公民黨 CIVIC PARTY 郭家麒醫生 Dr. Hon. Kwok Ka Ki
立法會議員 Legislative Councillor

立法會
衛生事務委員會主席
李國麟議員, SBS, JP, PhD, RN

立法會CB(2)644/16-17(01)號文件
LC Paper No. CB(2)644/16-17(01)

李主席：

關注香港愛滋病建議策略(2017-2021)文件事宜

香港愛滋病顧問局(下稱顧問局)於 2016 年 11 月 1 日發佈香港愛滋病建議策略(2017-2021)公眾諮詢文件，就香港未來 5 年預防、治理和控制愛滋病病毒感染及愛滋病的政策向政府提供意見。

就相關報告，香港愛滋病建議策略(2012-2016)，當中所提及的十一項目標推行進展大致達成目標，可見顧問局於上一個五年能完成所訂立的目標。根據香港每年愛滋病病毒感染及愛滋病統計數字，由 2012-2016 年間，個案數字不跌反升，而且升幅比以往更高。由此可見，顧問局所訂立的香港愛滋病建議策略根本未能對症下藥。

同時，本人接獲多個愛滋病非牟利機構的意見，均對於顧問局所制訂的香港愛滋病建議策略(2017-2021)表示不滿，他們作為前線工作者均認為文件的策略過時，包括並未將國際上開始使用的接觸前預防性投藥(PrEP)納入建議、亦未將現時社群人士在香港獲取接觸後預防性投藥(PEP)所遇到的重大障礙現況反映。聯合國愛滋病規劃署(UNIAIDS)早於 2011 年曾針對香港愛滋病建議策略(2012-2016)向顧問局發信，指出「『依舊行事』的愛滋病風險預防方式在男男性接觸者和跨性別人士社群裡已經不再可見。這些人群的愛滋病感染數據顯示出我們的集體預防方式遇到失敗的頻密程度遠遠多於成功或接近標準。」

自 1994 年起，顧問局共發表五份愛滋病建議策略文件，作為香港過去應對愛滋病疫情的藍本。顧問局作為香港政府委任的一個永久性非法定組織，向政府提供香港預防、治理及控制愛滋病毒感染及愛滋病的政策向政府提供意見，惟本會從未就顧問局有關文件作出討論、諮詢。

香港中環立法會道1號立法會綜合大樓812室
Room 812, 8/F, Legislative Council Complex,
1 Legislative Council Rd., Central, H.K.
電話 TEL：2677 6877 傳真：2677 6876
電郵 E-mail：kkk@kkkwok.hk 網址 Website：www.kkkwok.hk

公民黨 CIVIC PARTY
郭家麒醫生 Dr. Hon. Kwok Ka Ki
立法會議員 Legislative Councillor

就此，本人希望　閣下盡快將以上議題加入議程，讓委員就相關事宜作出討論，並邀請食物及衞生局局長、衞生署署長、香港愛滋病顧問局主席及相關人員出席。

另外，本人希望就此議題召開公聽會，讓相關的持分者能就此作出討論及表達意見，同時亦能作為讓公眾得悉有關議題的渠道，達致衞生署的「三零目標」(零新感染、零死亡、零歧視)。

專此函達，順頌

台安！

衞生事務委員會委員

郭家麒

二零一七年一月十六日

附件

1. Letter from HKCASO
2. HIV/AIDS Statistics in Hong Kong 1984-September 2016
3. HIV Stigma Watch Brief Report
4. Joint statement from sex workers support groups
5. Report of HKCASO Community Consultation Meeting on Draft Recommended HIV/AIDS Strategy for Hong Kong (2017-2022)
6. UNAIDS letter to ACA Hong Kong Strategy

香港中環立法會道1號立法會綜合大樓812室
Room 812, 8/F, Legislative Council Complex,
1 Legislative Council Rd., Central, H.K.
電話 TEL：2677 6877　傳真：2677 6876
電郵 E-mail：kkk@kkkwok.hk　網址 Website：www.kkkwok.hk

Appendix (1)

Dr. Kwok Ka Ki
Legislative Council member
Room 812, Legislative Council Complex
1 Legislative Council Road
Central, Hong Kong

13 January 2017

Dear Dr. Kwok Ka Ki,

I am writing to bring to your attention the opinions we collected from the community regarding the Recommended HIV/AIDS Strategy (2017-2021) by Hong Kong Advisory Council on AIDS.

To consult the opinions of different stakeholders on the draft strategy, the Hong Kong Coalition of AIDS Services Organizations (HKCASO) conducted a community consultation session on 13 October 2016, for which the report has been attached with this letter.

There has been significant progress in recent years in driving up HIV testing rates and tying people with HIV onto treatment. However, we are now in a new phase of the epidemic. As members of the HKCASO, we are concerned that some of the important opinions from the community are missed out in the strategy. With the HIV epidemic rising faster than ever before, we are afraid that the health authorities would miss the opportunity to contain the epidemic in the next 5 years.

According to the latest figures published by the Centre for Health Protection, the number of HIV infections has risen for more than 56% since 2011, with the record of nearly 2 new HIV infections per day. In the face of this troubling HIV position, it is important that the following new opportunities for HIV prevention are fully grasped.

(A) Mental health services for people living with HIV (PLHIV)

According to the research 'Stigma Watch', the mental health score of 53.6% of the PLHIV was below the World Health Organization's recommended level. The

poor mental health well-being of PLHIV does not only contribute to poor health outcomes including depression, drug use and isolation, but also significantly raises their risk of unsafe sex and limits the effectiveness of HIV prevention efforts.

Therefore, we suggest that clinical psychology and drug treatment services for PLHIV be enhanced and incorporated into the public healthcare system more strongly.

(B) PrEP and nPEP be included into HIV combination prevention services

Pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis for non-occupational exposure (nPEP) are interventions that use anti-HIV medication to help stop HIV-negative people from getting infected with HIV. Although the effectiveness of PrEP and PEP are now irrefutable, they are not being used effectively in Hong Kong.

We suggest that the strategy should go further in positively identifying PrEP as one of the key interventions among all the other HIV combination prevention services in the coming 5 years. PEP should also be provided to high risk communities for non-occupational use in the public healthcare system with clearer risk assessment guideline to ensure easy access.

(C) HIV/AIDS strategy for heterosexual men with multiple sex partners

With heterosexual contact constituting almost half of the HIV infections (43%), there are no particular HIV/AIDS strategies mentioned to meet the needs of the community 'heterosexual men with multiple sex partners' in the strategy.

It is worrying to notice that barely 36.5% of the male clients of female sex workers are receiving HIV testing services in 2015[1]. Tailored HIV prevention approaches should be implemented to ensure this target group has easy access to a combination of HIV prevention services. We suggest that the government step up their efforts in public HIV education to increase the sexual health awareness among high risk heterosexual men. Voluntary HIV testing and

[1] 2015 HIV/AIDS Response Indicator Survey

counselling services can also be incorporated into the normal health check-ups in the public healthcare system to identify infection cases more effectively.

(D) Anti-discrimination and anti-stigma measures

We are also disappointed to notice that the strategy is quite limited on its comments on supporting the following anti-discrimination and anti-stigma measures, which are essential for mitigating the impact of HIV/AIDS on high risk and affected communities.

(i) HIV anti-stigma education for the public and relevant social sectors

With more than affordable medical treatment in Hong Kong, 34% of people living with HIV (PLHIV) are still not receiving medical care in the public health system[2], which has serious implications on not just the PLHIV's health but also greatly limits the HIV prevention efforts to contain the epidemic.

Many people living with HIV refrain from getting early treatment because they have poor HIV knowledge, and are deterred by perceived discrimination and internalized stigma.

Therefore, basic HIV education to the public and regular sensitization training for workers in relevant social sectors (including teachers, social workers and healthcare workers) are urgently needed to ensure PLHIV's friendly access to HIV-related services. We are sad to notice that there is no clear review of this respect in the strategy though 'regularize sensitization training' has been mentioned as one of the 11 targets of ACA strategy (2012-2016).

