

Strategies
for AIDS Prevention,
Care & Control
in Hong Kong

Advisory Council on AIDS Hong Kong

1994

Preface

The AIDS epidemic is more than just a health issue. Its impact on the individual and the society poses a challenge to our policy-makers, the administration, service providers, as well as the community.

The Advisory Council on AIDS, since its establishment in 1990, has been actively involved in the strategic planning of the AIDS programme in Hong Kong. The provision of an overall policy framework is clearly indicated for guiding the development of effective measures to contain the infection. *Strategies for AIDS Prevention, Care & Control* is prepared by the Council for achieving this purpose.

Through the publication of *Strategies for AIDS Prevention, Care & Control*, the Council sets out strategic directions to consolidate and coordinate the local programme on AIDS. AIDS concerns everyone. As a comprehensive document, there are certainly aspects which are relevant to each community sector in Hong Kong. An executive summary is prepared in parallel for easy reference of the general public.

The Advisory Council welcomes comments on this document as well as the implementation of Hong Kong's AIDS programme. They should be addressed to:

Secretariat
Advisory Council on AIDS
C/o Department of Health
21st floor, Wu Chung House,
213 Queen's Road East, Wan Chai,
Hong Kong

Tel: (852) 961 8550
Fax: (852) 836 0071

Secretariat
Advisory Council on AIDS
Hong Kong
October 1994

Contents

| Page | |
|------|--|
| 1 | Preface |
| 2 | Contents |
| 4 | 1. Background |
| | 1.1 The HIV/AIDS Pandemic |
| | 1.2 Global Response to AIDS |
| | 1.3 Development of AIDS Programme in Hong Kong |
| 10 | 2. Development of AIDS Strategy |
| | 2.1 Objectives |
| | 2.2 Pre-requisites for an effective AIDS Programme |
| | 2.3 Key Principles |
| 14 | 3. AIDS Strategy – an Overview |
| | 3.1 Prevention of HIV Transmission |
| | 3.2 Care of People with HIV/AIDS |
| | 3.3 Surveillance & Control |
| | 3.4 Partnership in HIV/AIDS Prevention & Care |
| 25 | 4. Meeting the Needs of HIV/AIDS Patients |
| | 4.1 Background |
| | 4.2 Development of a coordinated HIV Management System in the Public Service |
| | 4.3 Roles & Responsibilities of Involved Parties |
| | 4.4 Future Development |
| 31 | 5. AIDS Policy in the Community |
| | 5.1 Media |
| | 5.2 Schools & Students |
| | 5.3 Workplace |
| | 5.4 Adolescents & Youth |
| | 5.5 Women |
| | 5.6 Children |
| | 5.7 The Homosexual Community |
| | 5.9 Sports |
| | 5.10 The Haemophiliacs |
| | 5.11 Health Care Settings |
| | 5.12 Blood Transfusion |

- 63** **6. Policy for Communities practising High Risk Behaviours**
 - 6.1 Substance Abuse
 - 6.2 Prostitution/Sex Industry
 - 6.3 The Prison Setting
 - 6.4 STD & AIDS

- 72** **7. AIDS & the law**
 - 7.1 The Public Health
 - 7.2 Transmission Offences
 - 7.3 Privacy and Confidentiality
 - 7.4 Anti-discrimination and Equal Opportunities

- 77** **Appendix I** : Abbreviations

- 79** **Appendix II** : References

- 82** **Appendix III** : Organizational Structure of Hong Kong' s AIDS Programme

- 83** **Appendix IV** : Advisory Council on AIDS

- 84** **Appendix V** : Useful Addresses & Telephone Numbers

Background

1

1.1 The HIV/AIDS Pandemic

AIDS is the acronym for acquired immunodeficiency syndrome. It represents the late stage of human immunodeficiency virus (HIV) infection which causes progressive depletion of a person's defence system, thereby predisposing oneself to the complications of superimposed secondary infections and/or tumours.

AIDS has in fact been depicted as the plague of modern time in view of its propensity to disseminate and claim human lives. Irrespective of all myths and controversies surrounding HIV/AIDS, there are in fact only a limited number of routes for HIV transmission to occur – sexual intercourse with an infected person, sharing of contaminated syringes/needles or use of infected blood/blood products, and from an infected mother to her baby.

Since the diagnosis of the first AIDS case in the United States in 1981, the infection has been spreading to virtually every inhabited country on earth. As of the end of June 1994, a total of 985,119 AIDS cases have been reported to the World Health Organization (WHO). The estimated number of infection, however, stands at 17 million, out of which over four million have already progressed to AIDS. On a global level, sex remains the commonest mode of transmission, accounting for >3/4 of all cases known to date. By the year 2000, the WHO projects that there would be as many as 30-40 million HIV infected persons in the world. On the other hand, the Global AIDS Policy Coalition, an independent authority, set the upper bound as 110 million.

HIV infection is still in a dynamic state, and is gaining momentum in its dissemination in many parts of the world. The geographical location of Hong Kong puts it in the heart of the major focus of the epidemic in the nineties – Asia. Despite the relatively small number reported in this part of the world, there is compelling evidence that, at a regional level, there are in existence all the favourable factors for an explosive HIV/AIDS problem to occur. In Hong Kong as of the end of August 1994, the cumulative number of HIV infection reported was 480, of which 115 had developed AIDS and 70 died. Based on epidemiological analyses undertaken in the past two years, it is believed that the true figure of HIV infection is in the range of a few thousands.

The impact of HIV/AIDS surmounts its clinical consequences. In Hong Kong, AIDS has attracted much public attention despite its relatively low prevalence. It is clear that AIDS carries with it more social than medical meanings. The media has, time and again, reminded us of the non-medical aspects of AIDS-discrimination against patients, controversy with confidentiality, failure in providing social services to the infected ones and their families, panic in facing an HIV+student or workmate, practice of compulsory HIV antibody testing, prostitution and its associated risk of HIV spreadto name a few. In places with a high HIV prevalence, for example, in Thailand, there is the additional burden of economic loss when young adults fall sick of AIDS. In USA, on the other hand, AIDS has already overtaken accidents and become the number one killer for those aged between 25 and 44.

Despite its incredibly short history, AIDS has alerted mankind to the complexity of a public health issue which demands the attention of all sectors of the community. It is essential that we understand thoroughly how the epidemic has come about, and how it is going to affect us, so that sensible strategies can be developed to bring the disease under control.

1.2 Global response to AIDS

Science has progressed at enormous speed ever since the diagnosis of the first AIDS case over a decade ago. The causative virus HIV was discovered in 1983, only two years after the initial diagnosis of AIDS in USA. In the ensuing years, it became clear that a comprehensive AIDS programme was crucial for all nations because of the complexities of the infection, its social implications and the likelihood that a cure will not be in sight in the foreseeable future.

In 1986, WHO established the Global Programme on AIDS to initiate, support and coordinate AIDS work at national and international levels. It was resolved by the World Health Assembly in 1987 that AIDS should be treated as a global emergency. In October of the same year, the United Nations General Assembly called for coordinated and international action against AIDS, the first time that a disease was put on its agenda. Such a move was echoed and consolidated by the London Global Summit attended by health ministers of 148 countries in January 1988.

The WHO has defined the following integral components for a national AIDS programme: (1) an appointed advisory committee; (2) a manager to take charge of the programme; (3) an action plan and (4) a budget. By 1990, all countries had a programme on AIDS, though it might not comply with all these WHO requirements. A multisectoral approach had been adopted, and some committees (e.g. Thailand, Uganda, USA) were directly responsible to the heads of states. Most of the national AIDS committees are, however, responsible to the health ministers. AIDS has gradually been taken not just as a health problem but a social, economic and development issue, particularly by such international organizations as UNDP (United Nations Development Programme), UNICEF (United Nations Children's Fund) and the World Bank.

In the past decade, national and international AIDS programmes have assumed a high profile and have aroused much public awareness. Emphases on mass media campaigns, safe blood supply and epidemiological analyses represent major achievements accomplished in some places so far. In the midst of an ever-growing HIV/AIDS pandemic, the world is now at its crossroad – what, then, are the missing elements of an effective AIDS programme? The last decade witnessed modifying individual behaviour as the prime strategy for AIDS control. Though crucial, it is now considered insufficient to effect desirable changes. International organizations, including the WHO, are now seeing societal risk as the key determinant of vulnerability to HIV infection. AIDS prevention requires a favourable social environment for individual high risk behaviour to be modified. Sound policy, good leadership, and accessible health infrastructure in a non-discriminatory society are important in effecting behavioural changes, which are central to prevention of transmission in any nation.

1.3 Development of AIDS Programme in Hong Kong

1.3.1 Historical Development

HIV infection was first diagnosed in Hong Kong in late 1984, at a time when the significance of a positive blood test was still a mystery. In confronting the disease, we have gone through the following phases:

The initial phase 1984-1986

An expert committee was established in late 1984 by the then Medical & Health Department to advise the government on how to cope with the new disease. A scientific working group was formed in the following year to implement, coordinate and monitor prevention activities. Key achievements of this short period included: establishing an AIDS counselling clinic and a hotline, supply of safe heat-treated blood products, safeguarding blood supply through blood-screening by the Hong Kong Red Cross Blood Transfusion Service, establishment of a surveillance system, and provision of HIV antibody testing to people at risk of infection.

The intensification phase 1987-1989

Public education was high on the agenda for this second phase of AIDS programme development. A committee on education & publicity on AIDS and a publicity working group were formed to initiate, implement and coordinate publicity and education programmes. These were conducted with the assistance of various government departments as well as the community. As for media publicity, television spots (APIs) were produced by the Government Information Service focusing on all aspects of HIV/AIDS. The AIDS Counselling and Health Education Service of the Medical & Health Department was expanded to become an operational arm of the Committee, which organized educational activities targeting different community groups..

The consolidation phase 1990-1993

A central Advisory Council on AIDS, appointed by the governor, was established in March 1990. The Council has served to develop AIDS strategy and streamline the operations of the Committee on Education & Publicity (CEPAIDS), the Scientific Working Group and the Department of Health. The CEPAIDS expanded considerably through the formation of 7 working groups targeting general public, drug abusers, community groups, schools/students, youth and also focusing on training activities and research/evaluation. Community participation was encouraged. Both the Hong Kong AIDS Foundation and the AIDS Concern were formed during this same period, so were the homosexual organizations. In early 1993, the AIDS Trust Fund was set up to provide ex-gratia payment to HIV infected haemophiliacs and transfusion recipients, and to fund educational and AIDS care projects.

1.3.2 Structure of the Existing AIDS Programme

Committee Structure

The governor-appointed Advisory Council on AIDS (ACA) provides the overall supervision of the AIDS programme in Hong Kong, Its terms of reference are:-

1. To keep under review local and international trends and developments relating to HIV infection & AIDS; and
2. To advise Government on effective programmes for prevention of AIDS and support services for HIV-infected persons and on further development of a comprehensive strategy of AIDS.

With the exception of the Director of Health, the consultant of the AIDS Unit of the Department of Health, representatives of the Health & Welfare Branch, and the Hospital Authority who are government or public service officials, all other members are community leaders, professionals or heads of voluntary organizations.

The Advisory Council is underpinned by 3 committees which have executive functions – the Scientific Committee on AIDS(SCA), the Committee on Education and Publicity on AIDS(CEPAIDS) and the AIDS Services Development Committee (ASDC). Secretarial and the main operational supports are provided for by the Department of Health.

Government Operations

A multisectoral approach is adopted in the planning and implementation of AIDS programme in Hong Kong. Some of the programme areas are integrated in the existing government structure in its execution. Government department/Branches with active involvement in the AIDS programme include the Information Services Department, Education Department, Social Welfare Department, Department of Health, City & New Territories Administration, Health & Welfare Branch, Correctional Services Department, Narcotics Division of the Security Branch and Hospital Services Department (now the Hospital Authority). Their work is supplemented by other public bodies, notably the Hong Kong Red Cross Blood Transfusion Service.

A significant proportion of AIDS-related activities are initiated and undertaken by the AIDS Unit which is operative under the Special Preventive Programme of the Department of Health. It is responsible for the provision of the following services:-

- (a) AIDS counselling service (with a hotline).
- (b) Health education programme on AIDS.
- (c) A special Medical Clinic which provides consultation, HIV screening, clinical treatment and support service for HIV positive individuals in the public sector.
- (d) Operation of a resource centre.
- (e) Epidemiology and surveillance activities.
- (f) Research.

Voluntary Agencies

There are currently two AIDS services organizations in Hong Kong-AIDS Concern and the Hong Kong AIDS Foundation, which were established in 1990 and 1991 respectively. Concurrently, other voluntary agencies have also been playing an active role in complementing the government's educational efforts, through their participation in programmes organized by the Committee on Education and Publicity on AIDS. Some of these organizations are Caritas, the Hong Kong Federation of Youth Groups, Family Planning Association, the Hong Kong Children & Youth Service, SARDA etc.

Financing

Majority of the funding for the local AIDS programme has come from the government, which is available through the following channels:

(a) The Public Service

Activities on HIV/AIDS prevention and control are funded by the government in the public sector through the financing of programmes directly or indirectly relating to AIDS, but a single overall "AIDS budget" does not exist.

Department of Health –

Running of the AIDS Unit (HIV/AIDS surveillance, education, counselling and care), Social Hygiene Service (STD prevention and treatment), Virus Unit (undertaking HIV tests), Pathology Service (CD4 counts and other laboratory tests), Methadone Clinics and support to the Advisory Council on AIDS and its committees/working groups.

Hospital Authority –

Provision of hospital services to HIV/AIDS patients, undertaking pre-donation HIV screening at the Hong Kong Red Cross Blood Transfusion Service.

Social Welfare Department –

Social support to HIV/AIDS patients whenever necessary.

(b) AIDS Trust Fund

on 16 April 1993, the Finance Committee of the Legislative Council approved a sum of HK\$350 million for setting up the AIDS Trust Fund, under which the Financial Secretary Incorporated is the trustee. The money is to be used for

- ♦ exgratia payment for persons infected by HIV through the transfusion of blood or blood products prior to August 1985 (\$100 million)
- ♦ funding projects on medical and support services for HIV/AIDS patients (\$200 million)
- ♦ funding AIDS publicity and education projects (\$50 million)

Development of AIDS Strategy

2

2.1 Objectives

HIV/AIDS is more than a clinical problem. It affects predominantly young people, who concurrently constitute the important workforce in a society, and may therefore predispose to economic loss. Its links with human behaviour and attitudes produces a complex picture no other diseases have faced before. Infected people are usually healthy for a long period of time before they succumb to fatal complications. The chronicity, absence of miraculous cure, and non-existence of a useful vaccine all mean that we need to focus on prevention as well as care for the infected ones. It should be noted also that even if a cure is here today, the society still has to face and bear its social and health implications in the years to come.

It has become clear, in recent year, that the objectives of an effective AIDS strategy should go beyond HIV prevention by taking into consideration how the disease has actually been, or will be, affecting the human society. As AIDS observes no border boundary, collaboration and cooperation with other countries are essential in its prevention and control. The success of an AIDS programme should, in future, be judged not by how infection has been prevented, but how the society at large has been functioning to achieve that goal. Recommended objectives of an effective AIDS programme, adapted from the WHO and the Global AIDS Policy Coalition, are:

- (1) To prevent HIV infection;
- (2) To reduce the negative impacts of the disease on the individual and the society;
- (3) To reduce societal discrimination and promote respect for human rights and dignity;
- (4) To develop and strengthen global solidarity against HIV/AIDS, thereby advancing the health of all people.

2.2 Pre-requisites for an effective AIDS programme

An effective AIDS programme requires the following components to be in place before the objectives outlined in section 2.1 can be attained:

(1) Information and education

Availability of information and provision of education are the key pre-requisites for an effective AIDS programme. Such necessities should be accessible to all sectors of the society, packaged in such a way that they are accepted and understood, and that effort should be sustained to achieve the optimal outcome.

(2) Clinical and support service

Information and/or education is insufficient by itself to motivate at-risk individuals to seek advice, the critical step towards behavioural modification. Counselling, advice, medical treatment and support services are important supplementary measures for a comprehensive programme. Like information/education, these services should be affordable and accessible to all in the society, especially for the marginalized groups (e.g. drug users, commercial sex workers, prisoners) whose participation in the AIDS programme is essential in our fight against the disease.

