The First Decade of AIDS in Hong Kong - a collection of essays

Hong Kong Advisory Council on AIDS

1999
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- a collection of essays

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1999
To
All who have contributed
to Hong Kong's AIDS programmes

The Hong Kong Advisory Council on AIDS has facilitated the collection, editing and publication of "The first Decade of AIDS in Hong Kong". The views contained are those of individual author and not those of the editors or the Council.
The First Decade of AIDS in Hong Kong
Editors: S S Lee & C W Chan

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FOREWORD

Coined “Plague” of modern times, HIV infection has not only ravaged the world but revolutionised mankind’s approach to communicable diseases. In view of the complex virologic, ecologic and social factors inherent to the community, it is crucial to curb its spread as well as to provide care for those infected. It is clear therefore that the HIV epidemic often needs to be addressed from more than one perspective. In other words, a multidisciplinary and multisectorial approach is indicated.

While we are planning the future AIDS strategy, it is important that we take reference from past experience. Elsewhere, loads of publications have cumulated over the years, ever since the first AIDS cases were diagnosed in 1981. In Hong Kong, however, “The first decade of AIDS in Hong Kong” is the first piece of comprehensive work devoted to tracking our past both in the context of HIV/AIDS’s impacts and the local community’s responses. I commend the authors and contributors, all state-of-art experts in their fields, for undertaking this seemingly daunting task. The book will be a useful reference for health care and social professionals, researchers and anyone interested and/or involved in Hong Kong’s AIDS work. The experiences reported in this work may also be useful when confronting new or other emerging infections. I am hopeful that this book shall pose as an example for further research to be conducted, both on AIDS as well as other public health issues.

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Chairman, Department of Community and Family Medicine
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June 1997
FOREWORD

Established in 1990, the Advisory Council on AIDS is charged with advising on Hong Kong's AIDS policies. Over the years, we find it essential, in our deliberation, to seek the input of service providers, academics and the community, before formulating strategies best suited to local needs. Their views had since become cornerstone of the principles of our recommended policies.

Ten years on, AIDS is still in the middle of us. Naturally, a question emerged repeatedly in the last couple of years: how well have we dealt with HIV/AIDS here in Hong Kong. To address this question, the Council has considered it timely to review our local programmes and situation. One useful yet unconventional way of evaluating our past is, again, to seek the views of the community. This publication is a collection of ideas of many who have devoted time and energy towards improving our AIDS strategy in the last decade. While not representing the stand of the Council, their views are surely invaluable in leading us to our next phase.

I am grateful to Dr C W Chan and Dr S S Lee for the editorial work, and would like to thank the Council Secretariat for undertaking the mammoth task, which looked impossible at the start. Whereas 1997 marked the watershed time for Hong Kong, it was the same also for our AIDS programmes. Written in 1996/1997, this book is a useful piece of reference for all who are interested in the prevention, care and control of AIDS in Hong Kong. It is also a testimony to the community spirit which has been cultivated in our response to AIDS in the first decade.

Dr Conrad KS Lam, JP
Chairman (1996-1999)
Hong Kong Advisory Council on AIDS

September 1998
The idea of publishing "The First Decade of AIDS in Hong Kong" originated a few years back when the editors were busy planning a training course on AIDS for nurses in Hong Kong. Despite the availability of a large number of education materials on the subject, few had it covered in a local perspective. Consider the following questions: How bad (or good) is the HIV/AIDS situation in Hong Kong? How have we responded to the epidemic? What is the impact of AIDS on our society? How are people with HIV/AIDS treated? The complexity of AIDS has made it difficult, if not impossible, for the questions to be addressed in a monograph, or by a single person. Consequently, a project was conceived to review the first ten years of AIDS in Hong Kong as a collective effort. The editors are pleased to have the support of seventeen contributors to undertake this work.

This book begins with a chronology, which is a recollection of important events between 1984 and 1996. Dr KH Wong et al then summarises the impacts of HIV/AIDS as a communicable disease in Hong Kong, with emphases on its similarities with and differences from that in other countries. An overview of the Government's response to the epidemic is presented by Mr Vincent Yeung, who also touches on the possible track of future development. Care of HIV infected people is addressed in three chapters - from the perspective of a public hospital by Dr Patrick Li, alternative care by Miss O C Lin, to the special needs of children by Professor Y L Lau et al. The context of social support is reviewed by Mr Billy Ho from his angle as a social work professional.

Public awareness is often an area of concern in any AIDS programme in the world. Dr Joseph Lau evaluates a series of studies conducted in the last decade, thereby tracking not just public awareness but attitude of people towards AIDS and people living with AIDS. Miss Diana Yeung takes us through her analysis of the role of the media in the context of its impact on the society. Three chapters address specific community groups in respect of AIDS prevention and care - drug users by Dr J B Hollinrake, homosexuals by Mr Andrew Lo, and workplace policy by Dr Y C Lo and Dr L C Kwan. This book ends with a chapter which rightly directs us to an area demanding our future attention - AIDS in China by Professor K L Zhang.
As when this book was planned, the editors have aimed at inviting views and generating debates on all aspects of AIDS prevention, care and control in Hong Kong. The final product is therefore one of variety rather than conformity. As the contributors are the same people who have worked in the local AIDS programme, their words are an invaluable addition to our understanding of the subject. They are the candles. While we enter the second decade, our historical past serves as a yardstick against which future development of our AIDS programme can and shall be developed. The editors hope to have been useful as the mirrors.

Our gratitude goes to the Secretariat, Hong Kong Advisory Council on AIDS, for its support of this work.

_There are two ways of spreading light: to be the candle or the mirror that reflects it_- Edith Wharton

The editors
December 1996
PREFACE

In 1996, seventeen contributors were approached to write on various aspects of HIV/AIDS in Hong Kong. The product was a collection of twelve articles covering situation analysis, prevention and care of HIV infection as they relate to the unique circumstance of Hong Kong. These articles became useful references when the Hong Kong Advisory Council on AIDS subsequently planned and conducted the AIDS situation and programmes review in 1998.

Hong Kong's AIDS programme has now entered a new phase, featuring enhanced community participation, introduction of community planning and new strategy development. The Council's Secretariat has decided to publish this collection of highly regarded landmark articles for the reference of whoever is interested in Hong Kong's AIDS programme development. It is the Secretariat's belief that through mutual learning, we would become better able to improve our strategies on AIDS prevention and care in Hong Kong.

Secretariat
Hong Kong Advisory Council on AIDS
March 1999
A CHRONOLOGY 1984 - 1996

S S Lee
Introduction

In designing our future AIDS prevention, care and control strategies, it is often necessary to look back at how the epidemic has affected us, and how the society has responded. The following chronology is prepared to help us track our past. Only selected highlights are presented as it is impossible to cover everything that has occurred in the last decade. Instead of a comprehensive review, the chronology offers an overview for readers. It could hopefully help place the chapters in this book in perspective.

1984

• An Expert Committee on AIDS and a Scientific Working Group were set up by the Medical and Health Department.

• The first cases of HIV infection in Hong Kong were diagnosed.

1985

• An HIV/AIDS surveillance system was established within the Medical and Health Department

• The Hong Kong Red Cross Blood Transfusion Service commenced screening of all donor blood as from August.

• Safer heat-treated blood product was procured by the Government to replace unsafe products used in the treatment of haemophilia.

• AIDS awareness campaign was started with focus on safer sex and drug use.

• An AIDS Counselling Service, including a telephone service, HIV antibody testing and clinical follow-up service, was set up by the Medical and Health Department.
• The first case of AIDS in Hong Kong was reported.

1986

• Three patients were reported to have contracted HIV through transfusion of contaminated blood in Hong Kong.

• Seminars were organised by the Government for doctors, nurses and paramedical personnel.

1987

• The Committee on Education and Publicity on AIDS was formed to undertake public education on AIDS prevention.

• The first API (announcement of public interest) was produced by the Government Information Service (GIS) and screened on television.

• A Publicity Working Group was formed to implement media publicity on AIDS.

• The Medical & Health Department published its first Information book for doctors and dentists. In conjunction with Education Department, the guidelines "Prevention of bloodborne diseases in schools" was also published.

• AZT (zidovudine) treatment was first introduced to patients with AIDS.

• The cumulative total number of HIV infected persons reported as of the end of the year was 107.

• Education talks on AIDS were organised by the AIDS Counselling Service for secondary school students.
1988

- The first World AIDS Day was commemorated on 1 December, parallel with education activities for various community groups.

- AIDS Counselling Service was expanded, with the introduction of a hotline for the public (27802211).

- The Medical & Health Department published its first Information book for nurses in Hong Kong.

- The Consumer Council released its first report on the quality of condoms on sale in Hong Kong.

1989

- Free confirmatory tests were provided by the Government’s Virus Unit to other laboratories for preliminary positive samples.

- The first case of HIV infected drug user in Hong Kong was reported. Publicity activities targeted drug users in the same year.

- Education activities focused on youth in the second World AIDS Day titled “AIDS and Youth”.

1990

- The Governor appointed the Advisory Council on AIDS, which was chaired by the Director of Health.

- AIDS Concern, the first non-governmental organisation working on AIDS, was formed.
• A *Women and AIDS* seminar was, for the first time, organised in Hong Kong by the Committee on Education and Publicity on AIDS.

• An *Unlinked Anonymous Screening* programme was implemented to supplement existing surveillance activities.

### 1991

• *Hong Kong AIDS Foundation* was established.