(ii) Comprehensive and inclusive sex education

With more and more young men who have sex with men (MSM) being infected with HIV, it is important that comprehensive and inclusive sex education be implemented in schools to make sure young people of different sexualities are empowered to make informed decisions about their sexual health.

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[2] CHP reviews local HIV/AIDS situation in third quarter of 2016
http://www.info.gov.hk/gia/general/201611/29/P2016112900235.htm?fontSize=1

It is a pity that the strategy still uses 'controversial' to describe 'the discussion of sexual orientation or gender identity in schools', which discourages schools from openly talking about this important issue. If school sex education can include dispelling myths about the LGBT community, it would create a less discriminatory environment where young MSM would feel safer to seek help on sexual health and mental health issues, and have a positive impact on reducing the HIV epidemic.

(iii) Legal protection for high risk communities

Both the UNAIDS and WHO have recommended governments to implement positive anti-discrimination legal measures to protect the LGBT community, as international evidence shows that stigma and discrimination would increase the LGBT individuals' susceptibility to high risk sexual behavior and deter people from seeking HIV testing and care services. 'Decriminalization of sex work' and 'not using condoms as evidence of prostitution in court', on the other hand, are also legal measures proven to be effective in creating a friendly environment for HIV prevention, as sex workers will no longer need be driven underground, or be afraid of bringing and using condoms when they work.

We hope that the ACA can follow the international evidence and be more explicit in recognizing the importance of anti-discrimination legal reform, decriminalization of sex work and 'stop using condoms as evidence of prostitution in court' in ensuring the vulnerable communities' friendly access to HIV-related services.

Yours sincerely,

Andrew Chidgey
Chairperson of HKCASO

Appendixes

1. HIV/AIDS Statistics in Hong Kong 1984-September 2016
2. HIV Stigma Watch Brief Report
3. Joint statement from sex workers support groups
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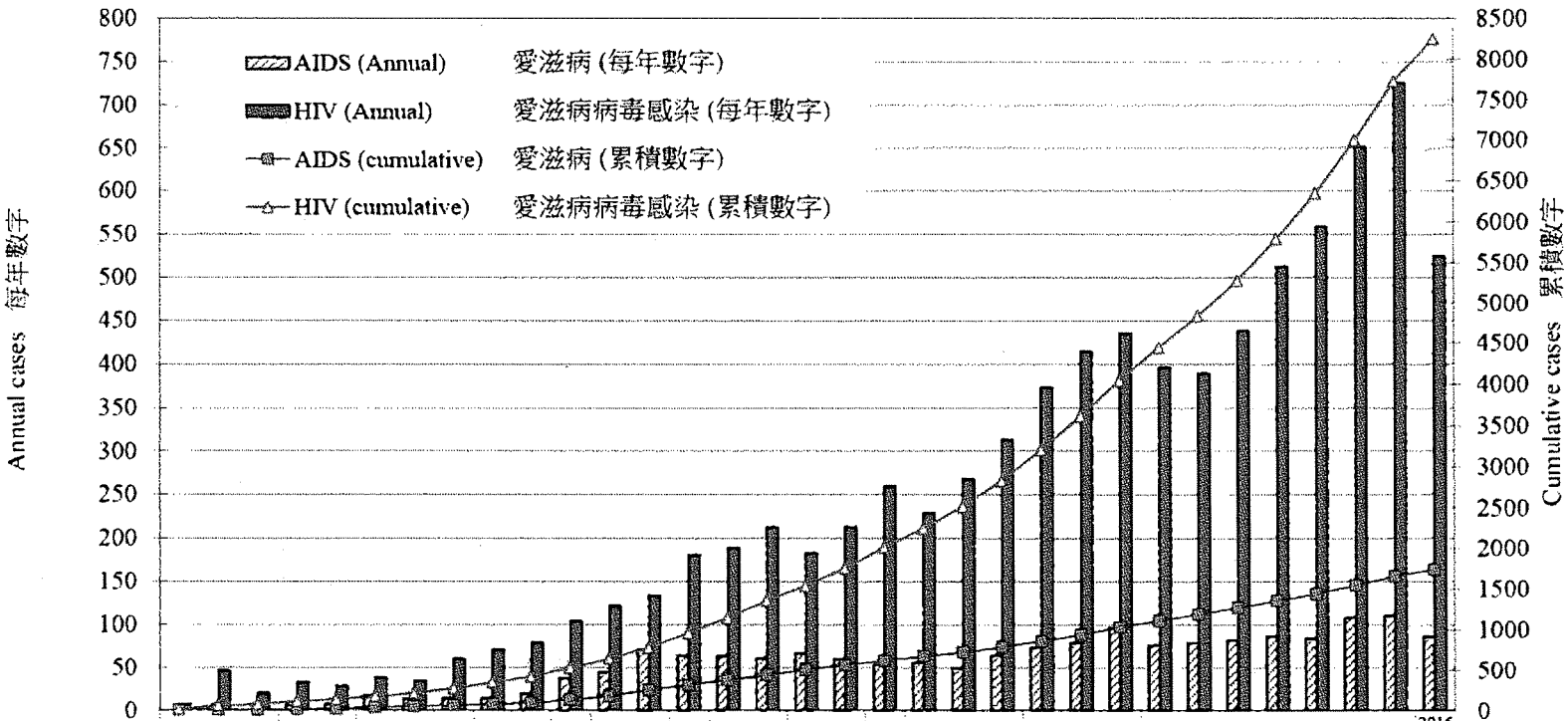
5. UNAIDS letter to Hong Kong Advisory Council on AIDS (ACA)

Appendix (2)

Appendix 1: Recent HIV/AIDS situation

HIV/AIDS Statistics in Hong Kong 1984 - September 2016 (N=8243/1741)
香港愛滋病病毒感染/愛滋病統計 1984年 - 2016年9月 (個案數字=8243/1741)



	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 (1-9)
AIDS (Annual)	0	3	0	6	7	17	13	14	14	19	37	44	71	64	63	61	67	60	53	56	49	64	73	79	96	76	79	82	86	84	108	110	86
HIV (Annual)	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	525
AIDS (cumulative)	0	3	3	9	16	33	46	60	74	93	130	174	245	309	372	433	500	560	613	669	718	782	855	934	1030	1106	1185	1267	1353	1437	1545	1655	1741
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	8243

Year 年份

Appendix (3)

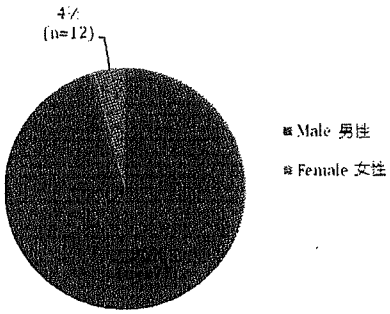
Organizers

Appendix II【Hong Kong HIV Stigma Watch】Brief Report

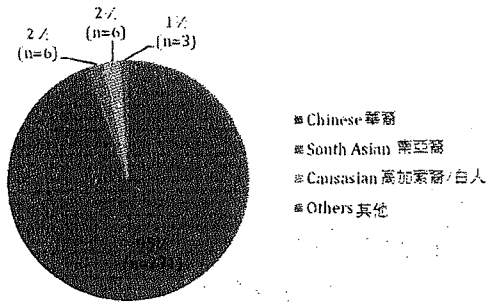
Basic Demographics

291 people living with HIV (PLHIV) were recruited in the study. 96% (n=277) of the participants were male and majority (95%, n=271) of them were ethnically Chinese. They had a mean age of 41.77 years. Three fourths (75%, n=210) of the participants were homosexuals. They had a mean year of diagnosis of 5.25 years.

