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Legislative Council

LC Paper No. CB(2)523/03-04
(These minutes have been
seen by the Administration)

Ref : CB2/PL/HS

Panel on Health Services

Minutes of meeting
held on Monday, 10 November 2003 at 8:30 am
in Conference Room A of the Legislative Council Building

Members present	:	Hon Michael MAK Kwok-fung (Chairman) Dr Hon LO Wing-lok, JP (Deputy Chairman) Hon Cyd HO Sau-lan Hon CHAN Yuen-han, JP Hon Mrs Sophie LEUNG LAU Yau-fun, SBS, JP Hon Jasper TSANG Yok-sing, GBS, JP Dr Hon YEUNG Sum Hon Andrew CHENG Kar-foo Dr Hon LAW Chi-kwong, JP Dr Hon TANG Siu-tong, JP Hon LI Fung-ying, JP
Members absent	:	Dr Hon David CHU Yu-lin, JP Hon CHAN Kwok-keung, JP
Public Officers attending	:	All items Mrs Carrie YAU, JP Permanent Secretary for Health, Welfare and Food Dr Regina CHING Deputy Director of Health

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Item III

Dr KO Wing-man, JP
Director (Professional Services and Public Affairs)
Hospital Authority

Mr Alex CHOW
Acting Assistant Director (Existing Buildings)
Buildings Department

Mr HUNG Chi-pai
Assistant Director (Operations)
Food and Environmental Hygiene Department

Mrs Angelina CHEUNG
Assistant Director, Home Affairs Department

Mr Bay WONG
Assistant Director (Estate Management), Housing Department

Mrs Kathy NG
Assistant Director (Elderly), Social Welfare Department

Mrs D Y SIN
Principal Education Officer (Hong Kong)
Education and Manpower Bureau

Mr Nicholas CHAN
Assistant Secretary for Health, Welfare and Food (Health)

Items IV and V

Miss Angela LUK
Principal Assistant Secretary for Health, Welfare and Food

Dr Thomas TSANG
Consultant Community Medicine (Communicable Diseases)
Department of Health

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Clerk in attendance	**:**	Miss Mary SO Chief Assistant Secretary (2) 4

I. Information paper issued since the last meeting
(LC Paper No. CB(2)224/03-04(01))

Members noted the above information paper entitled "Fact sheet on organisations dealing with infectious disease prevention and control in selected places" prepared by the Research and Library Services Division of the Legislative Council Secretariat, and did not raise any query.

II. Items for discussion at the next meeting
(LC Paper Nos. CB(2)256/03-04(01) and (02))

2. Members agreed to discuss the following items at the next regular meeting scheduled for 8 December 2003 -

(a) Progress on registration of Chinese medicine practitioners, regulation of proprietary Chinese medicines and development of Chinese medicines outpatient clinics in Hong Kong;

(b) Regulation of health claims; and

(c) Additional funding covering Severe Acute Respiratory Syndrome (SARS) related expenses incurred from August 2003 up to March 2004.

3. Members further agreed that the issue of progress report on the granting of ex-gratia allowance under SARS Trust Fund, proposed by the Administration, be followed-up by the Panel on Welfare Services.

III. Checklist of Measures to Combat SARS
(LC Paper No. CB(2)256/03-04(03))

4. At the invitation of the Chairman, Permanent Secretary for Health, Welfare and Food (PSHWF) presented the Checklist of Measures to Combat SARS through a power point presentation, details of which were set out in the relevant booklet tabled at the meeting.

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5. Director (Professional Services and Public Affairs), Hospital Authority (Director, HA) also introduced HA's three-tiered response for infectious disease outbreaks and how it corresponded with the Government's three-level response system for SAR as follows -

HA's response for infectious disease outbreaks	Government SARS response
Tier-one response (Green) Hospital alerted to an abnormal pattern of infection in the community or inside the hospital system and when there were existing guidelines to knowledge on treatment and control, and local action was judged to be adequate.	
HA's response for infectious disease outbreaks	Government SARS response
Tier-two response (Yellow) An abnormal pattern of infection which might have territory-wide implications, or required an HA-wide response, e.g. laboratory-confirmed SARS outside Hong Kong.	Alert a) Laboratory-confirmed SARS cases outside Hong Kong.
Tier-three response (Red) The outbreak had widespread or prolonged territory-wide implications, e.g. SARS Alert and re-emergence of SARS.	Alert b) A SARS Alert* in Hong Kong. Response level 1 When there was one or more laboratory-confirmed SARS case(s) in Hong Kong. Response level 2 When there were signs of local transmission of SARS.

