong Kong.

5.3.3 Committees of ACA (Box 5.3)

Currently, there are three Committees under the ACA which focus on different facets of AIDS: (1) the Scientific Committee on AIDS (SCA), (2) the Committee on Education and Publicity on AIDS (CEPAIDS), and (3) the AIDS Services Development Committee (ASDC). The committees are chaired by non-officials appointed by the Government.

Publicity and education activities on AIDS have been coordinated by the Committee on Education and Publicity on AIDS (CEPAIDS) formed by the Medical and Health Department in January 1987. Seven working groups (publicity, youth, schools and students, drug abuse, community, training of intermediaries, and research and evaluation) were formed in 1990 when it was expanded to become an

interdepartmental committee to develop targeted educational programmes. This has served to further enhancing the participation of various government departments and voluntary agencies. Activities were designed, co-ordinated and often executed by the task forces (previously called Working Groups). Following restructuring since 1993 and then 1996, there are now four Task Forces: Media & Publicity, Youth, School AIDS Education, and Drug & AIDS. In addition, a Planning/Evaluation Subcommittee serves as the think-tank of CEPAIDS. In the last two years, two new roles have been assumed: (a) coordination among Government and non-governmental organisations on AIDS education activities, particularly the World AIDS Day programmes; (b) examining various issues on AIDS prevention and education. Studies have been commissioned to provide background data for the examination of its members.

Box 5.3

Current terms of reference of

Committee on Education and Publicity on AIDS (CEPAIDS)

- (1) to develop appropriate strategies on education and publicity on HIV/AIDS,
- (2) to promote education, publicity and related research on AIDS through collaboration of government departments and non-governmental organisations, and
- (3) to evaluate the effectiveness of education and publicity programmes on AIDS in Hong Kong.

Scientific Committee on AIDS (SCA)

- (1) to supervise and evaluate the HIV/AIDS surveillance system in Hong Kong,
- (2) to develop and recommend technical and professional guidelines/protocols on HIV/AIDS prevention, management and control,
- (3) to recommend training for health care professionals on all aspects of HIV/AIDS prevention and management, and
- (4) to recommend and undertake research on the clinical, scientific and epidemiological aspects of HIV/AIDS with special reference to Hong Kong.

AIDS Services Development Committee

- (1) to recommend on the strategy of developing clinical and support services for HIV infected individuals in Hong Kong,
- (2) to co-ordinate available services and facilitate their accessibility to people with HIV/AIDS and their relatives who require them, and
- (3) to evaluate the quality and availability of AIDS services in the territory.

The Scientific Committee on AIDS (previously the Scientific Working on AIDS set up in 1985) works on the scientific, technical, professional and

surveillance aspects of HIV/AIDS. One important task of the Committee has been the establishment of professional guidelines on the prevention, control and management of HIV infection. It also supervises a research project on scenario construction and behavioural surveillance, undertaken jointly by the Department of Health and University of Hong Kong.

The AIDS Services Development Committee was set up in 1993 with the aim of better co-ordinating and enhancing services provided for people with HIV/AIDS and their significant others. Apart from direct or tangible services, the ASDC has also examined issue/policy which carry impact on HIV/AIDS, e.g. the subject of discrimination and the enactment of Disability Discrimination Ordinance (DDO). In 1994, the Committee published its report *A review of services provided to people with HIV/AIDS*. In 1995, the Committee set up a group to coordinate clinical AIDS services in the private and public sectors. A manual was compiled and published by the Committee for social welfare personnel in the same year.

5.3.4 Government operations

The Government's direct involvement in AIDS can be considered at two levels: (a) setting up of designated services and (b) the input of other programmes.

(a) Designated service

A significant proportion of AIDS activities are initiated and undertaken by a designated AIDS Unit which is operative under the Department of Health. The Unit forms part of a 'Special Preventive Programme' which also overlooks the Department's viral hepatitis programme. Apart from providing support to the activities of ACA and its committees, it is responsible for the provision of the direct clinical services (Chapter III), organisation of HIV prevention and health promotion activities (Chapter II), the maintenance of a surveillance system, and participation in research (Chapter I). AIDS Unit has been growing steadily in the last years. Three new initiatives are in progress: (a) setting up of an AIDS education, resource and

research centre (Red Ribbon Centre) in 1997 to provide technical support to enhance and facilitate the community's response; (b) development of a behavioural surveillance system and programme indicators to track HIV in Hong Kong, and (c) the opening of an integrated day centre to incorporate clinical services on HIV, STD and skin diseases.

(b) Other government operations

There are activities inside and outside Department of Health. A number of units of the Department of Health play parallel role in the local AIDS programme (Appendix V.2). They are (1) STD prevention, counselling and treatment by Social Hygiene Service, which is provided free to the community, (2) HIV antibody tests, CD4 T lymphocyte subset test and plasma HIV load tests by the Pathology Institute, and (3) education, and harm reduction activities for drug users by the methadone clinics.

Outside the Health Department, some programmes are integrated in the existing government structure. Government department/policy bureaux with active involvement in the AIDS programme include the Information Services Department, Education Department, Social Welfare Department, Department of Health, Health & Welfare Bureau, Correctional Services Department and others (Appendix V.6). A total of seven of the 84 department/bureaus have set up special mechanism (e.g. establishment of or representation in special committees) in their involvement in the AIDS programme. The work of the government is supplemented by other public statutory bodies in their fields of expertise. Two specific examples are the Hospital Authority (previously the Hospital Services Department) which organises clinical services, and Hong Kong Red Cross Blood Transfusion Service which looks after blood safety. The Hospital Authority runs both designated and non-designated services to provide care to people living with HIV/AIDS.

5.3.5 AIDS Trust Fund

The AIDS Trust Fund is addressed separately as its role does not fit into that of other Government operations. Following the public outcry in response to the rejection by school of an HIV infected haemophilia patient, the Government set up a special fund (Box 5.4) in 1993 to give financial support to those living with the dual tragedy of HIV infection and haemophilia. Exgratia payment ranging from HK\$0.3 to HK\$1 million was provided to those infected before August 1985 (Box 3.2).

Box 5.4

Council for the AIDS Trust Fund

A HK\$350 million fund was set up in 1993 by the Government - HK\$100 million for ex-gratia payment for HIV infected haemophiliacs, HK\$200 million for medical and support services, and HK\$50 million for publicity and education. A Council for the AIDS Trust Fund has been set up by the Government to advise on the use of the fund. The Council is chaired by a non-official appointed by the Government. Members are appointed from the community and include also the Secretary for Health and Welfare, and Secretary for the Treasury. Three subcommittees have been formed to vet submission for funding under the different categories – (a) ex-gratia payment subcommittee, (b) medical and support services subcommittee, and (c) publicity and public education subcommittee.

Over the years, the Fund has assumed another role in Hong Kong's response to AIDS, through facilitating the community's involvement. A majority of the AIDS NGOs are now receiving financial support from the Fund. The Fund has also supported research activities and the participation in overseas conferences by local workers as well as people living with HIV/AIDS. There are a few unique features in the granting of financial support: (a) the grant is given on a one-off basis, recurrent/ongoing expenses are not considered¹, (b) there are four cycles each year in granting the fund, (c) the secretariat is operative within a policy bureau, the Health & Welfare Bureau.

¹ Council for the AIDS Trust Fund: Explanatory notes for applicants. 1997.

5.4 Involvement of the Community

5.4.1 An overview

Increasing community involvement has been evident in the recent few years. Earlier on, community involvement has been largely in form of participation by community leaders and active organisations of activities by NGOs. Their activities supplement and complement government programmes. Unlike Governmental programmes, members/volunteers in addition to paid

staff, have been recruited to run the activities (Box 5.5). NGOs working on AIDS can be divided into AIDS(-specific) and non-AIDS (-specific) ones. The former comprises those formed with the prime aim of providing AIDS services and prevention, while the latter is involved in AIDS as part of its scope.

There are official and un-official coalition of the AIDS NGOs to share experience and enhance co-operation/collaboration.² One example is the Committee on AIDS under the Council of Social Service which co-ordinates activities of AIDS NGOs and other community organisations. As of early 1998, an official coalition of AIDS services organisations is in the process of being inaugurated, which aims to encourage joint participation, collaboration and decision making. Today, there is clearer delineation of the specific roles and functions of each AIDS NGOs, and efforts of minimising duplication.

²United Nations Development Programme - Hong Kong Polytechnic University Collaborating Centre (1996), Enhancing Government-NGO Collaboration in HIV/AIDS Policy and Services - the case of Hong Kong.

Box 5.5 Volunteers and members of AIDS NGOs

	Volunteers	Members
Action for REACH OUT	>40	25
AIDS Concern	200	N/A
AIDS Memorial Quilt Project	15	N/A
AIDS Project, Hong Kong Council of Social Service	N/A	N/A
HIV Information & Drop-in Centre	50	N/A
Hong Kong AIDS Foundation	300	400
Society for AIDS Care	100	132
TeenAIDS	200	30

**N/A – data not available*

5.4.2 AIDS NGOs

The first NGO on AIDS was not formed until 1990. Today there are seven NGOs working specifically on AIDS. The ‘eighth’ one, Action for REACH OUT, though not an AIDS-NGO by definition, is considered here because of its focus on commercial sex workers and its strong component of AIDS education. These AIDS NGOs fall into either one of the following groups: (a) those working on broad areas of preventive education and service for those infected, (b) those focusing on a particular aspect of either preventive education or patient service, and (c) those providing support to other organisation or the community through training and coordination.

Activities of AIDS NGOs are often developed by the executive team, comprising both staff and volunteers. For most NGOs, there is an advisory board of directors which supervises the direction of programme. The operative team reports to the Board. The Board directors are usually elected or co-opted and work on a voluntary basis. There may be different advisory and executive structures set up for

different purposes. It is noted that some new NGOs have actually been formed by members of AIDS Concern, the oldest AIDS NGO. This has facilitated the development of expertise in selected areas. The number of volunteers and members of the AIDS NGOs are shown in Box 5.5.

(a) AIDS NGOs with broad range of activities

Both Hong Kong AIDS Foundation and AIDS Concern fall into this category. *Hong Kong AIDS Foundation* (HKAF) was set up in 1991 by the government, through the advice of the ACA, with a seeding fund of HK\$15 million from the Government and another \$15 million from the then Royal Hong Kong Jockey Club. Its mission is “to limit the spread of HIV infection in the community and provide support to those affected by HIV/AIDS”. An executive board and an advisory board supervise the work of five committees. The Foundation is housed within the Government’s Shaukeiwan Jockey Club Clinic building.

AIDS Concern was founded in 1990. Its goal is “to generate extensive community involvement in the provision of AIDS education and support services through trained volunteers”. AIDS Concern is housed within the compound of the Hospital Authority’s Pamela Youde Nethersole Eastern Hospital in Chai Wan.

Box 5.6

NGOs with broad range of activities

AIDS Foundation: Activities include education and publicity, support group, drop-in centre, AIDS helpline, telephone counselling, face to face counselling, HIV antibody blood test, referral service, PWA support fund (for people living with HIV/AIDS), and volunteer coordination. In recent years, it has become actively involved in developing collaborative work with mainland.

AIDS Concern: Activities include: buddy support service, soup delivery and transport service for PWA, community education, helpline, library, and volunteer training. The targets of outreach education are migrant workers, female sex workers and gay men.

(b) AIDS NGOs with focussed activity profile

Most of the NGOs in this category focus on preventive education – HIV information and Drop-in Centre, TeenAIDS, AIDS Memorial Quilt Project, and

Action for Reach Out. Society for AIDS Care is the only one established to provide services to people living with HIV/AIDS.

The *HIV Information & Drop-in Centre* was open in 1995. It runs a drop-in centre within the compound of St. John's Cathedral. Other services include education, facilitation of arrangement of memorial service, volunteer and referral service. *TeenAIDS* was set up in 1994 with the goal of preventing youth from becoming infected with HIV through health education in a user-friendly way. The targets include youth, parents and teachers. Its services include: school AIDS awareness and education through drama and games, peer education, parent education, volunteer training, and regular publications in newspapers. It is based in the Warehouse Project in Aberdeen. *The Hong Kong AIDS Memorial Quilt Project* is the Hong Kong branch of the International NAMES Project AIDS Memorial Quilt. This project provides a memorial to people who have died of AIDS, through the making of quilt and dissemination of messages. The Project is in the process of being reorganised³. *Action for REACH OUT* was set up in 1993, through the support of AIDS Trust Fund, for the welfare of women working in the commercial sex industry. Services include hotline, outreach and public education, drop-in centre, advocacy and referrals. Strictly speaking it is not an AIDS NGO but it works closely with other AIDS NGOs and is active in HIV prevention and education. It is now based in Yaumatei.

The Society for AIDS Care was established in 1994. The service is based in Sheung Wan. It provides home care nursing and runs a residential care centre for people living with HIV/AIDS, supports families and carers, and trains health care workers on HIV/AIDS. The residential care centre is based at Tai Po Lookout. Its service provision is covered in Chapter III.

(c) AIDS NGOs playing a supporting role to other organisations

The AIDS Project of Hong Kong Council of Social Service is the only group in this category. Established in 1994, the AIDS Project organises training

³In March 1998, the AIDS Memorial Quilt Project announced that it had stopped operating as an independent organisation, and would be working in collaboration with TeenAIDS.

for social welfare personnel and develops operational guidelines for social welfare personnel. It produces regular publications for information dissemination, and supports member agencies to enhance delivery of service to people living with HIV/AIDS. The Committee on AIDS (COA) was set up within the Council of Social Service in late 1994. Besides supervising the implementation of activities under the AIDS project of the Council, the COA provides a forum for representatives from various NGOs to discuss on AIDS issues, service development and agency policy formulation. It coordinates activities among AIDS NGOs and the social service agencies. There were the establishment of working groups for achieving better accessibility of services for people with AIDS

5.4.3 Other Community groups

Three categories are discussed here: (a) those involved in working for people living with HIV/AIDS specifically, (b) agencies which participate but do not regularly work specifically on AIDS, and (c) agencies which may be potentially useful to people living with HIV/AIDS but have not been actively involved in the overall programme.

The formation of community groups involving people living with HIV/AIDS comes only very recently. The AIDS Advocacy Alliance was established in late 1997 to act as advocates for people with HIV/AIDS in their search for fair, just, and compassionate treatment. Its members (about 10) include people living with HIV/AIDS, friends and family members, health care workers and volunteers. Knowingly, there are two other groups composing of only people living with

HIV/AIDS – Positive Living Group and House of Hope – comprising about 10 members each.

Some pre-existing voluntary agencies are also involved in the local AIDS programme. These organisations complement the overall educational and care efforts, through their participation in programmes organized by the Committee on Education and Publicity on AIDS, as well as self-initiated activities. Their primary contribution may be either through co-ordination, pursue of community education or delivery of social and support services.⁴ Many of the activities are, however, project-based. Examples of these agencies are: Caritas Hong Kong, Lions Clubs International District 303 Hong Kong and Macau, Family Planning Association, Society for the Aid and Rehabilitation of Drug Abuse and its affiliated Pui Hong Self-Help Association, Community Drug Advisory Council, St. Stephen's Society, Society for the Rehabilitation of Offenders, Hong Kong Sex Education Association, and a number of homosexual groups like Hong Kong 10% Club, Horizons and the Satsanga.