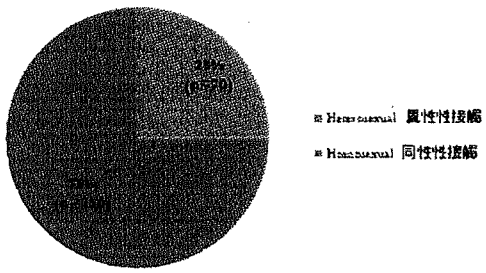
Gender 性別



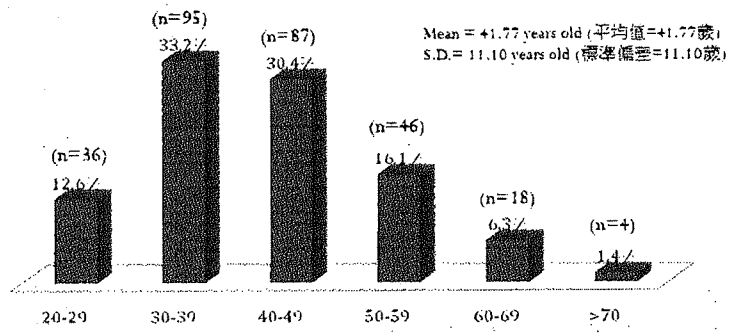
Ethnicity 族裔



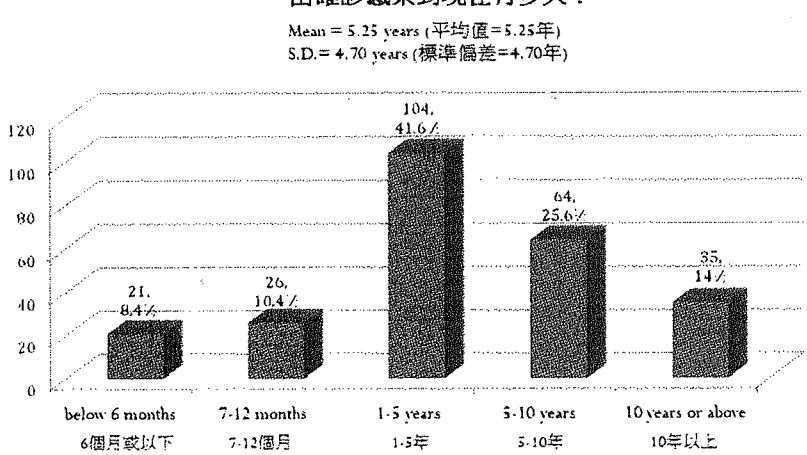
Sexual Orientation 性傾向



Age Group 年齡組別



How long has it been since being diagnosed with HIV?
由確診感染到現在有多久？



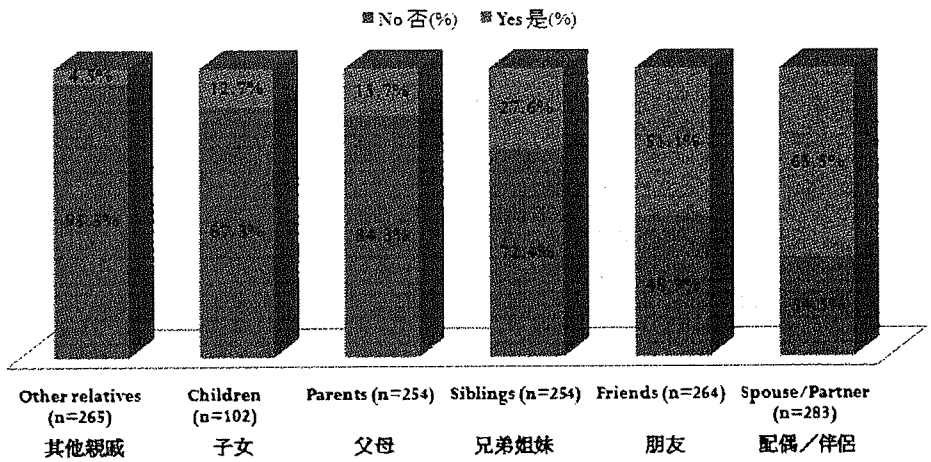
Organizers

Research Findings

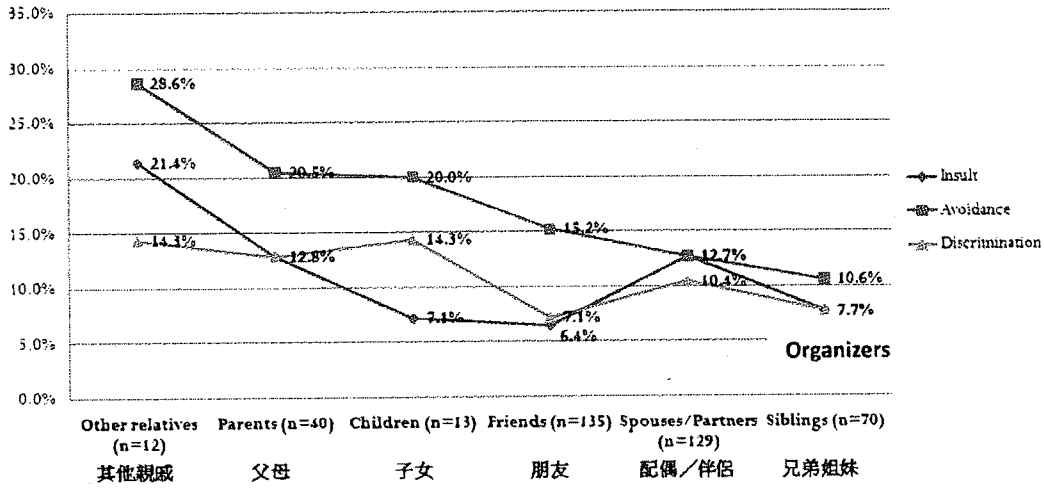
1. Disclosure of HIV status to family members, partners and friends

75.9% (221 out of 291) of the participants have disclosed their HIV status to their family members, partners or friends. In particular, relatively more participants (65.5%) have revealed their HIV status to their spouses or partners, whereas only a few of them (4.5%) have disclosed their HIV status to other relatives. 16.7% (37 out of 221) of the participants who disclosed their HIV status, have experienced insults, avoidance or discrimination from their family members, partners or friends.

If you are involved in the following social relationships, does anyone in the relationship know of your HIV status?
若你有以下社交關係/接觸以下社交圈子，圈子裡有人知道你的感染狀況嗎？



Insult, avoidance and discrimination experienced in the past year
過去一年曾經受過侮辱、迴避和歧視



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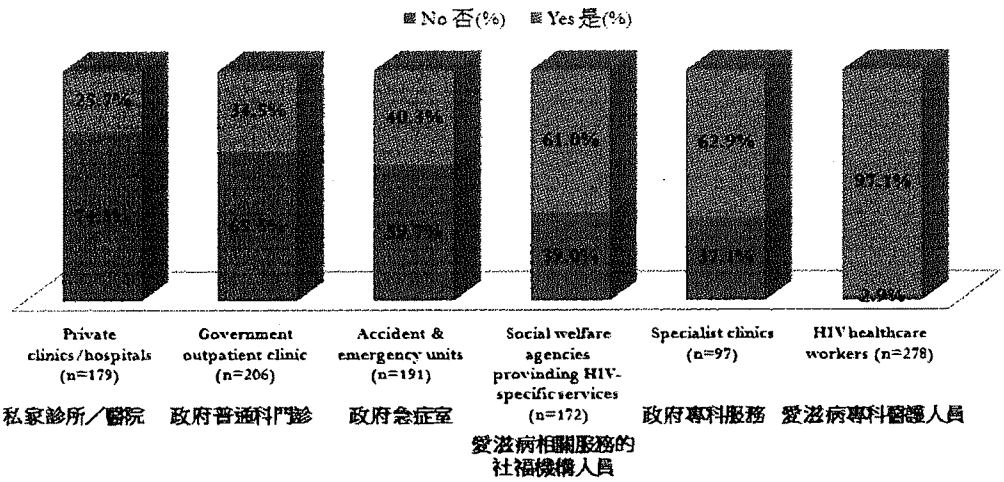
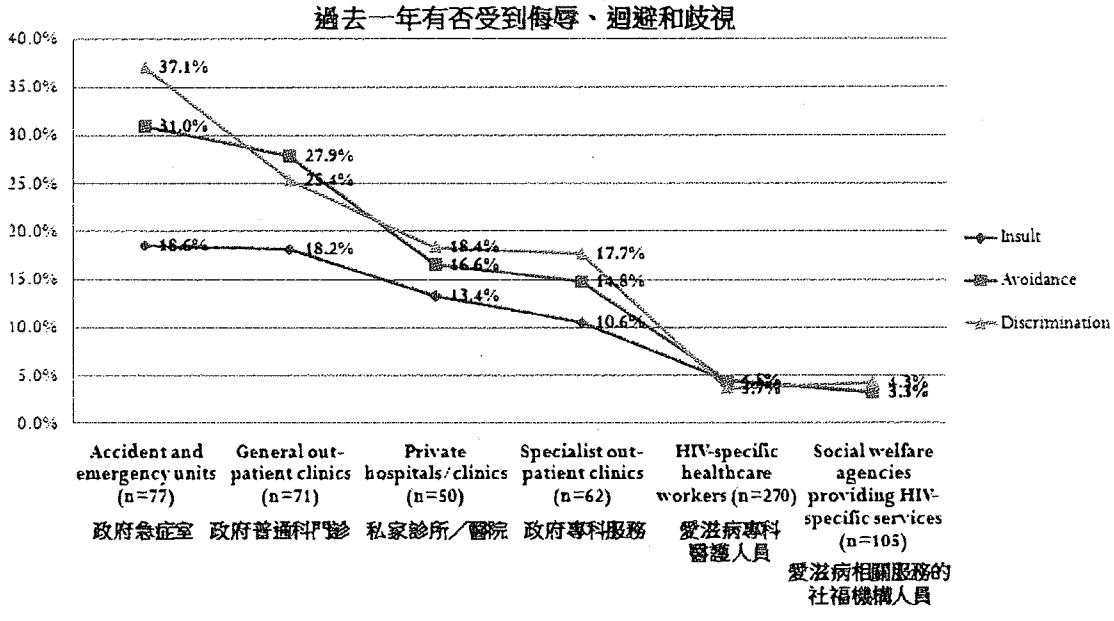
2. Disclosure of HIV status to healthcare and social service providers

