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For Information
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Legislative Council Panel on Health Services

HIV and AIDS Response Measures Formulated in relation to the Recommended HIV/AIDS Strategies for Hong Kong (2017-2021)

PURPOSE

This paper briefs Members on the HIV situation and local response in Hong Kong in relation to the "Recommended HIV/AIDS Strategies for Hong Kong (2017-2021)" ("the Strategies") issued in May 2017.

BACKGROUND

2. Hong Kong reported its first case of HIV infection in 1984. Since then, designated clinics have been set up at Queen Elizabeth Hospital ("QEH"), the Department of Health ("DH"), and Princess Margaret Hospital ("PMH"), providing treatment services for HIV infected patients. The DH has also been responsible for providing prevention and testing services, as well as disease surveillance to closely monitor the HIV epidemic in Hong Kong. The situation of HIV infection formed the basis for the development of the Strategies by the Hong Kong Advisory Council on AIDS ("ACA"), and funding allocation of HIV projects by the Council for the AIDS Trust Fund ("ATF").

The HIV situation in Hong Kong

3. The annual number of newly reported HIV infections increased from 7 cases in 1984 to almost 700 in 2016. Regarding the route of transmission, an increasing proportion of cases involving men who have sex with men ("MSM") who acquired the infection through homosexual contact has been observed since 2004. In contrast, the proportion of heterosexual transmission has continued to drop. Figures showing the annual HIV/AIDS statistics and the route of transmission are at **Annex I**. Of all age groups, those aged 20-29 accounted for

the greatest proportion of MSM in recent years. Tables summarising the age distribution of HIV infection transmitted through homosexual and heterosexual contact in Hong Kong from 2010 to 2016 are at **Annex II**.

4. Community-based surveys conducted by DH showed that HIV prevalence of the MSM community was 5.86% in 2014, which was 58 times higher than the 0.1% of the general population. A table summarising the results of the community-based surveys is at **Annex III**.

Hong Kong Advisory Council on AIDS

5. The ACA was established by the Government in 1990 as a permanent, non-statutory body to provide advice on policy relating to the prevention, care and control of HIV infection in Hong Kong. It comprises members drawn from different sectors of society, including community leaders, health professionals and representatives of Government departments so that more comprehensive views can be collected. The Special Preventive Programme ("SPP") of DH is its secretariat. The ACA Membership list is at **Annex IV**.

6. One major task of ACA is to issue the Strategies every five years. It serves as a blueprint for a coordinated and consolidated response to the growing HIV epidemic. The whole community, including the government, non-governmental organisations ("NGOs"), the commercial sector and general public are called on to take actions accordingly.

The RECOMMENDED HIV/AIDS STRATEGIES FOR HONG KONG (2017-2021)

7. The Strategies was issued on 22 May 2017 by the ACA. During the formulation process, ACA took into account the local HIV situation, local HIV response, scientific developments on HIV, recommendations of international health agencies, and opinions of stakeholders and the general public. The Strategies, as well as the report of community stakeholders' consultation, and a supplement explaining the rationales of setting the objectives and targets with discussion on controversial issues, is available on-line (http://www.aca.gov.hk). A summary of the Strategies is at **Annex V**.

HIV AND AIDS RESPONSE MEASURES IN HONG KONG

8. The Strategies issued by the ACA provides a clear direction and targets for different parties of the community to follow. The major players will be DH, Hospital Authority ("HA"), Council of ATF and AIDS NGOs. However, the private health sector, academia, other government policy and bureau, as well as society at large should also be involved.

9. While DH and HA are financed directly by the Government, AIDS NGOs, to varying extents, obtain their resources by applying to ATF for specific programmes and projects. In their vetting process, ATF makes general reference to the recommendations of the Strategies to prioritise applications.

10. The Government has begun implementation of various measures to control the HIV epidemic since the 1980s. Nowadays, a comprehensive HIV/AIDS response exists which comprises (a) education and health promotion, (b) disease prevention, (c) HIV testing and self-testing, (d) HIV treatment and support services, (e) continuous monitoring of the HIV epidemic, and (f) funding and resources.