Concurrently, other voluntary agencies in Hong Kong are providing different kinds of social services which are potentially useful to people with HIV/AIDS, e.g. home help service. Such provision, if delivered, can help to give support and care to people with HIV/AIDS and their families. The AIDS Committee of the Hong Kong Council of Social Service serves to coordinate efforts of NGOs under the Council. Overall, their actual participation in the delivery of care has been minimal.

5.4.4 Academic institutions

Compared with community organisations, the involvement of academic institutions has so far not been an extensive one. There are four possible areas of involvement that can be discerned: (a) conduction of academic research, (b) teaching, (c) policy advice, (d) clinical service.

In Hong Kong, there has not been any active interest in basic science research on AIDS. Clinical research is limited to those conducted by designated services in the Government or Hospital Authority, rather than academic institutions.

⁴ Yeung FYV (1996). An assessment of NGOs efforts and roles in Hong Kong's AIDS programme. In: Proceedings Hong Kong AIDS Conference 1996, 8-9 November 1996.

Social science and epidemiological research, though again limited, have been the major areas of interest. Apart from independent researchers, activities of the Community Research Programme on AIDS of the Chinese University of Hong Kong, and AIDS Scenario and Surveillance Research Project (University of Hong Kong and Department of Health) have been the two major initiatives, which are covered in Chapter I. They are unique in that they supplement activities of two committees of the Advisory Council on AIDS – Scientific committee on AIDS and Committee on education and Publicity on AIDS.

While clinical services are largely delivered through the designated clinical services (Chapter III), the contribution of academic institutions is small. Teaching on AIDS has been receiving more attention, but there has not been any coordinated efforts to achieve a certain standard in health, social science and other professionals. On the other hand, academics have actively participated in the programme through their representation in the Advisory Council on AIDS, various Government committees, as well as those of NGOs. At the Advisory Council on AIDS, for example, 3 members are university professors.

5.5 Relationship with the Mainland and the International Community

HIV observes no country boundary. An assessment of the local AIDS programme is incomplete without addressing its relationship with our neighbours, the Mainland in particular, and the international community.

5.5.1 Relationship with the mainland

There have been various means of collaborating with mainland China in the past decade on the prevention and control of HIV/AIDS. These means can be broadly categorised as⁵: (1) World Health Organisation (WHO) or United Nations (UN)-supported activities, including consultancies in the Mainland, (2) participation in conferences and meetings, in the two places, and elsewhere, (3) joint education/training activities, (4) reciprocal visits of government officials and non-governmental organisations. These activities have enhanced information exchange, sharing of experience and programme development in both places.

In the last two years, the Hong Kong AIDS Foundation has been working through a Hong Kong-China AIDS Committee to enhance communication with mainland counterparts. The committee is actually a joint venture of the Foundation and the Chinese Association for STD/AIDS Prevention and Control. The Hong Kong AIDS Foundation has been developing education and training activities in the mainland, and has organised satellite meetings at international/regional conferences to examine the subject of AIDS in Chinese communities.

Despite closer collaboration, there is currently no central coordinating mechanism to facilitate the development of cross-border programmes in the longer term. Activities to date are largely isolated projects, or activities organised under the auspices of the UN system but with the participation of both parties. In 1997, the Department of Health, with the funding support from AIDS Trust Fund, established the Red Ribbon Centre to facilitate and enhance community response to AIDS in Hong Kong. The Centre has also served as a focal point for networking individuals and organisations working on AIDS in the mainland. In 1997 alone 80 overseas guests have visited the Centre, many of whom were from the Mainland.

5.5.2 Relationship with the International Community

Ever since the beginning of the AIDS epidemic, there have not been direct participation of international AIDS agencies in Hong Kong's AIDS programme.

⁵ Advisory Council on AIDS paper. Collaboration between Hong Kong and the Mainland on AIDS Prevention, Care and Control; 1997.

Nevertheless, there were some interaction with the WHO and the UNAIDS (previously the Global Programme on AIDS) in the areas of (a) epidemiological surveillance, (b) information sharing on prevention and education, (c) acquisition of technical advice and (d) coordination with other countries. These activities were effected through participation in meetings, visits, training, and attendance of conferences. Since early 1996, an AIDS homepage was launched on Internet by the AIDS Unit and Advisory Council on AIDS to inform both overseas and local workers of Hong Kong's AIDS programme and situation. In September 1997, the Community Research Programme on AIDS of the Chinese University of Hong Kong launched the Hong Kong AIDS Information Network at the Internet.

There were smaller areas which had incorporated the input of international agencies. One example was the AIDS education programmes in Vietnamese refugee camps participated by United Nations High Commission on Refugees (UNHCR), Safe the Children and Medecis Sans Frontiers. These activities also had the input of local organisations and government departments. Harm reduction has been one focus in this setting. With the orderly repatriation of Vietnamese in the last years, these project have been put to an end in 1997.

5.6 The Links between Programmes and their Monitoring

Over the years, the Government has not set up an all-inclusive programme on AIDS, nor has this been its strategy of that of any community organisation. At a glance it looks as if all organisations have been working independently on the different aspects of AIDS. Closer examination revealed that different programme parts are linked intricately with each other. There have been numerous mechanisms in place which formally or informally

bring the programmes together. This section deals with three different means which are present in Hong Kong. They are the mechanisms of support, coordinating efforts as well as monitoring

5.6.1 Supporting mechanism

The various programmes cannot stand alone. They need supports of one form or another, in terms of funding, technical assistance, and advice.

(a) Funding

The funding mechanism of different AIDS programmes varies. (Chapter VI) Currently, the Government is the major funding source of a majority of the AIDS programmes. Funding support therefore becomes one link in the overall activities on all aspects of AIDS prevention, care and control. For Government operations, they come under capital expenditures and the annual budgets. Community activities are funded through a multitude of means, and the Government is one of those. With the establishment of the AIDS Trust Fund, the latter has become one important source of support to community activities on AIDS. The Fund supports education and service activities, research, and Conference attendance.

(b) Technical assistance

Technical assistance includes the input of surveillance and behavioural data to help organisations understand the situation in Hong Kong, for the purpose of designing relevant intervention strategies. Other forms of technical assistance are secretarial support and administrative support. In general technical assistance is rendered by the Department of Health's AIDS Unit to government operations, and the Advisory Council on AIDS. The newly established Red Ribbon Centre also provides technical assistance to community organisations in their conduction of projects, e.g. through the provision of venue for activities, and the use of administrative facilities. NGOs are providing technical support to each other. AIDS

Concern, because of its broad base and long history, is an important example in the rendering of technical support.

(b) Advice

Professional and technical advice are needed, especially by policy-formulating bodies in their deliberation of issues, and in the process of integrating AIDS activities in non-AIDS NGOs. The Advisory Council on AIDS and Government departments collect their advice largely through or as coordinated by AIDS Unit. Council for the AIDS Trust Fund is advised by Health and Welfare Bureau. In the non-governmental setting, NGOs are supporting each other through formal and informal networks (see 5.6.2).

5.6.2 Coordination

Effective coordination serves the dual purpose of avoiding duplication and providing mutual support to programme operators. The formation of committees has been one popular means of achieving the aim of coordinating activities, personnel and organisations. In retrospect, four types of committees have been formed in coordinating AIDS efforts:

- (a) Committees of the Advisory Council on AIDS, particularly its Committee on Education and Publicity on AIDS (CEPAIDS), has been playing the role of coordinating designated services, non-designated services, be they from the Government or the community.
- (b) Ad hoc committees have been formed from time to time for activities, for example around World AIDS Day. This role is often filled either by the CEPAIDS or the Department of Health.
- (c) Committees have been formed by community organisations for networking, and facilitating implementation of joint activities. The AIDS Committee of Hong

Kong Council of Social Service is playing this role, particularly for enlisting the support of non-AIDS NGOs, establishing operational guidelines and for facilitating linkage between them and the AIDS NGOs.

- (d) Committees in health care settings which coordinate service provision. The Hospital Authority has set up a Working Group on Management of AIDS in HA hospitals in 1994 with representatives from various public hospitals (Box 5.7).

Box 5.7

Working Group on Management of AIDS in HA (Hospital Authority) Hospitals

Terms of reference:

1. To advise HA on the strategy for provision of quality care for AIDS/HIV patients
2. To advise HA on the resources and training implications of the HA AIDS services
3. To advise HA on the coordination, development and delivery of services for AIDS/HIV patients within HA hospital system
4. To advise HA on training for health care staff under HA in the provision of quality care for AIDS/HIV patients

Other means of coordination have also been witnessed. A few NGOs have their origin traced back to AIDS Concern. These NGOs are AIDS Memorial Gilt Project, TeenAIDS, and Society for AIDS Care. AIDS Concern has subsequently maintained an informal network in the operation and development of the other NGOs. The provision of mutual support is considered an important common strategy in the efforts of promoting coordination. Lately, a Hong Kong Coalition of AIDS service organisations is being formed.

5.6.3 Monitoring

There are monitoring mechanisms both internal and external to individual organisations. These mechanisms are largely informal. Internal monitoring mechanisms are often those developed by advisory and/or executive boards of NGOs. Government operations, for example AIDS Unit, are monitored by the department's management information system. Their financial management is subject to the scrutiny of the Legislative Council.

There is not a central monitoring mechanism to evaluate and govern the operations of the collective programmes of the Government and the community. The Advisory Council on AIDS has conducted a number of review focusing on specific programme areas, either by itself or through its committees. To quote a few examples, in 1996 the Council reviewed the programmes in prisons. Its AIDS Services Development Committee has evaluated the service provision in 1994, research activities in 1995, and legal provision in 1997. The Scientific Committee has examined the training of professionals in HIV/AIDS management in 1995, standard of antiretroviral treatment in 1997, and regularly provides feedback to the surveillance system of the Department of Health. CEPAIDS has evaluated the responses to and effectiveness of media campaigns undertaken by the Government, and has examined the need for strengthening sex education in Hong Kong.

5.7 Characteristics and Constraints

5.7.1 Characteristics of the AIDS programme structure

Apparently Hong Kong's AIDS programme is a relatively small one with the involvement of a limited number of people and organisations. There are, however, a number of unique characteristics identified in its operating and monitoring mechanism:

- (a) Government initiation - AIDS programme in Hong Kong is characterised by an early (1984) initiation by the government and continued efforts in the subsequent years. The first AIDS NGO was not formed until 1990. The government initiated the appointment of the central advisory body (ACA), set up designated services to address AIDS, established the AIDS Trust Fund, and screened all blood donors for HIV antibody since 1985. Some of the moves were proactive

and had been initiated from within the government while others were responsive to outside pressures.

- (b) Role of health care professionals As a medical disease, the AIDS programme has been started and operated largely by health care professionals. Active participation of health care professionals was not restricted to the care of patients but also prevention and health promotion. In fact, a majority of AIDS education activities were developed by doctors and nurses within the government, especially in the first three phases of programme development. Health care professionals also plays a key role in the work of NGOs in the recent years.
- (c) One central Council. Though there is not an all encompassing programme on AIDS, a central Council has been set up by the Government. Apart from being a policy-advising body, the Advisory Council and its committees have been responsible for the design, supervision, coordination and implementation of a significant proportion of the AIDS programme.
- (d) Little involvement of pre-existing voluntary agencies. A majority of community services were provided by AIDS NGOs, whereas the participation of pre-existing voluntary agencies has been minimal. Incorporation of AIDS into service provision by community facilities have been scarce thus far.
- (e) Blurred line between Government and community. It is confusing to the public what constitutes the Government programme. The Advisory Council on AIDS has been set up to provide independent advice to the Government, but has often been treated as a government unit on its own. The representation of both Government and the community in the Council and its committee has made the dividing line even less distinct.

- (f) Interrelationship with control programmes for communicable disease/STD. HIV infection is but one communicable disease, and is itself a sexually transmitted disease. Its prevention, care and control programme is, however, run rather independently. The public health and clinical programme on STD is organised by the same Department (DH) but with a very different mode of operation, strategy and monitoring mechanism. Similarly, the AIDS control programme is not linked with the overall infectious diseases control system in Hong Kong, nor is its clinical management integrated with that of other infectious diseases.

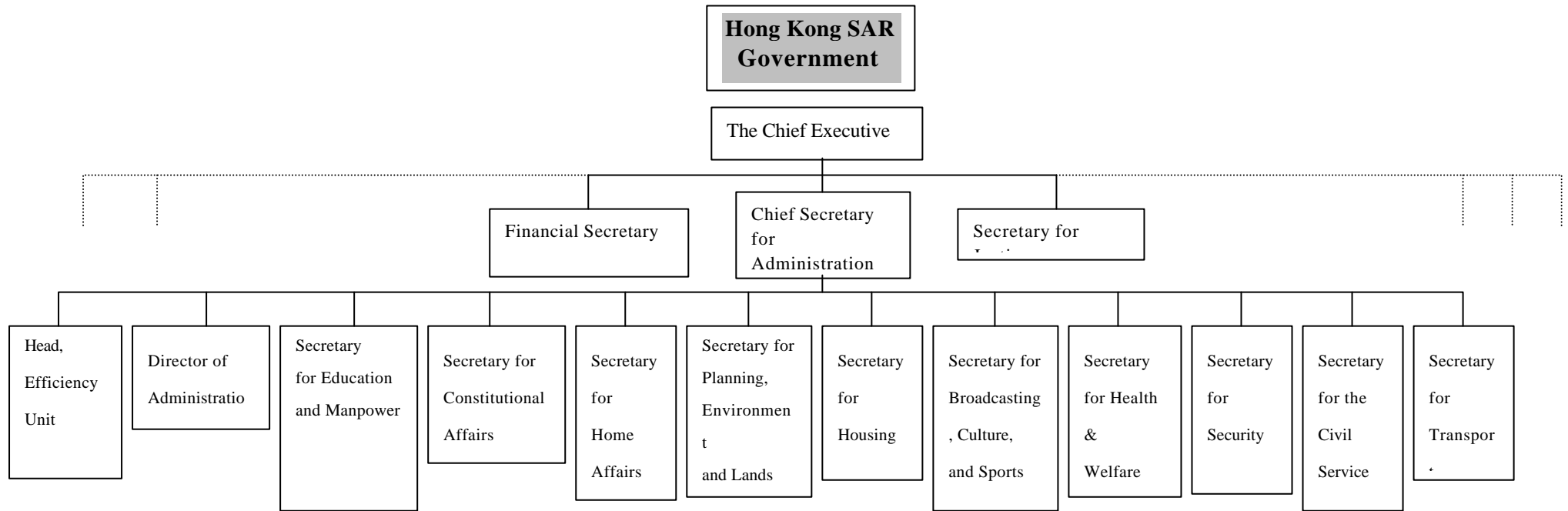
5.7.1 Constraints of the existing programme

The limitations of the local AIDS programme in Hong Kong are:

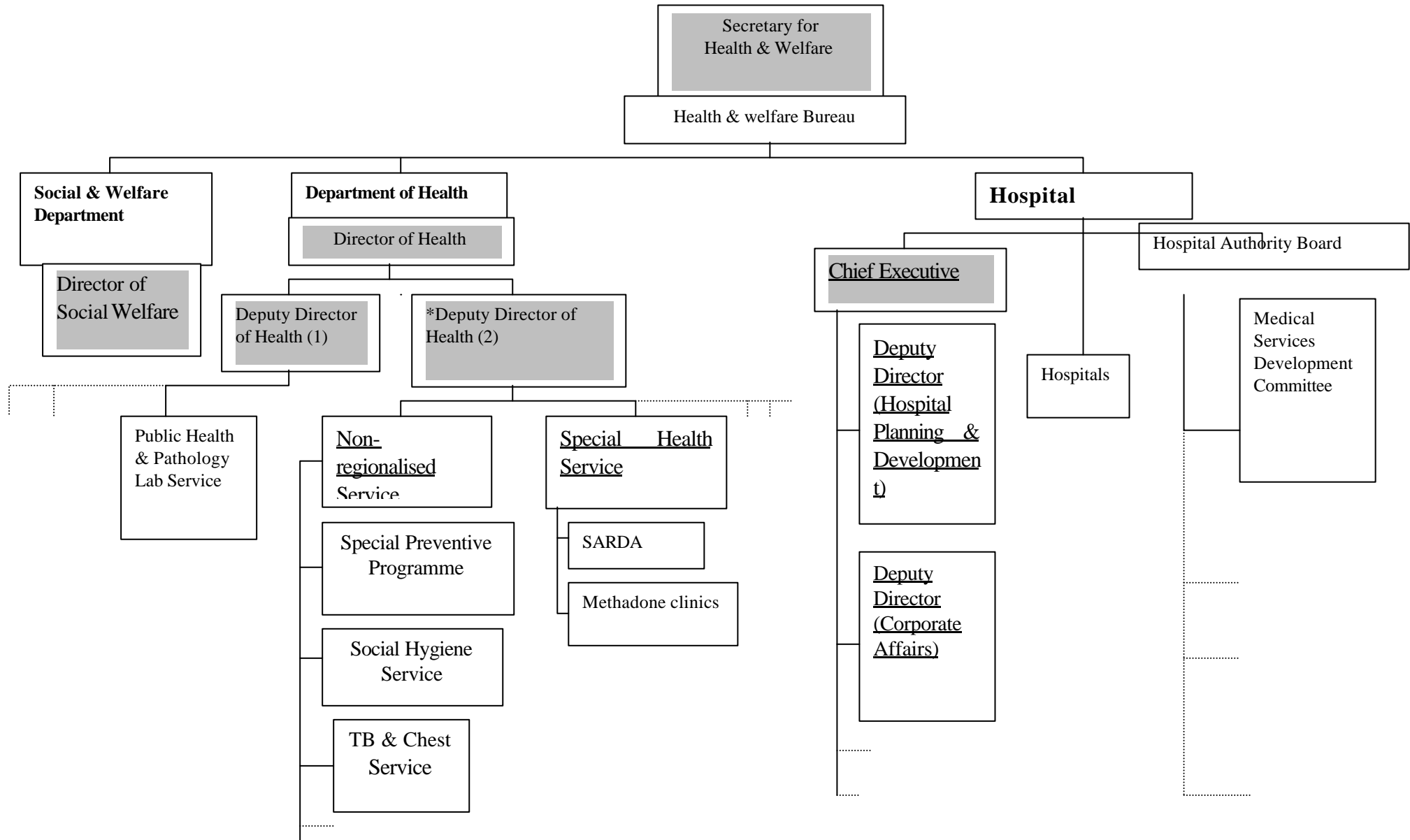
- (a) Lack of a coordinated overall programme plan. The programme activities thus far have been largely self-set by the different organisations. The agenda of each organisation is affected by the interaction of factors like the perceived needs of the society, direction of governing board, and funding. One drawback of this approach is the duplication of some programme areas and, perhaps more importantly, missing out of key areas by the service providers.
- (b) Lack of a systemic evaluation mechanism. While programmes are often evaluated by the implementing organisation, a central mechanism is not in place to develop evaluation which could carry a broader perspective for benefiting all players in the local programme.
- (c) Status of ACA. Currently ACA is pegged with the Department of Health with AIDS Unit providing Secretariat, operational and technical support. While striving to execute its role as a central advising body, its relationship with the Department of Health has often confused the public (NGOs in particular) about its true independent nature.

(d) Limited involvement of government departments. The extent of a multisectoral approach for the present AIDS programme is limited. With only a handful of government departments and policy bureaus contributing to the AIDS programme, their degree of involvement remains to be addressed. High level commitment and coordination is yet lacking.

Appendix V.1 Organisation of the Hong Kong SAR Government



Appendix V.2 Structure of the Government's Administration relating to AIDS in Hong Kong



Appendix V.3 Historical Development of AIDS Programme in Hong Kong (1984 - 1996)

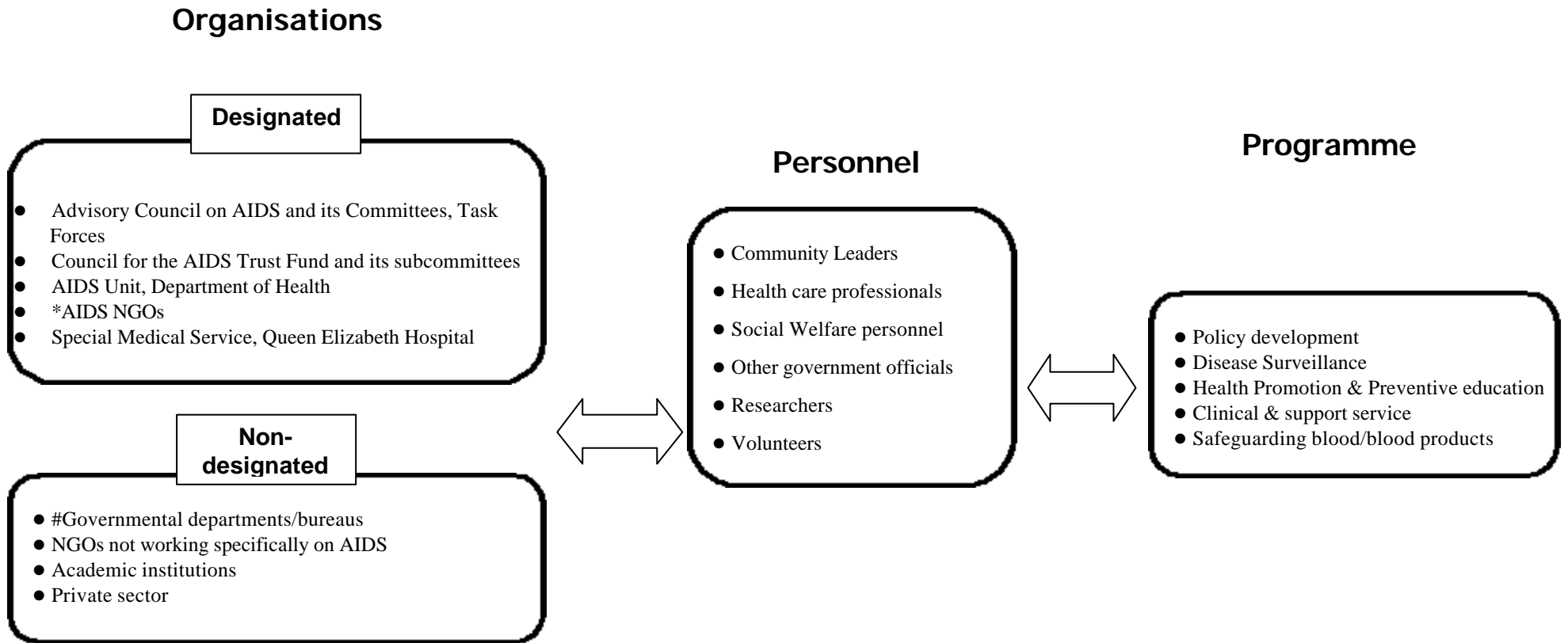
	<u>1984 – 1986</u> First phase	<u>1987 – 1989</u> Second phase	<u>1990 – 1993</u> Third Phase	<u>1994-1997</u> Fourth Phase
Structure	<ul style="list-style-type: none"> ✧ Expert Committee on AIDS ✧ Scientific Working Group (SWG) 	<ul style="list-style-type: none"> ✧ CEPAIDS, Publicity Working Group 	<ul style="list-style-type: none"> ✧ Advisory Council on AIDS (ACA) & its 3 committees 	<ul style="list-style-type: none"> ✧ More AIDS NGOs ✧ Red Ribbon Centre
Main themes	<ul style="list-style-type: none"> • Safeguarding blood & blood products - screening, heat treatment • Initiation of surveillance system • Provision of hotline, counseling & HIV testing service • Initiation of awareness campaign 	<ul style="list-style-type: none"> • Media publicity & others • AIDS education & training • AIDS counseling & clinical service 	<ul style="list-style-type: none"> • Streamlining the organisation structure • Expanded surveillance activities • Enhanced structured educational activities • Establishment of the first non-governmental organisations • Set up of the AIDS Trust Fund 	<ul style="list-style-type: none"> • Publication by ACA of “<i>Strategies for AIDS Prevention, Care & Control in Hong Kong</i>” • Increased community participation • More NGOs were set up • Re-organisation of ACA • Enhanced coordination and collaboration with mainland China, regional and international parties

Appendix V.4 Overview of programme areas and players

<i>Disease surveillance & control</i>	<i>Health promotion</i>	<i>Clinical & support services</i>	<i>Policy</i>
ACA	ACA	HA	ACA
AUDH	AIDS NGOs	AIDS NGOs	AIDS NGOs
DH	AUDH	AUDH	H&W B
HA	Government Departments, e.g. DH, ISD, ED, CSD, SWD	SWD	
Private health sector	EOC	Private health sector	
Academic institutions	Other NGOs		
	Private firms		

ACA Advisory Council on AIDS
 AUDH AIDS Unit, Department of Health
 DH Department of Health
 HA Hospital Authority
 ISD Information Services Department
 ED Education Department
 CSD Correctional Services Department
 SWD Social Welfare Department
 H&WB Health & Welfare Bureau

Figure V.5 Key players of the Hong Kong AIDS Programme



*Action for REACH OUT, AIDS Concern, AIDS Memorial Quilt Project, AIDS Project, Hong Kong Council of Social Service, HIV Information & Drop-in Centre, Hong Kong AIDS Foundation, Society for AIDS Care, TeenAIDS

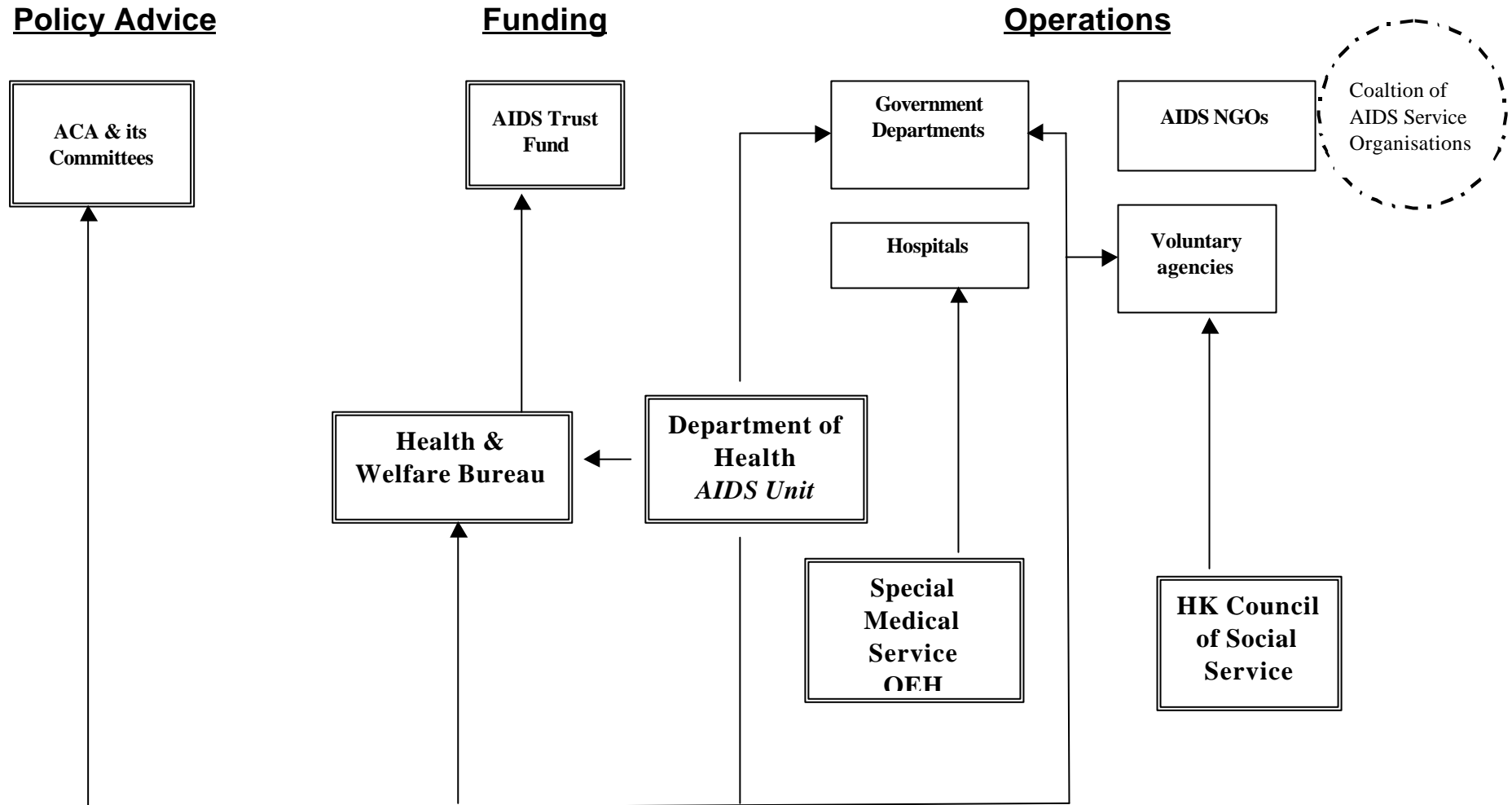
#Department of Health, Information Services Department, Education Department, Correctional Services Department, Social Welfare Department, Hospital Authority

Appendix V.6 Components and functioning mechanisms of the government's AIDS programme

Department/Bureau	Designated structure	Mechanism of relating to others
Correctional Services Department	Special Health Committee	-
Department of Health	AIDS Unit	Secretariat support to ACA, technical support to others
Education Department	-	Membership in ACA and CEPAIDS
Information Services Department	-	Media & Publicity Task Force of the CEPAIDS
Social Welfare Department	-	Membership in ACA, ASDC
Civil Service Bureau	-	Charter
Health and Welfare Bureau	-	Membership in ACA, Secretary of ATF

Only 7 (out of 84) policy bureaus, departments or agencies are obviously involved in the AIDS programme

Appendix V.7 Support to AIDS Programme in Hong Kong



Internal Assessment Report

A review on the HIV/AIDS situation and the programmes on its prevention, care and control in Hong Kong

Chapter VI :

Finance

Advisory Council on AIDS 1998

VI. Finance

6.1 Introduction

6.2 Historical Landmarks

6.3 Costs of the Programmes

- 6.3.1 HIV prevention
- 6.3.2 Clinical and support services
- 6.3.3 Surveillance and research
- 6.3.4 Other service providers
- 6.3.5 Estimation of total cost

6.4 Programme Financing

- 6.4.1 Public sector
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- 6.5.1 Government expenditures
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6.6 Characteristics of the Financial Situation and its Constraints

- 6.6.1 Limitation of the review
- 6.6.2 Characteristics of the financial situation
- 6.6.3 Constraints in the current finance system

Appendix VI.1 Dynamics of resources utilization in the community

Appendix VI.2 Costs of programmes 1994-97 (charts)

Appendix VI.3 Programme revenue 1994-97 (charts)

VI. Finance

6.1 Introduction

The dynamics of resource utilization in the community, in the context of the current AIDS programmes, could be viewed as in the flow chart in Appendix VI.1. The community provides the resources, through a number of financing means, to the service providers for certain expected outputs. In the context of HIV/AIDS control and minimization of its impacts in the community, the outputs fall under three main types: (1) HIV prevention, (2) provision of clinical and support services, and (3) surveillance and research. Resources, generated by the community, are collected and pooled together to support these programmes. While resources may represent a variety of inputs, we limit the scope of this initial assessment to examine the direct monetary support. In this regard, four financing methods, each with different nature, are identified. They are (1) government or public revenue, which is collected through taxation by the government machinery; (2) community funds, which may be set up by business community or charity groups; (3) donations or fundraising activities, for gaining input from private sector or individuals; and (4) out-of-pocket charges, collected directly from end-users. There are certain regulatory mechanisms, formal or informal, for monitoring and evaluating these transactions.