(3) Supportive environment

Individual behaviour has always been the prime focus of action for interrupting HIV transmission. In keeping with this advocacy, a supportive social environment is crucial to effect behavioural modification. There should, therefore, be no legal or other barriers to the dissemination of information/education, hindrance imposed on people for receiving and acting on such preventive measures, and obstacles in accessing health and social services in general.

2.3 Key Principles

There are certain basic or key principles which form the backbone of the prerequisites detailed in section 2.2. If observed, such principles would facilitate the establishment of an effective AIDS programme, and would guide us to achieving the objectives set out in section 2.1.

2.3.1 *Non-discrimination*

People who are marginalized or discriminated against would not be in a favourable position in modifying risky behaviour, thereby causing hindrance in ultimately promoting health in the society at large. It is therefore crucial that a non-discriminatory principle is observed in implementing all activities (provision of information/education, conduction of surveillance and delivery of patient service) pertaining to the development of a comprehensive AIDS programme in Hong Kong.

2.3.2 *Commitment*

AIDS prevention and service programmes cannot be effective in the absence of full support from society – its people, as well as the government. Such commitment is necessary BOTH at the operational level and amongst community leaders and policy-makers. The latter is particularly important in creating a favourable environment (section 2.2) for behavioural modification to occur.

2.3.3 *Integration*

HIV/AIDS, because of its vast social and potential economic implications, should never be dealt with an isolated health issue. Good AIDS programmes are often integrated into existing or developing general and specific health/social programmes. Some examples are the integration of AIDS education into sex education activities, a combined STD (sexually transmitted disease)/HIV management system, and a coordinated AIDS/drug awareness campaign.

2.3.4 *Sustained effort*

In the absence of an effective vaccine or cure, HIV/AIDS is likely to be with us in the years to come. Even if the virus stops propagating today, there would still be a substantial number of infected people which a society needs to take care of. These, together with the complexities of AIDS as it relates to human behaviour, imply that the AIDS effort should be sustained, continued and adjusted to meet the changing requirement of individual and society. It is imperative, therefore, that an AIDS programme should be built into the existing framework of health and social infrastructure, instead of being conducted as fragmented isolated campaigns.

2.3.5 Solidarity

Meaningful AIDS programme is built upon a caring society with people sharing the common goals of HIV prevention and reduction of its negative personal and social impacts. This sense of solidarity is essential not just within a community, it holds also for the society at large. Since the virus observes no country, race or cultural barriers, global solidarity is, or should be, the cornerstone of strategy development in our fight against AIDS. This underlines the importance of promoting better understanding and cooperation with our neighbouring countries within the region, and also on a global scale.

AIDS Strategy – an Overview

3

3.1 Prevention of HIV Transmission

Prevention is indisputably the most important objective of the global strategy, since it is the only way to avert all the human, social and economic costs of HIV infection, which is lifelong and in the absence of curative drugs, believed to be ultimately fatal (Global strategy for the prevention and control of AIDS: 1992 update, WHO.GPA). As there are only 3 major routes for HIV transmission, prevention strategy can be considered under 3 respective headings – prevention of sexual transmission, blood-borne transmission and perinatal transmission. These three components are supported by international cooperation and financial commitment, as detailed in the last two sections in the chapter.

3.1.1 *Prevention of Sexual Transmission of HIV*

HIV infection today is largely a sexually transmitted disease. Transmission risk is proportional to the scale of practice of high risk sexual behaviour. Modification of sexual behaviour is, therefore, the most important strategy in our fight against HIV transmission. The essential integral components of an effective AIDS strategy on prevention of sexual transmission are as follows:-

(a) Provision of Information and Education

Essentially all men and women should be informed and educated about HIV infection, how it can and cannot be transmitted, and how they can protect themselves and their partners from infection through sexual intercourse. The need for avoiding having multiple sex partners and the risk of engaging in unprotected penetrative sex should be stressed.

Programmes for AIDS education should convey clear messages, and should be tailored for different communities – women, adolescents, school setting, parents, drug users, commercial sex workers (prostitutes), homosexuals, religious groups, prisons – taking into consideration the pre-existing socio-cultural patterns and values. As sexual behaviour is private, peer education is particularly relevant to bring about behavioural modification.

(b) Accessible Health Services

Early detection and prompt treatment of STD (sexually transmitted diseases) reduces the risk of HIV transmission. Attendance at an STD clinic also offers a unique opportunity for AIDS information and education to be conveyed to the clients. Voluntary use of a generally accessible STD service which provides prompt diagnosis and effective treatment of STD through trained health professionals is one important key to a successful AIDS programme.

Other opportunities for AIDS education are the maternal & child health centres and family planning clinics for women of child-bearing age, general practitioners' clinics for families and chest clinics in the community for some working adults.

(c) Supportive Environment

Behavioural modification is encouraged if the environment is supportive of such change. For Hong Kong, a supportive environment bears the following meanings:

PERCEPTION of safer sexual practice as the norm in the peer group or in the community.

ABSENCE of legal or other barriers to the dissemination and adoption of safer sex messages, including condom promotion.

ACCESSIBILITY of information/education and health services to 'marginalized' people in the society, including the homosexuals, commercial sex workers, drug users, prisoners, migrants and Vietnamese detainees.

FIRM public support for AIDS educational programmes.

3.1.2 Prevention of Blood-borne Transmission of HIV

Blood-borne transmission of HIV may occur through (a) needle-sharing among intravenous drug users; (b) transfusion of contaminated blood or blood products and (c) accidental injury or mucosal contacts with infected blood/body fluids in the health care setting. On a global scale, the potential for HIV to spread through needle-sharing is, by far, the highest compared with the other circumstances.

(a) Injecting Drug Use

The risk of HIV infection among injecting drug users is related to the practice of high risk needle-sharing behaviour. Like any behaviour problem, education is naturally the most effective means for modification to come about. The long term goal should be the reduction of demand for psycho-active drugs. There should also be the intermediate goal of reducing drug injection, to be backed up by a more immediate goal of reducing the risk of injection. Strategies for achieving the latter goals are directly linked with HIV prevention, which requires:-

THAT educational campaigns be organized targeting drug users and ex-drug users;

THAT access to clean needles (disposable needles and/or bleach for cleaning needles) be made readily available;

THAT information/education on preventing sexual transmission be packaged together with the programme on preventing infection through drug injection;

THAT health promoting norms be encouraged among drug users, and that legal repression, stigmatization and social exclusion be minimized.

(b) Blood and Blood Production

To minimize the risk of HIV infection through blood and blood product transfusion, it is necessary that:

THE system of testing every unit of donor blood for HIV antibody be continued;

THE concept of donor deferral be pursued to further safeguard blood supply;

EDUCATION of prescribers be developed to reduce unnecessary transfusion;

DONOR-screened, heat- or detergent-treated safe clotting concentration be used for haemophilia treatment.

(c) Health Care Setting

The best means of further minimizing the already uncommon occurrence of HIV transmission in the health care setting is by adherence to good infection control practice. The guiding concept, as suggested by WHO, is that of ‘universal precaution’, which embodies the assumption that all blood/body fluids are potentially infectious. Health care workers should therefore adopt standard infection control practice in handling all blood or body fluids. Identification of procedures instead of ‘high-risk’ patients should naturally follow.

3.1.3 Prevention of Perinatal Transmission of HIV

Prevention of sexual transmission of HIV to women is primarily the best strategy for preventing perinatal HIV transmission as infection of women of child-bearing age usually occurs sexually.

For women who are already HIV-infected, the most effective means of preventing perinatal HIV transmission is by avoiding child-bearing. Knowing that only 15%-40% of infants born to HIV+ mothers are infected, and that there are significant social, psychological and economic consideration for child-bearing and childlessness:

POTENTIAL mothers should be provided with information, education and counselling on HIV and child-bearing;

DECISION to or not to bear a child should be made by the mother, with the psychological, social and health support provided.

3.2 Care of People with HIV/AIDS

Whereas AIDS prevention programmes aim at reducing HIV infection in the community, AIDS care programmes involve relief of physical and psychological suffering, and minimize the impact of the disease on the society. On an operational level, AIDS prevention and care activities are often conducted simultaneously – the effectiveness of one often enhances that of the other programmes.

3.2.1 Clinical Management

After variable length of asymptomatic disease, people with HIV infection often develop complications arising from the underlying immune defects. Clinical management involves therefore activities relating to HIV diagnosis in the initial phase, followed by prevention and treatment of complications, notably opportunistic infection and/or neoplasms. As a chronic illness with yet no cure and which carries significant social stigma, it is necessary:

FOR HIV tests to be available in the public service in context of counselling, which should be supported by appropriate health and social services for those tested +ve or at high risk of infection;

THAT quality clinical services be organized for HIV positive patients in the public sector;

THAT clinical services are affordable, accessible, continuous, and are responsive to the needs of patients;

FOR humane care to be available to HIV/AIDS patients, the same way that it is provided for other diseases, irrespective of the routes of transmission and the social background of the individual patient;

THAT clear guidelines be developed for the treatment of HIV disease and its complications;

FOR evaluation to be regularly conducted with the objectives of improving the standard of care and the efficiency of the delivery system of available clinical services;

THAT community-based treatment models be developed to facilitate integration of HIV/AIDS patients in the society.

3.2.2 Social and Other Support Services

HIV/AIDS especially affects marginal groups in the society. In the recent years, heterosexual HIV transmission has been on the rise and that more women are becoming infected with the virus. It is clear also that patients with the disease are often faced with psychological stress, discrimination, stigmatization and isolation, which are in addition to the long-standing physical illness they have to bear. It is prudent to see that:-

PUBLIC assistance and other forms of financial assistance provided for other diseases are equally available to HIV/AIDS patients, and their families;

COMMUNITY-based support services (community nursing, home-help, terminal care and other voluntary services) currently available for patients with chronic illnesses are extended to HIV/AIDS patients;

SPECIFIC psychosocial support services, which take into account needs of individual HIV/AIDS patient, are developed in the public service as well as by voluntary organizations;

TRAINING of health care workers and intermediaries are developed for the promotion of better clinical and psychological care to patients;

TRADITIONAL community mechanism and new mechanism are identified for coping with HIV infection and its impacts.

3.3 Surveillance and Control

3.3.1 *HIV Surveillance*

The World Health Organization defined public health surveillance as the collection of information of sufficient accuracy and completeness regarding the distribution and spread of infection to be pertinent to the design, implementation or monitoring of prevention and control programmes and activities. HIV infection, in view of its complexities and considerable social implication, is a superb example of why a good surveillance system is necessary for the purpose of strategic planning on the provision of appropriate, accessible and quality services as well as educational programmes for the control of the disease and its implications.

HIV surveillance is an **epidemiological** exercise. The design of an HIV surveillance methodology should:-

- (a) maximize the likelihood of obtaining useful and accurate epidemiological information about the distribution of HIV/AIDS in the community: and
- (b) minimize the likelihood of adverse individual or community consequences.

3.3.2 *The HIV Tests*

The performance of HIV antibody tests, leading to the generation of information on prevalence and incidence, is a key component of an HIV surveillance programme. An HIV antibody test may, however, carry either an epidemiological or personal objective. In Hong Kong, HIV antibody tests should be undertaken only under any one of the following three circumstances (Under no circumstances should mandatory or compulsory HIV tests be performed):

Voluntary HIV Testing

There is as yet no cure for HIV/AIDS. A positive HIV antibody test carries with it profound psychological impact and possible serious social and financial consequences to the individual. HIV testing should, therefore, not be taken as a routine investigation. It is recommended that:

- (a) HIV antibody testing should be performed only with explicit and informed consent of the individual. An individual should be counselled on the meaning of an HIV antibody test (positive or negative), the medical, sociopsychological and possible insurance implications and the importance of risk reduction.
- (b) In exceptional circumstance where it is not possible to obtain consent due to the individual being unconscious or unfit to give consent, the consent of the parent, legal guardian or close relative should be sought if the doctor believes that testing is necessary for the preservation of the patient's health or for the safety of persons other than the patient.

- (c) As testing will identify individual HIV-infected persons, attention to confidentiality is essential.
- (d) Supporting clinical and social services should be available for patients who are tested positive for HIV.

Unlinked Anonymous Screening (UAS)

This is the testing of a specimen for HIV antibody after elimination (unlinking) of all personal identifying information for each specimen. As an epidemiological method, UAS for HIV is NOT directed to the individual but carries primarily public health objective. The following guidelines are recommended in undertaking UAS for HIV surveillance:-

- (a) UAS involves use of specimens already collected for other purposes. Appropriate consent should be obtained for the procedure's primary purpose but NO additional consent is required for the HIV test itself.
- (b) No information should be requested in addition to that normally collected for the primary purpose for which the specimen is obtained.
- (c) All data that could potentially identify the individual must be removed from the specimens before they are tested by the laboratory under the UAS protocol.
- (d) There should be no possible way in which test results could be traced back to the individual, and anonymity should be preserved.

Screening Before Blood (or other organ) Donation

HIV testing is performed on blood and semen donors, and also potential donors for organ (including marrow, kidneys) transplantation in order to protect the recipients from the risk of HIV transmission. Donor (or potential donors) should be informed of their requirement of undertaking an HIV test, and encouraged to seek voluntary HIV testing if they are at risk of HIV transmission. Donor (or potential donors) should be informed of their requirement of undertaking an HIV test, and encouraged to seek voluntary HIV testing if they are at risk of infection. A referral system is devised whereby HIV positive donors could be channelled to the respective clinical service for medical follow-up, counselling and support.

3.3.3 Reporting HIV/AIDS

HIV infection and AIDS are not notifiable diseases by law in Hong Kong. The system has been adopted in view of the possible sociopsychological impacts of disclosing the identities of HIV-infected people, and the need for preserving confidentiality. In so doing the government is actually encouraging people to seek counselling and HIV testing if they have been at risk of contracting the disease. Medical practitioners, however, are advised to voluntarily report cases to the Department of Health for statistical and epidemiological reasons. A special report form (DH 2293) is used for reporting (i) newly diagnosed HIV infection; (ii) newly diagnosed AIDS; and (iii) change(s) of status of previously diagnosed HIV/AIDS cases. Reporting is channelled through the Special Preventive Programme of the Department of Health, and all information is kept in strictest confidence. Submission of the names and personal identifying information of the reported cases is not necessary.

Diagnostic Criteria

A diagnosis of HIV infection is made if a serological test for HIV antibody is positive by a preliminary testing system (usually a so-called “ELISA” test) and confirmed by a reliable secondary step (usually the “Western Blot” test). A diagnosis of AIDS is made if a patient satisfies the 1987 Centers for Disease Control (CDC) case definition, i.e. a positive HIV antibody result and the evidence of immunodeficiency as demonstrated by presence of one of the indicator diseases listed by the CDC. The revised criteria put forward by the CDC in 1993 has not yet been widely accepted by the international community. The Advisory Council’s Scientific Committee on AIDS is monitoring the progress of its development internationally, and may consider changes in due course.

Co-existence of other notifiable infectious diseases

It is clear, however, that HIV infected people are immunodeficient. They are therefore prone to development of complications especially opportunistic infections. Some of the latter are notifiable under the Quarantine and Prevention of Disease Ordinance (revised 1986). Should this happen, the attending physician should notify the Special Preventive Programme for arranging public health control measures. The epidemiological data thus collected would be submitted via the TB and Chest Service (for TB cases) or the Regional Health Offices (non-TB cases) for statistical analysis. Patients’ particulars will again be kept in strictest confidence. This system of arrangement was detailed in guidelines established by the Scientific Working Group of the Advisory Council on AIDS in 1992.

3.3.4 Behavioural Surveillance

HIV prevalence and incidence are indicators of how extensive the society has been affected by HIV. In order that an effective prevention programme can be designed, it is necessary to look into the vulnerability of the society. It is prudent, therefore, to collect data on AIDS-related behaviours in different communities on a regular basis, a concept similar to the collection of HIV antibody testing results in the HIV surveillance programme. Here, however, HIV-related behaviour instead of prevalence/incidence is monitored. As the practice of high risk behaviour comes before HIV transmission, the knowledge of the changing pattern of such behaviour is invaluable for the design of appropriate prevention programme. These behaviour should involve:

HIGH risk sexual behaviour – e.g. high number of sexual partners, indulgence in casual sex, unprotected sexual intercourse; and

HIGH risk drug taking behaviour – e.g. injecting drug use, needle-sharing.