*Definition of a SARS Alert, as defined by the World Health Organization (WHO), is where two or more health care workers in the same ward/unit fulfilling the clinical case definition of SARS and with onset of illness in the same 10-day period; or hospital acquired illness in three or more persons (health care workers and/or other hospital staff and/or patients and/or visitors) in the same ward/unit fulfilling the clinical case definition of SARS and with onset of illness in the

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same 10-day period.

Preventive measures against SARS for residents of Residential Care Homes for the Elderly (RCHEs)

6. Dr LAW Chi-kwong said that on average, 2 000 elders died of pneumonia each year, mostly acquired at hospitals. Dr LAW pointed out that if on-site medical care could be provided to residents of RCHEs, this would greatly minimise their risk of contracting infectious diseases whilst seeking treatment at out-patient clinics. In the light of this, Dr LAW asked about the work which had been done by the Administration and HA in that regard.

7. Director, HA responded that outreach service of HA's Community Geriatric Assessment Teams (CGATs) had all along been providing comprehensive and multi-disciplinary assessment and management to elders living in residential settings. In order to prevent elders from contracting SARS during the SARS outbreak, support from CGATs had been strengthened in terms of professional advice on infection control and triaging of suspected case. Furthermore, private practitioners were recruited as Visiting Medical Officers (VMOs) to provide daily visits to designated homes for on-site management of episodic illnesses of residents. The purpose was to reduce avoidable hospital admissions. In view of the favourable feedback from participating private practitioners, home operators and CGATs for the VMO scheme during the SARS outbreak, a new CGAT/VMO collaborative scheme for implementation in RCHEs was introduced by HA to continue the partnership after the SARS crisis. Under the new collaborative scheme, VMOs, working under CGATs covering the corresponding districts, would provide regular on-site visits to RCHEs and manage episodic illness and subacute problems in elderly residents. Geriatricians would provide clinical supervision and specialist support to VMOs through clinical rounds, case conferences and tele-conferences. CGAT nurses would act as liaison between geriatricians, VMOs and RCHEs ensuring residents' accessibility to secondary and tertiary care when necessary.

8. Assistant Director (Elderly), Social Welfare Department (AD(E)SWD) supplemented that the new CGAT/VMO collaborative scheme for implementation in RCHEs had come into operation in October 2003. It was envisaged that through such a structured mechanism for referral and specialist support set up between CGATs and VMOs under the new CGAT/VMO collaborative scheme, the medical needs of RCHE residents could be better met than in the past. AD(E)SWD pointed out that although all RCHEs engaged private practitioners to take care of the medical needs of their residents, services provided by these private practitioners varied greatly from one home to another. For instance, some private practitioners only provided weekly visit to the homes for on-site management of

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episodic illnesses of residents, whilst others only provided the same on a bi-weekly basis. There were also the cases where some private home operators arranged the visiting doctors to conduct annual medical check-up for residents.

9. Dr LAW Chi-kwong remarked that the introduction of the new CGAT/VMO collaborative scheme for implementation in RCHEs was indeed a move in the right direction. Dr LAW however was of the view that it would be a more effective use of resources if money spent on remunerating VMOs were allocated to service recipients, say, the home operators or the elderly residents, who would be in a better position to judge whether the VMOs concerned could genuinely meet their medical needs. Dr LAW was also of the view that it would be a more efficient use of resources if VMOs were remunerated on the number of cases they handled rather than on an hourly basis.

10. Dr LO Wing-lok said that according to the feedback from the participants of the CGAT/VMO project implemented during the SARS outbreak, over 40% of home operators indicated that they were willing to purchase service from VMOs if there was sufficient backup by CGATs. In the light of this, Dr LO opined that it would not be a prudent use of resources for HA to foot the bill for those home operators who were willing to pay for the services provided by VMOs.