With this framework, we examine the costs of Hong Kong's AIDS programmes operated by major service providers on the various components of the programme, namely, HIV prevention, clinical and support services, and surveillance and research (programmes described in Chapters I to III). The financing means of these programmes are also examined to determine their relative contributions. We also explore the existing regulatory mechanisms in the monitoring and evaluation of the existing funding cycles, and finally identify the characteristics and constraints. Like the previous chapters, we obtain input through a questionnaire survey conducted in February 1998, which is

supplemented by additional interactions with specific service providers and funding agencies. Limitation of the methodology is discussed in the last section.

6.2 Historical landmarks

Hong Kong's responses to AIDS have been featured by an initiation of the government and its subsequent long-standing support. Much of the resource input is channeled through governmental establishments. Outside the government machinery, there has only been little or scattered involvement of the private sector. It was since the set-up of the non-governmental organizations and community-based projects that the involvement of the community both in terms of resource and technical input become more evident. To illustrate these changes, several historical landmarks could be identified.

The very first indication of the government's financial commitment is demonstrated in the setting up of a mass screening programme for HIV antibody in donors' blood at the Hong Kong Red Cross Blood Transfusion Services in 1985. Through this sole agent of blood supply, the government's introduction of HIV antibody tests has aimed at ensuring that none of the population would be infected through reception of contaminated blood. In the same year, HIV tests had also become regularly available for voluntary testing and surveillance activities.

When was the AIDS budget first created? It is hard to tell the exact date. In 1985, Queen Elisabeth Hospital established the AIDS counseling service through deployment of medical and nursing staff from within the hospital. The gradual expansion of counseling services, the initiation of inter-departmental education committees and the launching of media campaigns in 1986 had called for an increase in resource support. In 1989, when the then Medical and Health Department separated into two independent structure of Hospital Authority and the Department of Health, the heavy prevention

component of AIDS activities made AIDS a programme area under the Department of Health. A separate AIDS budget was created to cover AIDS activities of the Department.

The next landmarks were those on facilitating the community's involvement. In 1991, the government, together with the then Royal Hong Kong Jockey Club, each injected HK\$15 million as seed money to set up the Hong Kong AIDS Foundation, which was to operate as a non-governmental organisation. In the early phase, technical support had been mobilized from the government.

The setting up of the AIDS Trust Fund constituted another milestone demonstrating the government's support to community based activities. Established in 1993 with a sum of HK\$350 million from the government, the Fund has, in fact, catalyzed the establishment of new non-governmental organizations working specifically on AIDS.

Another important change noted at the similar time is the increasing involvement of private sectors and business communities. Their increasing involvement had come in parallel with the formation of AIDS NGOs. Some NGOs have, in addition to financial input, drawn in direct involvement of the business sectors in HIV prevention programmes.

6.3 Costs of the Programmes (Appendix VI.2)

Costs of the AIDS programmes refer to the resources devoted to serve the purposes of effecting HIV/AIDS prevention, care and control in the community. As stated in the introduction, we use the monetary outlay, or the expenditures spent by the service providers on the programmes or services on AIDS. The opportunity costs and the indirect costs are not included in this initial assessment.

The baseline financial data in this section are obtained from a questionnaire survey (or Survey, in the following discussion) conducted for the review. (see Box 6.1,

and supplement for full report) In this exercise, we build up the baseline estimates by including only those expenditures of (a) AIDS NGOs, and (b) the government, the latter referring only to expenditures designated to AIDS. Additional communications with and/or interviews of selected service providers were made to estimate and verify expenditures on specific items. Gazetted price is taken as reference when direct estimations from the service providers are not available.

In line with the previous descriptions of the local programmes, we classify all the expenditures into three ultimate purposes of HIV prevention, provision of services for people with HIV/AIDS, and surveillance and research. The providers are further differentiated into governmental and non-governmental in view of the difference in the operating and monitoring mechanisms. (see section 6.5)

Box 6.1

A questionnaire survey to determine the designated expenditures on AIDS programmes from 1994 - 1997

The expenditure presented in this section is based on the reported data in the questionnaire survey.(see supplement). For the purposes of this report, only those resources allocated on services provided directly by AIDS NGOs are included as the “non-governmental output”. These NGOs are Hong Kong AIDS Foundation, AIDS Concern, Hong Kong Council of Social Services, HIV Information and Drop-in Centre, TeenAIDS, Society for AIDS Care. (Action for Reach Out and Hong Kong AIDS Memorial Quilt Project did not supply any information on expenditures). For the governmental provision, we include that of the AIDS Unit of Department of Health, AIDS Service of the Queen Elisabeth Hospital, AIDS specific laboratory services provided by the government virus unit and Hong Kong Red Cross Blood Transfusion Services, and Haven of Hope Hospital hospice services.

We assume all designated AIDS expenditures fell under one of the three main outputs, i.e. HIV prevention, clinical and support services, and surveillance and research. The related administrative cost, training, research and others spread, in proportion, over the three categories. AIDS Concern provides only the overall expenditure as published in their annual report. As advised, a 3:1 ratio has been made on the HIV prevention and support services. The 1997 expenditures of AIDS Concern and HIV Drop-in and Information Centre are not available and the 1996 expenditures with a 10% increment have been used for this estimation.

The annual expenditures designated on AIDS programmes, as obtained from the questionnaire survey, are **HK\$22.658M, HK\$31.632M, HK\$43.233M, and HK\$62.785M** from 1994 to 1997. These, however, represent only a fraction of the total expenditures. Adjustments are made subsequently mainly on the inpatient costs, and the costs of laboratory services in the clinical management of HIV/AIDS.

6.3.1 HIV prevention

The item “HIV prevention” includes preventive measures and health promotion activities organised for the purpose of preventing the spread of the infection in the community. The total expenditure on HIV prevention for the years 1994-1997 through the government and the AIDS non-governmental organisations amounted to, on a yearly basis respectively, *HK\$11.202M*, *HK\$15.635M*, *HK\$19.593M*, *HK\$22.972M*. The ratios of those spent through governmental and non-governmental programmes are 1.73, 1.53, 0.99, 1.04. These costs include (1) HIV prevention programmes operated by the the AIDS NGOs except AIDS Memorial Quilt Project and Action for Reach Out (Box 6.1), (2) AIDS Unit expenditure on HIV prevention, and (3) blood and blood product screening at the Hong Kong Red Cross Blood Transfusion Services.

It is discernible that a significant proportion of the public sector funding on HIV prevention has been spent by the AIDS Unit of the Department of Health. The expenditures of AIDS Unit fall under two categories: the provision of (a) professional and secretarial support to the Advisory Council on AIDS and (b) HIV prevention activities conducted by the AIDS Unit itself and through other collaborative works. The latter includes those with other units of the Department of Health, other government departments, and community-based organisations. It is estimated that approximately half of the staff cost and 25% of the recurrent expenditures were for the provision of technical support to the Advisory Council on AIDS and its committees.

6.3.2 Clinical and support services

This section deals with the costs of clinical and support services provided to people living with HIV/AIDS. The costs refer to that of clinical services, including expenditure on medication and laboratory services, and that of other support services.

(a). Clinical services

Clinical services include the direct outpatient services provided at the two designated HIV clinics (see Chapter III), inpatient costs, and drug costs. The survey had provided the expenditures of the two designated outpatient clinics of the Department of Health and the Queen Elisabeth Hospital, the hospice services of the Haven of Hope Hospital, and Lookout at a total of ***HK\$4.406M, HK\$5.290M, HK\$7.221M, and HK\$11.812M*** from 1994-97. These also include the provision of voluntary HIV testing services at the Department of Health and the maintenance of a designated information and counseling hotline on AIDS (27802211).

The inpatient costs are estimated using the reported number of inpatient days attributable to HIV/AIDS provided by Hospital Authority, and the gazetted price of average inpatient bed maintenance. The annual inpatient costs from 1994 to 1997 are ***HK\$4.773M, HK\$5.731M, HK\$7.508M, and HK\$6.589M***. These are to support on annual basis, of 1843, 2069, 2399, and 2105 inpatient days¹.

In addition, a significant amount has been spent on drugs. The annual drug costs estimated from the survey are ***HK\$2.768M, HK\$5.100M, HK\$8.221M, and HK\$17.240M*** from 1994-97.

(b) Laboratory services

Laboratory services are classified as a sub-item of the clinical services. Three types of laboratory services are included: the HIV screening tests, viral load testings, and CD4 monitoring. The other routine haematological, biochemical, and serological tests are not included in the following estimates.

HIV Screening - There are no designated HIV laboratory in Hong Kong.

The support for HIV testing and clinical monitoring has been provided

¹ Sources: inpatient days supplied by the Hospital Authority. Gazetted hospital maintenance fees (per day) are used, which means: 1994: HK\$2,590; 1995: HK\$2,770; 1996 and 97: HK\$3,130.

through extension of the existing laboratory services. The most important support for voluntary HIV screening testing was rendered by the Department of Health Virus Unit ², which is one of the three HIV confirmatory laboratories in the public sector. The number of tests conducted in this laboratory was between 80-90% of all. The other two confirmatory laboratories were at the Queen Elisabeth Hospital and the Prince of Wales Hospital. Their services may have been operating at a higher unit test cost because of the smaller scale of services. As an adjustment, an extra 20% was added to their expenditure in the calculation. The annual expenditures on the provision of HIV testing are estimated as **HK\$2.713M, HK\$2.994M, HK\$3.193M, and HK\$3.528M** for the years 1994 to 97.

CD4 monitoring - CD4/CD8 monitoring is provided primarily by the Department of Health. The estimated cost for each test was HK\$1,000 and the total amounts to **HK\$0.399M, HK\$0.698M, HK\$0.969M, and HK\$1.376M** from 1994 to 1997 ³.

Viral load measurements - Viral load measurements in the public service were started in mid-1995. The expenditure on this item had to compete with that for other laboratory activities. The annual expenditures on viral load tests ⁴, with an estimated cost of HK\$1500 per test, were **HK\$0.057M, HK\$0.4M, and HK\$1.008M** from 1995 to 97. The numbers of tests done in each of these years were 38, 267, and 672.

(c). Support services

Community organisations have account for a large proportion of the

² Expenditures on HIV screening at the Department of Health Virus Unit are HK\$2.261M, HK\$2.495M, HK\$2.661M, and HK\$2.940M from 1994 to 1997 respectively

³ Source : Number of tests and estimated cost per test provided by Pathology Institute, Department of Health

⁴ Sources : Numbers of tests done provided by Department of Health Virus Unit and Microbiology Unit, Queen Elisabeth Hospital. Gazetted price used

expenditure on support services. Our survey showed that the total expenditure on the provision of support services from three AIDS non-governmental organizations, namely, the Hong Kong AIDS Foundation, AIDS Concern, and Society for AIDS Care amounted to **HK\$1.446M, HK\$1.495M, HK\$4.434M, and HK\$6.088M** from 94-97. Frontline workers involved in the provision include paid staff with nursing background, social work training, and some volunteers. Support services were generally coordinated and supervised by programme staff with social work or nursing background.

Other support services of community organisations that had been set up well before the AIDS era have also been extended to serve the HIV infected. Their involvement has so far been minimal, and no designated funding is assigned.

In the public service, medical social workers serve as a middle-person to directly interview the patients, assess their needs, and the mobilisation of the appropriate support (Box 6.2). Currently, there is one full-time medical social workers supporting the clients of the Department of Health HIV clinics. For patients under the care of public hospitals, the workload is shared by a number of medical social workers, amounting to an equivalence of approximately 50% of effort of a medical social worker. We estimate the costs of the medical social services provided by the Social Welfare Department as **HK\$0.4 and 0.6 M** in 1996 and 97 respectively.

Box 6.2

Safety Net

Safety net (social security) for people with HIV/AIDS is provided, like all other citizens of Hong Kong, on the basis of unemployment status instead of the medical diagnosis. The rationale is to help the unemployed meet the basic needs, at times of individual economic hardship. Direct financial aid from the public sector, primarily through the Social Welfare Department, is obtained under the item called Comprehensive Social Security Assistance (CSSA). Fine adjustment of the supported amount is, however, made with a consideration of the marital status, housing condition, age, and health status. Except for the waiver for the medical consultation and other medical equipments (see 6.4.1), the other financial support are, strictly speaking, not considered under the medical and health expenditures in the current context. However, to mobilise these resources to the needed, registered medical social workers are required to conduct the necessary assessment and follow-up. On the non-governmental side, the Hong Kong AIDS Foundation is operating a PWA (Persons with AIDS) fund using input from the community.

6.3.3 Surveillance and Research

Surveillance forms one important part of the AIDS programme. This is undertaken by the AIDS Unit of the Department of Health. The cost is based on the professional input contributing to (1) the maintenance of the reporting system, (2) conduction of other surveillance activities and data collection, (3) interpretation of epidemiological data and their distribution. As for research, two research initiatives provide supplementary information directly to the AIDS programmes. They are Community Research Programme on AIDS (CRPA) based in the Chinese University of Hong Kong, and AIDS Scenario and Surveillance Research (ASSR) of University of Hong Kong (see Chapter I). Research expenditures are on project basis and are hard to be assessed in terms of their annual costs.