3.3.5 Effective Approaches to Surveillance for HIV/AIDS Prevention and Control

To effectively fulfil the objective of public health surveillance (3.3.1) it is necessary that the following approaches are adopted:-

- (a) An infrastructure is established for efficiently collecting, analysing data and reporting to the relevant authorities and the public.
- (b) Epidemiological surveillance is not equivalent to case-finding. As a separate system, voluntary HIV testing is made available and accessible to those at risk of infection, and the service is organized in the context of counselling.
- (c) HIV surveillance should be supplemented by HIV-related behavioural surveillance so that appropriate interventional activities can be designed before the infection takes hold in the community.

3.4 Partnership in HIV/AIDS Prevention & Care

3.4.1 *Community Participation*

At the World Summit of Ministers of Health in London 1988, Dr. Halfdan Mahler, the then Director-General of World Health Organization, stressed the importance of community involvement as one of the pillars in the development of global strategy against AIDS. The message has actually paved the way for the declaration of the World AIDS Day 1992 – AIDS: a community commitment. The prime advantage of community participation lies in its access to individuals and the credibility of community organizations, which have well been demonstrated in the tackling of other social and health problems in human history.

Community participation is achieved by

- ♦ Mobilizing existing community-based organizations to incorporate relevant AIDS prevention/care activities into their agenda for action;
- ♦ Involving the community in the design, implementation and/or review of the AIDS programmes in Hong Kong;
- ♦ Promoting the development of AIDS prevention and care projects to supplement the existing programme;
- ♦ Providing support to non-governmental AIDS services organizations.

For effective community participation to occur, there is the need of (a) ensuring that relationship among relevant parties (governmental and/or non-governmental) is based on mutual respect; (b) acknowledging the unique credibility of associations formed by or for persons with HIV/AIDS; and (c) recognizing that maintenance of autonomy and collaboration between parties in areas of common concern are not mutually exclusive to each other. Currently the AIDS Trust Fund established in April 1993 is supporting AIDS prevention and care projects developed in the community.

3.4.2 *International Cooperation*

An effective AIDS Strategy calls for efforts not only at national but also international levels. It is clear that a supportive global environment is the key to the development of a good HIV/AIDS prevention and control programme for the human race. It is important, however, that national and international leaders are not blinded by complacency and denial, which may easily cause obstruction to strategy development. Hong Kong, because of its unique identity as an international city, its location as a gateway to China, and its possession of a rich communication system in the heart of Southeast Asia, is well placed to take on an active role in international AIDS movements. Such a proactive role would be beneficial to people of Hong Kong as well as the international community.

At international level, the following strategy is adopted by Hong Kong:

THAT there is active sharing of knowledges and resources with overseas countries, particularly our neighbouring nations;

THAT coordination of international HIV/AIDS research is pursued for promoting sharing of experiences and information, and for accelerating the development of strategies and technologies in the field;

THAT consensual policy shall be developed with neighbouring countries on issues of common concern by the adoption of universal principle of non-discrimination.

Meeting the Needs of HIV/AIDS Patients

4

4.1 Background

AIDS originated as a clinical problem. Despite considerable scientific advances made in the last decade, HIV/AIDS remains an incurable disease. Infected people usually go through a variable period of asymptomatic disease before half of them develops clinical complications defined as “AIDS”. Like any disease, the clinical outcome varies with the availability of health facilities, which encompass both medical as well as other support services.

In Hong Kong, of all reported HIV infection cases, about half have used the service provided in the public sector, notably that of the Department of Health. While the number of AIDS patients has remained small, demands for specific HIV/AIDS services would steadily increase because of (a) the general trend of early diagnosis and (b) enhanced public awareness and (c) progression of asymptomatic patients with time. In developing strategies for the provision of HIV/AIDS care, the following factors are considered:-

- (a) HIV infection is a chronic illness affecting young people in their prime years, and who are often in the working age range. Clinical and support services to HIV-infected people would therefore be meaningful not only to the individual but also the economy.
- (b) Because of the social stigma, HIV-infected people in Hong Kong are almost invariably unwilling to have their identities disclosed. Preservation of confidentiality is, therefore, one important principle in the organization of any forms of AIDS service in the territory.
- (c) HIV infection is still a relatively small clinical problem in Hong Kong. The advantages of centralizing AIDS services (with administrative convenience and facilitation of staff training) should be carefully balanced with its potential drawbacks of isolation, stigmatization and limitation of the development of expertise to only a small group of health care staff.
- (d) Except for periods of complication affecting physical health and in the terminal stages, HIV/AIDS patients are and should be encouraged to lead a normal life. This concept underlines the importance of adopting a community-based approach in the delivery of clinical and social services.
- (e) Clinical and support services are generally available from the public sector, voluntary agencies as well as the private sector. It is crucial that development should be facilitated and coordinated, with services supplementing and/or complementing each other appropriately.

4.2 Development of a Coordinated HIV Management System in the Public Service

4.2.1 Introduction

HIV management in Hong Kong was first initiated by the Medical & Health Department in 1985, which operated a small core team of health care staff based in Queen Elizabeth Hospital. The team was responsible for providing counselling as well as both out-patient and in-patient treatment programmes centred in the same hospital. The policy, however, was that all hospitals should be able to take care of HIV/AIDS patients, which generally did not require the use of sophisticated instruments or provision of a special treatment centre. The AIDS clinic (also called the Special Medical Consultation Clinic) now operates under the Department of Health and has recently been relocated to the Yaumatei Jockey Club Clinic, which is within walking distance from the Queen Elizabeth Hospital.

Certainly the HIV management system today differs markedly from the original concept, and in developing a better strategy, we have to take into consideration complexities arising from the following development :-

- (a) The number of HIV-infected cases today, though small, is considerably higher than that reported in the eighties. In fact over 1/2 of all reported cases were diagnosed in 1991-1993.
- (b) Whereas haemophilia (through the use of contaminated clotting concentrates) was one important factor contributing to HIV infection in 1984-1986, its importance has fallen behind sexual transmission, and in particular heterosexual contacts. The needs of patients today is therefore very different from those 10 years ago.
- (c) Management of public hospitals (including Queen Elizabeth Hospital) has come under the Hospital Authority since December 1991, whereas the overall AIDS prevention, care and control in Hong Kong is a key programme of the Department of Health.
- (d) Social support is recognized as an important component of an effective AIDS care programme. Patients are taken care of by a multidisciplinary team of clinical and social support staff. The traditional view of a doctor-centred management concept is falling out of favour. This is particularly true as non-governmental organizations are assuming important roles in the care system in the recent years.

4.2.2 A Team Approach

A team approach is considered most appropriate in the delivery of AIDS services in Hong Kong. This concept has taken into consideration:-

- The relatively small number of HIV/AIDS patients in Hong Kong;
- The need for providing training to health care staff;
- The general policy that no patients should be turned away by any hospital;
- Importance of ensuring continuity of care;
- Cost-effectiveness;
- Response of the community.

The HIV team management system requires the following components:-

- (a) The operation of clinical AIDS services in the public sector needs to be coordinated in its provision of outpatient care, in-hospital treatment, support services, counselling, as well as staff training. In this regard, the key coordinating role played by the AIDS clinic (Special Medical Consultation Clinic) of the Department of Health, now physically located at the Yaumatei Jockey Club Clinic, should be continued, with joint participation of other involved parties.
- (b) All acute public and private hospitals would need to be prepared to take in HIV/AIDS patients if they present for treatment. For clinical referrals, admission to the nearest general hospital should be facilitated, both in the private and public service.
- (c) For paediatric cases, in view of the special needs and the propensity for more rapid progression, paediatric units of individual hospital should be ready for both in- and out-patient treatment according to protocols developed by the Scientific Committee on AIDS in 1994.
- (d) Clinicians taking care of HIV/AIDS patients should have provision to liaise with designated specialist service for arrangement of consultations (e.g. for eye, chest, psychiatric, skin, venerological and ENT problems) when necessary. The principles of continuity of care and preservation of confidentiality should be applied in these cases.
- (e) Hospital Authority, Department of Health, private practitioners, private hospitals and community groups should be collaborative partners in developing a co-ordinated care system for HIV/AIDS patients in Hong Kong.
- (f) Under the Hospital Authority, clinical AIDS services would need to be integrated into the existing hospital system under the direction of regional or cluster coordinators. No hospital or clinic should turn away or refuse to attend HIV/AIDS patients.
- (g) Training of staff needs to be developed at both undergraduate and postgraduate levels, and should be integrated into the existing health care training programmes.

4.3 Roles & Responsibilities of involved Parties

4.3.1 Department of Health

In the development of a care team for HIV/AIDS patients, the Department of Health is poised to play an important role in the provision of direct service, organization of training for health staff, coordination with other units/parties and mobilization of resources. Specifically the Department of Health is responsible for:-

- (a) The running of the AIDS clinic under the Special Preventive Programme in the provision of medical treatment, HIV tests, counselling, social support service (through the functioning of medical social worker(s)), coordination with DH/HA specialists, liaison with hospitals and non-government organizations. It should gradually evolve to become a training centre in HIV management.
- (b) Operation of STD clinics (Social Hygiene Clinic) to provide effective diagnosis and treatment of STD and HIV diseases, and support to the AIDS clinic in the management of HIV+ patients.
- (c) Providing consultation to other medical practitioners and institutions (public or private) so as to facilitate their participation in the care of HIV/AIDS patients in Hong Kong.
- (d) Planning the future development of clinical service in consultation with other departments/units involved and under the supervision of the AIDS Services Development Committee of the Advisory Council on AIDS.

4.3.2 Hospital Authority

The Hospital Authority is a key partner in the discharge of AIDS care by:-

- (a) The provision of hospital treatment to adult and paediatric HIV/AIDS patients who require in-hospital care, and in equipping clinical units with the skills and expertise for the management of these patients.
- (b) Participating in the organization of training for professional staff involved in the delivery of clinical services to HIV/AIDS patients.
- (c) Facilitating the system of referrals for patients who require the care of experts specializing in other branches of medicine in the public service.
- (d) Maintaining close collaboration with other parties involved in the delivery of AIDS service to ensure continuity of care, and seeing that there is best allocation and utilization of resources.

4.3.3 Social Welfare Department

The Social Welfare Department (SWD) is seeing that services offered to patients suffering from other chronic diseases are also available and accessible to HIV/AIDS patients. A designated medical social worker affiliated to the AIDS Clinic of the Department of Health is bridging the gap between the clinical setting and the community. The department is also responsible for liaison with voluntary agencies and the conduction of training programmes.

4.3.4 Private Hospitals/Practitioners

Patients who choose to use the service of a private hospital should not be denied the access on the ground of the HIV status. This applies to both acute management, hospital support as well as long-term care. The Department of Health would need to work closely with private hospitals and private practitioners to provide the necessary support as required.

4.3.5 Non-governmental Organizations (NGOs)

There are two categories of NGOs – those with objectives which are solely or predominantly AIDS-related; and others with AIDS components formally or informally added to their existing programmes in the wake of the HIV/AIDS epidemic. These AIDS services organizations are responsible for:-

- (a) Providing an alternative system of care which could supplement the inadequacy of services delivered by the private or public sectors;
- (b) Meeting the specific needs of some patients because of their credibility with those they were set up to serve;
- (c) Working as mediators between people they serve and the providers of public services; and
- (d) Assisting in the development of AIDS care strategy in Hong Kong by serving as advocates for a certain community or society at large, by liaising with other parties, and by participation in planning the implementation of AIDS care programmes.

4.4 Future Development

The AIDS Services Development Committee of the Advisory Council on AIDS is responsible for:-

Recommending on the strategy of developing clinical and support services for HIV-infected individuals in the territory;

Coordinating available services and facilitating their accessibility to people with AIDS and their relatives who require them;

Evaluating the quality and availability of AIDS services in the territory.

Strategic development of clinical service should therefore be a dynamic process and would take into consideration the following:-

- (a) The rate of rise of HIV infection and AIDS.
- (b) Scientific advances made in diagnosis and treatment of HIV infection and its complications, and prophylaxis against complications.
- (c) Parallel development of health care structure in Hong Kong.
- (d) Specific needs of patients with HIV/AIDS and the society.
- (e) Flexibility of the system in accomodating a higher number of HIV/AIDS patients should this occur.

AIDS Policy in the Community

5

5.1 Media

5.1.1 Introduction

Media is influential in setting the agenda for public issues and is effective in conveying health messages. It is important to note that, though the media can be powerful in the dissemination of AIDS messages, its role in effecting behavioural changes is arguable. Against these backgrounds, 18 Television advertisements (Announcement of Public Interest or APIs) on AIDS have been produced by the government since 1986. A survey conducted in late 1992 suggested that over 90% of adults aged 18 or above have seen these APIs, and most agreed that they have increased their awareness. The London Declaration on AIDS Prevention made by the World Summit of Ministers of Health in 1988 considered that "..... information and education programmes should be aimed at the general public and should take full account of social and cultural patterns, different life styles, and human & spiritual values". The media was included as one of the 'groups' which these principles should apply to.

Media, in the context of AIDS publicity, includes television, radio, newspapers, magazine and other printed materials. Another survey conducted by the Department of Health in 1992 revealed that of 1817 persons interviewed, television was the most favoured medium (75.3%) for AIDS publicity, followed by posters (53.8%), radio (46.7%) and newspapers (41.8%). The difference in opinions between male and female was not marked.

5.1.2 *The Role of Media Campaigns on AIDS*

- (a) Mass media focuses on the public in general, and such initiatives should be supplemented by the more targeted health educational programmes for specific community groups such as homosexuals, intravenous drug users, student etc.
- (b) Media publicity on AIDS aims at arousing awareness, setting agenda and creating a climate for other educational interventions to operate. They may therefore be intended to affect the public's knowledge, attitude or behaviour, or any combination of these, though the impact on behaviour would be most difficult to achieve or even assess.

5.1.3 *Approach to Media Publicity on AIDS*

The media is involved either (a) as campaigns organized by the government or voluntary agencies or (b) as coverages initiated by the media itself. Both are equally important in affecting the public's perception, attitude and awareness towards AIDS and its related problems. The following, however, are recommended approaches for initiatives which use the media in conveying AIDS education, i.e. media campaign.

Commitment of the Government

Globally, most mass media campaigns on AIDS have been conducted by the government either directly or indirectly, and Hong Kong is no exception. It is essential that such commitment should be sustained.

Continuous Presence

AIDS should be kept on the public agenda by maintaining a continuous and steady media presence, rather than merely through the launching of solitary high profile campaigns. This is important to lead the public to believe that AIDS is an issue of concern. Messages should be consistent and should create an atmosphere of continuity. Such a continuous approach can be punctuated by additional campaigns to tie in with educational efforts for individual community groups.

Strategies

Different strategies have been adopted in Hong Kong and overseas alike, and the effectiveness of each strategy varies with the course of the epidemic, culture, and the conduction of collateral educational programmes. Some of the strategies are (a) fear provoking, (b) using life-style images, (c) authoritative by featuring medical expert or community leaders, (d) personal testimonials featuring HIV-infected people and (e) humorous or light-hearted messages (e.g. use of cartoon). Some of the strategies may be more useful in conveying a certain message than others, and more than one method could be used under certain situations.

Themes

Media Publicity targets the general public. Most media campaigns have been directed towards the young population. It is important that different aspects of the infection are presented to the audience, including how transmission can and cannot occur, the messages of safer sex, the social and psychological problems faced by people living with HIV/AIDS, and how the disease can be prevented. Despite the 'general' nature of media campaigns, it may be the only way of reaching some people at high risk.

Evaluation

Effectiveness of media campaigns is difficult to assess, because of the existence of other factors which influence an individual's awareness, attitude and behaviour. To help design better strategies on media publicity, regular evaluation exercises are essential in assessing the impact of the programmes, including:-

- (a) The reception rate (which in the case of TV APIs, implies the viewing rate).
- (b) General opinion towards a certain strategy (whether the campaign is rejected by the public, or has caused resentment).
- (c) Self-acknowledgement of the influence of the campaigns.

5.2 Schools and Students

5.2.1 *Background and General Principle*

HIV is not spread by casual, everyday contact. Infected students/teachers generally do not pose a risk to others in the school setting and they should be allowed to stay in their classrooms and jobs. AIDS education is, nevertheless, important in school to protect young people from HIV transmission through the routes of sexual contact and injecting drug use, to dispel misconceptions about the disease, and to foster a supportive attitude towards those suffering from the infection. Because of the intimate relationship between AIDS, sex and other behavioural issues including drug abuse, it is crucial for the teaching of these subjects to be integrated to achieve the best outcome.