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11. PSHWF agreed to give the suggestions made by Dr LAW and Dr LO further thoughts.

Collaboration with the private health care sector

12. Ms LI Fung-ying enquired about the Department of Health (DH)'s collaboration with the private hospitals and medical practitioners to deal with possible resurgence of SARS.

13. Deputy Director of Health (DDH) responded that DH had held meetings with representatives of private hospitals in September and October 2003 to exchange views on ways to tighten collaboration in the prevention and early detection of SARS. To this end, private hospitals had agreed, amongst others, to submit to DH daily reports on patients with clinical or suspected SARS and on the number of health care workers reported sick with clinical or suspected SARS and acute respiratory illness. These daily reports received would be analysed by staff from the Disease Prevention & Control Division and by staff responsible for the registration and inspection of private hospitals, who would then jointly initiate appropriate follow-up action(s). Where necessary, private hospitals could submit urgent reports to DH via email, fax or telephone. To facilitate early detection and reliable testing of SARS, DH had agreed that its Public Health Laboratory Centre would provide public health laboratory consultation for private hospitals and

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SARS tests for private hospital patients with clinical indication for testing.

14. DDH further said that the same meetings had involved medical associations which represented large numbers of medical practitioners. To keep private medical practitioners, as well as dentists and Chinese medicine practitioners, abreast of the latest developments in the prevention and early detection of SARS, letters were regularly sent to inform them of the latest information on SARS. The updated clinical case definition of SARS developed by WHO was a case in point.

Surveillance of SARS

15. Responding to Ms LI Fung-ying's enquiry about the measures which would be taken by HA to deal with suspected SARS cases, Director HA said that the patients concerned would be isolated pending laboratory findings for SARS-coronavirus. Director HA pointed out that although the following clinical case definition of SARS had been further developed by WHO for public health purposes after the post-SARS crisis -

(a) A history of fever (≥38°C); and

(b) One or more symptoms of lower respiratory tract illness (cough, difficulty in breathing, shortness of breath); and

(c) Radiographic evidence of lung infiltrates consistent with pneumonia or respiratory distress syndrome (RDS) or autopsy findings consistent with the pathology of pneumonia or RDS without an identifiable cause; and

(d) No alternative diagnosis that could fully explain the illness,

a patient fulfilling such definition would not be confirmed as with SARS until his/her case was supported by positive laboratory findings for SARS-coronavirus. In the light of this and the fact that many influenza-like illnesses (ILIs) and pneumonia had symptoms similar to that of SARS, patients who did not completely fulfill the clinical case definition of SARS but still considered to be highly likely of SARS on clinical judgement would be isolated. With the completion of alteration and addition works in nine acute hospitals to enhance their facilities for handling probable and suspected SARS patients, each suspected SARS patient would be put in an isolation room by himself/herself as far as possible. If a suspected SARS patient was subsequently confirmed with SARS, the full infection control guidelines for SARS, including use of enhanced personal protection equipment (PPE) and restriction of visiting would be put back in force.

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As for those patients diagnosed to have infected with ILIs, they would be discharged immediately to recuperate at home.

16. PSHWF supplemented that when there was one or more suspected SARS case(s) in Hong Kong, corresponding preventive actions would be taken by the Administration at the community level. These would include measures such as disinfecting the building which the patient concerned lived and requiring persons who had come into close contact with the patient concerned to undergo home confinement, etc.