48.8 % (142 out of 291) of the participants have disclosed their HIV status to general healthcare professionals. In particular, relatively few participants (25.7%) revealed their HIV status to the healthcare workers from private clinics or hospitals. 26.8% (38 out of 142) of the participants who disclosed their HIV status, have experienced insults, avoidance or discrimination from general healthcare workers. In particular, relatively more participants have experienced avoidance and discrimination from the healthcare workers at the accident and emergency units as well as general out-patient clinics.

If you are involved in the following social relationships, does anyone in the relationship know of your HIV status?
若你有以下社交關係/接觸以下社交圈子，圈子裡有人知道你的感染狀況嗎？



Insult, avoidance and discrimination experienced in the past year
過去一年有否受到侮辱、迴避和歧視



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3. Unfair treatment from healthcare service providers

During the past one year, 13% (37 out of 285) of the participants were made to wait until last in the hospital or clinics. 9.6% (27 out of 282) of the participants were arranged to use disposable eating utensils during hospitalization while others were not. 9.1% (26 out of 287) of the participants were denied healthcare services.

Unfair treatment from healthcare service providers over the past year
過去一年曾受到醫療服務提供者不公平對待

4. Unfair treatment from employers

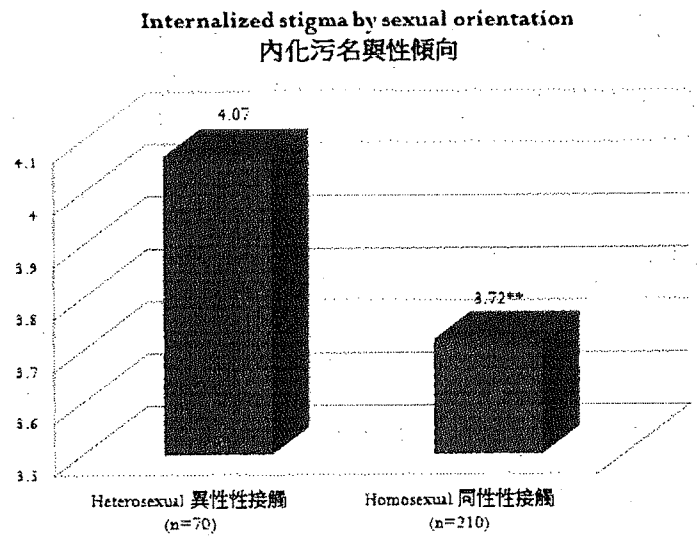
During the past one year, 10.6% (30 out of 282) of the participants were required to provide information about their HIV status on the application form when applying for jobs. 5.4% (15 out of 279) of the participants were fired or forced to quit the job because of their HIV status.

Unfair treatment from employers over the past year
過去一年曾受到僱主不公平對待

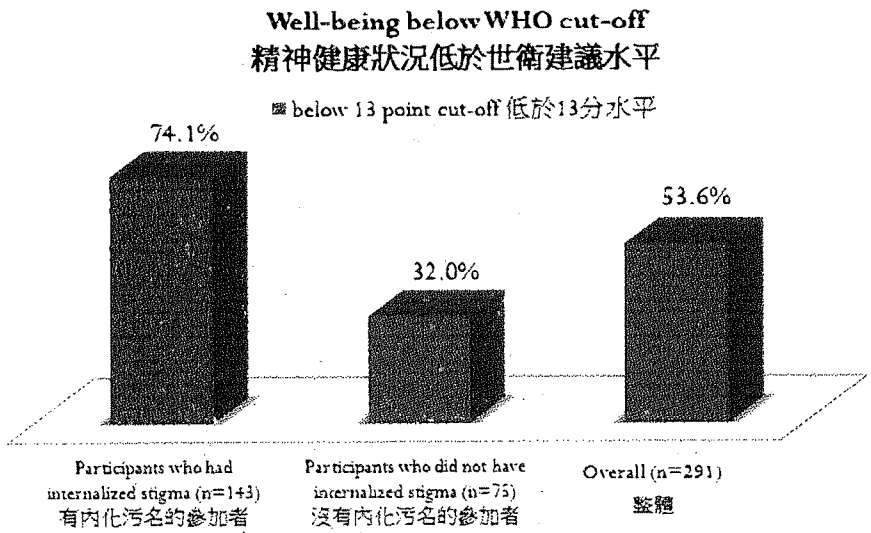
Organizers

5. Internalized stigma and well-being

49.3% (143 out of 291) of the participants had internalized stigmatizing beliefs about their identity as a person with HIV. (On a scale from 1 to 6, mean=3.82, SD=1.16) Specifically, homosexual participants had a significantly lower internalized stigma (p=.03) than heterosexual participants.



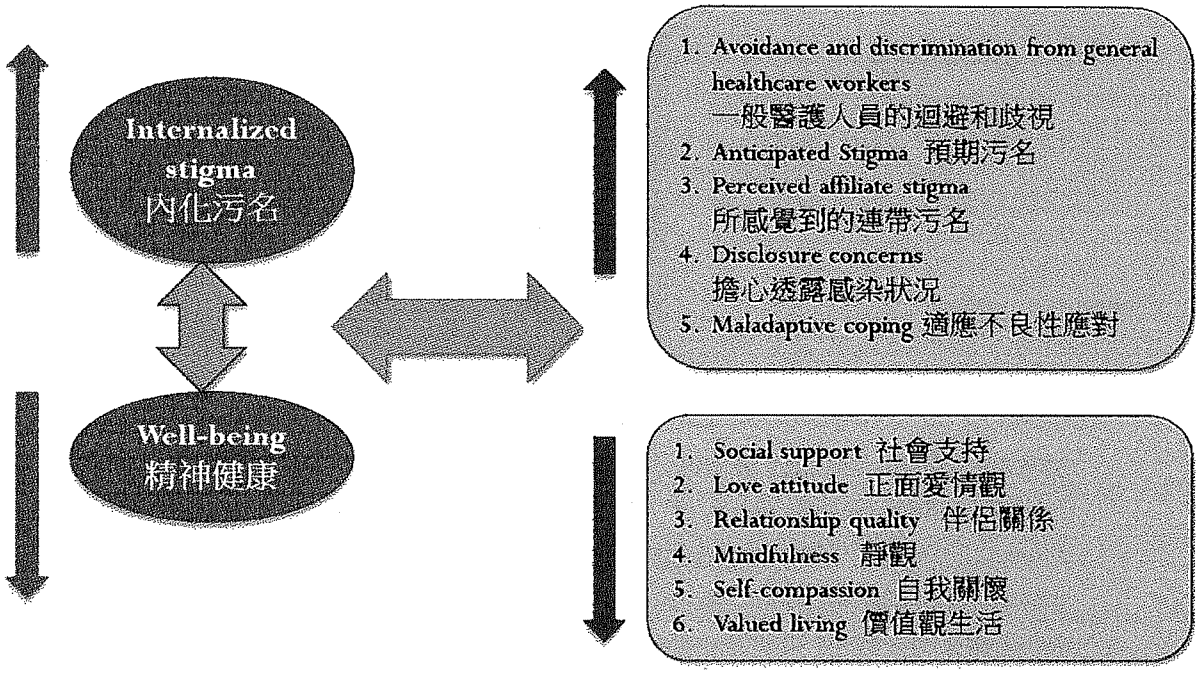
53.6% (156 out of 291) of the participants' WHO5 score was below the WHO's recommended cut-off point of 13, indicating poor well-being. (Full score=25, Mean=12.68, SD=4.64) Among participants who had internalized stigma (n=143), majority (74.1%) of them had a WHO5 score that was below the cutoff. Their well-being was worse than those who did not have internalized stigma.