5.2.2 *An HIV-infected Student or Staff In School*

The following recommended policy was developed jointly by the Department of Health and the Education Department:-

- (a) HIV-infected pupils, teachers or other staff in schools should be allowed to continue with normal activities, which in the case of pupils, implies normal schooling. Restriction is required only if it were medically indicated, as recommended by and in consultation with a medical practitioner.
- (b) HIV status of a pupil (or other persons in school) should be kept in strictest confidence. Disclosure should only be made on a need-to-know basis, and with the consent of the pupil/parents. In some cases, parents may choose to disclose the information to the class master/mistress and school social workers in view of specific psychological needs. A sympathetic attitude should be fostered, and again with all data kept confidential.
- (c) In general, no special precautionary measures are necessary even if a certain pupil is known to be HIV-infected. The concept of universal precaution and procedures suggested in section 5.2.3 are sufficient to significantly minimize the risk of transmission in the school setting.
- (d) Special arrangements (e.g. special schools or private tutorship) may be made on the basis of the pupil's specific educational or physical need instead of the HIV status.
- (e) Special arrangement for pupils with behavioural problems may be necessary for the protection of the pupils and their schoolmates from injuries which may lead to exposure to blood-borne diseases. Again, this should be considered because of a person's behaviour, instead of his/her HIV status. Advice from the Education Department and other professionals (psychologist, medical practitioner) may be sought for such circumstances.

5.2.3 *General Prevention Measures for Blood-borne Diseases*

(abstracted from guidelines on the prevention of blood-borne diseases in school 1994)

Even in the health care setting where health care workers are routinely exposed to blood, the risk of HIV transmission is extremely low. Since the beginning of the epidemic, no reports have been received whereby HIV transmission has occurred in the school setting. To further minimize this already low infection risk, adherence to universal precautions is advocated. It implies the establishment of infection control guidelines for procedures where contact with blood is anticipated, disregarding a person's HIV status:-

- (a) Whenever direct physical contact with blood and body fluids is anticipated as in the handling of abrasions, cuts and wounds, the use of barrier (wearing of disposable gloves) is advised. Body fluids which have been linked to transmission of HIV include blood, semen, vaginal secretion and breast milk.
- (b) Avoid direct physical contact with blood and other body fluids.
- (c) If direct contact with blood or body fluids has occurred, the contaminated part should be washed immediately and thoroughly with soap and water.
- (d) Expert advice from the Ambulance Service or Accidents & Emergency Department of hospital should be sought in major accidents, in which cases, gowns, masks and eye coverings may be required, depending on the extent of exposure.
- (e) Apply household bleach (diluted in water in proportion of 1:3) to the contaminated surface.
- (f) Blood-soiled gloves, dressing, cotton wool, cloth should be placed in double plastic bags and sealed for disposal. Advice from Urban Services Department/ Regional Services Department should be sought if dealing with high amount of blood-soiled wastes.
- (g) Personal hygiene should be observed, and items like tooth brushes and razors should not be shared.
- (h) First aid boxes should be equipped with the essential items of disposable gloves, cotton wool, gauze/dressing and antiseptic for emergency use. When outdoor activities are organized, first aid kits including these items should be available.
- (i) Science experiments – Science experiments or activities in school which carry a risk of transmitting blood-borne disease(s) should be avoided, e.g. practicals involving taking of human blood and cell samples. Other precautionary measures include avoidance of mouth sucking with pipette, wearing of disposable gloves when performing experiments, proper use of knives and scalpels during dissection classes.

5.2.4 AIDS Education in School

Objectives

Schools should play an active role in educating pupils on AIDS and other blood-borne diseases. Teaching should carry with it the following objectives:-

- (a) Promotion of understanding of AIDS, its meaning, nature, modes of transmission, prevention and sources of appropriate resource, advice, counselling and medical care.
- (b) Acquisition of skills in developing general hygiene and healthy practice, having a perspective on AIDS, and making mature decisions that would protect pupils from AIDS and other blood-borne diseases.
- (c) Development of positive attitude towards AIDS as an illness, its effect on society and impact on people with the disease.

Teaching Format

The following approaches are recommended:-

- (a) Teachers' training as well as appropriate resource materials should be developed in parallel with AIDS teaching for pupils.
- (b) AIDS teaching can be organized within existing formal or informal curriculum.
- (c) Teaching should take into account the needs of pupils at different educational levels. For kindergarten and lower primary children, emphasis should be on the development of good hygiene habit and fostering supporting attitudes towards people with disease. For upper primary levels, the nature of AIDS and blood-borne diseases can be introduced and clarification made on misunderstanding and misconception. At the secondary level, AIDS can be introduced in the context of moral values and in association with sex education.
- (d) The development of attitudes and skills is a continuous process for staff and pupils. Teaching should be introduced gradually over time and suitably reinforced to suit the need of pupils.
- (e) Education on HIV/AIDS is most effective if pupils receive the same accurate information consistently at school, at home and in the community. It is, therefore, desirable for schools to take the initiative to involve parents in their AIDS education programmes.

5.3 Workplace

5.3.1 Introduction

With the exception of the health care setting, there are no known cases of HIV transmission in the workplace. HIV cannot be contracted by casual everyday association at work since the virus is fragile and is incapable of surviving easily outside the body. Despite the non-existence of occupational risk of infection, there have been unfounded fears of HIV transmission between workers, from worker to clients and vice versa. A consultation on AIDS and workplace was convened by WHO and the International Labour Office in June 1988 to address the following 3 issues:

To ascertain the minimal risk associated with HIV infection in the workplace;

To examine the responses by business and workers to HIV/AIDS; and

To promote the use of the workplace for health education activities.

Similar to overseas countries, the majority of Hong Kong's HIV-infected persons are of the age of active employment. Workplaces are naturally becoming important foci for discussing AIDS and its implications, for undertaking AIDS education, and for fostering a supportive atmosphere toward those who are infected. The themes of the following sessions are taken from the Statement from the Consultation on AIDS and the Workplace issued by WHO in association with International Labour Office in June 1988.

5.3.2 Key Principles

- (a) There should be no discrimination in the handling of employees who are HIV-infected or who are at risk of infection. They should be treated in the same way as others without the infection in his/her work.
- (b) The HIV status of an individual, same as any personal health matters, should be treated in the strictest confidence.
- (c) Promotion of AIDS awareness and dissemination of prevention education should be facilitated in the workplace.

5.3.3 Recommended Guidelines on AIDS and the Workplace

- (a) Pre-employment HIV screening as part of the assessment of fitness to work is unnecessary and should not be required. For persons in employment, mandatory HIV screening should not be performed.
- (b) Confidentiality regarding medical information, including HIV/AIDS status, must be maintained. There should be no obligation of the employee to inform the employer regarding his or her status.
- (c) Provision of health education on AIDS should be facilitated.
- (d) HIV-infected employees should not be discriminated in regard to access to and receipt of occupationally related benefits.
- (e) HIV infection by itself is not associated with any limitation in fitness to work, nor is it a cause for termination of employment. As with many other illnesses, persons with HIV-related illness should be able to work as long as medically fit for available, appropriate work.
- (f) Standard blood precaution is effective against HIV transmission. This involves, in the workplace setting, general first aid facilities for the purpose of minimizing transmission of blood borne diseases. Excessive and unnecessary precaution while handling a knowingly HIV positive employee should be avoided.
- (g) Companies, organizations and institutions are advised to formulate written non-discriminatory AIDS policy, and to provide general information on AIDS, in order to counter unnecessary fear and unrest.

5.4 Adolescents and Youth

5.4.1 Introduction

The commonest route of HIV transmission worldwide is unprotected sexual intercourse, followed by high risk drug-taking behaviour. Young people are affected in most of these cases. In 1989, the theme for World AIDS Day was “Youth”, which called for a focused attention on AIDS and its relationship with young people. In Hong Kong as of the end of 1993, over 70% of the reported HIV infection have occurred among those between the age of 18 and 39, and the majority (over 90%) were males. Youth and AIDS is in fact a concern all over the world, irrespective of race, class, religion, sexual inclination or even disability.

Given the growing incidence of HIV/AIDS, there is a need to help young people become informed about the disease and take steps to protect themselves from infection. As a sexually transmitted disease which has far-reaching implication on behaviour and sexuality, AIDS education is particularly relevant for youth and adolescents because:-

Majority of the affected individuals are young people.

Adolescents are coming up to a sexually active age who require information/education to protect from exposure to sexually transmitted diseases.

Behavioural and attitudinal issues centering on youth are equally relevant to those linked with HIV, e.g. sexuality, drug abuse.

The AIDS policy in the school setting is covered in the section 5.2, whereas this chapter focuses on the general policies relating to HIV/AIDS in the youth population.

5.4.2 Key Principles

- (a) AIDS education should be incorporated into youth programmes on personal and social education, including those conducted on family-life education and sex education, in the school setting, through voluntary agencies and also in the community at large.
- (b) To be effective, AIDS and sex education needs to recognize the reality of a young person's emotional and sexual development, sexual inclination (e.g. homosexuals) as well as the social context.

5.4.3 Approach to Effective AIDS Education for Youth and Adolescents

- (a) Cross-sectional cooperation between health, education and voluntary sectors is essential in achieving effective AIDS education for youth. Such initiatives should, as far as possible, be integrated in the existing framework of the health/education system for delivery of effective and optimal outcome.
- (b) Involvement of young people would facilitate the design and implementation of AIDS education programmes. The traditional view of merely “protecting young people from AIDS” is not warranted.
- (c) Training of staff on AIDS involved in youth activities should be prioritized, and should be integrated into existing pre-service and/or in-service training programmes on related personal, health or social subjects.
- (d) Education on sex, AIDS and behavioural issues should be organized in a lively and innovative manner. Such programmes should be accessible and receptive to adolescents and youth, and should not be simply about factual learning, but should also focus on knowledge and skills on healthy sexual and emotional lives.
- (f) Youth is a heterogeneous community. Initiatives in AIDS prevention and care should be tailored to meet the needs of different people, which in some cases, could be facilitated by the use of peer education or outreach activities. The latter is particularly relevant for young offenders and marginal youths.
- (g) For young people in institutions, the same basic non-discriminatory principle applies as regards to the accessibility to information, education as well as clinical/support services directly or indirectly relating to HIV infection and AIDS. Under no circumstances should compulsory or mandatory HIV testing be performed inside institutions (including boys’ and girls’ homes) or before admission.

5.5 Women

5.5.1 Background

The global pattern of HIV transmission has changed dramatically in the last decade. Worldwide about 40% of the infected population todate (cumulative) are women. By 2000, 50% of the new infection would have occurred among the female population. In Hong Kong, about 8% of the reported HIV infection occurred among women, and this figure has been increasing steadily with time.

HIV infection in women is a matter for concern because of the general vulnerability of the female population:-

Biologically

Women run a bigger risk of acquiring HIV infection and other STD from her male counterpart than vice versa, because as a receptive partner women have a larger mucosal surface exposed during sexual intercourse and that semen contains a higher concentration of HIV than vaginal fluids.

Socially

Many women have less power or control of their sexual relationship with men and this creates an unfavourable environment for AIDS prevention to be achieved. Many women do not perceive themselves to be at risk of infection, and there are those in the marginalized communities, e.g. commercial sex workers (prostitutes), who are prone to HIV transmission.

Apart from physical illnesses, HIV infection in women carries far-reaching implications of perinatal transmission, as well as familial disruption arising from parental ill-health and the problem of orphaned children.

The natural history of HIV infection in women is similar to that in men, though the amount of available research work is limited in this field, especially in Asian countries. Infected women are, however, at an increased risk of cervical dysplasia due to human papilloma virus, particularly strains 16 and 18. Other commonly associated gynaecological infections reported among HIV positive women are vaginal candidiasis, bacterial vaginosis and trichomoniasis. The systems of providing early diagnoses, prophylaxis against opportunistic infections, clinical monitoring, treatment of complications and counselling are important for men and women alike.

5.5.2 Key Principles

- (a) HIV/AIDS education should be available and accessible to women, and presented in a way that is acceptable to the female population, taking into consideration their specific needs, concern and cultural restrictions.
- (b) The accessibility, quality and standard of clinical and support services should be no different from that offered to male patients or patients with other chronic medical diseases.
- (c) Routine or mandatory HIV testings should not be performed. HIV tests, if required, should be done voluntarily with the consent of the client and in the context of counselling.

5.5.3 Specific Issues on Women and AIDS

Antenatal HIV Screening

The advantages of identifying HIV infection in pregnancy are that delivery of relevant service could be optimized, that provision of HIV counselling, education on the avoidance of breast feeding, and treatment with anti-retroviral drugs and management of complications can be facilitated. On the other hand, detection of HIV infection can cause depression, family disruption and may carry social stigma. In Hong Kong where the current overall HIV prevalence is low, the efficacy of antenatal screening is likely to be low. HIV testing for pregnant women should not be a routine investigation. It can be offered to those who have been exposed to the risk of HIV transmission, and must be conducted voluntarily with the clients' consent, and in the context of counselling.

HIV Infection and Pregnancy

All HIV positive women should be counselled on the possible vertical transmission of HIV to her baby (15%-40%) before embarking on a pregnancy. The variation in transmission rate may depend on maternal HIV status and other factors. The choice of termination of pregnancy should be discussed and the mother's decision overriding. Possible interventions during pregnancy to decrease the transmission rate are not validated enough for general recommendation. Caesarian section and antiretroviral treatment have, however, been implicated to carry a slightly lower risk of transmission.

Counselling of HIV positive mothers should cover psychosocial issues including the effect on family, availability of family and community support, financial situation, care of babies, and the need for mobilizing community resources to provide support to the mother and the family.

HIV and Family Planning

AIDS was frequently approached as an isolated health problem. This has frequently led to the development of solitary AIDS programmes with strategies emphasizing on changing individual behaviour. Integration into other health programmes would be beneficial in enhancing the effectiveness of AIDS preventive education, in particular, those for women. There are obvious parallels between family planning and AIDS programmes which policy-makers could capitalize for improving the capabilities of AIDS education programmes. Such efforts should be strengthened in 3 areas:-

- (a) Education – through the development of joint activities on AIDS awareness and preventive education and with the production of relevant resource materials for client in the family planning setting.
- (b) Counselling – through provision of counselling on safer sex practice by strengthening existing channels for referrals to specific service/units providing the counselling.
- (c) Condom Distribution – the dual role of condom for contraception and STD/HIV prevention should be stressed, and the programme of condom distribution facilitated.

Family planning services provide an infrastructure accessible to sexually active women. Despite the obvious advantage, the pace, level and extent of integration with AIDS programme needs to be thoroughly assessed, taking into consideration the availability of existing facilities, experience of staff and the potential for programme expansion. The concern of AIDS stigmatizing the family planning services should also be considered in the development of appropriate strategy.

Promotion of Sexual Health

Educational efforts on HIV prevention among women cannot be effective without addressing such issues as sexuality, the role of gender in HIV transmission and the importance of women's empowerment. Designing programmes for promoting women's sexual health is therefore the long term goal, instead of focusing on HIV/AIDS alone. The following strategies should be adopted in promoting sexual health for women:

- ♦ Training and training materials for staff of family planning services, women's organizations and AIDS services organizations should be developed, which shall be tailored to meet the needs of our society.
- ♦ Provision of service and educational programmes for promotion of sexual health needs to be evaluated periodically to help design relevant strategies.
- ♦ Social constraints which hinder the promotion of sexual health among women should be identified through research and be appropriately addressed.

5.6 Children

5.6.1 Introduction

Children are vulnerable members of our society. Children may become infected with the HIV through any of the following routes:

Transfusion of contaminated blood and use of contaminated medical instruments in the health care settings, especially in the developing countries where resource is scarce;

Receipt of contaminated clotting factors in the treatment of haemophilia;

Perinatal transmission from an infected mother to her baby either before birth, during delivery or postnatally as in the case of breast feeding.

To date, it is estimated that over 1 million children have already been infected with HIV globally, the modes of transmission of whom varied from nation to nation. In the industrialised world, most of the early cases of paediatric HIV infection occurred amongst the haemophiliacs, whereas the health compromised populations were faced with the problems of perinatal and bloodborne transmission. With the increase in heterosexual HIV transmission worldwide, perinatal HIV infection is becoming a global threat.

In Hong Kong, as is the case in some industrialized countries, only a handful of children have become HIV infected so far. These were invariably the results of blood/blood products transfusion undertaken before August 1985 when donor HIV screening and the use of safe clotting factors were not yet available. The first case of mother-to-child HIV transmission was diagnosed in mid-1994. With the rising number of HIV-infected women reported in the past couple of years, it is speculated that a new wave of childhood infection may be evident very soon.