The total expenditures on surveillance and research estimated from the survey are *HK\$0.574M, HK\$1.615M, HK\$1.102M, and HK\$1.732M* from 1994 to 1997. These do not include most other research projects supported by the AIDS Trust Fund. (refer to 6.4.1)

6.3.4 Other service providers

There are a number of other service providers both in the government and community who have been involved in the AIDS programmes. Although many of the governmental programmes have been collaborating and obtaining technical support from the AIDS Unit, other non-designated resource input has been involved. There are still other non-governmental organisations that have been involved in the AIDS programmes, some through an integrated approach while others with specific AIDS activities. (Box 6.3)

Box 6.3

Other service providers involved in AIDS programmes	
<u>Governmental service providers</u>	
Department of Health	Condom supply at STD clinics Condom supply at methadone clinics
Information Services Department	Production of APIs Organisation of publicity campaigns
Education Department	School education
Correctional Services Department	Guidelines, resource centres
<u>Non-governmental service providers</u>	
Family Planning Association	Integrating HIV counselling and prevention in the context of sexual health
Other social work organisations	Group activities on HIV prevention in existing NGOs such as Caritas, The Hong Kong Federation of Youth Groups, Boys and Girls Clubs Association of Hong Kong, Hong Kong Young Women's Christian Association, Hong Kong Federation of Women's Centres etc.

6.3.5 Estimating the total cost

The estimated total costs of the HIV/AIDS programmes in the years 1994 to 1997 are **HK\$28.282M, HK\$38.616M, HK\$53.042M, and HK\$72.946M**. This represents a conservative estimate of the cost of the programmes. (see limitations under 6.6)

Table 6.1: Breakdown of the estimated total costs:

Year	1994	1995	1996	1997
HIV Prevention	\$11.202M	\$15.635M	\$19.594M	\$22.972M
Clinical, laboratory and support services	\$16.506M	\$21.366M	\$32.346M	\$48.241M
Surveillance and Research	\$0.574M	\$1.615M	\$1.102M	\$1.733M
Total	\$28.282M	\$38.616M	\$53.042M	\$72.946M

6.4 Programme Financing (Appendix VI.3)

As discussed in the introduction, we examine programme financing under the four main methods, namely, government revenue, community funds, private donations or fundraising, and direct charge from end-users. We also look at the role of private insurance although its contribution is probably small in the local health care system. There has been no designated revenue for social or health welfare uses in the public sector.

The method for collecting the data on programme financing is the same as for the former parts of the report - from the Survey and supplemented by additional interviews or communications. There has been no attempt to look at the application of individual financing mechanisms in relation to the programme output as many non-governmental organisations have input from more than one sources. On the other hand, all the public sector recurrent expenditures are financed through the government account.

6.4.1 Public sector

The general taxation in Hong Kong supports the public sector expenditure (Box 6.4). There are three separate mechanisms that allow the utilization of this money on AIDS programmes. First, the government supports new set-ups within

the government with a commitment to its long term recurrent expenditures. Second, the government supports the recurrent expenditures of the existing services. And third, the set up of one-off fund for designated groups and/or services, ie. through the AIDS Trust Fund.

Box 6.4

Government revenue

The government revenue comes from a number of sources of which the profit and salaries tax constitutes the most important part, both collected by the Inland Revenue Department. Profits tax is charged on net profits arising in Hong Kong or derived from a trade, profession, or business carried out in Hong Kong. Profits of unincorporated business are currently taxed at 15% and profits of corporations at 16.5%. Salaries tax is charged on emoluments arising in, or derived from, Hong Kong. Tax payable is calculated on the basis of a sliding scale but with a maximum of 15% of total income. About 47% of the territory's workforce has no salaries tax liability because of the generous personal allowances under the Hong Kong tax law. The other revenue sources are property tax, stamp duties, betting duties, estate duties, land sale, investments and rents from government properties etc. The government could also derive its own revenue. Fees and charges for services provided by the government departments generated a total of about HK\$9.9 billion, or about 6% of the total revenue in 1995-96. It is government policy that fees should in general be set at levels sufficient to recover the full cost of providing the goods and services. Certain essential services are, however, subsidized by the government or provided free.

(a). Capital set-up of the government

This is usually how new governmental service could be set up. As the government needs to be responsible for the recurrent cost, including technical and manpower support of these new services, it has been extremely cautious in providing funding support and committing to new developments. Under normal circumstances, the needs of the new services have to be elucidated and fully justified for approval to be granted. Several years of planning and assessment is usual. In view of the pace of AIDS programme development, this means has been less useful to meet the demand perceived by the involved personnel.

(b). Public sector recurrent expenditure

Financing of government units and their services to the public is secured under this public account. The Hong Kong government has been allocating resources to the existing services with a built-in evaluation system.(see next

section) The government recurrent expenditures on designated AIDS programmes or services, as obtained from the survey are HK\$17.052M, HK\$21.987M, HK\$28.650M, and HK\$42.134M from 1994 to 1997. As for the clinical inpatient services, the public sector has been financing 97% of the maintenance costs for the hospital beds. These add another HK\$4.674M, HK\$5.607M, HK\$7.346M, and HK\$6.446M⁵ (1994 to 1997) to the recurrent expenditures. Adding those on other laboratory services, the recurrent expenditures supported by the public sector amount to ***HK\$22.065M, HK\$28.349M, HK\$37.366M, and HK\$50.964M*** for the years 1994 to 1997.

Box 6.5

Public expenditures on health

The total public expenditures in 1997-98 was HK\$ 243.905billion (revised estimate, Finance Bureau information <http://www.info.gov.hk/fb/est98-99>), and remained around 18% gross domestic product. The expenditures on health was HK\$28,180M (11.55% of the total public expenditure) with approximately 10% spent by the Department of Health. The AIDS expenditure for the year 97(HK\$50.964M) approximated 0.2% of all health expenditures.

(c) The AIDS Trust Fund

The set up of this fund allows the government to support community based projects in a much more flexible manner. Established in 1993 with HK\$350 million, it provides exgratia payment to the HIV infected individuals who contracted HIV through blood or blood products before 1985. It also supports community education and service projects on AIDS in Hong Kong.

On the administration side, the Fund is primarily overseen by the Council for the AIDS Trust Fund whose members are appointed by the government, and include academics, businessmen, and community leaders. The Health and Welfare Bureau provides secretarial support. Under the main Council, three subcommittees are set up to review the project proposals submitted for each of

⁵ The public sector pays more than 97% of the hospital maintenance fees, while the users pay the rest. The gazetted out-of-pocket payments of the users are (per inpatient day): 1994: HK\$54, 1995: HK\$60, and 1996-97: HK\$68.

the three purposes. As for the account management, the government Treasury has been responsible.

Ex-gratia payment - Anyone who has acquired the infection via reception of contaminated blood or blood products before 1985 could apply to receive a specified sum of money. The amount varied with the marital status, number of children and survival status of the infected. (see Chapter III, Box 3.2) A sum of HK\$100M in the AIDS Trust Fund is allocated to pay for this purpose. To date, 56 successful applicants had received a total sum of **HK\$32.150M**. Those affected through blood or blood product infusion after 1985 are, however, not eligible for the payment.

Projects on education, publicity and medical services - The remaining HK\$250M of the Trust Fund is used to enhance community participation through supporting community based projects. They could be HIV prevention programmes and/or clinical and support services.

In the past four years, initial set up of the following AIDS NGOs had been supported by AIDS Trust Fund: The Society for AIDS Care (1995)'s Home Care and Lookout projects (1996), the AIDS Memorial Quilt Project (1994), the HIV Information and Drop-in Centre (1995), and Action for Reach Out (1994). In 1993, the Community Research Programme on AIDS was set up under the Centre for Clinical Trials and Epidemiological Research of the Chinese University of Hong Kong. In 1994, Trust Fund granted the establishment of Red Ribbon Centre as a model to solicit community responses to AIDS.

As of Feb 5, 1998, a total of **HK\$83.979M** had been approved to support projects on AIDS. A major proportion is on medical and social services, with a sum of **HK\$58.445M** for 28 out of 36 applications. The remaining **HK\$25.533M** supports 159 out of the 203 projects on HIV education and prevention. These funding have included HK\$7.887M on research projects and HK\$1.185M for

conference attendance. The total amount is considerably greater than that of **HK\$25.742M** estimated from the survey. The discrepancies are due to the following possible reasons: (1) the amount reported by the AIDS Trust Fund is the total approved amount while some of them are yet to be transferred to the successful applicants (see next section on monitoring and evaluation), often in instalments; (2) not all those who have obtained support from the AIDS Trust Fund participated in the survey; (3) the funding may not have been disbursed within the same time-frame as that specified in the Survey.

(d). Other forms of public expenditures for community projects

In 1991, the government and the then Royal Hong Kong Jockey Club each injected a HK\$1.5 million seed money to support the establishment of the Hong Kong AIDS Foundation. The grant was, in principle, to generate interest to provide partial support to the operating cost of this organisation. Technical support has also been obtained from the government in the initial phase.

The government is also providing non-financial support to some non-governmental organisations. Examples are the office space provided to the Hong Kong AIDS Foundation and AIDS Concern.

There are two funds both established by the government and operated by the Hospital Authority for supporting health research and education projects. They are the Health Care and Promotion Fund and Health Services Research Grant. They were not known to have supported any projects specifically on AIDS.

6.4.2 Community Funds

There are a number of funds set up and maintained in the private sector or by some other community groups (Box 6.5). Objectives of these funds are primarily to encourage community involvement of public programmes or to build up corporate images. Varied by the set up agencies, each of these funds has its

own priority and project vetting procedure. Support from these funds accounts for a significant proportion of the resource input of AIDS NGOs. The amounts obtained by the NGOs were *HK\$1.052M, HK\$0.806M, HK\$2.233M, and HK\$5.854M* for 1994 to 1997.

Box 6.6

Community Funds that have supported AIDS related programmes

Keswick Foundation
Hong Kong Bank Fund
The Marden Foundation
St. Michaelmas Fair
Matilda Hospital Charity Fund
Levi Strauss & Co Grant
Murphy Foundation
The American Women's Association of Hong Kong Limited
The Board of Chinese Permanent Cemetery Fund

6.4.3 Private sector

The role of private sector in the financing of AIDS programmes is more on disease prevention. Private donations from business sectors or philanthropists account for a portion of the income of AIDS NGOs. Some NGOs also raised funds through joint functions which benefit both the participating NGO and the business sector.

(a). Pharmaceutical companies

Drug companies have been known to be active within the medical and health arena, usually as part and parcel of the drug promoting exercises. Some pharmaceutical companies have been contributing to AIDS related activities in Hong Kong in both disease prevention, health promotion or providing support to research (Box 6.6). The contributions may be pegged with drug sales or that separate budgets may have been set up for health promotion or for building up the

corporate image. The total expenditure of these companies on AIDS is estimated to be approximately HK\$0.8M in 1997.

(b). Business community

The participation of the business community has been primarily on donations or providing financial support for publicity events organised by AIDS NGOs. These partnerships serve the dual functions of encouraging greater community participation (in terms of deriving private sector funding support, and in involving them in the AIDS programmes) as well as arousing public awareness towards AIDS.

Box 6.7

Examples of pharmaceutical companies' contribution to the overall AIDS resources

HIV Prevention

- Production of z-cards on AIDS and hepatitis for health care workers
- Purchasing and distribution of professional education materials, such as conference news, journals, and reprints Publications
- Production of booklets for patients
- Publication

Research Support, and Conference Attending

- Supporting overseas experts to Hong Kong, group meetings, seminars
- Sponsoring conference participation of medical practitioners, local and overseas

Mass Transit Railway Corporation is unique in its being directly and actively involved in AIDS education in the past few years. Under the company policy, each new employee undergoes an interactive group session on HIV/AIDS covering knowledge and managing people with HIV/AIDS. Resource packages and learning materials have also been produced. Human resources staff are responsible for the implementation. With the encouragement of the Community Charter on AIDS, other companies have also participated in AIDS education, primarily through provision of AIDS education to their employees. The commitment has, however, been relatively less. Their contribution in fiscal terms cannot be determined in the current assessment.

6.4.4 Out-of-pocket payments

At the point of service delivery, the service receiver makes a small sum of payments out of their own pockets. The out-of-pocket amount varies with the setting and service. The amount of payments in public sector is: HK\$68 for each inpatient day and HK\$45 for each specialist outpatient. The total out-of-pocket payments is therefore a function of the number of inpatient days and clinic visits. We estimate that, for the years 1994 to 97, the annual out-of-pocket payments amount to *HK\$0.167M, HK\$0.206M, HK\$0.303M, and HK\$0.340M* ⁶.

We estimate that less than 10% of the known HIV infected were under the clinical care of private doctors. As for the remainder, consultation may be sought from the private sectors but less likely on HIV related conditions.

6.4.5 Other means

Other financing means include membership fees, investments or interests etc.

Private health insurance is becoming an important means to pay the clinical services, especially in private sector. It has been estimated that approximately 15% of the local population have private health insurance mostly as a work benefit. However, on HIV/AIDS care, its involvement is apparently insignificant. Those who are in a later stage of the infection and require the costly medications regularly tend to be seen at the public sector. Private insurance may, nevertheless, have supported some of the non-HIV specific care received by the people with HIV/AIDS

⁶ Sources: Number of inpatient days supplied by Hospital Authority, outpatient visits estimated from both designated clinics. Gazetted user charges per inpatient day: 1994:\$54, 1995:\$60, 1996-97: \$68, per outpatient visit: 1994: \$36, 1995:\$40, and 1996-97: \$44.

6.4.6 Total community input

The following table (table 6.2) provides a summary of the available information concerning the contributions from different sources. The public recurrent expenditures finance basically the output of the Hospital Authority and the Department of Health. Money from AIDS Trust Fund is provided on a project basis, mostly to support community-based education/service projects or research projects. Clinical services users are generally charged a minimal amount of out-of-pocket payment at the point of service delivery. The remaining financing methods are mainly for non-governmental organisations.

The table shows that a significant proportion of the AIDS programme costs are from the public sector – as the governmental recurrent expenditures and projects supported by the AIDS Trust Fund. The private sector has also important contribution of approximately HK\$6 million per year in the past three years. The contribution of out-of-pocket payments is minimal.

Table 6.2: Breakdown of annual AIDS programme finance

Year	1994	1995	1996	1997	Remarks
Public Recurrent Expenditure	\$22.065M	\$28.349M	\$37.366M	\$50.964M	Estimated from survey and other sources
AIDS Trust Fund	\$2.750M	\$3.623M	\$5.069M	\$14.265M	ATF* reported total support approved <u>HK\$83.979M</u> (Apr 93 - Feb 98)
Community Funds	\$1.052M	\$0.806M	\$2.233M	\$5.854M	From survey
Private sector	\$2.262M	\$6.746M	\$6.132M	\$6.801M	Fundraising and donations, data from survey
Out-of-pocket payments	\$0.167M	\$0.206M	\$0.303M	\$0.340M	Clinical services only

Others	\$1.125M	\$0.963M	\$1.396M	\$6.120M	From survey, including membership fees, interests, investments etc
Total	\$29.421M	\$40.693M	\$52.499M	\$84.344M	

*Ex gratia payments HK\$32.150M not included.