Organizers

6. Correlation among Internal stigma, mental health and other factors

Avoidance and discrimination from general healthcare workers, anticipated stigma, perceived affiliate stigma, disclosure concerns and negative coping were positively correlated with internalized stigma, and were negatively correlated with well-being. In addition, social support, love attitude, relationship quality, mindfulness, self-compassion and valued living were negatively correlated with internalized stigma, and were positively correlated with well-being.



Organizers

HIV/AIDS and HIV Stigma Watch Glossary

Anticipated stigma	Members of stigmatized groups expect how the public would endorse the negative labeling, prejudice and discrimination towards the stigmatized group in general.
HIV antibody test	Antibodies are made in one self's blood when his/her body is exposed to HIV infection. HIV antibody testing is a blood test carried out to find out if one self has contracted HIV. If HIV antibodies are present, the test is positive. It means that the person is HIV-infected. If one self receives a negative result after the window period, it means that he/she not been exposed to the infection.
Internalized stigma	Members of stigmatized groups internalize the negative labeling, prejudice and discrimination from the public, resulting in negative perception and devaluation towards themselves.
Maladaptive coping	Coping strategies that are not favorable to adaptation are used for stress management, for example self-blame, denial, escape, etc.
Mindfulness	Intentionally and non judgmentally bringing moment-to-moment attention and awareness to the present experience (Kabat-Zinn, 1990)
People living HIV, PLHIV	The term "People living with HIV "(PLHIV) reflects the fact that an infected person may continue to live well and productively for many years. AIDS has long been categorized as a chronic disease and with proper treatment, PLHIV can lead healthy lives just like the others. And since most of the time, a person with AIDS is not in the role of patient, using the term "AIDS patients" does not reflect the real-life situation.
Perceived affiliate stigma	Members of stigmatized groups perceive their associates (such as family members, partners and friends) would face the negative labeling, prejudice and discrimination from the public.
Safer Sex	Safer sex refers to sexual behavior which avoids direct contact with partner's body fluid like, semen and blood with consistent and correct usage of condoms. It is important to note that practicing safer sex greatly reduces chance of contracting sexually transmitted infections (STI) and HIV.
Self-compassion	Caring and compassionate attitude towards oneself in the face of hardship or perceived inadequacy. (Bennett-Goleman, 2001)
Valued living	Perceived importance and consistency of life values in various domains of life.

References

Bennett-Goleman, T. (2001). Emotional alchemy: How the mind can heal the heart. New York: Three Rivers Press.

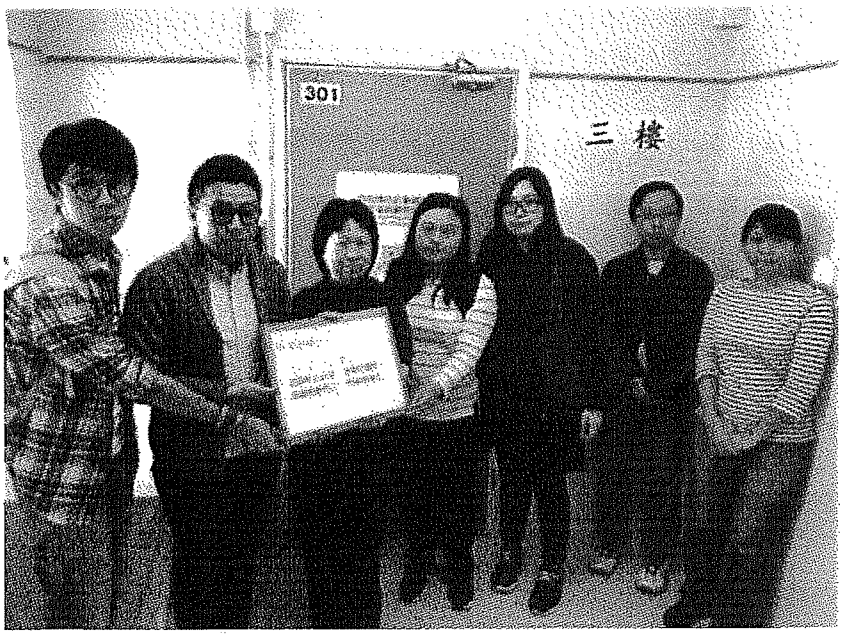
Kabat-Zinn, J. (1990). Full catastrophe living: Using the wisdom of your body and mind to face stress, pain and illness. New York: Delacorte.

Appendix 4

Appendix III

性工作者支援團體聯合聲明 — 促請愛滋病顧問局正視「警察使用安全套作證物」的問題

週三 2017-01-04



性工作者支援團體聯合聲明—
促請愛滋病顧問局正視「警察使用安全套作證物」的問題

愛滋病顧問局擔當著影響香港愛滋病政策制定的重要角色，其五年一度的《香港愛滋病建議策略》已經開展諮詢，性工作者社群均有積極參與起草階段的社區持份者諮詢會議，提出最有利於性工作者進行愛滋防治的政策倡議。

諮詢階段已步入最後的公眾諮詢，但公眾諮詢文件反映當局並沒有認真聆聽性工作者社群的意見，尤其於「警察使用安全套作證物」的問題上。局方將改變政策的責任推卸於性工作者社群及相關支援團體，妄想維持現時性工作者與警察之間的會議，便能讓情況得以改善。事實是停止使用安全套作證物的訴求已提出多年，警方卻態度強硬，絲毫未有打算改善。他們更多次於拘捕性工作者後高調展示安全套、潤滑油、快速檢測的宣傳

單張等與愛滋病防治息息相關的物品予傳媒拍照。警方的做法使不少性工作者怯懼於隨身攜帶及在工作場所存放安全套，讓自己陷入「無套工作」的風險。

安全套成為證物妨礙性工作者職業安全

於 2013 年年底，本港四個支援性工作者的團體：青鳥、青躍、姐姐仔會及午夜藍，於本港性工作者社群開展了「性工作者使用安全套之障礙」的問卷調查，並於同年 12 月 17 日（國際終止暴力對待性工作者日）發佈調查結果[1]。

是次調查訪問了 157 名性工作者，調查對像包含男性、女性及跨性別的性工作者。調查結果顯示，超過六成受訪者表示害怕被人看到自己擁有安全套，其中 40 名受訪者表示害怕被警察看到安全套。此外，超過七成受訪者認為性工作者會因為攜有／藏有安全套而被捕，亦有約三成受訪者表示會因為想降低被捕風險，而減少或完全不攜有／藏有安全套，當中甚至有 6 人表示因相同理由會減少或完全不使用安全套進行性交易。