5.6.2 Problems faced by HIV infected children

Irrespective of the level of a country's socioeconomic development, the impact of paediatric HIV infection represents yet another challenge to the health and social service system. Some of the problems are:

Health Context

HIV affects a person's immune system. The impact of HIV on the immature immune system of a child carries higher morbidity and mortality than is the case for adults. An HIV infected child may therefore progress to AIDS more rapidly than his/her adult counterparts. On the other hand, definitive diagnosis of HIV infection is difficult in the first year of life because of the presence of circulating maternal antibodies in the child's body. Furthermore, the occurrence of HIV infection in a haemophiliac child is indicative of a double tragedy. All these problems are implying that a good health system is necessary to take care of HIV/AIDS children or babies born to HIV positive mothers.

Family Context

Childhood HIV infection may lead to familial disruption. A child born to an HIV positive mother may become orphaned should either of the parents die. The care of the child could be jeopardised if the parent(s) is/are sick, or if they are practising high risk behaviour (e.g. drug abuse), thereby predisposing to other social problems.

Social Context

HIV/AIDS is still a social stigma. An HIV-infected child may find it difficult to cope with a social environment which has a poor understanding of the disease and its implications. There are concerns about possible breach of confidentiality, schooling, need for specific psychosocial support, financial hardship, chronic care, terminal care etc.

5.6.3 Key Principles

- (a) HIV-infected children have the right to receive love, care and education, and to grow up in a supportive and sympathetic environment as is the case for other children in the community.
- (b) The general principle of non-discrimination and preservation of confidentiality apply to children as well as adults.
- (c) Children with HIV infection are faced with the unique clinical, psychological and social problems which require the concerted efforts of a multidisciplinary team (consisting of doctors, nurses, social workers, counsellors, clinical psychologists) for effective and quality services to be delivered.

5.6.4 Guidelines on the Prevention and Management of Paediatric HIV infection

The general policy adopted for AIDS prevention, care and control is also applicable to children in broad principle. The Scientific Committee on AIDS, in association with some paediatricians in Hong Kong, has developed a set of management protocol in mid-1994 on the subject of paediatric HIV management, which was subsequently endorsed by the Advisory Council on AIDS in the same year. The protocol forms the framework of the following recommended guidelines:-

- (a) Prevention of heterosexual HIV transmission is the most important weapon in the prevention of children becoming infected with HIV. It follows therefore that the strategy for preventing paediatric HIV infection is an inseparable component of the overall AIDS programme focusing on preventing sexual transmission of the virus.

- (b) Infants born to HIV positive mothers should be carefully and closely monitored for the purpose of providing early diagnosis of potential infection as well as care to the infected ones.
- (c) For children under 15 months with probable perinatal infection, because maternal HIV antibodies may confound the results of HIV antibody tests, clinical and laboratory monitoring are required and breast feeding should be discouraged as safe alternative feeding is available in Hong Kong.
- (d) Babies born to HIV positive mother should have access to appropriate immunization, prophylaxis against infection, antiretroviral therapy and treatment of complications in accordance with established protocols.
- (e) A paediatrician should be designated in each major hospital to be the coordinator in looking after children with HIV infection, so as to facilitate provision of multidisciplinary care.
- (f) Networking of paediatricians is advocated for updating all paediatricians on HIV/AIDS regularly, for coordinating management, creating a more refined picture of paediatric HIV infection locally, and deciding on future recommendations of management.
- (g) HIV infected children, their parents and sibs should have access to psychosocial support as provided by counsellors, social workers and other professional personnel.
- (h) Schooling must be maintained if a school-aged child is asymptomatic and the decision on schooling for a symptomatic child should be made on a case-by-case basis. Home teaching may be desirable and should be available for selected cases. Confidentiality must be respected and diagnosis is generally not required to be released to teachers (section 5.2).

5.7 The Homosexual Community

5.7.1 *Historical background*

Some people equate HIV infection with homosexuality, a concept which can be traced back to the historical development of the HIV/AIDS epidemic in the United States and Europe. In 1981, the first AIDS cases were diagnosed among some previously healthy young homosexual men who presented with unexplained immunodeficiency. The same clinical presentations were seen in homosexual people in other parts of the world, a phenomenon which has led some early investigators into believing that AIDS originated from homosexuality *per se*. The subsequent isolation of HIV and its identification as the cause of AIDS refuted the original proposition. This is confirmed by epidemiological studies which demonstrated that HIV infection may also take hold amongst heterosexuals, intravenous drug users, babies of infected mothers, haemophiliacs and transfusion recipients.

It is clear that HIV can be contracted via sexual intercourse with an infected person, irrespective of the sexual inclination of the ones involved. The risk of transmission is strongly linked with the practice of high risk activities e.g. high number of sexual partners and unprotected sexual intercourse, rather than to homosexuality itself. Anal sex is known to carry a high risk because of the probable occurrence of trauma to the rectal mucosa, thus providing access to viral entry. Anal intercourse is again not limited to homosexuals but is practised also among heterosexuals and bisexuals.

To date, most of the reported AIDS cases acquired sexually in USA have occurred among homosexuals, but the number of heterosexually acquired infection is rising as a global phenomenon. In many African countries, heterosexual transmission has always been the commonest mode of HIV spread. In Hong Kong the epidemiological trend has evolved over a similar pattern as in other western countries. Before 1990, most of the cases of sexually acquired HIV infection have occurred among the homosexuals. By 1993, the ratio of homosexual to heterosexual among the newly diagnosed cases has reversed. There are now two times more heterosexually acquired new infection reported to the Department of Health than homosexual cases.

5.7.2 *Problems and Controversies*

The common goals of preventing HIV infection and care of the infected ones apply equally to the homosexuals and those of other sexual inclinations. The situation is, however, compounded by the following problems, and the controversies which are commonly associated:

- (a) In Hong Kong, as is the case elsewhere, only very few homosexual people choose to openly acknowledge their homosexual status because of the social stigma attached. This has hindered organization of targeted education and service programmes on HIV/AIDS.

- (b) As a minority and less open community, assessment of its needs and conduction of behavioural research of the homosexuals and bisexuals are difficult.
- (c) The taboo attached to sex is compounded by the dimension given by sexuality and AIDS when the latter are considered, which together contribute towards a scenario with additional complexities.
- (d) The relationship of AIDS with homosexuality, though ill-founded, has further stigmatized the homosexual community, putting the latter in a less advantageous position for fulfilling the objectives of AIDS prevention and care.
- (e) There is often the dilemma of having insufficient targeted AIDS programmes for homosexuals and bisexuals on one hand, and the danger of further stigmatizing these communities by the adoption of the targeted approach.

5.7.3 Key Principles

- (a) AIDS prevention education, counselling and other service programmes should be available and accessible to people of any sexual inclinations including the homosexuals, with the understanding that the specific needs of the latter are adequately catered for.
- (b) The general principle of non-discrimination should be observed in the provision of education and service to the homosexual community, the same way that it is observed in all other settings.

5.7.4 Approach to HIV/AIDS Prevention, Education and Care for the Homosexual Community

- (a) Targeted AIDS prevention and education programmes should be organized for the homosexual community, taking into consideration the sensitivity of issues concerned, and the specific needs of the community.
- (b) The involvement of homosexual people and non-governmental homosexual organizations should be considered in the design and implementation of AIDS educational activities to facilitate generation of effective outcome.
- (c) As far as possible, the needs of the homosexual community should be considered in the process of providing AIDS education to other community sectors (e.g. the workplace), or when targeting the general public through the media.
- (d) Behavioural research on the homosexual community in the context of HIV/AIDS should be conducted to provide benchmark data and to monitor the changing risk patterns of the homosexual people in Hong Kong.

- (e) Legal or other obstacles which hinder the development of AIDS programmes for the homosexuals should be identified and removed. The decriminalization of homosexuality in 1991 was one major step taken by the government towards the same aim.
- (f) The homosexual (with or without HIV) status of an individual should be kept in confidence.
- (g) Efforts should be made to strengthen and improve the delivery of education on sex and sexuality in Hong Kong, in particular, the youth population.

5.8 Travel and Migration

5.8.1 Introduction

Human mobility (involving migrants, travellers, refugees) by itself has no medical consequence. HIV infection is not transmitted by casual contact, and the routes of transmission (sexual contact, transfusion of contaminated blood or use of contaminated injection equipment and from an infected mother to her child) are the same worldwide. There are, nevertheless, countries which have imposed restrictions on the movement of people with HIV/AIDS across frontiers either by law restricting entry to a country and/or through the implementation of routine HIV screening on travellers. To address the issue, the WHO convened a meeting on 2-3 March 1987 in Geneva which concluded that:-

- (a) No screening programmes of international travellers can prevent the introduction and spread of HIV infection.
- (b) HIV screening programmes for international travellers would at best, and at great cost, retard only briefly the dissemination of HIV both globally and with respect to any particular country.
- (c) The diversion of resources towards HIV screening of international travellers and away from educational programmes, protection of blood supply and other measures to prevent parental and perinatal transmission, will be difficult to justify in view of the epidemiological, legal, economic, political, cultural and ethical factors mitigating against adoption of such a policy.

The International Federation of Social Workers, at its general meeting held in Washington on 18 July 1992, passed a resolution demanding removal of travel restrictions for persons with HIV by all governments. Similarly the Forty-first World Health Assembly (1988) urged Member States “to protect the human rights and dignity of HIV-infected people and people with AIDS and of members of population groups, and to avoid discriminatory action against and stigmatization of them in the provision of services, employment and travel”. According to the WHO International Health Regulation, the only health document that can be acquired from international travellers is a valid vaccination certificate against yellow fever. Requirement of proof of HIV negative status is considered impractical and ineffective by the WHO.

Refugees may be considered a category of migrants. Screening of refugees is not a policy of the UNHCR, which considers that asylum seekers should NOT be singled out as a group at special risk. The emphases, however, were on health promotion, provision of counselling, support and medical management for HIV-infected persons, monitoring and active discouragement of high risk practice, and technical support of health services within the framework of the local AIDS programme.

The policy developed in Hong Kong in the context of travelling is adapted from strategies adopted and advocated by WHO and other international bodies.

5.8.2 Key Principles

- (a) International travellers are not at increased risk of HIV infection. Travellers, however, should be properly informed about how the virus is transmitted, the behaviour that may put them at risk, and the need for adherence to precautions regarding high risk behaviour.
- (b) Travel restrictions, requirement of HIV negative certificates, and screening of travellers have no prevention effect on the spread of the virus and thus should not be introduced.
- (c) Counselling and medical consultation is required for HIV-infected travellers for the purpose of minimizing the risk of compromising their health.

5.8.3 Guidelines on HIV Prevention in the Context of Travelling

- (a) Educational materials should be made available for international travellers to increase awareness of how HIV is transmitted and how it can be prevented. It should be distributed through all appropriate outlets for travellers as well as the general public.
- (b) Policy-makers should be aware of the ineffectiveness of HIV screening of international travellers and travel restriction on HIV positive individuals.
- (c) Focus of health education to international travellers should be on the behaviour leading to HIV infection instead of the risk of travelling. The risk of travellers acquiring HIV from infected needles or blood varies with the HIV prevalence, and the practice of routine screening of donor blood for HIV antibody in individual country. Travellers should be alerted to the situation, and be advised to minimize such risk by seeking health care at facilities where donor blood screening is carried out routinely.
- (d) HIV-infected persons should be advised to refrain from donating blood, semen or tissue; notify potential sexual partners of their HIV status and observe safer sex practices; inform health care providers of the clinical status and need for blood precaution; and avoid recreational use of sharing of needles/syringes.
- (e) National and regional cooperation and collaboration are necessary in the development of consensual policy for the welfare of the mobile population.
- (f) Development of a health educational programme for migrants should take into consideration the cultural, social and language difference inherent in the communities. Whereas those engaging in risky behaviours share equal responsibility, migrants or tourists should not be singled out as vectors of HIV transmission.

5.9 Sports

5.9.1 Introduction

There has been no documented instance of HIV transmission during participation in sports. The very low risk of HIV transmission when there is presence of bleeding wound coming into contact with a skin lesion/mucous membrane can be largely eliminated by adhering to good hygiene practice. The concern about HIV infection during sports has largely been borne out of fear due to misconception. A consultation on AIDS and sports was convened in Geneva in 1989 by the WHO's Global Programme on AIDS in collaboration with the International Federation of Sports Medicine. This provides the framework for the policy and recommended practice in this chapter.

5.9.2 Key Principles

- (a) There is no medical or public health justification for testing or screening for HIV infection prior to participation in sports activities.
- (b) General hygiene practices on blood precaution is sufficient in preventing possible transmission of blood-borne pathogens (including HIV) in sports or other social settings.
- (c) Persons who know they are HIV-infected should seek medical counselling about further participation in sports to assess risks to their own health as well as to minimize the risk of transmission of HIV to others.

5.9.3 Guidelines for Sports Executives and Sports Organizations Concerning HIV & Sports

- (a) **General hygiene measures should be adopted:**
 - i. Wash hands before every match/game.
 - ii. Examine hands (and exposed surfaces) for wound which, if present, should be covered with water-repellent plaster.
 - iii. Avoid blood contacts as far as possible.
 - iv. Wash hands with water and soap after treatment or after each match/game.
 - v. Dispose of soiled materials properly (needle, if used, should be put in appropriate containers).
 - vi. A first aid box should be available in the area where the game is held.

(b) For sports involving direct body contacts and those where bleeding may be expected to occur:-

- i. Skin lesions, if observed, should be immediately cleansed with a suitable antiseptic and securely covered.
- ii. If a bleeding wound occurs, the individual's participation should be interrupted until bleeding has been stopped and the wound is both cleansed with antiseptic and securely covered or occluded.

These measures apply to all situations irrespective of the HIV status of the participating person.

- (c) Protective gloves should be worn for the safety of personnel drawing blood samples from athletes, similar as in health care settings. Gloves should also be worn (stocked in first aid kits or boxes) in the handling/treatment of wounds.**
- (d) Sports organizations, clubs and other groups have special opportunities for additional meaningful AIDS education of the athletes, sports officials and ancillary personnel. Information on how HIV can and cannot be transmitted should be available, and its relationship with high risk behaviour be stressed.**

5.10 The Haemophiliacs

5.10.1 Haemophilia and HIV Infection

Haemophilia is a term given to blood disorders resulting from an inherited deficiency of a coagulation (clotting) factor. It is a rare group of diseases, the best-known of which is Haemophilia A, a sex-linked entity occurring in 1 out of 10,000 to 20,000 male population. Affected patients suffer from bleeding tendency, and the cornerstone of therapy is the administration of commercially available purified clotting factors. The latter was produced by concentrating and purifying pooled plasma from donated blood.

When the AIDS epidemic began to hit America in the early eighties, infected blood was unknowingly used in the preparation of clotting factors, leading to the transmission of HIV in the haemophilia community, with the introduction of safe heat- or detergent-treated clotting factors in 1985, HIV infection amongst the haemophiliacs is becoming a rare occurrence, compared with sexual transmission of the disease.

In Hong Kong, as of the end of August 1994, the Department of Health has recorded a total of 63 haemophiliacs infected with HIV through transfusion of contaminated blood products prior to September 1985. In responding to this double tragedy, the Council for AIDS Trust Fund was established to provide ex-gratia payment to these patients. These were one-off payments ranging from 0.3 to 1 million Hong Kong dollars offered to patients or family members (if deceased).

5.10.2 Key Principles

- (a) HIV infection in a haemophiliac patient is recognized as a unique circumstance carrying much physical, social and psychological implications which demands the appropriate medical and support services to be available and accessible to those affected as well as their families.

- (b) The supply of safe blood products should be ensured to prevent similar tragedies from happening in future. In the light of scientific advances made in the process of preparing safe purified blood products, such developments would be monitored to further safeguard the community from possible transmission of HIV and other blood-borne diseases.

5.10.3 Guidelines on Safeguarding Clotting Factor Concentrates

In avoiding the possible harmful effects of commercially available clotting factor concentrates, the following 2 issues are addressed:-

To eliminate the potential for transmitting infectious agents; and

To minimize any undesirable immune effects to the HIV-infected haemophiliac patients so as to stabilize their clinical condition.

For clotting factor concentrates derived from human donors, the following criteria, recommended by the Scientific Working Group of the Advisory Council on AIDS in July 1993, should be satisfied:-

- (a) The product should have been prepared from plasma units which have been individually tested and found to be negative for HbsAg, HIV and HCV.
- (b) The potential for transmission of infectious agents should have been eliminated by proven effective methods, either solvent / detergent treatment, super-dry heating and pasteurization.
- (c) The product should be of high purity, using separation procedures involving column chromatography steps in its preparation.