• *Homosexuality was decriminalised* through legislation. Ten Percent Club, a homosexual group, applied for registration in Hong Kong.

• A *female commercial sex worker* was reported to be HIV infected.

• The *Youth Funding Scheme* on AIDS was launched by the Committee on Education and Publicity on AIDS.

• The first *Training course on AIDS for nurses* was organised by the Government.

• *Female condoms* were introduced.

### 1992

• *Heterosexual* overtook homosexual contact to become the most important route of HIV transmission in Hong Kong.

• An "*AIDS and the Workplace*" seminar was, for the first time, organised in Hong Kong by the Committee on Education and Publicity on AIDS.

• An API on condom was screened in cinemas and during late hours on television.
- **Mike Sinclair**, an HIV infected dentist, disclosed his HIV status to the public. A special working group was formed by the Advisory Council on AIDS to establish guidelines for preventing HIV infection in health care settings.

- **DDI** (Dideoxyinosine), the second anti-HIV drug, became available.

- Some funeral homes repeatedly refused to provide service to deceased AIDS patients.

- Ming Tsai, a school boy living with HIV and haemophilia, was rejected by school authority for attending normal classes.

**1993**

- Legislative Council held an *adjournment debate* on AIDS on 10 February.

- **AIDS Trust Fund** was set up with a 350 million dollar grant by the Government, to provide exgratia payment to HIV infected haemophilia, and to support public education and service projects on AIDS.

- **Three committees** began operative under the re-appointed Advisory Council on AIDS. They were: Committee on Education and Publicity on AIDS, AIDS Services Development Committee, and the Scientific Committee on AIDS.

- In collaboration with the School of Professional and Continuing Education of the Hong Kong University, AIDS Unit started a training programme *Introductory Course on AIDS* for nurses, which was subsequently conducted on an annual basis.

- For the first time, the Government set up a booth at a *travel exhibition* to promote AIDS awareness in travellers.
The Government's **AIDS Hotline** was computerised, which was subsequently upgraded to provide pre-recorded messages in Cantonese, English and Putonghua, as well as counselling. Separate recorded messages were also available in Thai, Vietnamese and Tagalog, as were advice for health care workers on the management of needlestick injuries.

- Professor **Jonathan Mann**, ex-director of Global Programme on AIDS, visited Hong Kong on World AIDS Day, and addressed the health panel of the Legislative Council.

- The Government, AIDS Foundation and AIDS Concern jointly organised an **AIDSWEEK** to commemorate World AIDS Day of the year.

- Some private hospitals were reported to have refused AIDS patients from using their services.

- Frequent travellers entering China were reportedly required to undergo HIV antibody testing.

- **Action for REACH OUT**, a non-governmental organisation working with women in the commercial sex industry, was formed.

- The cumulative total number of HIV infection reached **416** as of the end of the year.

### 1994

- The Department of Health’s AIDS Counselling and Health Education Service was renamed **AIDS Unit**, and moved to its new premise in Yaumatei.

- Advisory Council on AIDS published its "**Strategies for AIDS Prevention, Care and Control in Hong Kong**".
• Dr Michael Merson, Executive Director of WHO's Global Programme on AIDS, visited Hong Kong and addressed business leaders in a meeting.

• Some home helpers refused serving people with HIV/AIDS.

• The Hong Kong Council of Social Service implemented an AIDS project and established an AIDS Committee to provide support to service agencies on the subject of AIDS.

• The Hong Kong AIDS Memorial Quilt Project was formed. It worked on a unique form of memorial activity for people who have died of HIV/AIDS.

• First case of mother-to-child transmission of HIV reported in Hong Kong.

• The Hong Kong Community Charter on AIDS was launched jointly by the Department of Health's AIDS Unit and Lions Clubs International District 303. The Governor was the patron of the project, while the Government took the lead to become one of the seven founder signatories.

• AIDS Foundation set the theme of its campaign for 1994/96 as AIDS and the Family.

• The guidelines HIV Infection and Health Care Workers were drawn up by the Advisory Council on AIDS. An Expert Panel was set up subsequently by the Director of Health to advise on the management of HIV infection in health care workers.

• Professor James Chin published the first scenario report for Hong Kong, which estimated that some 3000 persons have been infected with HIV.

• Over 30 Hong Kong delegates, including Mrs Elizabeth Wong, Secretary for Health and Welfare, attended the Tenth International Conference on AIDS in Yokohama, Japan.
• The first WHO/UNDCP training course on prevention of drug abuse and AIDS was organised in Hong Kong, with the participation of delegates from China and Macau.

• The AIDS Services Development Committee of Advisory council on AIDS published its report on the review of AIDS services provided to people with HIV/AIDS in Hong Kong.

1995

• The first case of HIV-2 infection in Hong Kong was reported.

• JJ, a local Chinese AIDS patient, featured in a new set of API screened on television in May. He died two months afterwards.

• The Disability Discrimination Ordinance was passed by Legislative Council. HIV/AIDS was specified as one form of disability.

• An Award for print media coverage on HIV/AIDS was organised by the Hong Kong Council of Social Service in collaboration with a number of NGOs in Hong Kong.

• Three non-governmental organisations were formed - TeenAIDS, a group working on AIDS education for youth, Society for AIDS Care which focused on hospice and home care services, and HIV Information & Drop-in Centre at the St John's Cathedral.

• Condoms and AIDS education materials were distributed by AIDS Concern to container truck drivers at the Hong Kong - China border.

• Government announced the establishment of an integrated day treatment centre for HIV, STD and dermatology patients in Kowloon Bay. The proposal was met with strong objection of residents of Richlands Garden.
• A nine-part AIDS *drama series* was screened on television, with the funding support of the AIDS Trust Fund.

• Officiated by Mrs. Lavender Patten, a public exhibition *"Cause for Concern - 10 years of AIDS in picture"* was staged by Committee on Education and Publicity on AIDS on World AIDS Day.

1996

• Five popular radio hosts were appointed *AIDS Awareness Ambassadors* by the Committee on Education and Publicity on AIDS. They also appeared on new APIs produced by the Committee.

• A *fourteen-year-old girl* was reported to have acquired HIV through sex.

• The *Equal Opportunities Commission* was formed.

• In collaboration with AIDS Unit, Hong Kong Sex Education Association launched an innovative *Dr Sex Hotline*. It reflected a new direction in the development of an integrated approach in promoting sex and AIDS education in Hong Kong.

• The *Advisory Council on AIDS* was restructured, following recommendations of its members in a review conducted early on. For the first time, the Council was chaired by a non-government official. The Council was charged to providing independent advice on AIDS policy in Hong Kong.

• The *Hong Kong Polytechnic University* and United Nations Development Programme jointly published a report on enhancing *NGO-Government collaboration* in AIDS work in Hong Kong.

• The *first Hong Kong AIDS Conference* was held in November, which was attended by local people as well as delegates from Macau and China.
1. ASSESSMENT OF THE MORBIDITY & MORTALITY PATTERNS OF HIV/AIDS

K H Wong, S S Lee and M Y Choi
Abstract

The HIV/AIDS epidemic in Hong Kong has entered its second decade. This paper reviews the disease presentation and mortality of local patients in the past years. As of the end of December 1995, there were a cumulative total of 642 HIV positive patients of whom 175 have progressed to AIDS. The majority were male, ethnic Chinese and many acquired HIV via sexual contacts. *Pneumocystis carinii* pneumonia (PCP) has been and remains the commonest AIDS-defining illness (ADI). Overall, the incidences of tuberculosis, and *Penicillium marneffei* infection have been rising since mid-1988 and they were significantly more common among Chinese patients. The well-known late complications of Cytomegalovirus disease and *Mycobacterium avium* infection have also become increasingly prevalent after a diagnosis of AIDS. Survival after AIDS diagnosis had improved from a median of 1.0 months before mid-1988, to 7.8 months in July 1989-1991, and to 14.9 months after 1991. A vast majority of the patients died prematurely from AIDS-related conditions. There was no difference in survival between Chinese and non-Chinese. Knowledge of the changing pattern of morbidity and mortality of AIDS in Hong Kong enables us to design appropriate management strategy relevant to the local setting.
Introduction

Human immunodeficiency virus (HIV) infection, the cause of acquired immunodeficiency syndrome (AIDS), is one most important global health problem that has emerged in the last two decades. First found in 1981 in Western and African countries, HIV/AIDS has spread to many places/countries in all continents, causing significant impacts to both the infected individuals and the society.

HIV is an unique infectious agent as it directly hampers the immune system. The natural history of HIV infection is characterised by a variable period of clinical latency during which the patient remains relatively free of symptoms and signs. As the disease progresses, clinical events of secondary infections and/or cancers commonly ensue and an average of 50% of the patients develop AIDS in ten years' time. Eventually, most of the patients die from the complications.

The spectrum of HIV diseases has been well characterised in western countries. In the last decade, the pattern of disease progression has been changing, resulting in a variation of clinical profile of AIDS reported in different countries, such as USA [1], United Kingdom [2] and Canada [3]. Asia has become a major focus of the global HIV/AIDS epidemic since the early 1990s. The World Health Organisation has estimated that as of the end of 1995, more than 4 million people in Asia had HIV or AIDS and the rate of increase of new infections has been the fastest in the world. Unfortunately, little data regarding the pattern of clinical manifestations and survival of HIV/AIDS in Asia has been collected.