Government's Three-level Response System to combat SARS

17. Mr Andrew CHENG expressed concern about the absence of an objective definition on signs of local transmission of SARS by which Level 2 Response would be activated by the Government. Mr CHENG urged that this deficiency be rectified, to avoid the recurrence of the argument as to whether the disease had spread to the community in mid-March 2003 in Hong Kong, and to ensure that appropriate infection control and public health measures were implemented. Mr CHENG further said that the duties of the Steering Committee to steer Government actions during a Level 1 outbreak should include assessing whether Level 2 Response should be activated, and that a person or person(s) should be appointed for making such a decision. In his view, the Secretary for Health, Welfare and Food (SHWF), who would chair the Steering Committee to steer Government actions during a Level 1 outbreak, was a suitable candidate. Mr CHENG also queried why the Chief Executive of HA, who was a core member of the Steering Committee to steer Government actions during a Level 1 outbreak, was not a member of the Steering Committee to steer Government actions during a Level 2 outbreak. Neither was the Secretary for Economic Development and Labour (SEDL), despite the fact that one of the duties of the Steering Committee to steer Government actions during a Level 2 outbreak was to assess the socio-economic impact of the crisis on Hong Kong and make decisions on the measures to minimise the impact.

18. PSHWF agreed that it would be useful to have a definition of signs of the local transmission of SARS, along the detail presentation adopted by WHO for definition of a SARS Alert. However, as there was no consensus amongst the health care community on the definition of local transmission of SARS, more time would be needed for the Administration to discuss with HA and other experts on coming up with such a definition. PSHWF further agreed that the duties of the Steering Committee to steer Government actions during a Level 1 outbreak should include assessing whether Level 2 Response or alert level (b) response should be activated, and that SHWF should be the person responsible for making such decisions. As regards the suggestions of including the Chief Executive of HA

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and SEDL as members of the Chief Executive (CE)'s Steering Committee, PSHWF said that the Administration would review the composition of the Chief Executive's Steering Committee in light of the suggestions raised. PSHWF however pointed out that the two Steering Committees to be established to steer Government actions during Level 1 and Level 2 outbreaks could both co-opt other senior officials and non-Government experts as circumstances warranted.

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19. Dr LO Wing-lok said that he did not understand why PSHWF said that there was no definition of signs of local transmission of SARS. According to WHO, local transmission of SARS occurred when one or more reported probable case of SARS most likely acquired their infection locally regardless of the setting in which this might have occurred. Moreover, there were three patterns of local transmission of the disease as follows -

(a) Pattern A

Imported probable SARS case(s) had produced only one generation of local probable cases, all of whom were direct contacts of the imported cases;

(b) Pattern B

More than one generation of local probable SARS cases, but only amongst persons that had been previously identified and followed-up as known contacts of probable SARS cases; and

(c) Pattern C

Local probable cases occurring amongst persons who had not been previously identified as known contacts of probable SARS cases.

20. Dr LO further said that the Government's three-level response system was confusing to the public because it was in effect a four-level response system, i.e. alert level (a), alert level (b), Level 1 Response and Level 2 Response. In the light of this, Dr LO suggested re-naming them to alert level 1, alert level 2, alert level 3 and alert level 4. PSHWF agreed to consider the suggestion.

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21. Ms Cyd HO queried the need for establishing the CE's Steering Committee as many of its duties, such as directing the mobilisation of resources and urgent legislative amendments, would invariably require the approval of the Executive Council (ExCo). Noting that the CE's Steering Committee would direct urgent legislative amendments, Ms HO sought clarification on whether the Director of Health (D of Health) would in future be taken away the power to invoke public

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health legislation for the closure of hospitals and quarantine of residential areas, etc.

22. PSHWF responded that establishing the CE's Steering Committee to steer Government actions during a Level 2 outbreak would allow greater flexibility in managing the SARS crisis. Not only could the CE's Steering Committee co-opt other senior officials and non-Government experts as circumstances warranted, it could convene meetings as and when needed without the restraints of ExCo which had fixed meeting dates and would be in recess, say, during the summer time. For important policy decisions and enactment of legislation which required the approval of ExCo, the CE's Steering Committee could bring these matters up for discussion at the regular Tuesday meetings of ExCo when it was in session. Where this not possible, a special ExCo meeting could always be held as circumstances warranted. PSHWF further said that D of Health would continue to be the sole authority to exercise the public health legislation, as practised in overseas jurisdictions. PSHWF pointed out that both CE and SHWF were aware of the exercise of relevant powers by D of Health.