It is recommended that the following areas be monitored so that appropriate revision to the specifications can be made when required:-

- (a) The relative safety and efficacy of recombinant (new technology for preparing clotting factors) clotting factor concentrates as compared with those derived from human sources;
- (b) The relative advantage of pure versus “ultra”-pure (prepared by immunoaffinity chromatography) clotting factor concentrates in stabilizing the clinical condition of HIV infected haemophiliac patients.

5.10.4 Managing HIV-infected Haemophiliac Patients

An ad-hoc study group on HIV infection of Haemophiliacs was appointed by the Secretary for Health & Welfare in January 1993 to carry out an independent investigation on the causes and extent of HIV infection of haemophiliacs in Hong Kong. Apart from ascertaining that hazards of such infection had been contained, the Study Group made recommendations on the management of this group of patients. Summarized as follows, these form the strategy underlining our approach to the issue:

- (a) The government should remain committed to ensure that appropriate medical services are affordable and available to haemophiliacs. A good HIV/haemophilia care system requires from the outset an efficient clinical network including at least the primary care physician and the haematologist plus a quality laboratory support service.
- (b) Health care providers who manage haemophiliacs need to be networked to achieve general consensus on the standards of management, treatment protocols, organization of service, procedural guide to streamline referrals and hospital admissions, infection control policy, staff training and education. Appointment of a coordinator in each hospital would further facilitate effective management.
- (c) A team approach is necessary to provide psychosocial support which is an inseparable component of the comprehensive care system for haemophiliacs. Services given by doctors, nurses, clinical psychologists, counsellors and social workers are essential in building up the team to assist haemophiliacs and their families.
- (d) Many HIV-infected haemophiliacs are children or adolescents who quite often have problems with schooling because of frequent absences from classes for treatment. The understanding of the schools and the Education Department is essential in ensuring that normal school education can be continued. Policy should be established by the schools and the Education Department to fulfil this goal of normal schooling, to dispel misconception and to promote a sympathetic attitude towards these patients in school.
- (e) Financial assistance should be extended on compassionate ground to haemophiliacs who contracted HIV through transfusion of blood products. [The establishment of the AIDS Trust Fund with HK\$350 million contributed by the government was the step taken as part of a comprehensive scheme recommended by the ad-hoc study group in responding to the problem faced by HIV infected haemophiliacs.]
- (f) Provision of support services should be made available: this includes chronic care for disabled HIV infected haemophiliacs, terminal care and meeting the bereavement needs.

5.11 Health Care Settings

5.11.1 Introduction

Health care workers, by their profession, are the providers of medical care and support to patients suffering from ill health. In the context of infection control, health care workers are defined as “persons, including students and trainees, whose activities involve contact with patients or with blood or other body fluids from patients in a health care setting” (UK Advisory Group on Hepatitis). These different definitions underline two issues in the AIDS era:- the health care worker’s duty towards patients, and the duties of the health care workers in preventing HIV transmission in the health care setting. The latter incorporates the policy on HIV-infected health care workers.

In August 1988, the General Medical Council of the United Kingdom issued a statement to all doctors in the country, which addressed 4 controversial issues (i) doctor’s duty towards patients, (ii) duties of doctors infected with the virus, (iii) consent to investigation or treatment and (iv) confidentiality. The essential messages were clear: that a doctor would extend to patients who were HIV positive or were suffering from AIDS the same standard of medical care and support which they would offer to any other patient; that doctors who knew or believed themselves to be infected with HIV should seek appropriate counselling and to act upon it when given; that HIV test (if necessary) should be performed after consent; and that confidentiality of a person’s HIV status be upheld.

In July 1990, the CDC in U.S.A. reported an incident of HIV transmission from a dentist to 5 of his patients (subsequently the 6th one was diagnosed in 1993). The report has led to extensive media coverage. In Hong Kong, the Joint Medical Ethics Advisory Committee stated in April 1992 that an HIV-infected physician should consult colleagues as to which activities he could pursue without creating risk to patients. Following the self-disclosure of HIV status by a dentist in Hong Kong in November 1992, professional bodies have met and agreed to establish guidelines to prevent HIV transmission in the health care setting. The document “HIV infection and the health care workers – recommended guidelines” was published in April 1994. The principles and practices outlined below are taken from the local guidelines as well as those established overseas, including that of the World Health Organization. Whereas these guidelines were written for medical doctors, their application to other health care professionals are equally relevant.

5.11.2 Key Principles

- (a) It is unethical for a registered medical practitioner to refuse treatment, or investigation for which there are appropriate facilities, on the grounds that the patient suffers, or may suffer from a condition which could expose the doctor to personal risk (GMC May 93).
- (b) The most effective means of preventing HIV transmission in health care setting is through adherence to universal precautions, thereby decreasing the risk of direct exposure to blood/or body fluids.
- (c) Voluntary instead of mandatory HIV testing is the best way of encouraging people (including health care workers) at risk of infection to seek counselling and appropriate treatment.
- (d) Health care workers should consider receiving counselling and HIV antibody testing if they have reason to suspect that they have been infected.
- (e) Health care workers are generally not required to disclose their HIV status to their patients or employers. Disclosure, if any, should be made on a need-to-know basis and with consent of the worker. Maintaining confidentiality is one way to prevent interference with individual's privacy. It is also essential in encouraging the health care workers (either infected or at risk of infection) to receive proper counselling and management.
- (f) Currently there is no justification for restricting practice of health care workers on the basis of the HIV status alone. Restriction or modification, if any, should be determined on a case-by-case basis.

5.11.3 Guidelines on Prevention of HIV Transmission in Health Care Setting

(a) Enforcement of Infection Control

The best way of preventing blood-borne diseases is to treat all blood (and certain body fluids) as potentially infectious. Universal precautionary measures should be adopted when handling blood, amniotic fluid, pericardial fluid, peritoneal fluid, synovial fluid, cerebrospinal fluid, semen and vaginal secretion. The risk of HIV transmission from faeces, saliva, nasal secretion, sputum, sweat, tears, urine and vomitus without overt blood staining is extremely low, and good simple hygienic measures should be sufficient. (Please refer to "Prevention of Transmission of HIV in Health Care Settings – Guidelines and Practices" issued by the Department of Health in July 1992)

Sound infection control practice with appropriate quality assurance should be implemented at all levels, taking into consideration factors unique to individual setting.

Infection Control Committee

Rapid advancement in medicine and technology has meant that it is essential to keep updated on issues relating to infection control practice. Infection control committees should efficiently serve the functions of developing, promulgating and updating infection control policies in each institution and for each clinical specialty.

Written Infection Control Guidelines

Written infection control guidelines on universal blood/bloody fluid precaution should be developed and periodically updated in all health care settings – by infection control committees or equivalents for institutions/government departments and by professional bodies for health care professionals in private and solo practice.

Infection Control Training

The subject of infection control should be made an integral part of undergraduate, pre-registration or pre-employment training for all health care workers who may come into contact with blood/body fluids. Similarly regular courses tailored to the infection control needs of individual specialties should be organized by professional bodies, universities/polytechnics as well as relevant government departments. It should be made known that those who fail to use appropriate infection control techniques to protect patients may be subject to charges of professional misconduct by the relevant governing body.

(b) HIV Counselling & Related Services for Health Care Workers

Information and counselling should be made easily available for health care workers who may have been exposed to HIV through risk behaviour, exposure to contaminated blood/blood products or occupational accidents. The importance of voluntary, confidential and anonymous counselling and HIV testing should be underlined.

(c) Rights & Responsibilities of HIV-infected Health Care Workers

Confidentiality

In general, health care workers are not required to disclose their HIV status to their employers or clients. HIV infection and AIDS are not notifiable diseases by law in Hong Kong, and reporting is on a voluntary basis. There are, however, occasions where the HIV status has to be made known on a need-to-know basis, and this will normally be with the consent of the infected worker. For example, doctors or specialists involved in evaluating an infected health care worker may need to know his HIV status. In exceptional circumstances, breach of confidentiality may be warranted, for instance when an HIV-infected health care worker refuses to observe the restrictions and patients have been put at risk.

Right to Work

The status and rights of an HIV-infected health care worker as an employee should be safeguarded. If work restriction is required, employers should make arrangement for alternative work, with provision for retraining and redeployment.

Ethical Issues

An HIV-infected health care worker should seek appropriate counselling and to act upon it when given. It is unethical if one fails to do so as patients are put at risk. The attending doctor of an HIV-infected health care worker should seek the advice of the expert panel formed by the Director of Health on the areas of management and possible need for job modification. The doctor who has counselled an HIV-infected colleague on job modification and who is aware that the advice is not being followed and patients are put at risk, has a duty to inform the Medical/Dental Council for appropriate action.

Source of Advice

Referral to the expert panel should be made by the health care worker's attending physician. Formed by the Director of Health, the panel shall decide on whether job modification, limitation or restriction is warranted. A case-by-case evaluation would be undertaken considering multiple factors that can influence risk and work performance.

(d) Responding to the Public

The issue of HIV transmission in health care setting has caused much public concern despite the minimal risk incurred. Focusing on health care setting in fact deflects the society from proper attention to the major transmission routes through sex and drug abuse. The health care profession has the duty of constantly reassuring the public, and to educate clients on how HIV can and cannot be contracted. More importantly, the public looks on the health care profession as an example of how AIDS should be dealt with. By adhering to the guidelines for prevention of HIV infection in the health care setting, public fear can be allayed.

5.11.4 Consent for HIV Testing

(The different settings for undertaking HIV tests is covered in 3.3.2)

Background

There is as yet no cure for HIV/AIDS. A positive HIV antibody test carries with it profound psychological impact and possible serious social and financial consequences to the individual. HIV antibody test should therefore not be regarded as a routine test in the medical setting and any person has the right to refuse HIV antibody testing. HIV tests, which entail an invasive medical procedure, should not be performed without the patient's consent. The doctor may expose himself to litigation and should be prepared to defend his action on the basis of necessity of testing the patient.

Recommended Guidelines

- (a) HIV antibody testing should be performed only with explicit and informed consent of the individual. Explanation should be given to the person concerning reason for the HIV antibody testing and its implications.
- (b) In exceptional circumstances where it is not possible to obtain consent due to the individual being unconscious or unfit to give consent, the consent of parent, legal guardian or close relative should be sought if the doctor believes that testing is necessary for the preservation of the patient's health or for the safety of persons other than the patient.

5.11.5 Needlestick Injury and Mucosal Contact with Blood or Body Fluids

Background

In the course of their work, health care workers may experience accidental needlestick injuries or mucosal contact with blood or body fluids, such as spillage into the eyes. This may expose them to the danger of blood-borne diseases of which hepatitis B is the commonest in the local community. The risk of HIV infection after occupational exposure (needlestick injuries) to infected blood/body fluids is approximately 0.4%.

Guidelines on Post-exposure Management

(Scientific Working Group on AIDS 1992)

- (a) First aid is of utmost importance for lowering the risk of infection. In the case of needlestick injuries, express blood and wash immediately and thoroughly with soap and water. The wound should then be disinfected and dressed. In case of mucosal contact, wash immediately and liberally with running water.
- (b) Management depends on the HIV status of the source patient. Patient perceived to be at risk should be counselled and asked to consent to HIV antibody testing.
- (c) If the source patient is HIV antibody positive or is of unknown status, the injured person should be encouraged to undergo baseline HIV testing. Counselling and consent are again important in this situation.
- (d) HIV testing of the injured person should be repeated at three months after exposure.
- (e) The use of Zidovudine (AZT) for post-exposure chemoprophylaxis remains an unproven strategy, though it has been prescribed for such use. In view of the possible side effects, clients should be adequately counselled before deciding on treatment.
- (f) Post-exposure counselling, HIV testing and further information are available from the AIDS Unit of the Department of Health.
- (g) the consulted doctor should assess the injury and risk of hepatitis B infection, and decide on whether post-exposure prophylaxis against hepatitis B is required.

5.12 Blood Transfusion

5.12.1 Introduction

Transfusion of HIV contaminated blood is a known route of transmission of the virus. The risk of HIV transmission can best be controlled by establishing blood transfusion services that provide for the collection and banking of blood and the application of quality assurance procedures on a routine and sustained basis. A consensus statement was produced by the Global Blood Safety Initiatives (participated by WHO's GPA, Unit of Health Laboratory Technology, the League of Red Cross and Red Crescent Societies, the United Nations Development Programme and the International Society of Blood Transfusion) in 1989 with the objective of developing strategies to reduce the risk of HIV transmission by blood transfusion. The document provides the framework for policies outlined in this chapter on safeguarding blood supply in Hong Kong.

5.12.2 Key Principles

To reduce the risk of HIV transmission by blood transfusion, there should be:-

Promotion of voluntary non-remunerated blood donation with effective mechanisms for self-exclusion of those with risk of infection

Effective blood screening for HIV before transfusion

The Policy of administering blood and blood products only when they are necessary for saving life or for preventing major morbidity

5.12.3 Prevention of HIV Transmission through Transfusion – the role of the Hong Kong Red Cross Blood Transfusion Service

In reducing the risk of HIV transmission, a safe-blood programme was initiated by the Hong Kong Red Cross Blood Transfusion Service since 1985, which is composed of the following elements:-

(a) Self-deferral

A pre-donation self-deferral system has been in place since 1983. Potential donors who perceived themselves to have been at risk of HIV infection are advised not to give blood. The Hong Kong Red Cross Blood Transfusion Service has devised a note listing all the risk conditions to be presented to all donors so that he/she could make an informed choice of not donating blood as appropriate. A 24-hour call-back system is in operation for donors who, after their donations, feel that their blood should not be used for fear of transmitting the infection.

(b) Screening of Donated Blood

As from August 1985, all donated blood units have been screened for anti-HIV antibody by EIA (Enzyme-linked immunosorbent assay). This test was changed to HIV1+2 since 1990. Repeatedly positive samples by screening are confirmed with Western Blotting at the Virus Laboratory of the Department of Health. Twenty-nine donors have been found to be HIV antibody positive so far.

(c) Counselling and Referral

Donors tested HIV positive are informed on a confidential basis, counselled by trained medical staff and referred to the Department of Health's AIDS Clinic (Special Medical Consultation Clinic) or the donor's family physician for subsequent follow-up and treatment.

(d) Look-back Programme

For multiple-times donors found subsequently HIV positive, sera from their previous donations of their blood/blood products are traced, and the recipients tested and followed up.

(e) Information and Education

Through the media, and with the production of printed materials (posters and leaflets) the Hong Kong Red Cross Blood Transfusion Service has been informing the public of the importance of safe, infection-free blood, and the advice against giving blood for the purpose of blood testing for HIV. There is a risk, albeit small, of infecting a recipient if an HIV infected donor gives blood during the window period before HIV antibody develops in the body. Potential donors are encouraged to use the confidential HIV testing and counselling system operated by the Department of Health if they perceive themselves to be at risk of HIV infection.

Policy for Communities

Practising High Risk Behaviours

6

6.1 Substance Abuse

6.1.1 Introduction

The sharing of injection equipment by intravenous drug users constitutes one important route of HIV transmission on a global scale. The significance of injecting drug use in relationship with HIV/AIDS varies from nation to nation and from one cohort to another. The National Commission on AIDS of U.S.A. called this a “twin epidemic” in its report published in July 1991, underlining the importance of Substance Abuse and HIV/AIDS in the country, as over 30% of all adult/adolescent AIDS cases were related to intravenous drug use. In our neighbouring countries, HIV transmission due to injecting drug use is becoming an increasing problem in Malaysia, where prevalence has risen from 0.14% in 1989 to 6.9% in 1991. The Yunnan Province in China is another focus of attention where a prevalence rate of 49% was described in one study in 1993. The situation in Thailand, Myanma and Vietnam are equally worrying, in view of their location adjacent to the Golden Triangle.

In Hong Kong, HIV seroprevalences have been low in studies involving voluntary testing and unlinked anonymous screening systems on those using the methadone clinics and drug rehabilitation services. The Department of Health has so far (end of August 1994) recorded a total of 11 persons infected with HIV through injecting drug use in the voluntary reporting system. As a volatile problem which hinges on human behaviour, the low figure is no reason for complacency, but a situation demanding better attention and understanding.