In Hong Kong, the first case of HIV and AIDS was reported in 1984 and 1985 respectively. Since then, the epidemic has been growing steadily in the last decade. The study of clinical complications of HIV/AIDS patients in Hong Kong, a predominantly Chinese community in south-east Asia, will improve our understanding of HIV disease manifestations, which may in turn facilitate the care of those infected in the local setting.
Diagnosis & Reporting of HIV Infection and AIDS

In Hong Kong, HIV infection is diagnosed when a screening test for HIV antibody (enzyme linked immunosorbent assay - ELISA) is positive, and is confirmed by a supplemental test (Western Blot). These tests have been available locally since 1985. The US CDC (Centers for Disease Control) surveillance criteria for AIDS has all along been used for patients in Hong Kong. In mid-1994, a new local AIDS surveillance definition was devised [4], which was adapted from the 1993 CDC definition [5] with the following modifications: (i) pulmonary tuberculosis was only regarded as an AIDS event in the presence of a CD4 count <200/ul, (ii) disseminated *Penicillium marneffei* infection was considered an AIDS-defining disease locally, and (iii) a CD4 level of <200/ul alone was not regarded as an AIDS-defining criterion. In other words, AIDS is basically a clinical diagnosis. A diagnosis of AIDS is made if an HIV infected patient develops a clinical condition suggestive of an underlying immune defect.

In Hong Kong, a voluntary reporting system has been adopted for HIV/AIDS since 1985. Under this system, patients' demographic characteristics, routes of transmission, clinical presentation, immunologic status, and outcome are collected. The reporting system not only sheds light on the local prevalence and trend of HIV infection but also provides invaluable information on the patients' characteristics. Mechanisms for collection of essential data have been rather consistent over the years. Reporting was made by doctors in both public and private services. A laboratory reporting system is in place in parallel.

Epidemiologic & Demographic Characteristics of Infected Individuals

As of the end of December 1995, 642 HIV patients had been reported to the Department of Health and 175 of them had progressed to AIDS (Table I). Amongst them, only 24 (3.7%) were aged 13 or less at time of detection. Eighty percent of the infections were related to sexual contacts, notably heterosexual transmission (45.5%). Less than 10% of the infections were due to transfusion of blood or blood products -
all of which occurred before August 1985. Injecting drug use accounted for only 2% of the cases and three perinatal HIV infections have been recorded thus far. Cumulatively, the male to female ratio was 8.6:1 though the gap has been narrowing in recent years. Nearly 70% of the reported cases were ethnic Chinese while 20% were Caucasians. In comparison with the overall infections, relatively more AIDS patients were adult, male and homo-/bisexuals.

The growth of the local HIV epidemic was noted to be steady, with a yearly increase of 20-30% of the cumulated cases. On the other hand, many new AIDS cases were diagnosed in recent years, as patients infected during the early phase of the epidemic gradually progressed to AIDS. The number of AIDS patients reported ranged between 0-7 before 1980, 12-19 from 1989 to 1993, and 38-45 since 1994. Nearly half of the cumulative AIDS cases since the start of the epidemic were reported in the past two years.

Table I. Demographic characteristics of 642 HIV/AIDS patients in Hong Kong (1984-1995)

<table>
<thead>
<tr>
<th></th>
<th>non-AIDS HIV (n=467)</th>
<th>AIDS (n=175)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>male : female</td>
<td>415 : 52</td>
<td>160 : 15</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chinese : non-Chinese</td>
<td>407 : 160</td>
<td>121 : 54</td>
</tr>
<tr>
<td>Age (mean±SD in yr)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV diagnosis</td>
<td>32.2±11.5</td>
<td>36±12</td>
</tr>
<tr>
<td>AIDS diagnosis</td>
<td>-</td>
<td>37.5±11.5</td>
</tr>
<tr>
<td>Risk factor (no. of patients)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>heterosexual</td>
<td>220</td>
<td>72</td>
</tr>
<tr>
<td>homosexual</td>
<td>116</td>
<td>61</td>
</tr>
<tr>
<td>bisexual</td>
<td>24</td>
<td>19</td>
</tr>
<tr>
<td>injecting drug user</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>transfusion</td>
<td>54</td>
<td>12</td>
</tr>
<tr>
<td>perinatal</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>undetermined</td>
<td>42</td>
<td>6</td>
</tr>
</tbody>
</table>
Changing Pattern of AIDS Indicator Diseases

The occurrence of AIDS usually signifies an advanced stage of immunosuppression in an HIV infected patient. An AIDS indicator disease is often an opportunistic infection or neoplasm. Its spectrum depends on many factors, e.g. prevalence of secondary infectious agents in the locality, stage of HIV infection of the patients, ethnicity and origin of the patients, availability and accessibility of medical services - specifically HIV treatment programme (antiretroviral therapy, treatment and prophylaxis of opportunistic complications), access of support services, and health-seeking behaviours of the patients. The progression to AIDS is associated with increased morbidity and death.

The first case of AIDS in Hong Kong was reported in 1985, when a patient presented with end organ cytomegalovirus (CMV) disease. As more and more AIDS cases were reported, the disease pattern became better defined. As shown in Table II, of the 175 AIDS patients reported so far, Pneumocystis carinii pneumonia (PCP) was the commonest (40%) initial AIDS event, followed by tuberculosis (12%) and Penicillium marneffei infection (9%). Other major fungal infections (oesophageal candidiasis and cryptococcosis) accounted for 12%, whereas that for Kaposi’s sarcoma, 7%. Though PCP is still the commonest primary AIDS indicator disease, its frequency has declined over the years [6]. In the recent two years, the relative contribution of tuberculosis had increased. Concurrently, the incidence of fungal infections, especially that of Penicillium marneffei, had been rising [7].

Seventy patients developed 109 episodes of AIDS-defining illnesses (ADI) after the diagnosis of AIDS (Table II), corresponding to a mean of 1.62 ADI (range, 1-5) in all the patients. End organ cytomegalovirus (CMV) disease was the commonest (24.8%) subsequent ADIs, followed by Mycobacterium avium intracellulare (MAI) infection (17.4%). Increase in incidence of MAI was particularly marked in the last two years. As CMV disease and MAI infection are often associated with a low CD4 count, their increases imply that patients with advanced HIV disease are surviving longer. Future incidences may however fall as primary prophylaxis for these infections, especially MAI, is becoming available. The temporal change of ADI over the years is analysed by an arbitrary division into three time intervals (Figure 1) - 1985 to June 1988 (period I), July 1988 to 1991 (period II), 1992 - 1995 (period III). Overall, the
relative frequency of PCP and Kaposi's sarcoma has decreased while that of MAI, CMV disease, penicilliosis, tuberculosis and cryptococcosis had increased over the years.

Table II. Profile of primary and subsequent AIDS-defining illnesses (ADI) 1985 - 1995

<table>
<thead>
<tr>
<th>Primary ADI</th>
<th>No. of episodes (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumocystis carinii pneumonia</td>
<td>70</td>
</tr>
<tr>
<td>Tuberculosis (extrapulmonary or pulmonary with CD4 &lt;200/ul)</td>
<td>21</td>
</tr>
<tr>
<td>Penicillium marneffei infection</td>
<td>16</td>
</tr>
<tr>
<td>Kaposi's sarcoma</td>
<td>12</td>
</tr>
<tr>
<td>Oesophageal candidiasis</td>
<td>11</td>
</tr>
<tr>
<td>Extrapulmonary cryptococcosis</td>
<td>10</td>
</tr>
<tr>
<td>CMV diseases</td>
<td>10</td>
</tr>
<tr>
<td>Cryptosporidiosis</td>
<td>6</td>
</tr>
<tr>
<td>Mycobacterium avium infection</td>
<td>5</td>
</tr>
<tr>
<td>Toxoplasmosis</td>
<td>4</td>
</tr>
<tr>
<td>Lymphoma</td>
<td>3</td>
</tr>
<tr>
<td>HIV encephalopathy</td>
<td>2</td>
</tr>
<tr>
<td>Isosporiasis</td>
<td>1</td>
</tr>
<tr>
<td>HIV wasting syndrome</td>
<td>1</td>
</tr>
<tr>
<td>Pulmonary candidiasis</td>
<td>1</td>
</tr>
<tr>
<td>Recurrent pneumonia</td>
<td>1</td>
</tr>
<tr>
<td>Chronic herpes simplex infection</td>
<td>0</td>
</tr>
<tr>
<td>Recurrent Salmonella septicemia</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subsequent ADI</th>
<th>No. of episodes (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis (extrapulmonary or pulmonary with CD4 &lt;200/ul)</td>
<td>8(7)</td>
</tr>
<tr>
<td>Penicillium marneffei infection</td>
<td>7(6.4)</td>
</tr>
<tr>
<td>Kaposi's sarcoma</td>
<td>6(5.5)</td>
</tr>
<tr>
<td>Oesophageal candidiasis</td>
<td>10(9.1)</td>
</tr>
<tr>
<td>Extrapulmonary cryptococcosis</td>
<td>8(7.3)</td>
</tr>
<tr>
<td>CMV diseases</td>
<td>22(24.8)</td>
</tr>
<tr>
<td>Cryptosporidiosis</td>
<td>3(2.8)</td>
</tr>
<tr>
<td>Mycobacterium avium infection</td>
<td>19(17.4)</td>
</tr>
<tr>
<td>Toxoplasmosis</td>
<td>5(4.6)</td>
</tr>
<tr>
<td>Lymphoma</td>
<td>3(2.8)</td>
</tr>
<tr>
<td>HIV encephalopathy</td>
<td>4(3.7)</td>
</tr>
<tr>
<td>Isosporiasis</td>
<td>0</td>
</tr>
<tr>
<td>HIV wasting syndrome</td>
<td>0</td>
</tr>
<tr>
<td>Pulmonary candidiasis</td>
<td>2(1.8)</td>
</tr>
<tr>
<td>Recurrent pneumonia</td>
<td>0</td>
</tr>
<tr>
<td>Chronic herpes simplex infection</td>
<td>1(0.9)</td>
</tr>
<tr>
<td>Recurrent Salmonella septicemia</td>
<td>1(0.9)</td>
</tr>
</tbody>
</table>