(a) Education and health promotion

(i) HIV and sex education in schools

- As confirmed with the Education Bureau (EDB), sex education is an integral part of the school curriculum in Hong Kong. Related knowledge, skills, values and attitudes are incorporated into the relevant Key Learning Areas ("KLAs") or subjects. As such, elements of sex education are embedded in various subjects, including General Studies in primary schools, as well as the Biology, Ethics and Religious Studies, Life and Society and Liberal Studies curricula in secondary schools. For example, knowledge of HIV and sexually transmitted infections is usually covered under Biology while respecting people with different sexual orientations is covered under Moral and Civic Education and other related KLAs or subjects, with an aim to developing students' knowledge, skills, values and

attitudes. Schools will make reference to the EDB's related curriculum guides and documents to plan their school-based sex education curriculum and organise related learning activities by taking into consideration the school contexts.

- In 2013, ACA formed a Task Force to coordinate a territory-wide baseline survey with the participation of EB and DH. It aimed to assess HIV education in lower secondary levels. Results showed that coverage of HIV education was high -
  - 91.7% of the responding schools had covered HIV education through KLAs/subject (i.e. traditional curriculum), with 80.8% using the life skills-based approach;
  - Around 70% included the message of "use condom to prevent HIV infection";
  - 67% had invited NGOs to conduct in-school HIV education; and 46% had invited DH; and
  - 66% had had training of their teachers by EB, NGOs or DH on HIV related knowledge.

- Over the years, DH has also been directly involved in sex education in primary and secondary schools. It provides educational information and organises promotional programmes on sex education to students through various means, including health talks about puberty at the Student Health Centres, interactive school-based programmes on sex education through its Adolescent Health Programme, life skills-based education on HIV and student-led HIV campagins in secondary schools led by SPP, as well as online resources on sex education. Regular revision is conducted to update the content and teaching approach to address the needs of students. Since 2013, SPP has started to screen HIV-related films in eight tertiary institutions for educational purpose. In addition, training seminar on preventing sexually transmitted diseases and AIDS for teachers is held every year by the EDB. During the seminar, SPP would describe the local HIV situation, and the NGOs would share their experiences in supporting schools to

implement sex education.

(ii) Health promotion for specific populations

- In recent years, the DH has increasingly targeted MSM for HIV prevention. Educational materials with messages on safer sex and annual testing are distributed during gay events, including Pink Dot Hong Kong, Hong Kong Gay & Lesbian Film Festival ("HKGLFF") and Hong Kong Pride Parade. HIV-related films were screened during HKGLFF and advertisements were launched in gay social networking apps and other social media. A designated mobile app "1069 Test finder (1069 試戴樂)", the website www.21171069.com and on-line short videos were also produced, with invited input from young MSM to ensure that they would be appealing to this important subgroup. Mass media campaigns were conducted when deemed necessary. (e.g. "Be Negative Campaign" in 2014).

- On the other hand, NGOs' projects targeting key populations are usually more personal in nature, client-oriented or aiming at psychosocial support. One-on-one peer counselling, health talks and supporting groups are common. Projects that target young MSM and the priority areas specified by the Strategies are generally given priority in applications to ATF.

(iii) Public education

- Publicity campaigns on safer sex, HIV testing, and acceptance of PLHIV have been held by DH in various public venues including borders, parks, etc. Messages to this effect have been advertised on public transport such as Mass Transit Railway, trams, and buses. Announcements of public information (30-second advertisements) have also been produced and broadcast on different mass media.

(b) **Disease prevention** - As of now, the latex male condom and oral anti-retrovirals (anti-HIV medication) are scientifically proven to be

the most effective ways of HIV prevention.

(i) Condom distribution

- For years, the DH has been distributing free male condoms to key populations and venues frequented by them, such as gay bars and saunas, to ensure their easy access to this important means of prevention. Free condoms are also given to NGOs for their further distribution. Since 2013, DH has extended free condom supply to eight tertiary institutions. The total number of condoms distributed by DH was 984,000 in 2010 and 1,006,100 in 2016.