Interventional strategies on HIV/substance abuse have been developed by WHO and national/international organizations ever since the mid eighties. Overall the concept of “harm reduction” has been perpetuated in recent years. It involves the perception of substance abuse as a social and behavioural phenomenon, and in fact a reality in modern living; and the urgent need for minimizing its harmful effects on personal health and the society instead of achieving the traditional goal of absolute abstinence.

6.1.2 Key Principles

- (a) Information, education and counselling on risk reduction are the best means of preventing HIV infection among drug injectors. Those programmes should be available, easily accessible and appropriate to the setting for drug injectors in our community, and should also incorporate other related health messages of safer sex and condom use.
- (b) Different modalities of drug treatment and rehabilitation services should be sufficient to meet the needs of all who wish to enter into the programme.
- (c) Barriers which limit the availability of new/clean injection equipment and thus encourage sharing should be removed.
- (d) Mandatory HIV testing is not warranted for drug injectors or drug users in general.

6.1.3 Recommended Approach for Risk Reduction Among Drug Injectors

Programmes on risk reduction among drug injectors should be designed by taking into consideration locally relevant social, behavioural factors, as well as taking reference from effectiveness of overseas programmes. Based on the principles established under 6.1.2, the followings are recommended:-

- (a) Information and education about HIV, its transmission and prevention should be incorporated into existing educational programme for drug users under care of government or non-governmental drug treatment/rehabilitation services.
- (b) development of outreach programmes for the provision of education, information (and counselling) should be facilitated; and wherever appropriate, drug injectors and/or ex-drug injectors may be involved in their planning and implementation.
- (c) HIV counselling and voluntary HIV antibody testing services should be developed or extended to drug abusers, and should be supported by appropriate medical follow up programmes. Mandatory testing as a pre-requirement for joining a rehabilitation programme is not warranted.
- (d) The behavioural pattern (needle-sharing & sexual behaviour) of drug users should be monitored regularly to help evaluate the current interventional programmes of risk reduction.
- (e) Training programmes should be regularly organized for drug rehabilitation workers on HIV/AIDS and risk reduction to equip them with skills in providing education and information, and to prepare them for the emergence of the HIV problem in the drug abuse community.
- (f) Better integration of the drug rehabilitation and AIDS programme should be developed in the long term both on the operational as well as policy levels. Initiatives should therefore originate from the Advisory Council on AIDS and also the Action Committee against Narcotics (ACAN).
- (g) Access to sterile needles/syringes and measures for decontaminating such injection equipment should be monitored and evaluated to ensure that their availability is suitably facilitated.

6.2 Prostitution/sex Industry

6.2.1 Introduction

WHO defined prostitution as a transaction in which sexual services are provided in exchange for money or things of monetary value provided to the prostitute or some other party. It is a recognized social phenomenon associated with economic, cultural, moral, behavioural and legal factors. There are male and female prostitutes (sex workers) though in many occasions we refer to the female ones. The number of sex workers in Hong Kong is not known. The Crimes (Amendment) Ordinance 1991 specified that “a person who harbours another person for the purpose of or with a view to that person’s prostitution shall be guilty of an offence and shall be liable on conviction on indictment to imprisonment for 14 years”. Prostitution may be voluntary or coerced, and in many cases motivated by economic considerations.

Prostitution is a risk factor for HIV transmission. Female sex workers are often considered a high risk group and this has led to stigmatization, creating a barrier to prevention education. In fact the terms “sex workers” and “sex industry” are preferred to “prostitutes” and “prostitution” because of the latter’s stigmatizing implications in some places. The prevalence of HIV infection among female sex workers varies from country to country, or even city to city. A review published in the Bulletin of WHO in 1993 gave such varying figures for seroprevalences as 0 to over 80%. Some Asian cities like Chiangmai, had an HIV seroprevalence of 36.5% according to one study. The exact situation in Hong Kong is not known.

It is clear that the relationship between prostitution and HIV hinges on a range of other factors including drug use, presence of sexually transmitted diseases, frequency of condom use, the forms of sex work, sexual behaviours and the socioeconomic condition. A consultation was convened by the WHO in 1989 to develop a consensus in facing the problem of HIV and prostitution, and it forms the framework for the policy adopted in this chapter.

6.2.2 Key Principles

- (a) Prostitution occurs virtually worldwide and Hong Kong is no exception. Intervention should be sustained and focused on decreasing health risks (including risk of HIV) to prostitutes and their clients.
- (b) HIV education, support and prevention services should be provided, expanded and integrated into the overall health care system in order to ensure that the greatest number of sex workers and clients of prostitutes are aware of the means of HIV prevention.
- (c) Use of condoms and their availability to sex workers and clients should be promoted without restriction by legislation or law enforcement practices.

- (d) Mandatory HIV testing of sex workers (and clients) should not be practised because of its ineffectiveness, as is the case of issuing of HIV-free certificates.

6.2.3 Interventions to Protect Prostitutes & Clients from HIV

HIV infection is linked with high risk behaviour. Prostitution has often been the focus of attention because of its complex relationship with high risk sexual behaviour, drug abuse and socioeconomic conditions which predispose prostitutes or clients to HIV transmission. Intervention to promote health should be based on reduction of risk instead of mere identification, labelling and thus stigmatization of those infected, who are often marginalized because of their involvement in a transaction (prostitution) which is socially unacceptable. Intervention should not be excessively focused on prostitutes as their clients constitute another community demanding more attention and educational efforts. The following programmes are important components of an effective system for prevention of HIV transmission through prostitution:-

- (a) Research on prostitution needs to be encouraged so as to provide a better understanding of how HIV transmission can be contained, taking into consideration cultural, legal, racial and economic factors inherent in Hong Kong.
- (b) Prevention education should be organized targeting not just sex workers and their clients, but also the general public on the importance of high risk sexual behaviour in the causation of HIV transmission.
- (c) Interventions should be, as far as possible, designed in consultation with sex workers/ex-sex workers and their clients, and be based upon results of local research instead of simple extrapolation of data obtained elsewhere.
- (d) Studies are needed to measure changes in HIV seroprevalence and risk behaviour over time amongst sex workers and clients to establish the strategy for effective intervention.
- (e) Use of condoms and their availability to sex workers and clients should be facilitated, and should never be restricted by legislation, law enforcement practices or other coercive action.
- (f) Participation of voluntary agencies should be encouraged in the design and implementation of prevention education, promotion of safer sex practices, conduction of social and behavioural research, provision of support services to sex workers with or without HIV infection.
- (g) Availability of quality and accessible service for STD diagnosis and treatment should be made an integral component of our AIDS programme targeting sex workers and their clients. Services provided by the Social Hygiene Service of the Department of Health would need to be continued and strengthened.

- (h) HIV testing, if performed, should be done voluntarily and in context of counselling. Supporting social and clinical services should be part and parcel of a quality HIV testing system.
- (i) Financial assistance, training and other social services should be organized to enable sex workers to find ways of supporting themselves and their children should they decide to give up sex work. This is particularly important for those who have been tested positive for HIV antibody.

6.3 The Prison Setting

6.3.1 Introduction

In many countries, a substantial number of prisoners are contracting HIV because of their background of high risk behaviour before their arrest, or through practice of such behaviour in the prison. Another dimension of the problem is the adoption of discriminatory measures in the prison setting (compulsory HIV testing, segregation, lack of confidentiality, and inaccessibility of medical/support services) in some nations, which have no public health rationale and are evidence of non-respect of ethical principles.

In 1987, WHO published guidelines opposing discriminatory measures against prisoners. These were updated in March 93 and form the principles underlining policy adopted in this chapter. The same strategies apply not only to prisons but other institutions including refugee camps, detention centers and boys' /girls' homes.

6.3.2 Key Principles

- (a) All prisoners have the rights to receive health care, including preventive measures, equivalent to that available in the community without discrimination. The general policy adopted by Hong Kong's AIDS programme (including that of confidentiality) should apply therefore equally to prisoners.
- (b) The prison environment provides a unique opportunity for AIDS information and education to be disseminated, which should be executed against the background of non-discrimination and humanity.
- (c) Compulsory testing of prisoners for HIV antibody is unethical and ineffective and should be prohibited.

6.3.3 Approach to HIV/AIDS Prevention, Education and Care in the Prison Setting

General Measures

- (a) Guidelines on HIV prevention, education and care should be established for prisoners to be promulgated in each prison, for the reference of prison staff at the administration, operational levels as well as in the health care setting. This should be done by taking into consideration patterns of risk behaviour, resource availability, legal perspectives and pre-existing health programme for prisoners in prison and after release.

- (b) An anticipatory approach is useful by the establishment of special committees to examine policy and practices, and to resolve controversies arising from management of HIV positive prisoners or those at risk of infection.
- (c) HIV testing, if performed, should be conducted in context of counselling and with the support of clinical and social services. Unlinked anonymous screening is a separate programme which could be undertaken by strictly adhering to guidelines established locally and internationally (section 3.3.2).
- (d) Prison staff should receive HIV/AIDS prevention information as initial and in-service training. There should be provision for prison staff to be trained to provide HIV/AIDS education to prisoners and colleagues.
- (e) In view of the importance of peer education, consideration should be made in involving prison staff, prisoners and/or ex-prisoners in the design and dissemination of information.
- (f) The prison setting provides a unique opportunity for the provision of AIDS education, and there should be opportunity for discussion to be held with qualified people. Close liaison with health care staff involved in the running of AIDS programme in the community should be maintained.
- (g) Access to drug rehabilitation and treatment programme should be facilitated for drug abusing prisoners.

Management of HIV-infected Prisoners

- (a) Information on the health status and medical treatment of prisoners is confidential and should be accessible to health personnel only. These may be disclosed to management and/or judicial authorities if such would assist in the care of the prisoner, provided that he/she consents.
- (b) Segregation, isolation and restriction of activities on the ground of the HIV status alone is unwarranted. Decision on the need to isolate prisoners with HIV should be taken on medical grounds and by medical personnel.
- (c) Medical follow-up and counselling for HIV-infected prisoners should be available and accessible during detention. Likewise prisoners should have access to information on treatment options and the right to refuse treatment.

6.4 Sexually Transmitted Diseases and AIDS

6.4.1 Introduction

On a global scale, sexual transmission is the most important route for HIV spread. HIV/AIDS and sexually transmitted disease bear remarkable similarity in that (i) both share the same route of transmission and (ii) both are related to the same pattern of high risk sexual behaviour. The relationship between the two is brought closer by the observation that STD poses as a risk factor for HIV transmission. The implications are clear:- prevention of either STD or sexual transmission of HIV would help reduce transmission of the other. STD clients therefore constitute a community requiring focused attention, targeted education and efficient clinical service STD/HIV prevention and control.

Coordination of STD and AIDS programmes has always been advocated by international and national bodies. The WHO, in its consensus statement issued in 1989, stressed the importance of coordination efforts, which encompassed interaction at peripheral (operational) and central (policy) level.

In Hong Kong, STD programme is managed by the Social Hygiene Service in the public sector under the Department of Health. The service takes care of 20%-30% of all STD patients in the territory. A free and open door policy has been adopted in the running of the local STD treatment programme. The Social Hygiene Service works closely with the Department's AIDS control programme in the provision of clinical service and public education. HIV tests are offered on a voluntary basis to all attendees of Social Hygiene Clinics. Statistics revealed that about one-fifth of all reported HIV infection in Hong Kong were diagnosed at the Social Hygiene Service.

The strategies used for STD and AIDS control are (i) health promotion and (ii) adequate management of patients with the diseases. Policies outlined in this session are adapted from those advocated by the WHO, but with a local perspective.

6.4.2 Key Principles

- (a) The importance of STD and AIDS programme coordination should be underscored while taking into consideration aspects of the 2 programmes which are distinct such as (i) AIDS-related opportunistic infection and neoplasms, (ii) specific STD-related complication and (iii) the importance of non-sexual transmission of HIV.
- (b) Legal, economic, social and structural barriers to the implementation for programmes for reducing sexual transmission of HIV/AIDS, including that of condom promotion, should be eliminated.
- (c) Based on data collected from operational research and surveillance, STD and AIDS control should be integrated at implementational level and coordinated at policy and programme management levels.

- (d) Efforts should be made to remove stigma attached to people with STD and/or HIV infection, and that accessibility to education and clinical service for these people should be facilitated.

6.4.3 Priority Activities for STD/HIV Prevention, Care and Control

It is clear that coordination of AIDS and STD programme could:

Enhance the overall effectiveness of programme implementation.

Serve the common goal in staff training and resource development.

Promote the development of innovative strategies for control of the 2 diseases.

In the light of these advantages, the following priority areas are identified for development of STD/AIDS integrative programmes in Hong Kong:

- (a) Research, in the local context, is needed to assess sexual behaviour relating to HIV/STD for the purpose of designing appropriate interventional activities for preventing the two diseases.
- (b) The pattern of high risk sexual behaviour should be monitored regularly to provide input for strategic programme planning.
- (c) Specific information, education and communication which address the determinants of behaviour that place individuals at risk of HIV/STD should be developed through the combined effort of the 2 programmes in the public service.
- (d) Training of health care staff on STD and AIDS needs to be streamlined by the introduction of combined modules for incorporation into the basic and in-service training programmes for staff at all levels.
- (e) The HIV and STD clinical management systems should be reviewed and evaluated periodically to ensure:-
- ◆ Provision of appropriate health education on HIV at all Social Hygiene Clinics.
 - ◆ Early diagnosis and treatment of STD, particularly amongst women.
 - ◆ Development, in the long term, of effective clinical services for HIV/AIDS patients
Through the joint and coordinated efforts of staff in the 2 programmes.

AIDS and the Law

7

7.1 The Public Health

7.1.1 *Current Practice in Hong Kong*

In Hong Kong, there is no legislation dealing specifically with HIV infection and AIDS. A relevant one is the Prevention of the Spread of Infectious Diseases (Amendment) regulation 1994 Cap.141 which provides for the notification of selected infectious diseases. HIV/AIDS is, however, not one of the diseases listed in the Schedule. Similarly HIV/AIDS is not included in the Venereal Disease Ordinance Cap 275 under which medical practitioners are required to report suspected source of infection with sexually transmitted diseases to the Department of Health. The term “AIDS” is, however, specified under Schedule One of the Undesirable Medical Advertisement (Amendment) Ordinance 1988 in respect of which advertisements on treatment are prohibited.

7.1.2 *Public Health Legislations Overseas*

In England, there is an independent AIDS (Control) Act 1987 which makes provisions that periodical reports on matters relating to AIDS and HIV infection shall be made to each regional health authority and to the Secretary of State. Further, Regulation 5 of the Public Health (Infectious Diseases) Regulation 1988 provides that if a JP (Justice of Peace) is satisfied that an AIDS patient leaves the hospital and proper precaution to prevent to spread the disease would not be taken in his lodging or accommodation etc., may make an order for the detention of that patient in the hospital. According to the Health and Medicine Act 1988, Section 23, the Secretary of State may also provide by regulation to stop or punish those who sell or advertise HIV test kits and services.

In Australia, some jurisdictions have added AIDS and HIV infection in the already existing list of “infectious” or “notifiable” diseases and therefore subject to same legal regime as such other diseases. Some jurisdictions have enacted specific provisions laying down special public health powers and duties to address the particular issues by HIV/AIDS, which include:

- ◆ Notification of AIDS/HIV infection
- ◆ Powers of detention or isolation of people with HIV
- ◆ Powers of declare areas of quarantine
- ◆ Powers to compel testing and treatment
- ◆ Directions regarding disposal of bodies of people died with infectious diseases.

To date, not all countries have enacted specific AIDS-related legislation. However, many countries have laws and regulations which could be applied to people with HIV/AIDS.

7.1.3 *Future Development*

Whether Hong Kong should follow suit of other countries and to review the public health legislation relating to HIV/AIDS control is debatable. The following considerations should be made in guiding our future development:

- (a) A voluntary reporting system is already in place for the collection of epidemiological data on HIV infection and AIDS. Knowing that no reporting system on earth can provide a perfect picture of the dimension of the disease, its effectiveness should be regularly evaluated before deciding on the need for modification, amendments or alteration.

- (b) It has been argued that coercive public health measures are justified in the context of public health. On the other side, it could be put that these traditional public health measures are inappropriate for HIV/AIDS because of its limited modes of transmission, the very real risk of discrimination against people with such “stigma” and the need to encourage voluntary testing and changes in behaviour.

7.2 Transmission Offences

In Hong Kong, there is no legislation making an offence the conduct of people with HIV who transmits/attempts to transmit the infection to another or exposes another to the risks of infection. Should there be any such kind of cases, aid of Common Law has to be sought.