是次調查顯示，不少性工作者會害怕因攜帶或存放安全套而被捕，而減低帶備安全套工作的意欲。過份依賴客人自備安全套，使性工作者於進行安全性行為上變得被動，大大增加感染愛滋病及性病的風險。保障職業安全是基本人權，如同地盤工作必須佩帶安全裝備、公司應當為員工購買勞工保險等，安全套便是性工作者最重要的保護措施。我們無法接受執法部門的慣常做法妨礙性工作者維護自己的職業安全，「立即停止使用安全套作證物」的訴求絕無法讓步。

跨部門遊說是愛滋病顧問局的責任

愛滋病顧問局的建議對制定香港愛滋病政策舉足輕重，「立即停止使用安全套作證物」的訴求已提出超過十年，卻從未得到正視及跟進。我們實在無法接受愛滋病顧問局逃避愛滋病防治的責任，罔顧性工作者社群的職業安全。

我們現敦促愛滋病顧問局將性工作者社群的訴求清晰列入《香港愛滋病建議策略》，並積極遊說各政府部門跟從建議，改變現時的工作方式，包括要求警方立即停止使用安全套作證物，讓性工作者無需再為攜帶或存放安全套而提心吊膽。

上述訴求並非天方夜譚。事實上，在 2013 年三藩市地方檢查官 George Gascón 就宣布，永久禁止在性工作相關的刑事案件中將安全套用作檢控證據[2]。這項決議是各政府部門拿出誠意，與民間團體互相合作的成果。人權組織 Human Rights Watch 在 2012 年發布了橫跨四個美國城市的研究，發現俱樂部、按摩院等場所的東主因為害怕警方掃蕩時搜證，經常把安全套隱藏在不方便拿取的地方，甚至完全不存放安全套，導致性工作者在毫無保障、極高風險的環境下工作，直接妨礙了愛滋病防護工作的推行[3]。其後，三藩市市政府轄下的人權委員會主動介入，邀請了地方檢察官、警方、公共衛生部門、關

注性工作團體等持分者進行會議，各方都派了擁有決策權力的代表出席，最終一致同意停止將安全套用作檢控證據[4]。

愛滋病顧問局欠缺的，正正是這份誠意和決心。公眾諮詢文件清楚指出局方職權之一是向政府部門提供有關愛滋病政策的意見[5]，亦把保安局(即包括屬下的警務署)列入「推行愛滋病項目的關鍵參與者」[6]。局方理應可以擔當更主動和積極的角色，對警方現行做法採取更鮮明的立場，並提議政府盡快協調各部門作出改變，扭轉一邊在防治工作上投放資源、一邊助長不安全性行為的亂象。

青鳥
青躍
姐姐仔會
午夜藍

二零一七年一月四日

Appendix (I)

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Appendix IV

Report of HKCASO Community Consultation Meeting on Draft Recommended HIV/AIDS Strategy for Hong Kong (2017-2022)

Goal and objective

A community consultation meeting was held by the Hong Kong Coalition of AIDS Service Organizations (HKCASO) on 13 October 2016 with the aim of collecting the opinions of different target populations on the draft Recommended HIV/AIDS Strategy (2017-2022) by Hong Kong Advisory Council on AIDS (ACA).

It is important to note that two NGOs refuse to take part in the discussions because they believe that ACA is not willing to listen to community concerns on issues such as LGBT rights. This risks undermining community unity in attacking the epidemic and ACA is urged to consider how to respond on the important issue of LGBT rights.

Meeting Rundown

Time	Activities
15 minutes	***Introduction and highlights of the draft strategy*** – The Draft strategy has been translated into Chinese and sent to the participants beforehand to facilitate discussion in the consultation meeting. – The participants are reminded that the copy is NOT an official copy from ACA and just for their reference only. They can refer to the English version if there are any discrepancies between the two.

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40 minutes	***Break out group discussion*** – Participants are divided into the groups below according to the communities they are most concerned with relation to the HIV/AIDS strategy. The number of participants in each group is limited to no more than 8 to allow more time for individual participation. I. People living with HIV II. Men who have sex with men III. Heterosexual men with multiple sex partners IV. Injecting drug users – Discussion questions including the following: To tackle the HIV epidemic, from their respective affected community's point of view, what strategies written in the draft they find: A. Good/effective? B. Need to be further enriched/elaborated/revised? C. Missing?
20 minutes	***Report back*** – The facilitator or note-taker of each group to present highlights of its break-out discussion within 2 minutes
30 minutes	***Big group discussion for mutual learning*** – What strategies have you learned from other affected communities' discussions that you find important to your own community of concern, and want them to be included in the document? – What strategies would you like to recommend other affected communities to consider? – Overall, as strategies for all the affected communities and Hong Kong, anything written in the draft you find important, or that need to be emphasized, revised, or added?

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Number of attendees

Community group discussion	Number of attendees
Men who have sex with men	25
Heterosexual men with multiple sex partners	15
People living with HIV	7
Injecting drug users	3
Total	***50***

A. Overall comments on the Draft strategy

i. Some sections of the draft strategy are too vague and need strengthening with more specific courses of action to achieve the targets outlined in the strategy. Some suggestions are detailed further below.

ii. Government support is paramount to the implementation of HIV/AIDS strategy and there should be more emphasis on the role of the government in the draft strategy, especially their support in legal protection measures, training and education. At the moment the wording is weak and suggests to community members that the government will not do anything.

iii. Communities need to be empowered and given relevant information to take part in HIV prevention work, which should be emphasized throughout the strategy.

iv. There is concern over the definitions of 'key populations' and 'other populations' and the exclusion of some target groups. ACA needs to give clear explanation on why the prioritized areas in the previous community consultation are not accepted and mentioned in the draft strategy, including the following:

- The focus on clients of female sex workers. Some community members have suggested that consideration can be given to calling this group heterosexual men with multiple partners as this is more accurate and easier to engage community members
- Anti-discrimination legal protection measures for LGBT community

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- Legal protection measures for female sex workers, including not using condoms as evidence for prostitution in court
- Anti-stigma environment for people living with HIV
- Improve the mental health of people living with HIV
- Implement nPEP

v. Post-exposure prophylaxis for non-occupational exposure (nPEP) and pre-exposure prophylaxis (PrEP) are interventions which are not being used effectively in Hong Kong. PEP is widely used in other countries and access could be improved by making PEP more available outside accident and emergency departments. Some people go for private treatment because they can afford to but many decide not to because of the cost and inconvenience. With PrEP the international evidence is now irrefutable on the effectiveness. The strategy can go further in positively identifying implementation of PrEP as a key intervention in the coming 5 years and be included in the session of 'HIV combination prevention' in point 19.

vi. The Strategy can be clearer about resourcing. The number of people with HIV has increased by a large number is in the last 5 years, but the resources devoted to treatment and care of people with HIV has not increased in the same way. This is seen in the limited amount of time that the HIV/AIDS clinics have to deal with cases, limiting the potential for good follow up and prevention work. ACA is urged to recommend that an audit is carried out of staffing capacity and community needs to determine what appropriate staffing levels would be to deliver quality treatment and care. It is clear that the current staffing level is unsustainable. It is a false economy not to provide some investment here, because we are seeing more infections coming from people with HIV who know they are HIV positive.

vii. The need for more community research was an issue identified in a number of the target population discussions and this is something that has come up in other HKCASO discussions about the strategy. It seems that the public clinics cannot support research because of capacity problems. We suggest that there should be some process established for considering research proposals which can take place on high risk populations. Without such research it will remain difficult to establish clear evidence for the at risk populations to inform appropriate service development.

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B. Men who have sex with men

The introduction of PrEP and nPEP

nPEP (PEP for non-occupational use) is an important tool to reduce the HIV epidemic and participants think that it is a big mistake that nPEP is totally missed out in the draft strategy. nPEP should be mentioned in the strategy and the government should ensure that the guideline on nPEP prescription is thoroughly implemented to prevent potential HIV infections.

Participants also express that PrEP should be introduced and implemented in Hong Kong as soon as possible. The government should make sure resources are channeled into implementation research on PrEP to inform future implementation efforts.