6.5 Monitoring and Evaluation

Regulatory mechanisms are in place to monitor and evaluate the utilisation of resources to ensure its efficiency and effectiveness. There are, however, no central mechanisms to regulate the overall AIDS programmes financing. The government recurrent expenditures, the greatest portion of the total AIDS budget, are monitored and regulated under a series of processes at unit, departmental and governmental levels. As for the non-governmental organisations, monitoring is from the boards and accounting procedures. Monitoring and evaluative mechanisms of the AIDS Trust Fund are also examined.

6.5.1 Government expenditures

A number of administrative steps help the government to ensure that its programmes are accountable to public, both in terms of the resource allocation and the outputs. At the departmental levels, performance pledges are made and regularly examined by the Head of the government to monitor its performances.

(a) Bidding exercise

Each established unit or service of the Departments has to evaluate its own needs and service provision regularly, and estimate and justify that of the coming year. The department head, in association with the corresponding bureau, decides on the priority areas and propose a budget to the Financial Secretary. At the central level, the budget on existing items is evaluated, while competing with all other government services. A final overall government budget is prepared for the

endorsement of the Finance Committee at the Legislative Council (Provisional Legislative Council in 1998).

(b) Monitoring mechanisms

The operation of the government is monitored through a system of accounting procedures, workload statistics and programme indicators. Under the Management Information System, for example, the Department of Health monitors its own performance and workload using certain pre-defined quantifiable variables. Each unit or service has to review its own performance regularly to meet the set standard (Box 6.7). The performance of each government department as a whole is again evaluated against certain key indicators. Changes in these indicators are evaluated against the resource allocation for the coming year.

These processes serves to ensure public accountability in the design and implementation of governmental activities.

Box 6.8

Selected workload and performance indicators of the AIDS Unit, Department of Health

Health Promotion

Production of health education materials
Attendance at health education activities
Utilization of the pre-recorded health education telephone enquiry service
Utilization of the AIDS telephone services
Counseling attendance

HIV Management

Appointment for HIV screening within one week
Attendance at special out-patient clinics
New HIV cases receiving clinical care

6.5.2 AIDS Trust Fund

(a) Proposal submission and review

Project proposals are submitted to the Council for the AIDS Trust Fund Secretariat based as the Health and Welfare Bureau for review. Since 1996/97, a standardized form is devised to improve the efficiency of proposal review process. Essential information and other project details are sought by the Secretariat before the proposals are reviewed at the Subcommittees.

As for eligibility, three principles can be deduced from the Council's operation. First, funding support must be on a project basis. Second, those on AIDS are supported, as the nature could be education, publicity, service provision, or any combination. Third, the project must be meant for benefiting people of Hong Kong.

For all the projects submitted, a review process is undertaken for funding decision. For projects asking for more than HK\$500,000, the review would be undertaken in two steps. The project proposal is first examined by the relevant subcommittee and then assessed again at the main Council. For projects less than this amount, the subcommittees may approve support pending endorsement at the main Council meeting. The Council and its subcommittees generally conduct review meetings four times a year. With the increasing interest in conference attendance, the Council has decided new policy under which a maximum of one representative from each organization would be supported per year. For research projects submitted to the Medical and Support Services Subcommittee, opinions of external reviewer(s) are sought prior to the subcommittee meeting. For the other projects, professional opinions are sought from the Department of Health and the Social Welfare Department.

(b) Evaluation and monitoring

The Trust Fund monitors the resources granted to the projects in two steps. First, the approved fund is usually provided in several installments. Progress reports may be required in between payments. Second, an evaluation report with account statements is required when the project is finished.

The Council Secretariat has once attempted to introduce an in-house publication titled “*Trust News*” in 1995 to establish links with interested organisations and the general public. The titles and amount supported of the approved projects were listed. The publication was, however, terminated after the first two issues.

Since late 1997, reports of the projects supported by the AIDS Trust Fund are kept in the Red Ribbon Centre Resource Library for public’ s reference.

6.5.3 Non-governmental organisations

The financial situation of some non-governmental organisations are monitored from within by Board Committees. Extra-funding are generally sought, through donations and fundraising, with the input of the Board members, advisors and the patrons, mostly community leaders and prestigious persons in the society. In some, Board members also look after the programme direction of the organisations while in others, front-line executive staff enjoy a greater flexibility in determining the organisation’ s programme development. As for individual project, the programme nature, emphasis and priority may also be affected by the funding agencies, such as AIDS Trust Fund and the community funds.

When it comes down to the financial details, monitoring is through external accounting. The incomes and expenditures are usually made public in the annual reports. The input of auditors is often sought.

6.5.4 Output evaluation

The collective AIDS programmes, as operated by both governmental and non-governmental, designated and non-designated service providers, utilise the community resources to produce outputs to meet the objectives of HIV/AIDS control and impact encapsulation. While the monetary costs and the financing of

these programmes are reviewed in this chapter, we could hardly find any well-established system in output monitoring and evaluation, especially the HIV prevention programmes.

6.6 Characteristics and Constraints

6.6.1 Limitation of the review

This review is the first attempt to evaluate the costs and financing of the local AIDS programmes. The review carries a number of limitations as regards data input: First, the direct costs of the HIV prevention programmes is not all inclusive. They have not included at least two non-governmental agencies which are known to be active in AIDS prevention works. Second, the overhead and administrative costs of the designated programmes in the public sector have generally be spread out over the other existing services and have not been specifically included. Third, the specific expenditures of a significant proportion of projects supported by AIDS Trust Fund have not been available. Four, only the maintenance costs of inpatient services have been included in examining the hospital expenditures on HIV management. Finally, capital costs had not been included in the exercise.

In addition, this review has been focussing on the monetary costs of the designated programmes. The input from the Council and committee members and other participating individuals, the non-designated service providers, and opportunity costs of the service providers and users had not been examined. Neither is the indirect cost within the scope of this initial assessment.

6.6.2 Characteristics of the financial situation

(a) Growth in programme costs

The Hong Kong community spent HK\$72.346 million in the year 1997 to support the AIDS programmes with expenditures on clinical and support services to HIV prevention in a ratio of 2:1. The increase in nominal costs is steady at proportionally 30% rise per year, revealing also increase in real terms. The growth in expenditures in prevention and services provision in the last four years has been in pace. Surveillance and related public health research accounts for a small fraction of the total cost of the programmes.

(b) The government's share as service-provider

The public sector is the predominant service provider in terms of the costs of the programmes. This is especially so in the provision of clinical, laboratory and support services. As regards HIV prevention, the ratio of the expenditure of the government to NGOs has fallen over the years, and stands now at about 1:1.

(c) The costs of providing HIV/AIDS treatment services

Clinical and support services account for the largest proportion (61.2%) of the total programme expenditures. The inpatient treatment costs have fallen in 1997, whereas that for running the designated clinics has risen over the last four years, with drug expenditure increasing by over five-fold between 1994 and 1997. The costs of support services provided by community organisations have increased in parallel.

(d) The government's role in financing AIDS programmes

The public sector contributes the greatest portion of the programme's finance. The government recurrent expenditures and AIDS Trust Fund together have supported 80% of the total incomes in the past four years. The proportion has been decreasing slightly from 84% (using nominal terms) to 77% from 1994 to 1997. However, our review has not included the additional HK\$60 million granted by the AIDS Trust Fund but not reflected in the returns collected in the Survey (6.4.1 (c)).

(e) Increase in community participation

A four-fold rise in the nominal amount of additional resources channeled from the community to support the AIDS programmes was observed. In 1994, approximately HK\$5 million were received from outside the government while in 1997, about HK\$20 million have been obtained. This change reflects an increase in the community's involvement in the local AIDS programmes.

6.6.3 Constraints in the current finance system

(a) Pace in meeting demand

There have been enormous strategic changes over the last years in the development of programmes on HIV prevention and patient management. The pace of the current finance system in meeting up the new challenges is an area of concern. This is especially obvious in the governmental clinical service provision. First, the HIV screening services have been maintained at a relatively constant plateau level. New laboratory service demand has to compete within the assigned budget with the existing services for money and skilled technical support. Second, the rise in the demand of antiretroviral medication does create stress on resource allocation on the part of clinical service providers.

(b) Operation of the AIDS Trust Fund

AIDS Trust Fund has been set-up to encourage community participation. However, under the broad perspective of HIV prevention and providing support, there has not been any clearly established project review criteria in terms of the objectives, aims, quality and quantity, nor has any priority be set in this regard. As one major funding source of NGOs working specifically on AIDS, there has been little monitoring and evaluation on the quality and the project outputs after approval is granted. As the fund is provided on a project basis, there is concern as to how that can be translated into supports for sustained efforts in the community.

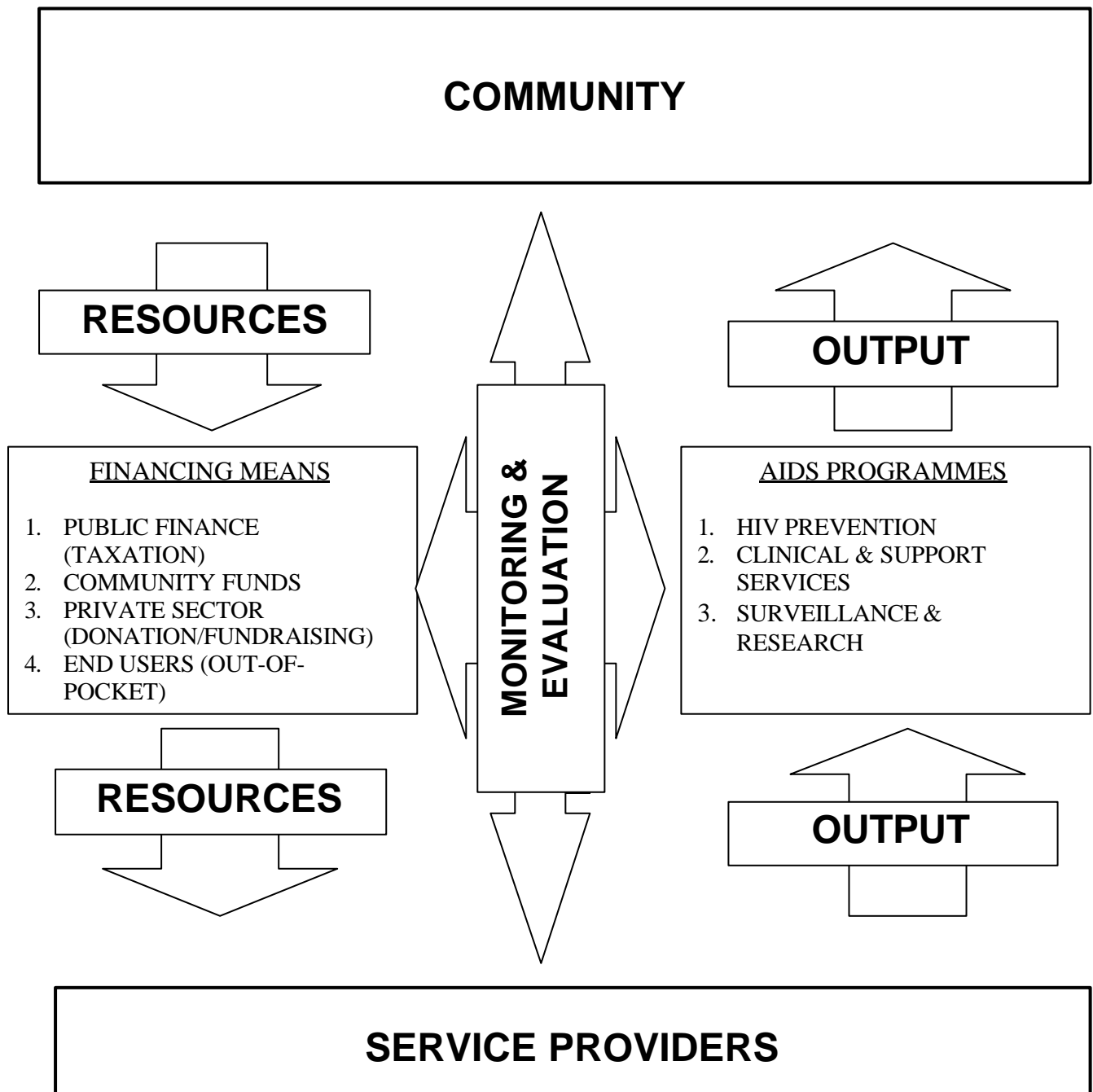
(c) Tapping community resources

The role of non-public sector financing to support AIDS programmes remains to be further explored. There are pros and cons to the approach. The up-side is the propensity to extend HIV prevention programmes into the private sector, thus enhancing community participation. The down-side is that service organisations would need to invest additional manpower and other resources to the relevant programmes, such as publicity functions, media campaigns, and fundraising activities.

(d) Absence of overall output evaluation

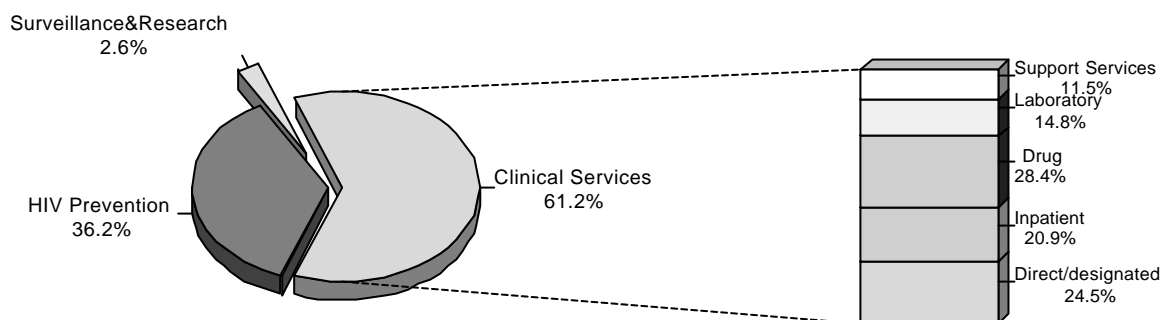
While the government's financing has a more clear-cut built-in mechanism for monitoring and evaluation, those of the AIDS Trust Fund and the community's financing means are relatively unclear or underdeveloped. Currently, funding sources are concerned with the effective and efficient use of resources on their sponsored activities, there is however hardly any visible monitoring and evaluation systems on the outputs of the service providers, not only at individual organisation level, but also the total outputs. The latter is essential to base decision making on future resource allocation, and in gaining the firm and sustainable support from the community.