Comparison is made on the occurrence of various ADI between Chinese and non-Chinese patients. While PCP and CMV disease were respectively the first and second commonest ADI in all patients, tuberculosis, cryptococcosis, Penicillium marneffei infection and MAI were more frequent among Chinese whereas Kaposi's sarcoma, oesophageal candidiasis and cryptosporidiosis were commoner in non-Chinese. The difference was significant for TB and penicilliosis in Chinese vs Caucasians (p=0.04 and 0.02 respectively).
Overall, the clinical spectrum of Hong Kong's AIDS patients did not differ significantly from that in other parts of the World [8], though tuberculosis and penicilliosis were relatively commoner in our local Chinese patients. Similar to overseas findings, the patterns of AIDS-related diseases have been changing in Hong Kong. Collection of this local information can facilitate the diagnosis and management of AIDS, as well as help identify areas that need more attention. Locally, the decline in PCP in the past few years was not as marked as in several other countries [2,3]. A majority of the patients were only detected HIV positive when they fell sick with PCP. They could not have benefited from the very effective PCP prophylaxis programme recommended for their use. On the other hand, diseases like tuberculosis and penicilliosis were found to be more common among ethnic Chinese. Understanding of the disease manifestation can hasten investigation for the underlying HIV infection and treatment of complications.

Figure 1: Reports of AIDS defining illnesses (ADI) among Chinese (CH) and non-Chinese (NC) across three periods (I - 1985 to June 1988; II - July 1988 to 1991; III - 1992 to 1995)

PCP=Pneumocystis carinii pneumonia, TB=Tuberculosis, KS=Kaposi’s sarcoma, PEN=Penicillium marneffei, CRP=Cryptococcosis, CMV=Cytomegalovirus, EC=Oesophageal candidiasis, CRS=Cryptosporidiosis, MAI=Mycobacterium avium intracellulare, Others=toxoplasmosis, lymphoma, isosporiasis, AIDS dementia complex, AIDS wasting syndrome, pulmonary candidiasis, recurrent pneumonia, herpes simplex, recurrent salmonella septicaemia
Non-AIDS Defining Illnesses

Prior to the development of AIDS, HIV positive patients may seek medical advice when they begin to suffer from “minor” signs/symptoms resulting from the infection. These are not classified as AIDS and are termed “non-AIDS defining illnesses”. Their presence helps doctors to diagnose HIV infection at a relatively early stage. A high index of suspicion is required when the “clues” appear in the patients. Locally, it is noted that nearly half of our AIDS patients first presented with either systemic symptoms like fever, malaise, weight loss or diarrhoea, or other minor HIV-related infections. The commonest non-AIDS defining opportunistic infections in the AIDS patients were oral candidiasis (23%) and herpes zoster (22%). These infections were also prevalent among symptomatic HIV-infected patients who had not yet developed AIDS. Their occurrence should alert health care workers to the possibility of the underlying HIV infection, especially when there is history of HIV-related risk behaviours.

Immunological Monitoring

T lymphocytes are cells of the immune system commonly targeted by HIV. There are many immune changes as a sequel of the interactions between the body and virus. Classical changes include polyclonal increase in immunoglobulin (Ig), raised neopterin level, and raised beta2-microglobulin. Diminished cell-mediated immunity is usually present even at early HIV disease.

The single most important immunologic parameter in HIV infection is indisputably the CD4 lymphocyte level. Its fall generally parallels the progression of HIV disease. Monitoring of CD4 level is useful both in predicting the occurrence of opportunistic infections and in guiding medical management. In the public service, CD4 enumeration for HIV positive patients by manual method was available in 1985. Flow cytometry technique was introduced in 1994 for automated quantitation. The normal range of CD4 count for local Chinese patients was found to be lower than the Caucasians [9], and there was higher percentage of natural killer (NK) cells in the circulation.
At the time of AIDS diagnosis, most of the patients in Hong Kong had significant immunosuppression with CD4 count less than 200/ul (87.4%) or even <50/ul (33.6%), with a median value of 74/ul. The CD4 count was found to be lower in recent years, indicating an advancement of the state of immunosuppression before the development of AIDS. CD4 level at AIDS varied widely in different conditions; the median values were: PCP (90/ul), extrapulmonary tuberculosis (94/ul), Kaposi's Sarcoma (115/ul), penicilliosis (36/ul), CMV disease (36/ul), and MAI (87/ul). On the other hand, mean HIV-to-AIDS interval was longer in diseases with advanced immunosuppression such as MAI and CMV than in complications like PCP and Kaposi's Sarcoma (25.9 months vs 8.6 months). Over the years, there was a rising trend of CD4 count of newly diagnosed HIV patients, which reflected an earlier diagnosis of the infection in the community.

Improving Survival

HIV infection is still an incurable disease. With time, a majority of the HIV positive patients progress to AIDS and may succumb from its complications. Survival after AIDS however varies from place to place, generally better in developed countries than developing ones. Similar to elsewhere, most AIDS patients in Hong Kong had died prematurely - at a median age of 39 - from the disease. PCP was the commonest cause of death (Figure 2), followed by MAI infection, cryptococcosis, penicilliosis and tuberculosis [10]. PCP was the first killer disease across the 3 time periods but its relative contribution has decreased over the years. On the other hand, MAI, Pencillium marneffei and tuberculosis have become more important causes of death. The survival pattern of the deceased patients was noted to be bi-modal - 45% of the deceased patients died within 3 months while 32% survived beyond 12 months. Median survival of patients who developed AIDS 6 months or less after HIV detection was 1 month compared with that of 11.5 months for those whose HIV-to-AIDS interval was >6 months.
In line with overseas findings, survival of the AIDS patients had improved significantly from period I to period III ($p=0.0012$); the median value being 1.0 months before July 1988, 7.8 months in July 1988 to 1991 and 14.9 months after 1991 (Figure 3). Survival was not related to ethnicity, sex or route of HIV transmission. Improvement

Figure 2: Known causes of death ($n=79$) of AIDS patients between 1985 and 1995.
in survival could have been due to earlier HIV detection, better antiviral treatment, more vigorous infection prophylaxis and more importantly, improved access to health care. The latest survival chance was, however, still slightly lower than that in other places [11,12].

Conclusion

In the last decade, HIV/AIDS has caused significant morbidity and mortality in infected patients in Hong Kong. Similarities as well as differences were noted among our patients as compared with their overseas counterparts. As the epidemic

evolved, there were changes in both the clinical presentation and outcome of the patients. The local HIV/AIDS epidemic, though relatively small in scale at the present moment, is deemed to increase in size in the future. Continued monitoring of the parameters for assessing morbidity and mortality is necessary for developing strategies in improving patients' management.

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2. EVOLUTION OF AIDS PROGRAMMES IN HONG KONG

Vincent F Y Yeung
Abstract

AIDS as a novel public health issue has posed immense challenges to governments all over the world. In Hong Kong, AIDS programmes have evolved out of uncertainties, and been punctuated with constant modifications. Yet, the way that Hong Kong as a whole is mobilised in fighting against AIDS can be regarded as rather successful. This paper sets out to examine the historical development, existing provisions and organisational structure of the local AIDS programmes. In the Hong Kong experience, early government intervention with anticipative attitudes, active NGOs involvement, and flexibility in adopting timely policy changes are all important lessons that can be learned over the years. As AIDS is arguably an encompassing social problem, we should pay due attention to its non-medical aspects. A review of the existing organisational structure deems necessary. After a decade's evolution, Hong Kong's AIDS programmes is heading toward the stage of routinization and normalisation. In this respect, active citizen participation with sustained government efforts are important elements for the further development of the AIDS programmes in Hong Kong.
Introduction

As a novel but sweeping public health issue, AIDS has posed immense challenges for governments all over the world. Most are unsure about how to handle the disease, and lots "were literally paralysed to develop coherent policies" [1]. In Hong Kong, we did not have definite and predetermined strategies to guide AIDS programme development at the start. Rather, in retrospect, local AIDS programmes have evolved out of uncertainties, and undergone constant modifications, and carried grossly a develop-as-we-go characteristic.

At first glimpse, as a cosmopolitan city of over six million population, Hong Kong possesses great potentials for rapid HIV transmission. High population mobility, increasingly open sexual attitudes and behaviours, and flourishing commercial sex industry [2] are some of the factors conducive to the spread of HIV. Yet, official figure reported only an accumulation of 702 HIV infected cases at the end of July 1996. [3] As compared to the situations in other countries, AIDS at present does not pose as a very alarming issue in Hong Kong as far as the dimension of the epidemic is concerned. [4]

There is certainly a host of factors accounting for the relatively low prevalence of HIV infection in Hong Kong. With a well-connected mass communication system focused in a small place, coupled with the generally high education level in the population, it is easy to deliver effective and pertinent AIDS-related preventive educational message to the community efficiently. However, despite these infrastructural factors, one cannot possibly deny the significant roles played by the Hong Kong government and related NGOs - especially in their overall anticipative attitudes as well as early intervention efforts towards the disease. In retrospect, indeed, the way that Hong Kong as a whole has been mobilised - not without efficiency, effectiveness, and timeliness - is a rather successful experience which deserves further analysis.