Engaging the community

23. Ms Cyd HO was of the view that the Administration should appoint a body to pool resources from the community and co-ordinate these resources with that of the government departments in combating SARS. Ms HO pointed out that the lack of such a body during the outbreak in Hong Kong from March to June 2003 had resulted in a lot of resources being wasted or not efficiently utilised. PSHWF surmised that the Social Welfare Department (SWD) might be in the best position to take up such a task. However, the Administration would need to further examine whether SWD would have the capacity to take up such additional workload in the course of combating SARS.

Preparedness for possible resurgence of SARS

24. Miss CHAN Yuen-han asked HA whether it was fully prepared for an onslaught of SARS which could return to Hong Kong at any time, in terms of PPE supply, infection control facilities and staff training.

25. Director, HA responded that most of the stage one alteration and addition works in nine acute hospitals to enhance their facilities for handling probable and suspected SARS patients had been completed. In regard to PPE, Director, HA said that HA had built up a three-month stock of PPE for most items equivalent to three times the peak monthly consumption during the last SARS outbreak. Additional suppliers for items likely to be in short supply, such as small size N95 Respirators, were being sourced. As to staff training, Director, HA said that

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basic training in infection control for front-line staff, in particular supporting staff (including contractors' staff), had been and would continue to be conducted to ensure they had an understanding of fundamental epidemiology and public health principles. So far, over 10 drills had been conducted in the public hospital setting to facilitate thorough understanding of the emergency response plans, to familiarise the various parties with the work procedures and to identify room for improvement. Plan was also at hand to train medical professionals in field epidemiology, virology and microbiology, which however would take a longer time to attain results. In addition, HA had allocated funds to each cluster for setting up Resource Centres where staff could access to obtain information on infection control, such as proper use of PPE.

26. Director HA further said that apart from the enhancement of the hardware and software mentioned in paragraph 25 above, HA had also enhanced its infectious disease surveillance through surveillance of sickness amongst health care workers in HA hospitals and surveillance of clustering of symptoms in RCHEs and other residential institutions. In respect of the former, all staff were required to report sick leaves or off work due to illness and the associated symptoms such as fever, running nose, sore throat, cough, myalgia chill, diarrhoea or abnormal chest X rays, to their workplace supervisors. In respect of the latter, the Accident and Emergency Departments of HA would collate, on a daily basis, data for attendance from RCHEs and other residential institutions presented with pneumonia for screening by the respective CGATs and Hospital Infection Control Officers. VMOs, through enhanced support from CGATS, would closely monitor respiratory illnesses amongst residents of RCHEs.

27. Miss CHAN Yuen-han said that apart from firming up the framework on infection control, HA should not overlook the details. For instance, during the last SARS outbreak, many health care workers contracted the disease whilst working in areas not considered high risk by HA and due to absence of facility to wash their hands immediately after caring for SARS patients.

28. Director, HA assured members that this would not be the case, as HA would continue to fine-tune its infection control procedures as it gained more knowledge of the disease and on infection and outbreak control.

Hospital mobilisation plan

29. Miss CHAN Yuen-han was of the view that given the proximity of the North District Hospital (NDH) to the boundary, it, instead of the Alice Ho Miu Ling Nethersole Hospital (AHNH), should be the designated hospital in the New Territories East (NTE) cluster to take in confirmed and suspected SARS patients entering Hong Kong from the Mainland.

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30. Director HA responded that the reason for designating AHNH as the receiving hospital to take in confirmed and suspected SARS patients in the NTE cluster was due to its more comprehensive services and close proximity to the railway station. Although NDH was located closest to Lo Wu, Lo Wu was not the only land border. Director HA further said that with the enhanced collaboration with the Mainland health authorities on surveillance of infectious diseases, including SARS, coupled with WHO's advice that each territory should ensure there was no exportation of confirmed or suspected SARS cases, it was envisaged that the number of such cases imported from the Mainland to Hong Kong should not be significant.

Others

31. Dr YEUNG Sum welcomed the Checklist of Measures to Combat SARS, and urged the Administration and HA to brief members on the progress made periodically.