- Many projects conducted by NGOs also consist of condom distribution. NGOs are often able to reach the hard-to-reach populations, such as non-venue going MSM, male-to-female transgender ("TG"), female sex workers ("FSW"), sex worker clients and EM. Regular surveys are conducted by DH to monitor access to free condoms by different key populations (MSM: 42.1%, TG: 64.4%, PWID: 78.3% (2016); FSW: 86%, male clients of female sex workers ("MCFSW"): 40% (2015)).

(ii) Treatment as prevention

- Anti-retroviral treatment is not only highly effective for medical treatment of patients but also capable of preventing further transmission from them. In recent years, the coverage of patients on treatment has quickly increased, so much so that over 90% of active patients in Hong Kong, regardless of disease stage, are now on treatment. This would help decrease the further spread of HIV from known diagnosed patients.

(iii) Pre-exposure prophylaxis ("PrEP")

PrEP is the daily use of the anti-HIV medication of tenofovir and emtricitabine to prevent the acquisition of HIV infection by uninfected persons. Overseas clinical

trials have shown that PrEP is effective in preventing HIV infection with effectiveness reaching 86% in high risk populations. Its real world effectiveness and risks, however, will be subject to the inherent risk levels of the users (generally should be offered to those with an annual risk of more than 3%), their adherence to the prescription, risk compensation (increased risk behaviour with the use of PrEP), and compliance with medical follow up. Overseas implementation studies to date have shown diverse results in terms of recruitment and drug adherence.

- In response to the recommendation of the Strategies, ATF recently approved the first PrEP study in Hong Kong, which was conducted by a local university. The study delivers heavily subsidised PrEP to high risk MSMs and assesses their acceptability, adherence and risk behaviour. In order to enhance understanding of PrEP, the DH has made information available on line regarding its proper use.

(iv) Post-exposure prophylaxis ("PEP")

- PEP is available in Accident and Emergency Departments of all public hospitals for prevention of HIV after suspicious exposure. Guidelines are also in place for PEP after occupational (health-care related) exposure. However, previous position statement by the Scientific Committee on AIDS and STI ("SCAS") under the Centre for Health Protection did not support the routine use for non-occupational exposure as, for example, in sexual contact. As recommended by the Strategies, the Committee plans to review its position and relevant guidelines in 2018.

(c) **HIV testing and self-testing**

(i) The DH has been providing free, anonymous and confidential HIV testing for the public since 1980s via its AIDS Hotline. Booking can be made by phone or on line. Since the 1990s, NGOs also provided HIV rapid tests (finger pricking) with

confirmation of test results by DH when necessary.

(ii) Studies have shown that HIV self-testing can help expand testing coverage to those who have never been tested and those who test only infrequently. Self-test kits are available over the counter in Hong Kong. In recent years, some NGOs have launched self-testing projects with the support of ATF, or as research projects in collaboration with local universities. In the coming future, DH plans to build on these efforts to promote the proper use of self-HIV tests, including the efficient referral of those who test positive for counselling, confirmation and care.

(d) **HIV treatment and support services**

(i) Outpatient HIV care is mainly provided by the Integrated Treatment Centre of DH, and QEH and PMH of HA. Most public hospitals are capable of providing inpatient care for HIV related complications, while complicated cases are managed by QEH, PMH, and Prince of Wales Hospital.

(ii) With the use of effective HIV treatment, the health status and the life span of PLHIV have been greatly improved. Treatment is provided to all patients regardless of disease stage. This has the added benefit of preventing further transmission. The fee charged for eligible persons is the same as that of other specialist clinics in public hospitals at a rate of HK$15 for each medication per 16 weeks.

(iii) In the course of HIV disease, opportunistic infections, co-infections, and co-morbidities may occur. A multi-specialty and multi-disciplinary team approach is therefore adopted. Collaboration with NGOs and other para-medical teams are also in place to strengthen support for the psychosocial needs of patients. This improves their retention to care, drug adherence and quality of life.

(e) Continuous monitoring of the HIV epidemic

(i) The HIV Reporting System under DH has been in place since 1984 for collecting data of HIV infection cases. Apart from that, DH has been collaborating with NGOs in yearly community-based surveys for key populations to monitor their risk behaviours and HIV prevalence. Every year, DH meets with its Mainland counterparts to share information on HIV situation and experience of controlling HIV. Regional conferences are held by academics and NGOs with overseas speakers on update developments of HIV control in other countries.