The primary focus of this paper is to document the evolution of AIDS programmes in Hong Kong. Attention is directed to examining the historical development, existing provisions, and organisational structure of the local AIDS programmes. The paper ends with a discussion on the implications of the Hong Kong
Three Phases of AIDS Programmes Development

Overall, the development of AIDS programmes in Hong Kong can be divided into three main phases: initial phase, intensification phase and consolidation phase.[5]

The Initial Phase (1984-1986)

Before the first case of AIDS in Hong Kong was diagnosed in February 1985, an Expert Committee was already set up by the then Medical and Health Department in November 1984. This Expert Committee was chaired by a Directorate staff from the Medical and Health Department, and the emphasis was to set up an infrastructure as quickly as possible for the containment of the disease.

During this period, a counselling clinic and a telephone hotline were established at the Queen Elizabeth Hospital, the largest acute public hospital at that time, to provide counselling services and information to people who feared they might have contracted the disease. In 1985, the Hong Kong Red Cross Blood Transfusion Service commenced screening of all donor blood for HIV antibody. In the same year, heat-treated blood products were supplied to all public hospitals. Establishment of a surveillance system and provision of HIV antibody testing were also introduced.

It should be noted that these early attempts were nearly all initiated by the government. Emphasis was placed mainly on the medical aspects of the disease. Deliberate effort to incorporate community participation was not apparent.

The Intensification Phase (1987-1989)

It was gradually recognised that public education and community participation were essential in the prevention of HIV infection. This second phase therefore began with the government’s establishment of a new Committee on Education and Publicity on AIDS in 1987. The Committee was charged with the responsibilities to initiate, implement and coordinate publicity and education programmes on AIDS. Influential
community leaders, representatives from various social service agencies, and
government officials were included in this Committee.

During this period, a whole range of printed materials and promotional films
were produced. Educational seminars were organized for social workers, teachers,
health care professionals, etc. There were deliberate efforts to involve the general
public to fight the AIDS epidemic.

The Consolidation Phase (1990-1996)

The consolidation phase commenced with the establishment of the Advisory
Council on AIDS in 1990. This Council was appointed by the Governor to advise the
Director of Health on all aspects of the AIDS programmes. It was generally felt
necessary to introduce more comprehensive strategies to guide the development of
AIDS programmes in Hong Kong. In 1994, a policy paper titled “Strategies for AIDS
Prevention. Care and Control in Hong Kong” was published by the Council.

In 1993, the AIDS Trust Fund was set up by the government with HK$350
million to provide ex-gratia payment to the HIV-infected haemophiliacs and
transfusion recipients, and to fund AIDS-related education and publicity activities, as
well as services provided for people with HIV/AIDS.

During the consolidation phase, different AIDS-specific NGOs gradually
emerged. Examples included AIDS Concern in 1990, Hong Kong AIDS Foundation
in 1991, AIDS Memorial Quilt Project in 1994, Society for AIDS Care in 1995, and
the HIV Information and Drop-in Centre in 1995.

Several characteristics were observed in this period. First, through the setting
up of the Advisory Council on AIDS, the government formulated a more
comprehensive strategy for the development of AIDS programmes. Second,
community participation was much more conspicuous. Different AIDS-specific NGOs
were established. Third, the establishment of the AIDS Trust Fund had a positive
effect on the growth of Hong Kong’s AIDS programmes. With financial support, a
good variety of AIDS-related initiatives have been developed. A concrete case in
point is that more AIDS-specific NGOs have been established since the Council for
the AIDS Trust Fund began operation.
The Current AIDS Programmes in Hong Kong

The current AIDS programme has resulted from years' work by different parties in the government and the community. For analytical purpose, the local AIDS programmes are categorised under three broad areas: a) preventive programmes; b) clinical services, and c) social and support services for persons with HIV/AIDS.

Preventive programmes include various forms of education activities targeting either the general public or specific groups (for example, commercial sex workers, adolescents and youths, intravenous drug users, women, etc). Through the use of mass media and the adoption of different approaches, these activities carry the ultimate objective of limiting the spread of HIV infection in the community. It is noted that some programmes are also devoted to lessen public discrimination against persons with HIV/AIDS. Overall, both government departments (mainly through the Department of Health) and NGOs are actively involved in these programmes. Some NGOs play a crucial role in specific community groups which they have established close connections with. For example, AIDS Concern, one of the prime local AIDS-specific NGOs, has developed close working partnership with homosexual groups and Asian migrants groups in Hong Kong. Similarly, Action for Reach Out, another NGO, has targeted female commercial sex workers. The Society for the Aid and Rehabilitation of Drug Abusers, which works with intravenous drug users, is another good example.

In the provision of clinical services, the role of the public sector is much more conspicuous. Three main areas of clinical services can be identified, namely, a) outpatient clinic, b) hospital service and c) supporting laboratory facilities. An outpatient AIDS clinic is operated by the Department of Health. Through the service, direct patient services and HIV antibody tests with pre- and post-test counselling are offered to the clients. If clients prefer to obtain HIV testing in an unofficial institution, they can approach the Hong Kong AIDS Foundation for help. The latter would pass the blood sample to the Virus Unit of the Department of Health for the assays. Hospital services are offered mainly by the Hospital Authority, in particular the Queen Elizabeth Hospital. Counselling services are provided to clients by a nursing officer in that hospital. In contrast, private hospitals are relatively inactive in providing direct patient services on HIV/AIDS. Supporting laboratory facilities include investigations relating
to diagnosis and monitoring of HIV infection, and tests employed in the diagnosis of HIV-related complications. Most of these testing services are offered by either the Department of Health or the Hospital Authority.

On social and support services for persons with HIV/AIDS, Hong Kong has a wide range of provisions. The AIDS Services Development Committee has identified twenty types of social and support services for persons with HIV/AIDS. While some are specifically for persons with HIV/AIDS, a majority are general community services open to every person in need. The followings are some examples of the services tailored for the special needs of persons with HIV/AIDS: face-to-face counselling, helpline / telephone counselling, buddying / volunteer services, self-help support groups, financial assistance, hospice care, centre service, personal care and home care services. The division of work between government departments and NGOs, or even among the NGOs themselves, is less distinct in the provision of social and support services. Service duplications exist, in particular those related to counselling and self-help support services. Yet, it is quite apparent that NGOs have played pioneer roles in initiating relevant new services catering for the specific and changing needs of the clients.

Overall, there is an obvious, whether intentional or not, division of work between the public sector (that is, Department of health and Hospital Authority) and NGOs in the provision of AIDS services in Hong Kong. We can see that clinical services are heavily shouldered by the public sector. On the other hand, NGOs have primarily involved themselves in organising preventive programmes, and also the provisions of social & support services for persons with HIV/AIDS.

The Organisational Structure

How are AIDS policy and service delivery strategies monitored and developed in Hong Kong? The following figure depicts the existing organizational structure of local AIDS programmes. The Advisory Council on AIDS is the formal and official forum designated by the government for policy discussions. It functions as an advisory body for the Hong Kong government to review the trend and development in HIV infection and AIDS, and to advise the government on programmes for the prevention
of HIV transmission and services for people with HIV/AIDS. At the time of writing, the Director of Health is the chairperson of this Council, and the Department of Health acts as its secretariat. Three areas are regarded as essential which demand establishment of special committees, namely, Scientific Committee on AIDS, Committee on Education and Publicity on AIDS (CEPAIDS), and AIDS Services Development Committee (ASDC). All the three committee operate under the Advisory Council on AIDS.

**Organisational Structure of AIDS Programmes in Hong Kong 1996**

![Organisational Structure Diagram]

The Scientific Committee was established in 1990 to monitor the epidemiology of HIV/AIDS and to set up guidelines for health care professionals and the like. Members are mostly medical professionals who are invited to join the committee based on their professional expertise, such as clinical practice, epidemiology or blood transfusion.

Prior to 1990, the main function of CEPAIDS was to execute AIDS publicity and education programmes. After its incorporation into the Advisory Council on AIDS, NGOs were invited to join the Committee and its working groups. Coordination with NGOs’ related activities has then become another important function of CEPAIDS. At present, there are five working groups under CEPAIDS: drug abuse, schools/students, youth, workplace and publicity.
In view of the gradual increase in the number of HIV infected cases and the proliferation of AIDS service activities, the AIDS Services Development Committee was set up in 1993 as a coordinating body which aimed at monitoring development of services for persons with HIV/AIDS. Two working groups - social/support services, and clinical services - were formed in its review of service provision in the territory.

The Council for the AIDS Trust Fund operates separately from the Advisory Council on AIDS. Its main functions are to provide ex-gratia payments for the HIV-infected haemophiliacs, and to fund medical and support services for persons with HIV/AIDS as well as HIV/AIDS publicity and education programmes. The Health and Welfare Branch acts as the secretariat.