Appendix VI.1 Dynamics of resource utilisation in the community (see text 6.1)



Appendix VI.2: Costs of the Programmes (1)

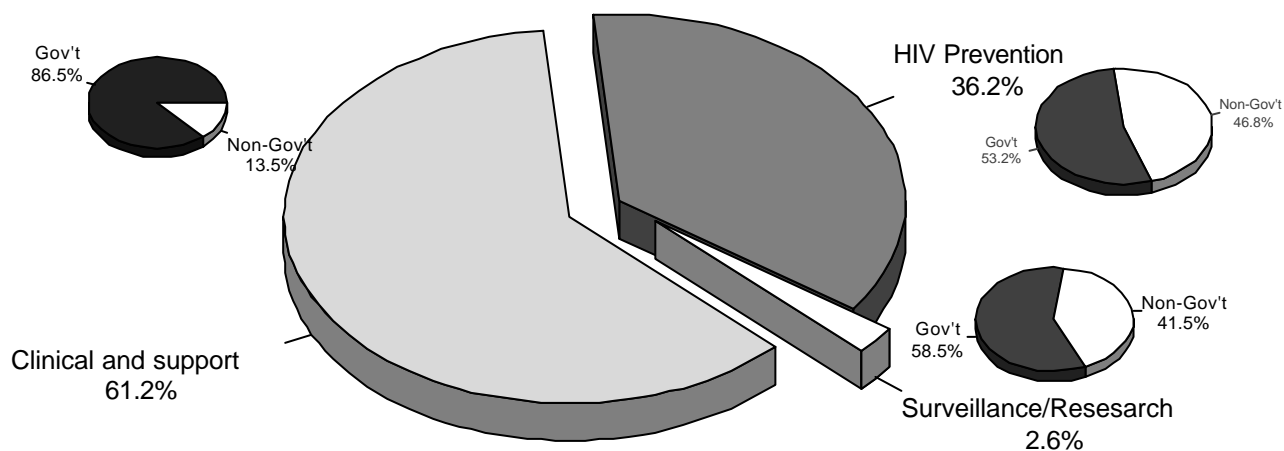
Hong Kong AIDS Program Financial Review Total Costs of Programmes (1994-1997)



Data: Review questionnaire survey Feb 1998 and upward adjustment of expenditures on clinical and laboratory services. (see text)
 Gov'tal: Department of Health, Hospital Authority
 Non gov'tal: HK AIDS Foundation, AIDS Concern, HIV Drop-in & Information Centre, Society for AIDS Care, Teen AIDS, Community Research Program on AIDS and HK Council of Social Service.

Hong Kong AIDS Program Financial Review

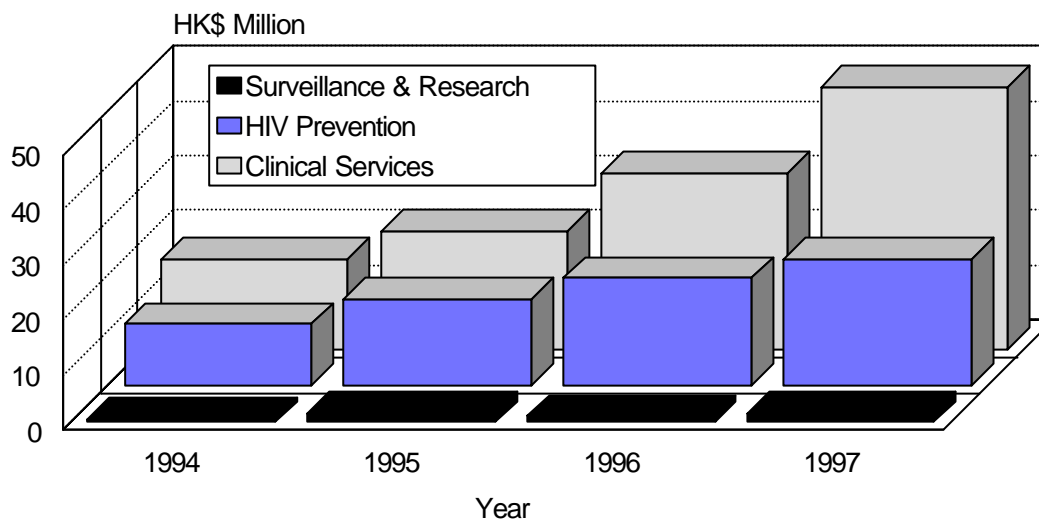
Costs of Governmental & Non-governmental Programme (1994 – 1997)



Data: Review questionnaire survey Feb 1998 and upward adjustment of expenditures on clinical and laboratory services. (see text)
 Gov'tal: Department of Health, Hospital Authority
 Non gov'tal: HK AIDS Foundation, AIDS Concern, HIV Drop-in & Information Centre, Society for AIDS Care, Teen AIDS, Community Research Program on AIDS and HK Council of Social Service.

Appendix VI.2: Costs of the Programmes (2)

Hong Kong AIDS Program Financial Review Annual Costs of Programmes (1994-1997)

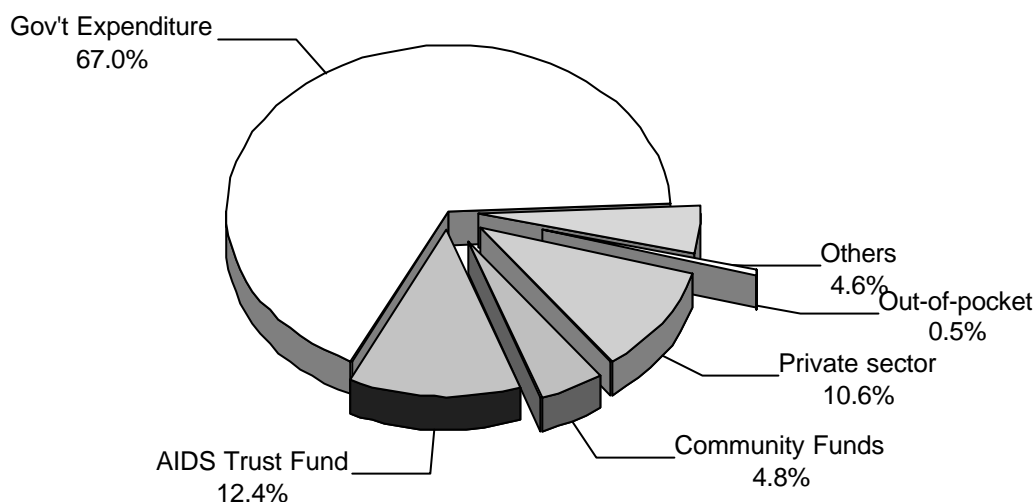


Data: Review questionnaire survey Feb 1998 and upward adjustment of expenditures on clinical and laboratory services. (see table 6.1)
Gov'tal: Department of Health, Hospital Authority
Non gov'tal: HK AIDS Foundation, AIDS Concern, HIV Drop-in & Information Centre, Society for AIDS Care, Teen AIDS, Community Research Program on AIDS and HK Council of Social Service.

Appendix VI.3: Programme Revenue (1)

Hong Kong AIDS Programme Financial Review

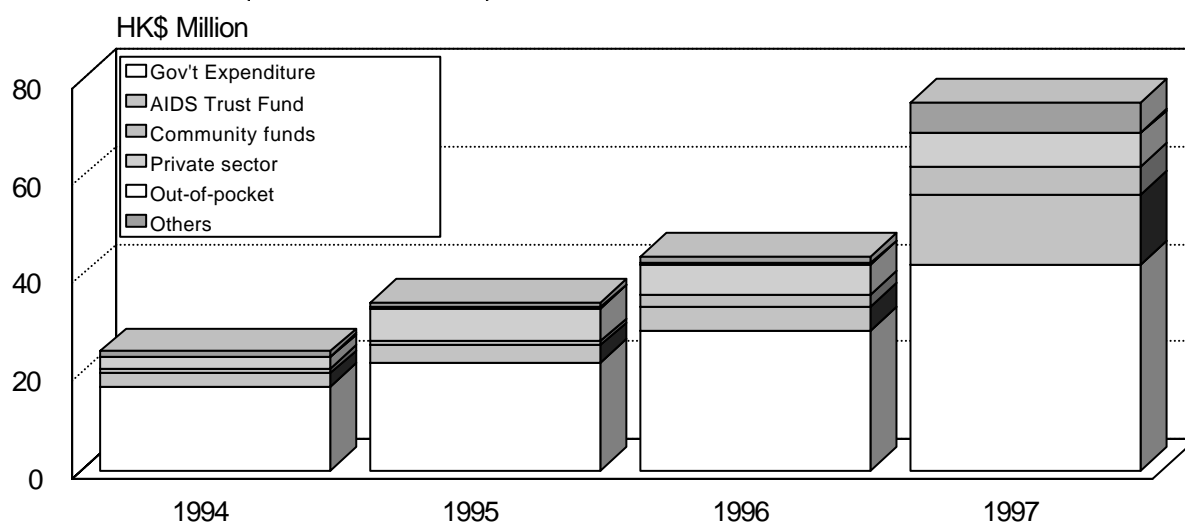
(a) Total Designated Revenue on AIDS (1994-1997)



Data: Review questionnaire survey Feb 1998 and upward adjustment of expenditures on clinical and laboratory services. (see text)
 Public expenditures : Government recurrent expenditures, AIDS Trust Fund
 Private expenditures : Community funds, fundraising, private donations, out-of-pocket payments, investments etc.

Hong Kong AIDS Programme Financial Review

(b) Annual Designated Revenue on AIDS by Method (1994-1997)

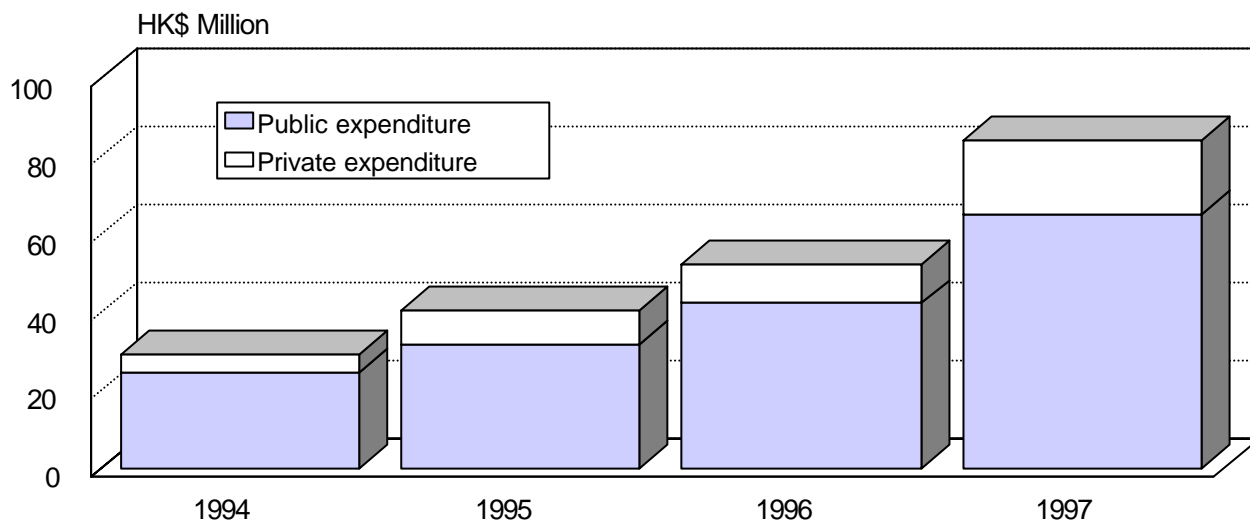


Data: Review questionnaire survey Feb 1998 and upward adjustment of expenditures on clinical and laboratory services. (see text)
 Public expenditures : Government recurrent expenditures, AIDS Trust Fund
 Private expenditures : Community funds, fundraising, private donations, out-of-pocket payments, investments etc.

Appendix VI.3: Programme Revenue (2)

Hong Kong AIDS Programme Financial Review

(c) Annual Designated Revenue on AIDS by Source (1994-1997)



Data: Review questionnaire survey Feb 1998 and upward adjustment of expenditures on clinical and laboratory services. (see text)
Public expenditures : Government recurrent expenditures, AIDS Trust Fund
Private expenditures : Community funds, fundraising, private donations, out-of-pocket payments, investments etc.

Internal Assessment Report

A review on the HIV/AIDS situation and the programmes on its prevention, care and control in Hong Kong

Supplements

Advisory Council on AIDS 1998

Review of Hong Kong AIDS Situations & programmes
- Report of the Questionnaire Survey Feb 1998 -

Background

1. In mid-1997, the Advisory Council on AIDS resolved to conduct a comprehensive review on the AIDS situations and programmes in Hong Kong to generate recommendations for future developments. It was decided to undertake a two-step process with an internal situation assessment followed by an external consultancy.
2. A 5-member steering committee was formed by the Chairmen of the Council and Committees to oversee the review. Three local advisors were also appointed. The methods and details of the review were laid down in the initial meetings.
3. A questionnaire survey was conducted to collect inputs from organisations and individuals, for the purposes of providing a framework for preparing the internal situation report.

Objectives

4. The objectives of this survey were:
 - (a). To collect updated information of the individuals and organisations involved in the local AIDS programmes;
 - (b). To examine the contributions of each of the involved parties;
 - (c). To understand the concerns of the involved parties;
 - (d). To prepare a comprehensive data base for later consultancy review.

Methods

5. A questionnaire was designed basing on the conceptual framework of the internal situation assessment. The questionnaire contained two parts. The first part covered nine areas: (1) set-up of the organisation; (2) HIV prevention; (3) clinical and laboratory services; (4) support services; (5) training provision; (6) research; (7) financial information; (8) other involvement; and (9) future plans. The second part was primarily an opinion survey. The involved parties and organisations were invited to raise their concerns and views.
6. This survey had targeted primarily service providers.
7. The questionnaire was distributed on Feb 6, 1998 to (1) members of the Advisory Council on AIDS, its committees and task forces; and (2) selected individuals or organisations who were known to have contributed to the AIDS programmes, but have not been included in the above list.

8. Data were reviewed, summarised and compiled by the ACA Secretariat.

Results

9. A total of 129 questionnaires were distributed. As of April 1, 98, 36 completed questionnaires were returned from organisations and an additional 4 from individuals. The names and areas of involvement of the participating organisations were shown in tables 1 and 2.

10. The submitted details on HIV prevention activities, research projects, and papers were compiled into separate data records and kept at ACA Secretariat for future reference.

11. A financial review was conducted to determine the costs of the AIDS programmes in the years 1994 – 1997 and the financing methods.

Cost estimation

12. Government and non-governmental organisations which had reported recurrent expenditures of designated AIDS programmes were included.

13. Government services included were: (1) AIDS Unit; (2) QEH HIV clinic; (3) HIV laboratory services based at the Department of Health Virus Unit; (4) HIV screening programme at Hong Kong Red Cross Blood Transfusion Services; and (5) Haven of Hope Hospice Services for HIV/AIDS.

14. Non-governmental organisations included were: (1) Hong Kong AIDS Foundation; (2) AIDS Concern; (3) Hong Kong Council of Social Service; (4) HIV Information and Drop-in Centre; (5) TeenAIDS; (6) The Society of AIDS Care; and (7) Community Research Programme on AIDS.

15. All expenditures were classified under three main categories: (1) HIV prevention; (2) clinical and support services; and (3) surveillance and research.