Participants feel the need to emphasize the role of the government in implementing PrEP and PEP in Hong Kong. It is the responsibility of the government to conduct more promotion and education to the community regarding PrEP and nPEP though convenient channels like Department of Health websites and mobile apps. Also, the government could ensure easy and subsidized access to PrEP and nPEP to reduce the HIV epidemic. The relative costs of treatment compared to lifetime treatment costs for HIV can be lower if these interventions are well targeted.

Mentioning male sex workers

Male sex workers should be included in the strategy as it is an important target population to serve in reducing the HIV epidemic. Overseas and cross-border male sex workers should also be highlighted in this target population. Male sex workers from Bangkok and other cities who come to Hong Kong are known to have very high prevalence of HIV.

Enhance support services for self-testing

Participants appreciate that home-testing is mentioned in the strategy as it is a good measure that makes it more convenient for MSM to have HIV testing. However, the strategy should mention the role of the government to regulate the quality and price of self-test kits and ensure a range of support services are given to self-test users.

Ensuring resources to stop leakage for linkage to and retention in care

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Although the draft strategy mentioned the importance of stopping leakage for linkage to care in point 39, it lacks clear explanation on how to achieve the goal. Participants point out that the difficulty of retaining new cases in care is rooted in the lack of human resources, as there are not enough staff members to support and retain each and every person living with HIV in care. People with HIV mention 'answering the questions they are asked in the right way to get their medication and get out of the clinic'. Therefore, the part of 'funding and resources' should be enhanced to ensure resources are channeled into this area.

Fostering a non-discriminatory environment for the MSM community

Although the strategy recognizes the importance of fostering a non- discriminatory environment for the MSM community in point 41, it lacks clear explanation on how to achieve it.

Participants suggest that the strategy go much further in stating the importance of legal protection for sexual minorities, discussing sexual orientation in school sex education and enhancing anti-stigma education for workers related to HIV-related services, especially substance abuse and sexual health-related services.

Some participants also suggest that the message of HIV testing can be more generalized to the public as a health concern for everybody to reduce the HIV stigma on the community.

Research

More research should be conducted to look into the substance abuse and unsafe sex behavior among MSM to inform intervention efforts. Ongoing research with consistent methodology should be used to monitor the behavior of MSM community.

Enhance the use of social media platforms to reach MSM in HIV prevention

Participants express that MSM are now harder to reach in physical venues and social media platforms should therefore be enhanced to reach more MSM in HIV prevention, especially YMSM. For instance, advertisements could be placed in popular online games and mobile apps to promote HIV testing.

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C. **Heterosexual men with multiple sex partners**

Inclusion in the strategy

With heterosexual contact constituting the second largest infection cases in HIV epidemic, most participants express that there is an urgent need to include and emphasize 'heterosexual men with multiple sex partners' in the strategy as one of the target population for action.

Participants point out that the community 'the clients of female sex workers' has been included in the last HIV/AIDS strategy (2012-2016) and was also one of the target groups who expressed their views in the ACA community consultation earlier, they wonder why this population has been totally missed out in the whole strategy and demand more justification from the ACA for the reasons behind.

It is recommended that the following be mentioned in the strategy:

i. 'Heterosexual men with multiple sex partners' should be mentioned in 'other populations' as one of the populations that need to be targeted in HIV prevention and treatment.
ii. There should also be clear description of the HIV situation among heterosexual men in the section of 'global and local HIV situation and future projection' and 'review of current response to HIV/AIDS' to inform future intervention efforts. It is particularly mentioned that the 'emerging service needs' (section 4B Point 9) should be clearly specified to indicate the new challenges and needs of the communities.
iii. 90% of 'heterosexual men with multiple sex partners' should have access to HIV combination prevention services in the last one year in the section of 'nine targets to be achieved by 2020'.

Rename the community as 'heterosexual men with multiple sex partners'

Participants express that the name of the community 'clients of female sex workers' should be changed to 'heterosexual men with multiple sex partners' instead to reflect the changing patterns of high risk sexual behavior from patronizing female sex workers in brothels and nightclubs to finding irregular sex partners via the internet or other places.

Resources and research

Many participants express the need for resource channeling into research on the

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sexual behavior of heterosexual men and developing HIV prevention measures for this particular population.

Enhance HIV prevention measures for high risk heterosexual men

It is suggested that HIV prevention measures that are targeted at other populations can also be implemented to high risk heterosexual men as well and resources should be channeled into the following measures.

1. Enhance HIV testing services for the general youth regardless of their sexual orientation by incorporating HIV testing with other body checks in government clinics
2. Enhance internet outreach and promotional activities to high risk heterosexual men

D. People living with HIV

Treatment and care

Participants express their appreciation for the quality of treatment they get in Hong Kong, but are generally worried about the continuous strain on resources with the projected rise of HIV infections. They suggest that resources be channeled to enhance the following services:

i. More service delivery points: open at least one more clinic in New Territories and the Hong Kong Island
ii. Open the clinics at more timeslots in the weekend
iii. Mental health services should be enhanced as the people living with HIV need to wait for long periods of time for counselling or psychiatry sessions. The role of clinical psychology for people with HIV should be enhanced and incorporated into the healthcare system more strongly.
iv. Healthcare services for people living with HIV should be enhanced as the quality of care is decreasing due to the strain of resources. There should be more time in each consultation session and more HIV training for the newly recruited healthcare professionals, who usually have lower sensitivity to people living with HIV.

PrEP and PEP

i. Participants recognize the need of implementing PrEP and PEP to partners of people living with HIV, but also raise their concerns on drug adherence and

drug resistance, as well as the potential strain on the workload of the current clinics.

ii. Participants suggest that PrEP should be implemented without compensating the current service quality to people living with HIV. Service models like subsidizing private medical institutions to provide PrEP can be a possible solution.

iii. Participants observe that many partners of people living with HIV are unable to get nPEP prescription in the public hospitals, and suggest that the guideline on nPEP prescription be thoroughly implemented to prevent potential HIV infections.

Priority population

Some participants suggest that people living with HIV be included in the 'priority populations' and there should be more emphasis on this community from the perspective of HIV prevention. Without proper treatment and care, many people living with HIV would have poor psychosocial functioning, which contribute to poor health outcomes and raise the risk of unsafe sex, which has bad implications on the HIV epidemic.

Anti-stigma environment for people living with HIV

There is no mentioning of the importance of creating an anti-stigma environment for people living with HIV in the section 8 'Priority areas for action' and should be added in the strategy, just like the previous recommended strategy (2012-2016).

E. Injecting Drug Users

Point 42: Reaching injecting drug users of ethnic minorities

Apart from Vietnamese, other ethnic minorities including Pakistani, Nepalese, new immigrants from China and Chinese nationals holding two-way permit should also be included in the strategy.

Point 43: Recruitment into methadone clinics

Injecting drug users should be recruited into 'methadone treatment programme (both maintenance and detoxification)' instead of 'methadone treatment programme'. IDU should be given the option to maintain their methadone usage overtime regardless of their injecting drugs behavior as a better approach in harm

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reduction.

Point 44: Maintain high HIV testing rate

Mobile testing should be provided and supported to reduce the economic and geographical difficulties IDU face in reaching physical testing venues. This can help monitor the HIV epidemic and ensure that newly diagnosed injecting drug users are immediately linked to HIV care.

Point 45: Avoid needle sharing

Injecting drug users should be educated and supported to use new and disinfected hypodermic needles to inject drugs. Clean needles should be freely distributed to injecting drug users. Needle disposal bins and clamps should be provided in places where injecting drug users usually appear, including methadone clinics, parks and public toilets, to ensure used needles are properly disposed. The HIV epidemic of the IDU, the injecting drugs and needle sharing behavior of the IDU, and the level of convenience in obtaining clean needles should be closely monitored.

Hepatitis C prevention education used as an HIV intervention measure

Participants suggest that the approach used in Hepatitis C prevention promotion, education, testing and treatment should be adopted as a key IDU intervention measure. Injecting drug users generally have much higher health awareness in Hepatitis C prevention and this approach can attract the injecting drugs users to be more concerned about their health.