It should be noted that all the government AIDS committees have incorporated non-official members coming from related professions and NGOs; and some have invited the participation of prominent community leaders. According to local political tradition, all these appointments are on personal capacity. In a way, such an arrangement enables the government to tap community/professional input in responding to AIDS on the one hand, while ensuring broader community participation and support on the other hand. However, it should also be reminded that the Advisory Council on AIDS, being advisory in nature, still allows the government to retain the ultimate power to accept or reject the former's suggestions. Therefore, the existing organisational arrangement actually exemplifies the overall executive-led decision-making structure of Hong Kong.

**Implications and Prospect**

What can we learn from the Hong Kong experience? An equally significant question is: after a decade’s development, what should be our next step? Here, we offer several observations for considerations. First, Hong Kong government has generally adopted an anticipative attitude towards the issue. Organisational structure is set up timely, and financial resources are available to facilitate the implementation of related programmes. We regard this is a correct move and is one of the important factors accounting for the relatively low prevalence of HIV infection in Hong Kong. As a matter of fact, as long as AIDS remains an incurable disease, it is essential that
anticipation, rather than reaction, be adopted as a key principle. Taking a comparative perspective, the Hong Kong case has presented a sharp contrast with those of other western developed countries. In some other nations, the governments had been slow to develop AIDS programmes, [7][8] and had lost as they “reacted by inactivity, a wait-and-see attitude”. [1] In this respect, Hong Kong government can be commended for their prompt actions and determinations in early interventive efforts.

Taking this anticipative attitude one step further, however, we see the urgent need to prepare possible challenges that lie ahead. [9][10] Hong Kong is becoming part of China and expectedly, there will be increasing contacts between people of the two places, in particular their heterosexual contacts. Still lacking empirical data, we are unsure how the flourishing commercial sex industry in some cities in China, and the emerging popularity of phenomena like “second wife” arrangement, may affect HIV transmission in Hong Kong. Nevertheless, one cannot afford to exclude the possible emergence of such grave scenario. A review of the present AIDS programme initiatives in Hong Kong, however, reveals there is a nearly complete absence of efforts directed to relating the situation in China. This is indeed an important niche that relevant government department and NGOs should work on. In short, we should further amplify the well-cherished anticipative attitude with prompt actions in the “China perspective”.

Second, after government initiation, Hong Kong is fortunate in having rather active NGOs’ participation in the AIDS arena. Indeed, AIDS as one of the public health issues possesses its own uniqueness in at least three ways. One, at least in the early stage, AIDS has close connections with two marginal groups in the societies - male homosexuals and bisexuals, and intravenous drug users - together they constitute the main bulk of AIDS cases. Yet, most governments have difficulties to conceive policies for them. Two, prevention of HIV transmission hinges on sensitive and controversial topics like human sexuality and condom education. Three, there is a wide social discrimination against persons with HIV/AIDS. These three characteristics are difficult issues which cannot be easily resolved. Under such circumstances, notwithstanding government’s efforts, NGOs with their community image, social connections, and enthusiasms, may possess greater potentials for flexibilities, innovations and effectiveness in launching related programmes.
In the Hong Kong case, the government has rightly introduced measures to incorporate NGO involvement at the early stage of AIDS programmes development through involving them in various AIDS committees, or granting financial support to their programmes. From 1990 onwards, several ADIS-specific NGOs gradually emerge on their own initiations, and they are playing increasingly active and significant roles in the local AIDS arena. Some have built up close connections with specific groups which may be vulnerable to HIV transmission. They have also developed various kinds of educational programmes targeting the general public as well as certain community groups. Some also devote their efforts in reducing public discrimination against persons with HIV/AIDS. In short, NGOs in Hong Kong are demonstrating their active involvement and commitment in the fight against AIDS. However, a word of caution: active NGO participation does not necessarily lead to a depreciation of government leadership in the fight against AIDS. The future direction should be: as community involvement is vital, further enhancement of government-NGOs partnership will be much desirable. [2]

Third, Hong Kong has generally adopted a flexible approach in the development of AIDS programmes. Within only a decade’s time, we already witness three different phases of AIDS programmes development. Recently, an ad hoc working group has been formed within the Advisory Council on AIDS to review the structure, administration and functions of the Council, with a view of making recommendations for further improvement. After systematic data collection, this working group had already submitted a proposal for reform in February 1996. Expectedly, we may soon be approaching the fourth phase of AIDS programmes development in the near future. Indeed, as AIDS is a novel public health issue, we are all uncertain what are the most “proper” policies and strategies. Under such circumstances, constant self-review, experiences from other countries, updating of world trend are all essential to guarantee possibilities for improvement suitable to the changing needs of the society. In this regard, Hong Kong is fortunate to have devoted staff in constantly reviewing policy development as well as harbouring willingness and eagerness to adopt timely changes for necessary improvement.

Fourth, it can be grossly concluded that local AIDS programmes, especially those in the public sector, are initiated, sustained, and developed within the medical and health sector. To be more exact, this denotes the Health and Welfare Branch, the
then Medical and Health Department, and later the Department of Health and the
Hospital Authority. In the organisational structure, the Director of Health also acts as
the chairperson of the Advisory Council on AIDS. In retrospect, the fact that AIDS
programmes have been generated principally within the medical and health sector
can be regarded as understandable and acceptable. This is particularly true in the
initial stage as there were still great scientific uncertainties surrounding the virus, and
that HIV/AIDS is much a public health issue and incurable disease after all.

However, as time goes on, it is clear that HIV/AIDS prevention and treatment
is social as much as - if not more than - medical. In essence, HIV/AIDS is an
encompassing social problem, which has triggered off endless social controversies -
most of which naturally fall outside the orbit of the medical sector. In Hong Kong,
questions have been increasingly raised about the appropriateness to maintain the
organisational structure under one narrowly defined functional policy branch and a
directly linked department, that is, the Health and Welfare Branch and the Department
of Health. At present, the involvement of other government policy branches and
departments is minimal. As such, the current organisational structure does not seem
to be able to tackle the HIV/AIDS challenge effectively in the future. There are
abundant evidences to support such claim: sex education in schools, drug abuse, social
discriminations against persons with HIV/AIDS, HIV transmission in prisons,
commercial sex industry (local, across the border in China and abroad), work and
employment in China, immigration from China and other countries; all these are
issues which fall outside the brief of Health and Welfare Branch and the Department
of Health. We are drawing to the impression that there is a need to review the existing
organisational structure, with the view of including more non-medical personnel in
the future AIDS programme development.[11]

To conclude, after a decade's development, the local AIDS programmes are
getting mature and are more structured. Hong Kong is now heading towards the stage
of routinization and normalisation - AIDS has become part and parcel of the
government's public health policy issue. With this trend AIDS can no longer be viewed
as an epidemic, but rather a chronic disease that society must live with. In this respect,
active participation from the civil society will be of great importance to partner with
the government in the continuous fight against AIDS.
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3. DEVELOPMENT OF CLINICAL SERVICES FOR
PEOPLE WITH HIV/AIDS IN HONG KONG

Patrick C K Li
Abstract

Clinical service for HIV/AIDS patients in Hong Kong is provided mainly by the Department of Health and the Hospital Authority, and supplemented by several non-governmental organisations. The approach has been to incorporate the required services into the existing health care infrastructure while simultaneously developing AIDS-specific programmes to meet the special needs of this group of patients. Concurrent with the advances in medical treatment, there has been growing emphasis on psychosocial support and community care for HIV/AIDS patients and as such, a multidisciplinary approach is developed. In designing Hong Kong's future model of AIDS clinical service, policy makers should consider patients' need and preferences, as well as the cost effectiveness of the various approaches. Organisations involved should also be well coordinated to ensure provision of seamless health care for the HIV/AIDS patients.
Introduction

The first patient in Hong Kong with AIDS presented to the Princess Margaret Hospital in October 1984, and he died four months later. Over the past ten years, significant progress has been made in the provision of clinical services for HIV/AIDS patients, not only in terms of the treatment options, but the scope of services, as well as the number and the types of agencies involved. AIDS patients today generally have a better chance of survival, and having their psychosocial needs met. Coordination of the various agencies, however, needs improvement and service gaps are still present. Many health care and community service workers have expressed reservation in serving HIV/AIDS patients for reasons ranging from a lack of specific training to fear of HIV transmission.

Despite an important centre for international travel, Hong Kong has, thus far, been fortunate in that it does not have an epidemic of the magnitude seen in Asian countries such as Thailand, India, or Myanmar. In this regard, Hong Kong benefits from its well-developed health care and social service infrastructure. It has so far been able to weather the impact of the epidemic. In anticipation of the increase in number of HIV/AIDS patients in the next few years, it would be opportune for Hong Kong to examine its model of service delivery so as to be better prepared for the future demand.

History of AIDS Clinical Service in Hong Kong

The AIDS programme in Hong Kong was initiated at the end of 1984 with the formation of an Advisory Committee on AIDS (later referred to as the Expert Committee on AIDS). Sero-surveillance on patients with sexually transmitted diseases (STD) attending the Government's Social Hygiene Clinics, haemophilia patients, and blood donors was started in April 1985. In July 1985, a Special Medical Consultation Clinic was established to provide medical assessment and follow up for individuals identified to be HIV-infected through the surveillance programme. This service was based at the Queen Elizabeth Hospital (QEH), which, apart from receiving referrals from public hospitals and clinics, offered consultation to medical practitioners
in the private sector. In November 1985, a telephone counselling service was established. HIV antibody testing was provided to individuals who had had practised risk behaviour.