(ii) Clinical and behavioural studies conducted by local universities help inform development of public health programmes. Results of some of the studies are presented and reviewed at the meetings of the SCAS and ACA. In response to the recommendations of the Strategies, ATF will accord priority to approval of operational research and socio-behavioural studies on key populations with suboptimal access to HIV services and drug abusers.

(f) Funding and resources

(i) ATF makes reference to recommendations of the Strategies in assessing project applications and in according resources to different key populations. From October 2012 to September 2017, ATF accorded the largest amount of resources to MSM (41%), followed by PLHIV (24%). This was in line with the Strategies for the period. Funding to other populations included: PWID (7%), sex workers (5%), MCFSW (4%) and multiple high risk groups (8%). Furthermore, resources have also been provided to other populations (11%), including prisoners, the deaf and mute, EM, general public, etc.

(ii) In view of the often rapid changes of the HIV epidemic and scientific developments, ATF Secretariat and SPP of DH hold regular meetings to discuss the HIV situation and the imminent needs of the community. ATF will adjust its

prioritisation and funding allocation if necessary.

Council for the AIDS Trust Fund

11. The ATF was established by the Government in 1993 with a sum of $350 million to provide funding to assist the HIV-infected haemophiliacs and to strengthen medical and support services, public education on AIDS as well as to support research applications from academics. In December 2013, another $350 million was injected. It was anticipated to support the funding applications for seven to twelve years as approved by the Finance Committee.

12. The ATF received project applications from organisations to conduct HIV related projects. Every application shall undergo a three-tier vetting process, including (i) assessment by the Technical Review Panel and invited reviewers; (ii) deliberation at Subcommittees and (iii) final approval by the Council. The process ensures that only projects that are of sound design, cost-effective and targeting the needs of the current HIV situation would be approved and funded.

13. From October 2012 to September 2017, a total of 131 projects with 142 million funding support were granted by ATF. MSM was the largest funded key population (41%), followed by people living with HIV ("PLHIV") (24%), people who inject drugs ("PWID") (7%), sex workers (5%), male client of female sex worker ("MCFSW") (4%) and multiple high risk groups (8%). Furthermore, resource also provided to other populations (11%), including prisoners, the deaf and mute, ethnic minorities ("EM") and general public. The above funding supported a total of 36 organisations, including 25 NGOs, 8 academia, 2 governmental units and one public hospital.