Decriminalization of the possession of hypodermic needles

Participants suggest that if police stop using possession of hypodermic needles as evidence in drug enforcement cases this could help create a more friendly environment for HIV prevention.

Priorities of the above points should be arranged as follows:

1	Point 45
2	Point 44
3	*Hepatitis C prevention education used as an HIV intervention measure*
4	Point 43
5	Point 42

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F. Female Sex Workers

One participant shows discontent over the lack of resources on female sex workers intervention measures, and the lack of legal protection for female sex workers. The participant demands justification for the missing points regarding decriminalization of sex work and not using condoms as evidence of prostitution in court as these legal measures are already proved to be effective in creating a friendly environment for HIV prevention.

G. Sex education

Participants from different communities have voiced out the importance of sex education in reducing HIV epidemic, and would like the strategy to enhance the part on 'training and education' (CI point 53) with the following additions:

1. The ACA should set a clear target on school sex education, specify ways to achieve it, and conduct regular evaluation on student knowledge and behavior regarding sexual health.
2. The description of sex education as being 'life-skills based' is too vague and the ACA should specify which key elements should be included in sex education. Participants express that the content of sex education should be comprehensive, including HIV knowledge, love and relationships, dispelling myths against the gay community and HIV anti-stigma message.
3. To further empower the youth in school sex education, empowerment activities such as peer counselling program should be implemented so that the sex education needs of the youth can be catered individually.
4. Sex education should be implemented in primary schools, secondary school and tertiary education institutions.
5. General sexual health education should be conducted through media platforms like TV and the internet to raise the HIV awareness of the public.

Appendix (6)

UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

UNHCR UNODC
UNICEF ILO
WFP UNESCO
UNDP WHO
UNFPA WORLD BANK

Secretariat
Hong Kong Advisory Council on AIDS
3/F Wang Tau Hom, Jockey Club Clinic
200 Junction Road East, Kowloon
Hong Kong

28 December 2011

Dear Sir/Madam,

As the Country Coordinator of the United Nations Joint Programme on HIV/AIDS (UNAIDS) China office, which also covers the Special Administrative Regions of Hong Kong and Macau, I have recently become aware that the Hong Kong Advisory Council on AIDS (ACA) is currently drafting the *Recommended HIV/AIDS Strategies for Hong Kong, 2012 – 2016.* Hong Kong is well-regarded in the region for its response to the HIV epidemic to date. I commend the ACA on its efforts to ensure that the new strategy is evidence-based and responds to the key drivers of the epidemic in Hong Kong. I also commend the ACA on the consultations around the new strategy that have been held with key community stakeholders. Communities are invaluable partners in every aspect of national and international responses to HIV.

In support of the drafting process, I would like to draw the ACA's attention to a number of recent documents that outline important commitments and strategies for national HIV responses. These documents may be of assistance to you in finalising Hong Kong's HIV strategies for the next 5 years.

In December 2010, the UNAIDS Programme Coordinating Board approved the UNAIDS Strategic Plan 2011-2015 *"Getting to Zero"* (http://www.unaids.org/en/aboutunaids/unaidsstrategygoalsby2015/). This outlines a strategy for all partners, including governments, for an effective HIV response. *Getting to Zero* was developed through wide consultation, informed by the best evidence and driven by a moral imperative to achieve universal access to HIV prevention, treatment, care and support and the Millennium Development Goals. The Strategy outlines a three-pillared vision and 10 concrete goals for 2015 towards attainment of the vision. The vision is: zero new HIV infections, and zero discrimination, and zero AIDS-related deaths.

As the new UNAIDS strategy is more closely aligned with the new Hong Kong strategy in terms of time frame, and has been formally approved by the Programme Coordinating Board, I would recommend that this document, rather than the *UNAIDS Outcome Framework: Joint Action for Results (2009-2011)*, be referenced as the relevant UNAIDS strategy in the Annex to the Hong Kong Strategy. I would also invite you to consider adopting the vision and goals of the UNAIDS Strategy as goals for the Hong Kong Strategy, as has been done already by China and South Africa. On 11 July 2011 China's Vice Premier Li Keqiang stressed in a meeting with UNAIDS Executive Director Michel Sidibé that *Getting to Zero* — the UNAIDS strategy calling for zero new HIV infections, zero discrimination and zero AIDS-related deaths

-8-1, Tayuan Diplomatic Office
uilding
4, Liangmahe Nalu
)ongwai Dajie
3eijing, China 100600

el: +8610 8532 2226
ax: +8610 8532 2228
/ww.unaids.org
/ww.unaids.org.cn

worldwide — constitutes a guiding vision for China's national HIV strategy. Given the strong external influences on the Hong Kong epidemic, the opportunity for alignment of priorities and actions between Hong Kong and mainland China presented by the new UNAIDS Strategy should be further considered by the ACA and its partners.

I would also like to highlight the importance of the *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS* (http://www.un.org/ga/search/view_doc.asp?symbol=A/65/L.77), adopted by the General Assembly in June 2011 following the High Level Meeting of UN Member States in New York. This Declaration contains concrete, time-bound goals for all national responses which are based on the most recent evidence regarding effective strategies for addressing HIV and AIDS. One of the key lessons learned through the history of the AIDS response globally is that stigma and discrimination against people living with and affected by HIV, and against key affected populations such as sex workers, men who have sex with men, transgender people and people who use drugs, create barriers to access to HIV prevention, treatment, care and support programmes for those most in need. Accordingly, Member States committed to, *inter alia:*

- intensify national efforts to create enabling legal, social and policy frameworks in each national context in order to eliminate stigma, discrimination and violence related to HIV and ... to promote and protect all human rights and fundamental freedoms with particular attention to all people vulnerable to and affected by HIV; and

- national HIV and AIDS strategies that promote and protect human rights, including programmes aimed at eliminating stigma and discrimination against people living with and affected by HIV, including their families, including through sensitizing the police and judges, training health-care workers in non-discrimination, confidentiality and informed consent, supporting national human rights learning campaigns, legal literacy and legal services, as well as monitoring the impact of the legal environment on HIV prevention, treatment, care and support.

Addressing HIV-related human rights issues through comprehensive programmes to reduce stigma and discrimination and increase access to justice for key affected populations will be critical to Hong Kong's ability to achieve the goals articulated in the draft strategy for 2012 – 2016. To the extent that priorities relating to the creation of enabling legal and social environments for people living with HIV and key affected populations (including men who have sex with men, transgender people, sex workers and their clients, people who use drugs, ethnic migrants and youth at risk) were identified in the report of the Community Stakeholders Consultation Meeting, I encourage the ACA to incorporate strategies and actions to address these issues in the next Hong Kong strategy. I can confirm that evidence from the region and globally consistently identifies punitive and discriminatory legal environments as one of the main barriers to effective HIV responses. For example, evidence from the 2008 Report on the Global AIDS Epidemic suggests that countries that have non-discrimination laws that protect most at risk populations have achieved higher HIV prevention coverage.

I encourage the ACA to consider strengthening the actions articulated in the draft strategy for creating an environment that is free of discrimination and conducive towards universal access for all, especially the populations most vulnerable to HIV transmission. Such actions include, but are not limited to: legal audits and law reform (including removing punitive laws and putting in place laws to prohibit discrimination

against key affected populations); programmes to reduce stigma and discrimination against people living with HIV and other key affected populations; legal services for people living with HIV and other key affected populations; legal literacy programmes such as 'know your rights' campaigns; training of health care workers on non-discrimination, informed consent, confidentiality and the duty to treat; programmes to improve law enforcement practices by police, lawyers and judges; and programmes to reduce harmful gender norms and violence against women and to empower women and girls in the context of HIV. Tools and guidance are available from UNAIDS to assist in the costing, monitoring and evaluation of these types of programmes (www.unaids.org).

I wish you the best in your continued collaboration with government and community partners to finalise the Recommended HIVC/AIDS Strategies for Hong Kong 2012-2016, and to implement the actions planned to achieve your goals.

Please let me know if I can be of any further assistance in this process.

Yours sincerely,

Chen Zhaoyan for

Mark Stirling
UNAIDS Country Coordinator
UNAIDS China