Since the initiation of its AIDS programme, the Medical and Health Department had taken the position that HIV/AIDS patients could be managed in the general ward of any major regional hospitals without the need for special facilities. Isolation of patients has been considered unnecessary, and universal precaution is recommended in the practice of infection control. The consultation service based at QEH had served as a referral centre for out-patient HIV care. Haemophilia patients identified to be HIV-infected were encouraged to continue follow-up by their attending haematologist. In those early years, most private hospitals were reluctant to accept individuals with HIV/AIDS. Any such patients were likely to be transferred to public hospitals once their HIV status was known.

Over the past decade, many HIV-infected patients of the consultation clinic at QEH were admitted to the same hospital for in-patient care when their health condition deteriorated. This arrangement, together with its reputation as a referral centre, resulted in QEH taking up a major proportion of the in-patient care for AIDS patients in Hong Kong. Of the 214 AIDS patients reported to the Department of Health (DH) up to the end of June 1996, 60% had been hospitalised at QEH. The caseload has provided ample opportunities for its staff to acquire experience and develop expertise in the management of HIV/AIDS. At the same time, it created the impetus for the hospital to enhance its quality of care for HIV/AIDS patients, while working to decrease the strain on its in-patient service.

In February 1994, the Special Medical Consultation Clinic together with the counselling service were relocated to Yaumatei Jockey Club Clinic, under the auspices of DH's renamed AIDS Unit. To facilitate the continuity of care, a Special Medical Service was maintained for HIV/AIDS patients at QEH. The latter service mainly catered for patients with advanced HIV diseases or AIDS, which made up around 50% of its caseload, and provided consultation service for the other hospitals under the Hospital Authority (HA). The two clinical services under DH and HA continued to collaborate closely with cross referral of patients, joint clinical rounds and meetings.
The policy of integrating AIDS services into the existing health care infrastructure had opened up opportunities for health care staff in the public service to participate in the care of people with HIV/AIDS. While the AIDS Unit of DH and Special Medical Service of QEH had continued to play a major role in providing clinical services for HIV/AIDS patients, a growing number of health care providers and institutions had participated in their management over the years. By September 1996, 48% of the institutions under HA had admitted HIV/AIDS patients under their care, the remainder being largely rehabilitation or psychiatric institutions. Many chest clinics under DH had also provided directly-observed treatment for a growing number of HIV/AIDS patients diagnosed with tuberculosis. A few private practitioners were providing medical service for HIV/AIDS patients. Many private hospitals had also recently indicated their willingness to accept such patients. A recent survey conducted by the Scientific Committee on AIDS showed that 40% of doctors in public practice, 16% of private practitioners and 34% of nurses had provided care for HIV/AIDS patients within the preceding 12 months [1].

Evolving Trend in Management of HIV Infection and AIDS in Hong Kong

When the first patients with AIDS in Hong Kong were diagnosed, the only available treatments were those for the control of opportunistic infections. The treatment options were very limited. Asymptomatic HIV-infected individuals were often monitored at regular intervals for the trend of their CD4 lymphocyte count. As their immune function deteriorated, very little could be offered apart from early detection and treatment of opportunistic infections.

In the ensuing years, considerable progress had been achieved in understanding the biological properties of HIV, its effects on the immune system and its pathogenesis in human. New treatments were developed for opportunistic infections, bringing hope to extend the life expectancy of patients already diagnosed with AIDS. Notable examples included ganciclovir and foscarnet for treatment of cytomegalovirus (CMV) disease, fluconazole and itraconazole for systemic fungal infection, and clarithromycin, azithromycin, rifabutin, ofloxacin and ciprofloxacin for Mycobacterium avium intracellulare (MAI) infection.
In terms of anti-retroviral therapy and standard of medical care, Hong Kong had kept pace with other developed countries. Its service was among those of the highest standard in the region. The first anti-retroviral agent, zidovudine (AZT), was introduced to the public service in Hong Kong in 1987 for treatment of patients with AIDS or severe symptomatic HIV disease. The use of this reverse transcriptase inhibitor was extended to asymptomatic patients with CD4 lymphocyte count below 500/ul in 1991. Two other anti-retroviral agents of the same class, didanosine (ddI) and zalcitabine (ddC), became available in Hong Kong in 1992 and 1993 respectively, providing an alternative to patients who failed to respond to or could not tolerate AZT. In 1995, combination therapy was introduced to delay emergence of drug resistance. In 1996, two additional reverse transcriptase inhibitors, lamivudine (3TC) and stavudine (d4T), and three protease inhibitors (indinavir, ritonavir, saquinavir) also became available for use in Hong Kong. The treatment options for HIV/AIDS patients had increased considerably, providing flexibility to clinicians for tailoring the regimen for individual patients.

Prophylaxis against recurrence of opportunistic infection for AIDS patients after successful treatment had all along been standard practice in Hong Kong. Since 1989, primary prophylaxis against *Pneumocystis carinii* pneumonia (PCP) had been offered to HIV-infected individuals whose CD4 lymphocyte count fell below 200/ul. This had contributed to the decrease in the incidence of PCP as an AIDS-defining illness and delay in the progression to full-blown AIDS. In 1995/96, primary prophylaxis against MAI infection was also introduced to HIV-infected individuals with CD4 lymphocyte count below 50/ul. Primary prophylaxis against other opportunistic infections such as tuberculosis, CMV disease and systemic fungal infection has remained controversial. Factors under consideration were the cost-benefit ratio of the protocol and the possible emergence of drug resistance.

**Changing Pattern of HIV Infection and AIDS in Hong Kong**

Following a relatively quiet initial four years, the annual number of AIDS patients reported to DH had shown a steadily increasing trend. The annual number of newly diagnosed AIDS patients rose from 16 in the year 1989 to 45 in 1995 [2] while
the number reported in the first six months of 1996 was already 39 [3]. The increase in demand for clinical service was evident, which had been reflected by the rising proportion of reported HIV-infected individuals with full-blown AIDS - 6% in 1985, 22% in 1991 and 30% by June 1996 (cumulative). There was a corresponding increase in the in-patient bed-days at QEH consumed by medical patients with HIV/AIDS from 456 patient-days in 1991 to 1703 in 1995.

Despite the government's AIDS campaign in the last decade, a large proportion of the HIV-infected individuals in Hong Kong had not volunteered for testing and therefore remained unidentified. Up to the end of June 1996, a total of 702 HIV-infected individuals have been reported to DH [3] but an expert estimated the true number of infections to be about three thousand [4]. Analysis of information on 167 AIDS patients who had attended QEH revealed that only 45% knew of their HIV status for more than six months before their diagnosis of AIDS. This implies that many HIV-infected individuals could not benefit from anti-retroviral therapy or opportunistic infection prophylaxis. These findings also highlight the lost opportunities to limit the spread of the epidemic, as the risk of HIV transmission rises with disease progression.

With the growing importance of heterosexual transmission, there was a greater chance of HIV spreading to more than one member of the family and the resultant psychosocial impact could be devastating. A survey from 1985 to 1989 showed that none of eight heterosexual partners of infected individuals was HIV-seropositive [5]. Analysis of similar results from 1994 to 1996 showed a seropositive rate of 65% for heterosexual partners of AIDS patients and 30% for asymptomatic or mildly symptomatic individuals. Among the infected couples, 14% also had an infected child.

With the improvement in diagnosis, prophylaxis and treatment of opportunistic infections as well as availability of anti-retroviral therapy, survival of AIDS patients had improved. The mean survival for the first 22 local AIDS patients was only five months [6] but recent analysis of data on 102 AIDS patients of QEH who had already died showed a mean survival of 13 months, with the maximum of 56 months. This prolonged life expectancy, often at low level of CD4 lymphocyte count, has resulted in a change in the pattern of opportunistic infections, which carries important resource implications.
The changing pattern of opportunistic infections among AIDS patients in Hong Kong is related to the improved survival, the widespread use of PCP prophylaxis, and change in the predominant route of HIV transmission. PCP predominated among the initial AIDS patients, occurring in 59% of the first 22 local AIDS patients [6]. Data on AIDS patients seen at QEH revealed that it remained an important opportunistic infection, occurring in 31% of patients as the initial AIDS-defining illness and in 37% during their lifetime. However, they mainly occurred among individuals who were not aware of their HIV status and therefore did not receive primary prophylaxis, or those who were not compliant with treatment.

In contrast to PCP which was on a decreasing trend, CMV disease, disseminated tuberculosis, MAI and penicillium infections had grown in importance, each occurring in 15-28% of the AIDS patients at QEH. Despite the availability of effective treatment, they nevertheless resulted in considerable morbidity such as visual impairment and wasting. The use of long-term suppressive therapy has resulted in adverse effect in some patients, causing a negative impact on the quality of life. Tuberculosis, likewise, carries potential risk of being transmitted to other patients, whether HIV-infected or not, and to the health care workers.

Model of Clinical AIDS Service in Queen Elizabeth Hospital

Psychological support has all along been emphasised in the development of clinical service for HIV/AIDS patients in Hong Kong. This was especially so early in the epidemic when relatively few specific treatment could be offered. The need for psychological care was highlighted in a recent study on 43 HIV/AIDS patients which showed that 33% had depressive symptoms [7]. With improvement in survival and an increasing proportion of patients being symptomatic, it became necessary to develop a wide range of services to cater for their physical, psychological as well as social needs.