IV. Collaboration on infectious disease surveillance among Guangdong Province, Hong Kong and Macao

(LC Paper No. CB(2)256/03-04(04))

32. DDH took members through the collaboration on infectious disease surveillance amongst Guangdong Province, Hong Kong and Macao, details of which were set out in the Administration's paper.

33. Noting that the Guangdong Province, Hong Kong and Macao had agreed to enhance prompt reporting to the two other places sudden upsurge of any infectious diseases of unknown nature or of public health significance, Dr LAW Chi-kwong asked whether there was any objective criteria for such reporting to be made.

34. DDH explained that sudden upsurge of any infectious diseases of unknown nature or of public health significance generally referred to abnormal pattern of infection in the community. Dr LAW considered such an arrangement of solely depending on the subjective judgment of each place to determine when to report to the other two places sudden upsurge of any infectious diseases of unknown nature or of public health significance unacceptable. Dr LAW was adamant that there should be clear and objective criteria in place, so that each place would know when it was required to report to the other two places of any sudden upsurge of any infectious diseases of unknown nature or of public health significance. For without which, authorities concerned might withhold from making such report to the other sides because of political and/or economical considerations. DDH

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responded that criteria for reporting were laid down in the agreement on the collaboration on infectious disease surveillance amongst the three sides. At the request of Dr LAW for a copy of the tripartite agreement, PSHWF said that she would need to seek consent from the authorities concerned in Guangdong Province and Macao before releasing the agreement to members.

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35. Mrs Sophie LEUNG said that DH should adopt a proactive and investigative approach, as practised by Centre for Disease Control-type of organisations, by exploring all possible channels to collect information/intelligence about any unusual pattern of infection in the Mainland and elsewhere, instead of merely relying on information coming from official sources. To this end, DH should, for instance, encourage medical practitioners, who had liaison with their Mainland counterparts, to come forward to report to DH if they got wind of any unusual pattern of infection in the Mainland. Mrs LEUNG pointed out that if this had been done by DH in the past, the SARS outbreak in Hong Kong might have been ameliorated. This was because some doctors in Hong Kong already knew about the atypical pneumonia outbreak in some areas of Guangdong Province through their Mainland counterparts, long before such an outbreak was officially announced by the health authorities in Guangdong in mid-February 2003.

36. DDH responded that recognising new disease threats and identifying serious outbreaks would be enhanced through the partnerships to be established with the health care professionals, community, academics, government departments, national and international authorities in the control of communicable diseases under the planned Centre for Health Protection. This would be further strengthened by the implementation of the recommendations of the SARS Expert Committee on surveillance, information and data information.

37. Consultant Community Medicine (Communicable Diseases), DH, supplemented that DH staff had been adopting a more proactive and investigative approach in collecting information/intelligence about any unusual pattern of infection in the Mainland and elsewhere, since the SARS outbreak in Hong Kong. For instance, apart from liaising with official bodies for information of unusual pattern of information in their jurisdictions and elsewhere on a daily basis, DH staff also searched for new disease threats and signs of infectious disease outbreaks from unofficial sources, for instance, on the internet and media. If there were reports of unusual outbreaks occurring in the Guangdong province, DH would make use of the point-to-point information exchange mechanism agreed by the three sides to find out more information about the incident. In a recent example, DH staff visited Guangdong on-site to learn more about the Japanese encephalitis situation there.

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38. Dr LO Wing-lok echoed views similar to that expressed by Dr LAW Chi-kwong and Mrs Sophie LEUNG in paragraphs 33 and 35 above. Dr LO further said that one way to widen the intelligence network on infectious diseases was to invite experts from the private sector of the three places to also attend expert group meetings organised by the health authorities of the three places, so as to enable experts from the private sector to also establish a point-to-point information exchange mechanism. Dr LO also said that one way to define sudden upsurge of any infectious diseases of unknown nature or of public health significance was, say, when there was a clustering of people/animals suffering from a same ailment on the same day or there was a clustering of deaths in animals/plant occurred on the same day, etc. DDH agreed to consider the suggestions raised by Dr LO.

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V. The adolescent health programme of the Department of Health
(LC Paper No. CB(2)256/03-04(05))

39. DDH introduced the Administration's paper detailing the latest development of the outreaching adolescent health programme (AHP) of DH.