There are a number of criminal offences under Common Law that could apply where a person exposes another to the risk of HIV infection, ranging from murder to assault and causing grievous bodily harm. However, according to the experiences of other countries, charges of such kind may not be successfully made due mainly to the following reasons:

- (a) Insufficient medical evidence establishing the risk of transmission – e.g. a report of the US National Institute of Justice concluded that there is no evidence of HIV transmission through biting or exchange of saliva – Hammett Update 1988;
- (b) Difficulties in proving causation by the Prosecution – It is a problem of establishing beyond reasonable doubt that it is the conduct of the accused that caused the victim to be infected with HIV and not some other intervening events;
- (c) Evidence of knowledge and/or implied consent on the part of the victim – It seems unlikely that common assault could successfully be prosecuted in a case of transmission of HIV through consensual sexual intercourse.

It is also true that linkage has to be established in a civil claim by the victim for compensation/damages against the person with HIV who causes or exposes the victim to infection. Furthermore, it should be noted that in USA, there are even claims for intense emotional stress for AIDS fear though no positive evidence of contracting HIV/AIDS could be traced.

7.3 Privacy and Confidentiality

The protection of confidentiality in relation to a person's HIV status is critical and important because HIV infection brings with it stigma and discrimination which are not present with many other diseases. In addition, it is an important part of public health strategies that require the trust and co-operation of people with or at risk of HIV infection in order to encourage voluntary HIV testing and measures to reduce the risk of HIV transmission.

According to the Article 14 of the Hong Kong Bill of Rights Ordinance, it provides that 'no one shall be subjected to arbitrary or unlawful interference with his privacy etc.', which therefore forms a basis for the protection of 'privacy' though it may not be of adequate footing. In this respect, the Common Law does not render additional personal data and information protection as it does not recognize a general right to privacy.

The Common Law in respect of the legal duty of confidentiality is clearer. It may be expressly provided for in a legally enforceable contract or may be found in special relationships, such as between doctor and patient in this context. In fact, certain government and professional bodies in Hong Kong have adopted ethical codes of practice and policies enforcing strict compliance with the rule of confidentiality. In relation to the health care professionals, a set of guidelines for the same purposes has recently been set out. Although such guidelines do not in themselves have legal force, they may be relevant to legal claims based in negligence as evidence while determining the issue of 'reasonable standard of care'. In Australia, health departments in several states have issued policy directives on the confidentiality of health records in hospitals and community health services and some have specifically dealt with the confidentiality of sensitive information on HIV/AIDS.

The most uncertain area which has not been resolved by courts of the commonwealth jurisdictions is whether a health care professional owes a duty to warn a third party about a risk of HIV infection at the expense of breaching the duty of confidentiality owed to a patient. According to a number of cases which are of persuasive authority to Hong Kong courts, the health authority/professionals need to take reasonable steps to minimize the risk of infections to third parties, which in practical terms would include sufficient counselling to attempt to persuade the patient to reduce or eliminate the risk to third parties.

Another controversial area is confidentiality versus public interest in knowing the truth. It seems that the English Court has, in a few landmark cases, adopted a balancing test between public interest in maintaining confidence so as not to deter patient from going to hospital for treatment and public interest favouring disclosure.

7.4 **Anti-discrimination and Equal Opportunities**

The law can assist implementation of HIV/AIDS strategy and policy by providing protection against discrimination and the protection of confidentiality for people with HIV or suspected HIV infection. The objective is positive: to give respect for such people with HIV/AIDS and to protect them from harmful or undesirable consequences e.g. being discriminated in the workplace or school.

The upcoming *Equal Opportunities Bill* appears to provide protection in this respect by making an offence discrimination on the ground of disability. It also makes it unlawful for an employer/education authority/club manager to discriminate against a person on the grounds of the person's disability in areas such as employment, education, accommodation, provision of goods and services, and attendances in clubs/associations. In the Bill, discrimination includes harassment. If, however, the Bill cannot be passed as statutory law, appropriate administrative measures shall be taken for these purposes accordingly.

Some prominent legal scholars advocate that the law can play a proactive role in seeking to change underlying social and economic factors that deprive individuals of the power to protect themselves from HIV infection, for example, by abolishing such laws which entrench the economic dependence of women through land ownership or paid employment. However, any proposal to amend the law should be thoroughly studied beforehand, taking into consideration possible pros and cons arising from the amendments. It is clear also that civic education through various means is an alternative or supplement to legal efforts in effecting changes.

Appendix I :

Abbreviations

| | |
|----------------|---|
| ACA | Advisory Council on AIDS. |
| ACAN | Action Committee against Narcotics, Hong Kong. |
| AIDS | Acquired immunodeficiency syndrome, a syndrome characterised by immune deficiency arising as a result of HIV (human immunodeficiency virus) infection. Certain case definitions have been used by national and international bodies for surveillance purpose. The most commonly used one (adopted in Hong Kong) was designed by the Centers for Disease Control in Atlanta in 1987. |
| API | Announcement of Public Interest. Brief television spots on issues of interest produced for publicity purpose. |
| ARC | AIDS-related Complex, a loosely defined term to label patients who are symptomatic but have not yet progressed to AIDS. |
| ASDC | AIDS Services Development Committee, one of the three committees under the Advisory Council on AIDS in Hong Kong. |
| AZT | Azidothymidine, Zidovudine (ZDV), Retrovir. This is the name of the first antiviral drug approved for use in HIV infection. |
| CD4 | Same as T4 or T-helper lymphocyte. This is one type of white blood cells which is the major target for HIV. Immune dysfunction can be demonstrated by a low CD4 count, CD4% or CD4/CD8 ratio in laboratory test. |
| CDC | Centers for Disease Control in Atlanta, USA. It has been recently renamed as Centers for Disease Control and Prevention. |
| CEPAIDS | Committee on Education & Publicity on AIDS, one of the three committees under the Advisory Council on AIDS in Hong Kong. |
| DH | Department of Health, Hong Kong Government. |
| ED | Education Department. |
| EIA | Same as ELISA. |
| ELISA | Enzyme-linked immunosorbent assay. A common laboratory technique used in the detection of HIV antibody. This is usually a screening test, the result of which needs to be confirmed with a secondary step, usually the Western Blot. |
| GIS | Government Information Service, also known as the Information Services Department. |

| | |
|---------------|---|
| GPA | Global Programme on AIDS, a unit of the World Health Organization. |
| HA | Hospital Authority. |
| HBsAg | Hepatitis B surface antigen, an indicator of infection with the hepatitis B virus, which bears similar routes of transmission as HIV. |
| HCV | Hepatitis C virus, another bloodborne infectious disease. |
| HIV | Human immunodeficiency virus, the causative agent of AIDS. |
| KS | Kaposi's Sarcoma, one form of "AIDS-defining" illness characterized by the appearance of a skin tumour. |
| NGO | Non-governmental organization. |
| PCP | Pneumocystis carinii pneumonia, one common form of opportunistic infection occurring in AIDS patients. |
| SARDA | The Society for the Aid and Rehabilitation of Drug Abusers |
| STD | Sexually transmitted disease. |
| SWD | Social Welfare Department. |
| TB | Tuberculosis. |
| UAS | Unlinked anonymous screening |
| UNDP | United Nations Development Programme. |
| UNICEF | United Nations Children's Fund |
| UNHCR | United Nations High Commission for Refugees. |
| WHO | World Health Organization. |

Appendix II:

References

WHO/International Guidelines & Documents

1. WHO/GPA Statements & Guidelines

- ◆ Statement from the consultation on AIDS & the workplace 1988
WHO/GPA/INF/88.7
- ◆ Consensus statement from the consultation on sexually transmitted diseases as a risk factor for HIV transmission 1989
WHO/GPA/INF/89.1
- ◆ Consensus statement from the consultation on AIDS & sports 1989
WHO/GPA/SFI/89.2
- ◆ Unlinked anonymous screening for the public health surveillance of HIV infections – proposed international guidelines 1989
WHO/GPA/INF/89.3
- ◆ Heterosexual transmission of HIV and certain common social situations 1989
WHO/GPA/INF/89.5
- ◆ Consensus statement from the first international meeting of AIDS services organizations 1989
WHO/GPA/INF/89.9
- ◆ Consensus statement on accelerated strategies to reduce the risk of transmission of HIV by blood transfusion 1989
WHO/GPA/INF/89.13
- ◆ The health of mothers & children in the context of HIV/AIDS 1989
WHO/GPA/INF/89.19
- ◆ Consensus statement from the consultation on global strategies for coordination of AIDS & STD control programmes 1990
WHO/GPA/INF/90.2
- ◆ Consensus statement from the WHO/UNICEF consultation on HIV transmission & breast feeding 1992
WHO/GPA/INF/92.1
- ◆ Statement from the consultation on testing & counselling for HIV infection 1992
WHO/GPA/INF/93.2
- ◆ WHO guidelines on HIV infection & AIDS in prisons 1993
WHO/GPA/DIR/93.3

2. *Other WHO Documents*

- ◆ Report on the consultation on international travel and HIV infection 1987
WHO/SPA/GLO/87.1
- ◆ Global Strategy for the prevention & control of AIDS – resolution of the 40th World Health Assembly 15 May 1987
WHA40.26
- ◆ AIDS prevention & control – Invited presentation & papers from World Summit of Ministers of Health on Programmes for AIDS prevention London 26-28 January 1988
- ◆ Report of a WHO consultation on the prevention of HIV & hepatitis B virus transmission in the health care setting 1991
WHO/GPA/DIR/91.5
- ◆ Global strategy for the prevention and control of AIDS: 1992 update
- ◆ The HIV/AIDS Pandemic 1994 Overview
WHO/GPA/TCO/SEF/94.4

3. *Other National/International Publications*

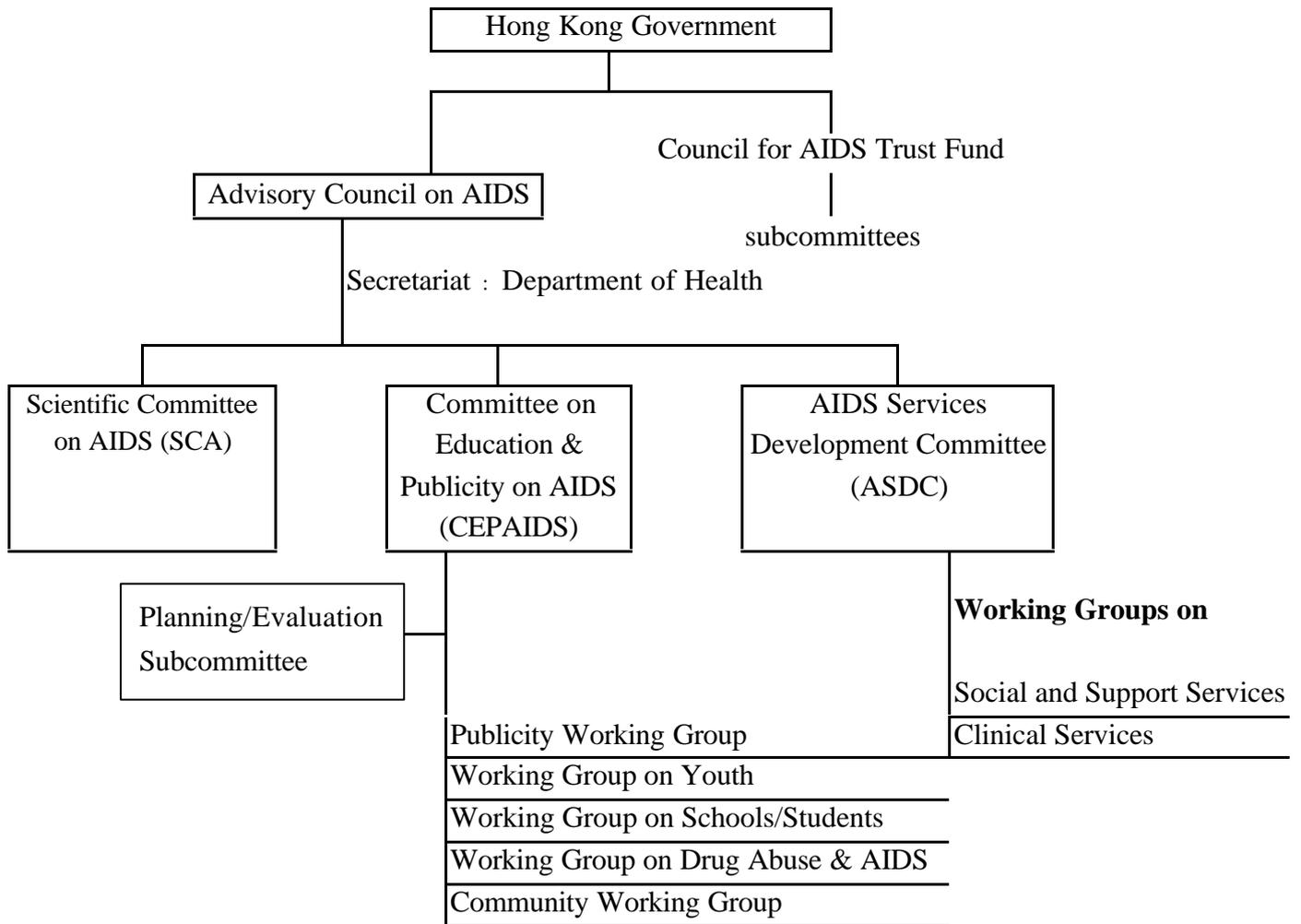
- ◆ AIDS-HIV infected health care workers: Occupational guidance for health care workers, their physicians & employers
UK Health Department 1991
- ◆ Living for tomorrow – National AIDS Trust 1991
- ◆ AIDS in the World – a global report
The Global AIDS Policy Coalition 1992
- ◆ Policy statement & guidelines to prevent transmission of HIV & hepatitis B through medical/dental procedures
New York State Department of Health 1992
- ◆ Preventing HIV transmission in health care settings
National Commission on AIDS. USA 1992
- ◆ Report: The twin epidemics of substance use & HIV
National Commission on AIDS. USA 1992
- ◆ Using Mass Media for AIDS public education by Susan Perl (article)
Transcript 1992
- ◆ Towards a new health strategy for AIDS
- a report of the global AIDS policy coalition 1993

Local Documents/Publications

- ◆ Disease notification in the context of HIV/AIDS
Scientific Working Group on AIDS (& Department of Health Circular) 1992
- ◆ Guidelines on consent for HIV testing
Scientific Working Group on AIDS (& Department of Health Circular) 1992
- ◆ Information on AIDS for doctors & dentists (2nd edition)
Department of Health 1992
- ◆ Prevention of transmission of HIV in health care settings – guidelines & practice
Scientific Working Group on AIDS 1992
- ◆ Procedures for management of needlestick injury or mucosal contact with blood or body fluids – recommended guidelines for HIV & hepatitis B prevention
Scientific Working Group on AIDS 1992
- ◆ Recommended guidelines for undertaking unlinked anonymous screening for public health surveillance of HIV infection in Hong Kong
Scientific Working Group on AIDS 1992
- ◆ Information on AIDS for nurses (2nd edition)
Department of Health 1993 – Chinese & English
- ◆ Proposed revised specification for clotting Factor Concentrates
Scientific Working Group on AIDS 1993
- ◆ Guidelines on management of HIV infection in children
Advisory Council on AIDS 1994
- ◆ Guidelines on the prevention of blood-borne diseases in schools
Department of Health & Education Department 1994
- ◆ HIV infection & the health care workers – recommended guidelines
Advisory Council on AIDS 1994

Appendix III:

Organizational Structure of Hong Kong's AIDS Programme



Operational government departments
(major ones) :

- Department of Health
- Information Services Department
- Education Department
- [Hospital Authority]
- Social Welfare Department

Non-governmental organizations :
(on AIDS) :

- Hong Kong AIDS Foundation
- AIDS Concern

Appendix IV:

Advisory Council on AIDS

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

1. To keep under review local and international trends and development relating to HIV infection and AIDS ;
2. To advise Government on effective programmes for prevention of AIDS and support services for HIV infected persons and on further development of a comprehensive strategy on AIDS.

The ACA is underpinned by three committees, namely:

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

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

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

Secretary: Mr. Aaron KWOK

Appendix V:

Useful Addresses & Telephone Numbers

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

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

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

4. Non-governmental organizations (on AIDS)
Hong Kong AIDS Foundation
Tel: 560 8528
Fax: 560 4154
AIDS Concern
Tel: 898 4411
Fax: 505 1682