ADVICE SOUGHT

14. Members are invited to note the content of this paper.

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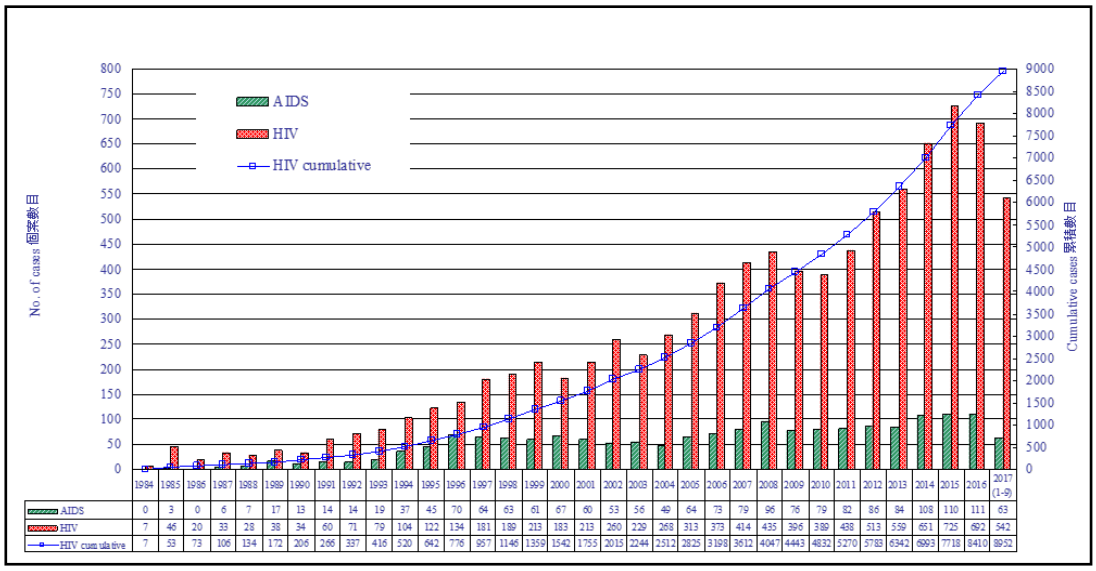
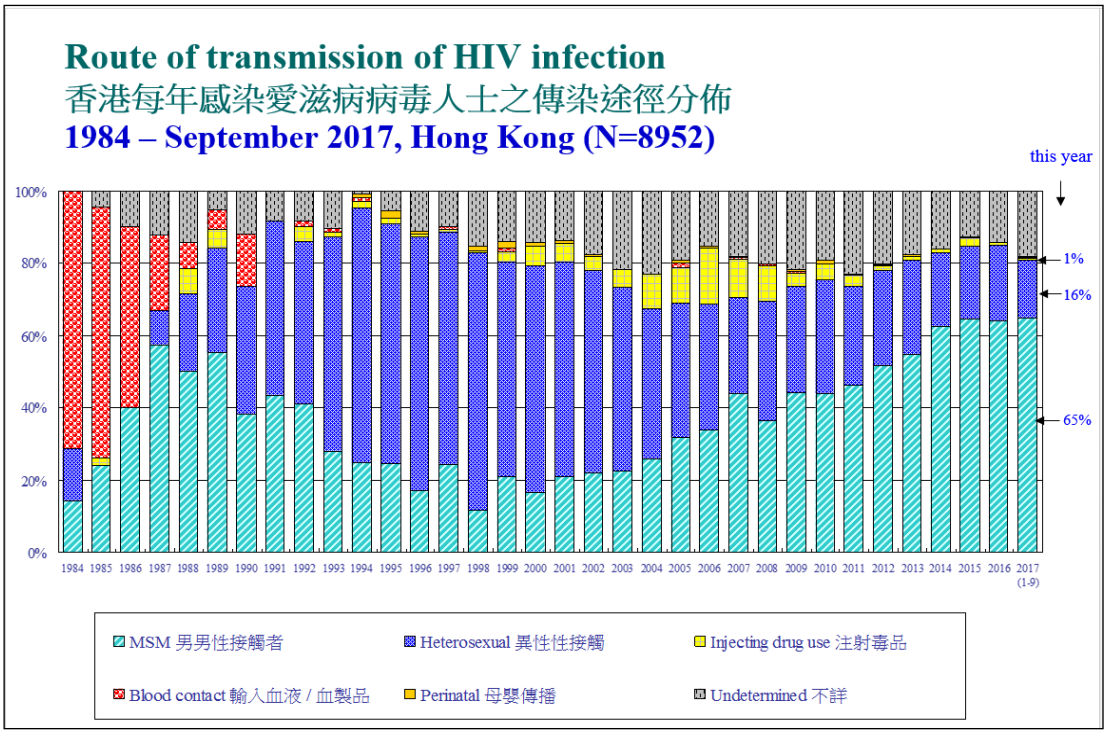
Annex I

Annual HIV/AIDS statistics



	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017 (1-9)
AIDS	0	3	0	6	7	17	13	14	14	19	37	45	70	64	63	61	67	60	53	56	49	64	73	79	96	76	79	82	86	84	108	110	111	63
HIV	7	46	20	33	28	38	34	60	71	79	104	122	134	181	189	213	183	213	260	229	268	313	373	414	435	396	389	438	513	559	651	725	692	542
HIV cumulative	7	53	73	106	134	172	206	266	337	416	520	642	776	957	1146	1359	1542	1755	2015	2244	2512	2825	3198	3612	4047	4443	4832	5270	5783	6342	6993	7718	8410	8952

Route of transmission of HIV infection



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Annex II

Age distribution of HIV infection transmitted through homosexual contact between men in Hong Kong, 2010-2016