40. Ms Cyd HO expressed concern about the proliferation of programmes carried out as extra-curricular activities to help students lead healthy lifestyles, which would invariably add to the already very workload of teachers and take away students' time for playing and resting. In the light of this, Ms HO said that themes covered by these programmes should be incorporated into the syllabus of the language subjects taught in classes, as practised in some overseas countries. She requested DH to convey such to the Education and Manpower Bureau (EMB) for consideration.

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41. PSHWF undertook to convey Ms HO's suggestion mentioned in paragraph 40 to EMB for consideration. PSHWF however pointed out that AHP would not create additional workload to teachers, as AHP was delivered by DH staff. Ms HO remarked that despite such, teachers were still required to stay with their students whilst the latter was attending an AHP activity.

42. Mr Andrew CHENG expressed support for AHP, and suggested that encouraging students to participate in sporting activities should be included as one of the core components of the "Basic Life Skills Training (BLST)" programme under AHP.

43. Ms LI Fung-ying noted that AHP had been highly rated by students with satisfaction level of 70-80%. Ms LI asked whether any evaluation of AHP had been conducted by the participating schools to assess the benefits to their students who had participated in the Programme.

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44. DDH responded that the evaluation of AHP was conducted by DH in collaboration with the University of Hong Kong using an objective and scientific methodology. In a pilot project conducted in 2001 involving 14 schools, students receiving AHP significantly fared better. The evaluative study revealed that 70-80% of students who had participated in AHP were satisfied with the Programme. The health-related knowledge of students who had participated in AHP had greatly increased one year later, and were better than those of the students who had not participated in AHP. Moreover, students who had participated in AHP were generally found to be better behaved and have a more positive attitude to life than students who had not participated in AHP.

45. Dr LO Wing-lok expressed support for AHP, as adolescents were more receptive to encouragement than discipline. Nevertheless, the fact that topics covered by the BLST programme, such as helping students to know the importance of and skills in objective analysis in decision-making, to value time and learn skills in efficient time management and to value money and learn skills in handling money more appropriately, did cast doubt on the education system as such fundamental knowledge and skills should have been indoctrinated into students since their kindergarten schooling.

46. DDH agreed that adolescents should have exposed to the subject matter covered by the BLST programme from their parents and teachers. However, in view of the fact that adolescence was a period of rapid physical, psychological, social and intellectual development, as well as a time when health-compromising behaviour were prone to occur, adolescents could still benefit from a tailor-made programme developed by trained AHP staff.

47. Miss CHAN Yuen-han shared the views expressed by Dr LO Wing-lok and Mr Andrew CHENG in paragraphs 45 and 42 above, and considered that DH should collaborate with EMB on implementing AHP. Miss CHAN then asked why DH implemented AHP. Noting that AHP was targetted at Forms 1 to 3 students, Miss CHAN wondered whether this was because it was easier to reach out to adolescents at schools. Miss CHAN hoped that consideration could be given to extending AHP to disadvantaged youths, such as those who were new arrivals and those who had left schools and were unemployed.

48. DDH responded that as a health advocate, it was incumbent upon DH to implement AHP which aimed at improving the physical and psychosocial health of adolescents. DDH further said that AHP targetted Form 1 to 3 students with active involvement from school staff. DH strongly encouraged active participation of teachers, school social workers, parents and relevant government departments in AHP. By sharing manuals and activity kits, AHP staff worked

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closely with school staff in running the programmes. This facilitated transfer of skills which in turn would make it easier for the programme to be integrated into the school curriculum. Moreover, teachers could reinforce key messages at appropriate times and might organise extended activities matching various themes of AHP.

49. Mrs Sophie LEUNG was of the view that more work should be done to help adolescents to know the importance of setting practicable goals in life, for without which their chance of leading a healthy and meaningful life would be compromised. Mrs LEUNG was also of the view that DH should collaborate with EMB on implementing AHP.

50. There being no other business, the meeting ended at 10:50 am.

Council Business Division 2
Legislative Council Secretariat
9 December 2003