16. For the two organisations (AIDS Concern and HIV Information and Drop-in Centre) which had not supplied the 1997 data, we estimated the 1997 expenditures by adding a 10% increase upon the 1996 expenditures.

17. The reported total expenditures of AIDS Concern was broken down into that of HIV prevention and support services in 3:1 ratio, as advised by the agency.

18. The expenditures of HKCSS on training provision were classified under HIV prevention as minimal direct services had been involved.

19. Total costs of programmes from 1994-1997 were: HK\$22.658M, HK\$31.632M, HK\$43.233M, and HK\$62.785 M.

Programme Revenue

20. The reported revenues of the above organisations/services and that of the Action for Reach Out were included.

21. Total revenues from 1994-1997 were: HK\$24.241M, HK\$34.125M, HK\$43.480M and HK\$75.176M.

Areas of Concern

22. The opinions collected in the second part of the survey were listed and attached.

Conclusion

23. Data collected from this questionnaire survey had been used as the baseline data for the compilation of the internal situation assessment. The figures reported in the internal situation assessment may include supplementary information gathered from other sources.

*ACA Secretariat
Review-survey
Apr 9, 98.*

Table 1: Organisations

<i>Name of organisation</i>	<i>Address</i>	<i>Established</i>
<u>AIDS NGOs</u>		
The Hong Kong AIDS Foundation	5/F, Shaukeiwan Jockey Club Clinic, 8 Chaiwan Road, HK	14-May-91
Action for Reach out	P.O. Box 98108, Tsim Sha Tsui, P.O. Kowloon	1993
The Society for AIDS Care	18A, Winning Centre, 46-48 Wyndham Street, Central, HK	1994
The Society for AIDS Care (Lookout)	18A, Winning Centre, 46-48 Wyndham Street, Central, HK	1995
St. John's Cathedral HIV Information & Drop in Centre	4-8 Garden Road, Central, HK	1995
Community Research Program on AIDS	CCTER, CUHK, 7B, Block B, Prince of Wales Hospital, Shatin, N.T.	1994
AIDS Concern Foundation Ltd.	Suite 17B, Block F, 3 Lok Man Road, Chaiwan, HK	1990
AIDS Project of Hong Kong Council of Social Service	Rm 1105, Duke of Windsor Social Service Building, 15 Hennessy Rd., Wanchai, HK	1994
Teen AIDS	116 Aberdeen Main Road, Aberdeen, HK	1994
Hong Kong AIDS Memorial Quilt Project	G.P.O. Box 5083, HK	1994
AIDS Advocacy Alliance	C/O Suite 17B, Block F, 3 Lok Man Road, Chaiwan, HK	1997
<u>Government Departments</u>		
AIDS Unit, Dept. of Health	5/F, Yaumatei Jockey Club Clinic, 145, Battery Street, Yaumatei, Kowloon	1992
Social Hygiene Service	3/F, Sai Ying Pun Jockey Club Clinic, 134 Queen's Road West, HK	Since health authority
Shek Kwu Chau Drug Rehabilitation Centre	3/F, 15 Hennessy Road, Wanchai, HK	1963
Narcotics and Drug Administration, Dept. of Health	8/F, Southorn Centre, 130 Hennessy Road, HK	1974
Tuberculosis & Chest Service, Dept. of Health	Wanchai Chest Clinic, 99 Kennedy Road, HK	1930
Government Virus Unit	7/F, Clinical Pathology Building, QMH, HK	1960
Council for the AIDS Trust Fund	HK Special Adm. Region, 19-20 Floor, Murray Building, Garden Road, Central, HK	30-Apr-93
Social Welfare Dept., Government of HK Special Adm. Region	8/F, Wu Chung House, 213 Queen's Road East, Waichai, HK	1958
Correctional Services Department	23-24 Floor, Wanchai Tower II, Harbour Road, Wanchai, HK	30-Jul-85
Information Services Department	29/F, Siu On Centre, 188 Lockhard Road, Wanchai, HK	
Education Department	Rm 1208, Wu Chung House, 213 Queen's Road East, Wanchai, HK	
<u>Hospital Units</u>		
Clinical Immunology Division, QMH		1978
Dept. of O&G, Our Lady of Maryknoll Hospital	118 Shatin Pass Road, Wong Tai Sin, Kowloon	1961
Dept. of Medicine, Princess of Margaret Hospital	Rm 210, Block J, Princess Margaret Hospital, Lai Chi Kok, Kowloon	
Dept. of Community and Family Medicine, CUHK	4/F, Lek Yuen Health Centre, Shatin, N.T.	1981
Queen Elizabeth Hospital	30 Gascoigne Road, Kowloon	1963
HK Red Cross Blood Transfusion Service	15 King's Park Rise, Kowloon	1978
Haven of Hope Hospital	Po Lam Road South, Tseung Kwan O, Kowloon	1955
<u>Other NGOs</u>		
Lions Clubs International District 303, Hong Kong & Macau	803-7, Dominion Centre, 43-59 Queen's Road East, Wanchai, HK	1917
The Family Planning Association of Hong Kong	10/F, Southorn Centre, 130 Hennessy Road, Wanchai, HK	1950
HKYWCA	1 Macdonnell Road, Chaiwan, HK	1920
Hong Kong Sex Education Association	P.O. Box 50419, Sai Ying Pun, HK	1985
Equal Opportunities Commission	Unit 2002m 20/F, Office Tower, convention Plaza, 1 Harbour Road, Waichai, HK	1996
Hong Kong Federation of Women's Centre	101, G/F, Hei Wo House, Tai Wo, Tai Po, N.T.	1981
Caritas – Hong Kong	Room 602, Caritas House, 2 Caine Road, H.K.	1953

Table 2: Involvement in the AIDS programme

<u>Name of organisation</u>	<u>HIV Prevention Function</u>	<u>Clinical and Laboratory services</u>	<u>Support Services</u>	<u>Research</u>
AIDS NGOs				
The Hong Kong AIDS Foundation	Y		Y	Y
Action for Reach out	Y			Y
The Society for AIDS Care	Y	Y	Y	Y
The Society for AIDS Care (Lookout)	Y	Y	Y	
St. John's Cathedral HIV Information & Drop in Centre	Y		Y	Y
Community Research Program on AIDS				Y
AIDS Concern Foundation Ltd.	Y		Y	Y
AIDS Project of Hong Kong Council of Social Service	Y			Y
Teen AIDS	Y		Y	Y
Hong Kong AIDS Memorial Quilt Project	Y		Y	
Government Departments				
AIDS Unit, Dept. of Health	Y	Y		Y
Social Hygiene Service	Y	Y		Y
Shek Kwu Chau Drug Rehabilitation Centre	Y	Y		Y
Narcotics and Drug Administration, Dept. of Health		Y		
Tuberculosis & Chest Service, Dept. of Health	Y	Y		Y
Government Virus Unit		Y		Y
Social Welfare Dept., Government of HK Special Adm. Region	Y		Y	
Correctional Services Department	Y	Y	Y	Y
Information Services Department	Y			
Education Department	Y			Y
Hospital Units				
Clinical Immunology Division, QMH		Y		Y
Dept. of O&G, Our Lady of Maryknoll Hospital	Y	Y		
Dept. of Medicine, Princess of Margaret Hospital		Y		
Dept. of Community and Family Medicine, CUHK	Y			Y
Queen Elizabeth Hospital	Y	Y	Y	Y
HK Red Cross Blood Transfusion Service	Y	Y		
Haven of Hope Hospital	Y	Y	Y	
Other NGOs				
Lions Clubs International District 303, Hong Kong & Macau	Y			
The Family Planning Association of Hong Kong	Y	Y		Y
HKYWCA	Y			
Hong Kong Sex Education Association	Y			
Hong Kong Federation of Women's Centre	Y			
Caritas – Hong Kong	Y			

Areas of concern

- opinions gathered in the questionnaire survey part II –

Surveillance and HIV situation

HIV situation

- The reported numbers and forecast at the moment, though with small numbers, do not represent that the situation has been under control. Three factors are discerned in making Hong Kong vulnerable to the intrusion of communicable diseases. They are: the movement of the population, geographic proximity of Hong Kong to the neighbouring countries which are still affected by epidemics and endemic infectious diseases, and, increase in the number of immigrants. Forecast statistics may give a false sense of security.
- The view is that high level of vigilance should be maintained on the AIDS situation in Hong Kong. A wider margin of safety is preferred than doing just a minimum. The efforts on AIDS control should also benefit programmes against STDs.

Public Health Surveillance

- The laboratory surveillance should be expanded and supported with new resources. One option is to incorporate a special laboratory section dedicated fully to AIDS in the new Central Public Health Laboratory of the Department of Health. This section should be placed under a full-time Consultant (virologist) responsible for AIDS with technical staff team.
- An epidemiological unit could also be established in the central laboratory to facilitate surveillance, with improvement in the liaison among Hospital Authority, Department of Health, and the private sector. Epidemiological studies should be encouraged.

Research

- The government, NGOs and research institutions should establish a research agenda based on the needs of the society, especially to encourage community-based research. One option is for the government to fund research activities by NGOs, community-based organisations, or academics.
- We need to take stock the AIDS research needs, and create channels to disseminate findings. Particular emphasis should be paid to the theoretical foundations of prevention programs.
- Research efforts need to be coordinated.

HIV prevention and health promotion

General

- The general public is well versed with the basic concepts while in-depth education aiming at attitude changes is lacking.
- Emphasis of AIDS education should be placed on skill development. Health promotion should have the objectives of empowering others, enabling their action, and encouraging supportive conditions.
- Many of the targeted messages turn out to be stigmatizing the target groups. One reason is insufficient planning, including academic and market research and lack of consultation to the target audience, and evaluation of publicity campaigns.
- The current behavioural model of health promotion is insufficient to modify behaviours without exploring the social determinants which increase the vulnerability of the target population.
- The current AIDS programmes are not deep enough to make a meaningful and lasting impact. One proposed option is to produce a long running serial for radio or television to be aired in prime time, and introduce AIDS gradually into the plot. One such example is the “Neighbors”, a TV series in Australia.
- Enhance prevention campaign targeting high risk groups at grass root levels.

Condom promotion

- Condom promotion on APIs of the government is insufficient. The government and the NGOs should promote the “respectability” of condoms.
- Emphasis of the local prevention programmes has been on “event” and “publicity” education instead of on safer sex and condom use. The effectiveness of the current prevention effort is also difficult to measure, basic data on sex behaviours is unavailable.

Gender

- The potentially vulnerable population, particularly women, is not reached.
- The issue of power and gender awareness should be the focal point for future plan.
- Education should be more gender specific, and should target on women and AIDS.

Youth, school and sex education

- More attention should be paid to youth and sex education.

- A major concern is the absence of any compulsory sex education in schools.
- Enhance sex and AIDS education in schools.
- There should be an integrative approach to health education in schools – such as to promote healthy life style or healthy schools, with better coordination between school programs.
- Education must be integrated into other areas of established concern and services.
- AIDS programmes must be integrated with sex education to break the sex taboo.

Travelers

- Greater attention should be given to advise the public and the profession on the importance of healthy travel.

Clinical and support services

Universal precaution

- The current two-tier universal precaution is stigmatising, and create a false sense of security among the health care workers.

Access

- The patients should have access to relevant services, include: antiretroviral therapy, testing and monitoring of HIV infection, information regarding support services, about treatment, about potential complications etc, and access to local support services.
- Concerns about doctor-patient communication and quality of services provided by the government, clinics, and NGOs are raised.
- The nature of support services should be aiming at resolving psychosocial and practical needs, instead of being “remedial services” only.

HIV antibody testing

- HIV antibody test should be recommended as one of the routine antenatal blood test like HbsAg, and VDRL. This will help to detect maternal infection early and decrease the chance of perinatal infection.
- Promote HIV testing to facilitate early detection and treatment.

Post-exposure prophylaxis

- Post-exposure prophylaxis should be extended to cover those who have exposed to unprotected sex, or in rape cases.

Training

- Awareness about HIV in health care workers should be raised to minimize discrimination. Public and private doctors should receive training in referral, clinical indication and awareness of the psycho/social dimensions of HIV infection.
- A more comprehensive programme with structured training can be designed to physicians who are keen in HIV/AIDS medicine, starting from HIV counseling, prevention, education to clinical management and therapeutics of AIDS patients, hospice care and acting as team leader in the working team.
- Education on medical students should be strengthened.

Policy, and patients' rights

Government policy

- The government should set a clear policy on AIDS.

Patients' rights

- The value of AIDS advocacy should be appreciated.
- There has been little effort to strengthen the networks of people living with HIV/AIDS, within the two main treatment centres, or within community-based organisations.
- The patient should have the right to choose the relevant treatment.

Programme structure and mechanisms

Coordination

- There should be more coordination among the service providers. Effective monitoring and evaluative mechanisms should be built in.
- The community needs a powerful AIDS council which does not only advise but has the authority to control budget and coordinate AIDS programmes.

NGOs

- Role of NGO needs to be examined.
- There needs to be greater collaboration between the government and NGOs on prevention and on the basis of equal partnership. There is a lack of overall – prevention strategy and little co-ordination between organisations.
- Government (DH/CEPAIDS) uses the expertise and service of NGO, but low recognition and no payment.

Private service provider

- Absence of privately run treatment units affected the choice of service users and service quality.

ACA

- The structure of ACA needs to be evaluated and / modified to maximize its effectiveness.
- Clear delineation of relationship between ACA and ATF.

Funding support

- Absence of long-term funding support for NGOs in Hong Kong, they have to spend a lots of efforts in raising funds to finance their programmes.
- It is timely to review whether the amount of resources put into this programme is appropriate, given the low number of people with HIV/AIDS in the past years compared to the nearby countries.
- There is insufficient transparency in the review process of the AIDS Trust Fund. Neither the decision making process of evaluating grant applications nor the criteria applied in this evaluation are clearly spelled out. Clear guidelines should be issued to applicants to minimize their frustrations and to ensure funds granted are used effectively.
- A lot of community-based programmes are threatened by inadequate funding. People are too anxious to look for money for the project rather than having enough time on the service.
- The funding mechanism of the AIDS Trust Fund is in serious need of revision. The current mechanism is to a large extent responsible for the sporadic and piecemeal nature of intervention work in Hong Kong. The danger is that intervention projects will be determined by what people think they can successfully secure funding. There are also concerns about the credentials of the members of the Council for the

AIDS Trust Fund, with some decision apparently being made on the basis of the moral opinions of Council members rather than on the basis of good public health strategy.

- Currently, funding support has been given to programme materials, with manpower or capital cost neglected. Most of the projects have then to rely on volunteer workers who

are usually unstable. Funding application creates unnecessary workload which affects the quality of service.

- The government should examine its commitment towards continuously sponsoring NGOs to run relevant AIDS programmes and services.
- Overall funding policy for various components of the AIDS programme by Government.
- Government to address issue of funding for clinical service for AIDS patients, especially anti-retroviral therapy.
- Low flexibility in the funding support, no subvention, cause great difficulty.
- AIDS Trust Fund causes misunderstanding to the community and difficulty to AIDS NGOs.

ACA secretariat

Review-survey part II

Revised. Apr 8, 98