Age group	Year						
	2010	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
< 10	0	0	0	0	0	0	0
10 - 19	3	4	5	3	11	20	8
20 - 29	37	57	79	104	177	184	167
30 - 39	60	56	87	101	110	146	132
40 - 49	48	58	72	72	72	78	79
50 - 59	16	17	15	16	24	34	39
60 - 69	4	8	5	8	9	5	12
>= 70	2	1	2	1	2	1	4
Unknown	0	1	0	0	0	0	0
Total	170	202	265	305	405	468	441

Age distribution of HIV infection transmitted through heterosexual contact in Hong Kong, 2010-2016

Age group	Year						
	2010	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
< 10	0	0	0	0	0	0	0
10 - 19	1	0	2	1	0	2	0
20 - 29	23	19	17	26	16	14	17
30 - 39	46	42	44	45	48	42	53
40 - 49	32	34	42	37	34	49	36
50 - 59	11	13	12	20	20	23	23
60 - 69	6	10	8	11	13	13	10
>= 70	5	2	10	6	2	3	7
Unknown	0	0	0	0	0	0	0
Total	124	120	135	146	133	146	146

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Annex III

Results of the community-based surveys

Populations	**HIV prevalence**	**Source**
General population	0.1%	HIV surveillance Report 2015
MSM	5.86%	HARiS 2014
Male-to-female transgender (TG)	18.6%	HARiS 2014 [Note 1]
Female sex workers	0.0%	HARiS 2013 [Note 2]
People who inject drugs	1%	HIV surveillance Report 2015

Note 1. Small sample size with 43 urine specimens collected.

Note 2. No HIV infection among 605 urine specimens collected.

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Annex IV

ACA Membership

Post	Name in English	Name in Chinese
Chairperson	Dr LI Chung-ki, Patrick, BBS, JP	李頌基醫生, BBS, JP
Vice-Chairperson	Director of Health	衞生署署長
Member	Mr CHAN Siu-hung, JP	陳紹雄先生, JP
Member	Dr CHENG Mei-ching, Joanne	鄭美菁博士
Member	Mr CHEUNG Tat-ming, Eric	張達明先生
Member	Mr CHU Muk-wah, Daniel	朱牧華先生
Member	Mr FUNG Hing-wang, SBS	馮興宏先生，SBS
Member	Ms HO Pik-yuk, Shara	何碧玉女士
Member	Dr KONG Shiu-ki, Travis	江紹祺博士
Member	Mr KWOK Lap-shu	郭立樹先生
Member	Dr LAM Ming	林明醫生
Member	Prof Albert LEE	李大拔教授
Member	Mr LEE Wai-kwong, Sunny, JP	李惠光先生, JP
Member	Dr Grace LUI	雷頌恩醫生
Member	Mr MUI Wai-keung, Moses	梅偉強先生
Member	Ms SUN Hau-kei, Binky	辛巧琪女士
Member	Mr TONG Tak-fai, Edmond	湯德輝先生
Member	Ms WONG Wai-kwan, Loretta	黃慧筠女士
Member	Dr YAM Wing-cheong	任永昌博士
Member	Chief Executive of Hospital Authority or Representative	醫院管理局行政總裁或其代表
Member	Director of Social Welfare or Representative	社會福利署署長或其代表
Member	Secretary for Education or Representative	教育局局長或其代表
Member	Secretary for Food and Health or Representative	食物及衞生局局長或其代表
Secretary	Dr CHAN Chi-wai, Kenny	陳志偉醫生

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Annex V

A summary of the "Recommended HIV/AIDS Strategies for Hong Kong (2017-2021)" (" the Strategies")

Areas	Summary
Emerging service needs	The Strategies highlighted the emerging service needs with regard to Men who have sex with men ("MSM"), including the increasing number of young MSM acquiring HIV, problems of their linkage to diagnosis, care and treatment, the rising popularity of mobile apps to seek sex partners, and the increasing use of recreational drugs before and during sex (chemsex) which leads to unsafe sex and poor treatment adherence. Other needs including low HIV testing rates among at risk populations and the late diagnosis and linkage to care among ethnic minorities ("EM") are also identified.
Four objectives and nine targets	Four objectives are set out to be achieved by the year of 2020 - • 90% of key populations to access HIV combination prevention services; • 90% of people living with HIV to know their HIV status; • 90% of people diagnosed with HIV to receive anti-retroviral therapy; and • 90% of people who are on treatment to achieve viral load suppression. The Strategies also set out nine specific targets to be attained by 2020. They covered the whole process from access to services, prevention, testing to treatment (Please refer to the original Strategies for details).
Six key populations	The Strategies identified six key populations. They are - **Primary target populations** • MSM; and • People living with HIV ("PLHIV"). **Other key populations** • People who inject drugs ("PWID"); • EM; • Male-to-female transgender ("TG"); and • Female sex workers and their male clients ("FSW and MCFSW").
Priority Areas for Action	The Strategies set out priority areas for actions, including (A) Areas to be strengthened; (B) Areas for further examination; and (C) Current response that should be maintained. **(A) Areas to be strengthened**

Areas	Summary
	For each of the six key populations, areas of actions were defined for strengthening - • **MSM -** recommends to target young MSM intensively, increase their condom use, advocate annual HIV testing, strengthen linkage to care and retention in care and for treatment, manage the problem of drug use, and foster a non-discriminatory environment for the MSM community. • **PLHIV** - recommends to adopt a multi-specialty, multi-disciplinary care approach, ensure equitable access to services, widely adopt the strategy of Treatment as Prevention (i.e. receive treatment as soon as diagnosed), and improve early detection and treatment of co-infections and co-morbidities. • **PWID** - recommends to expand reach to injecting drug users of ethnic minorities, enhance recruitment of drug users to methadone maintenance, promote avoidance of needle sharing, and maintain a high HIV testing rate among them. • **EM -** recommends to improve their condom use and promote regular HIV testing. Interpreters should receive training on knowledge of HIV. Services should be cultural sensitive. • **TG -** recommends to collect further data on the risk factors of infection among this hard to reach population. Sensitivity training should also be provided for front-line staff. • **FSW and MCFSW** - recommends to reach female sex workers of ethnic minorities as their access to HIV service is low. The current level of condom use and other prevention measures should be maintained. **(B) Areas for further examination** • **Pre-exposure prophylaxis** - recommends local research and pilot studies. High risk MSM and sero-discordant couples should be given priority**.** • **HIV self-testing (home test) -** recommends health care workers and non-governmental organisations ("NGOs") to improve the mode of delivery for people who self-test. Sufficient support should be given to users, and those who test positive should be referred for proper care. • **Re-testing of HIV for pregnant women -** recommends to explore with stakeholders the feasibility of repeat testing of pregnant women who are of high risk of HIV infection. **(C) Current response that should be maintained** • **Training and education -** recommends that public and school education regarding HIV knowledge, safer sex behaviour and HIV-related discrimination should be sustained. School-based comprehensive sexuality education using the life skills-based education (LSBE) approach should be adopted.

Areas	Summary
	Training for front-line workers, educators, parents and supporting staff regarding HIV knowledge, counselling skills and support to HIV positive students is encouraged. Continuing training for health care workers and students of health professions in both public and private services, including those not directly involved in HIV care, is recommended to improve their HIV knowledge, sensitivity to the key populations, and their acceptance of people with diverse needs.
	• **Post-exposure prophylaxis ("PEP") -** recommends to revise the local recommendations or clinical guidelines of non-occupational PEP, and to ensure that its use is safe and effective.
	• **Collection and use of strategic information -** recommends academia and NGOs to conduct regular surveys and research as needed, especially operational research and socio-behavioural studies of key populations.
	• **Funding and resources** - recommends that resources should be secured for HIV programmes targeting MSM, especially the young subgroup. Funding for other populations, on the other hand, should not be neglected. Quality patient services should be sustained with adequate funding and resources. The funding mechanism should also be flexible to react promptly to new changes of the epidemic. Regular review of funding distribution and the content of AIDS programmes is recommended to ensure resources are allocated to areas most in need and programmes with impact on control of the HIV epidemic.
	• **Supportive environment for HIV prevention and care -** recommends to strengthen communication and education to policy makers and senior staff of different fields including health care, substance abuse and social services to raise their sensitivity to the needs of PLHIV and to cultivate a non-discriminatory environment. The general public should also be appealed for an accepting attitude to PLHIV and populations who are at risk of HIV infection.

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