AIDS could be considered a multi-system disease with the lungs, gastrointestinal tract and nervous system being the principal organ systems affected. A multi-specialty team approach ensured that the patients received the best level of care for their complex
medical problems. At QEH, a core group of neurologists, gastroenterologists and respiratory physicians has been formed within by the Department of Medicine. An infectious disease specialist from the Department of Paediatrics provided care for infected children. Designated ophthalmologists from the Hong Kong Eye Hospital, dermatologists from DH, and dentists from QEH also offered their expertise to meet the patients' clinical needs. Specialists in other fields were consulted on a need basis.

AIDS patients not uncommonly expressed the desire to stay outside the hospital environment for as long as their health permits. A recent study on 49 HIV/AIDS patients revealed that 52% preferred to stay at home even when they could no longer maintain self care [8]. The reasons cited included convenience, comfort as well as access to support from their family members. Those who preferred hospital or hospice care usually lacked family support or had unfavourable home environment. To facilitate ambulatory management of patients with advanced HIV disease and AIDS, a clinic schedule with a high degree of flexibility was designed for the Special Medical Service at QEH. This reduced the need for patients to seek emergency admission when new symptoms developed and allowed early discharge of hospitalised patients. Whenever possible, treatment was home or clinic-based and investigations were conducted on an out-patient basis. For patients requiring long term intravenous medications such as ganciclovir or foscarnet, subcutaneous injection ports were surgically implanted to facilitate home therapy. These patients are closely supervised by the nursing staff with respect to their injection technique and supported by community nurses at home when necessary. This model of care of HIV/AIDS patients in the community helped them to maintain self control until the final stages of their illness, allowed them to remain in the home setting, facilitated their re-integration into the society, and in some cases permitted them to continue gainful employment.

Apart from clinical services catering for diagnosis and treatment of opportunistic diseases, increasing emphasis has also been placed on amelioration of symptoms and enhancement of physical well-being. At QEH, nutritional assessment and dietary advice are given by a designated dietitian to AIDS patients with weight loss or feeding problems. Vitamins, nutritional supplement and appetite stimulant are prescribed where appropriate. Physiotherapists and occupational therapists offer rehabilitation services for patients who are physically weak or have developed neurological complications. Home visits are arranged when necessary to advise on home modification to facilitate
their care. Palliative care specialists advise on symptom relief especially for patients in the terminal phase and those requiring hospice service are referred to the Haven of Hope Hospital or the Society for AIDS Care. For patients with financial hardship or accommodation problems, the medical social worker would provide help in applying for financial assistance and rehousing.

Early in the epidemic, most HIV/AIDS patients were inclined to isolate themselves for fear of exposure of their identity and subjection to various forms of discrimination. Over the years, patients have been encouraged to open themselves through the effort of nursing staff of the AIDS services and more recently volunteers from non-governmental organisations. While discrimination towards HIV/AIDS patients in the society was not totally eliminated, many have become more willing to meet other patients or volunteers either informally or in the setting of patient support groups. More of them were also willing to disclose their HIV status to their family members, who usually had a supportive attitude towards their illness. These changes opened extra sources of psychological support and permitted sharing of experience among patients and carers in their method of coping with various problems. A recent study confirmed the above trend, showing that 81% of HIV/AIDS patients expressed satisfaction towards the family support that they received while 70% had similar feelings over their peer support [7].

To ensure that the complicated physical and psychosocial needs of the patients were met, a multidisciplinary approach has been adopted at QEH. Management issues of individual patients are solved through personal communication and discussion during joint rounds and case conferences. These forms of regular communication serve to enhance the experience of team members, improve mutual understanding and facilitate decision on the management of difficult problems. To ensure smooth transition from the hospital to the patient’s home, ample time is given for pre-discharge assessment by the multidisciplinary team. Liaison was also established with the community nurses, home-help services of the Social Welfare Department, and staff of voluntary agencies to ensure adequate support for home care. Where possible, family members and close friends are encouraged to participate in the provision of care.
Generic versus Specialised Service

Whether the best model of clinical service should be a generic service integrated into the existing health care infrastructure or a centralised service run by dedicated and trained staff has frequently been debated. A generic service would be more flexible in coping with the demand for clinical service, whether early in the epidemic when the number of patients is small, or when the epidemic takes a rapidly escalating trend. By ensuring an equal share of the responsibility in providing care for HIV/AIDS patients, all health care workers feel the need to strengthen their knowledge about AIDS and all have the opportunity to acquire experience in HIV management. Assistance from specialists in various fields could be enlisted to cater for specific clinical problems. When HIV/AIDS patients are managed in the same manner as patients with other medical problems, the potential for stigmatisation or breach of confidentiality would be reduced. However, it would be difficult to ensure a consistent standard of training for the staff of generic services. Many might not appreciate the special needs of the HIV/AIDS patients and some staff with suboptimal training could display action of rejection or discrimination towards them.

A centralised service could on the other hand ensure the quality and expertise of the staff and enhancement of patient satisfaction. Rapport between the patients and the staff could be established more readily. Experienced and trained staff could ensure high standard of care while exercising judicious use of the expensive investigations and treatment. However, with a centralised service, it would be difficult for staff to have all-round expertise to cater for all the needs of the patients and a comprehensive AIDS-specific team would not be feasible. It would also be difficult to justify the staffing when the number of HIV/AIDS patients is small while a rapid increase in caseload would be beyond the capacity of any single team. This arrangement could encourage the other staff to refuse treatment to the HIV/AIDS patients for reason of lack of experience. By attending the specialised service, patients run the risk of becoming stigmatised as suffering from AIDS. It would also be inconvenient for some patients if they have to travel long distance to attend an AIDS centre for treatment.

A survey conducted in 1994 on 30 HIV/AIDS patients at QEH showed that 61% preferred to stay in a designated AIDS ward while 36% would like to attend a clinic or hospital that is close to their home. Another survey conducted by the Hong
Kong AIDS Foundation in 1995 among 31 HIV/AIDS patients on the need for hospice service showed that 35% preferred an AIDS-specific hospice while 65% preferred an integrated service catering for other patients with terminal illnesses [9]. The main concern raised was fear about stigmatisation with an AIDS-specific service. It seems that the current model of having generic clinical services supported by AIDS-specific services would offer the patients the flexibility of choosing the type of service that would most suit them individually and at different stages of their illness.

Financial Implications of AIDS Service Development

Under the current system of health care financing, patients attending the public medical sector are heavily subsidised by the Government. For AIDS patients, this included the cost of hospitalisation and pharmaceuticals for treatment of opportunistic infections and control of HIV replication. With the anticipated increase in number of patients, extended duration of their survival, and trend towards use of combination therapy with two or more anti-retroviral agents, the health care cost of providing clinical service for HIV/AIDS patients would become a major issue in the next decade.

The actual financial implications of providing clinical service for HIV/AIDS patients are difficult to assess as the human resources and laboratory support have been mostly absorbed by the existing clinical services provided by DH and HA. Based on an approximate annual cost of HK$100,000 in providing clinical care for each AIDS patient, it was projected that the yearly budget for AIDS clinical service would increase from 5.5 million in 1994 to 86.9 million (adjusted for inflation) by the year 2000 [4]. The actual pharmaceutical expenditure could run higher as the new anti-retroviral agents and drugs for treatment of opportunistic infection are very expensive. For example, the cost of providing a year’s treatment using a single reverse transcriptase inhibitor is approximately HK$15,000 to 20,000 while the expenditure for the new protease inhibitors could be as high as HK$35,000 to 50,000. Maintenance antiviral therapy to prevent relapse of CMV retinitis or long-term antifungal therapy to suppress cryptococcal meningitis would each incur a yearly cost of about $80,000.
Future Direction

A study commissioned by DH in 1994 estimated a total of 3,000 HIV-infected individuals in Hong Kong. Based on a conservative model, it was projected that by the year 2000, around three to eight thousand cumulative HIV infections would have occurred while the annual number of AIDS patients would range from 180 to 350 [4]. Paediatric AIDS was not expected to pose a major problem but it was estimated that there would be about 140 HIV-infected individuals with tuberculosis annually by then. The AIDS epidemic in Hong Kong is not expected to be as severe as the epidemic in countries such as Thailand but there would still be a need to “provide medical care and public health services to hundreds of AIDS cases annually”. This number would be greater than the total number of AIDS patients diagnosed in the first decade.

To prepare for the potential impact of the AIDS epidemic in the next decade and beyond, the existing clinical service for HIV/AIDS patients in Hong Kong would need to be strengthened. Training for health care workers in the public and private sectors should be reinforced so that the large number of patients could be accommodated by the existing clinical services. The urgency of this need was highlighted in a recent survey which showed that most health care workers were not confident about their ability to manage HIV/AIDS patients or offer advice to their family members [1]. About a quarter of the workers surveyed were also reluctant to take care of AIDS patients. As the number of patients increased, there would be a need to set up AIDS specific services in major regions of the territory to help in the management of difficult clinical problems. Their staff could also contribute towards training of the other health care workers. The financial implications should be more closely examined to ensure adequate funding for the services and formulation of the most cost-effective treatment strategy for the patients.

The practice of universal precaution among health care workers should be reinforced to reduce the risk of occupational transmission of HIV. With the anticipated increase in number of HIV-infected patients developing tuberculosis, laboratory facilities should be upgraded to facilitate early diagnosis and treatment. Compliance with anti-tuberculosis therapy should be emphasised to prevent the emergence of multi-drug resistant strains and isolation procedures should be reviewed to reduce the risk of nosocomial transmission of tuberculosis.
The predominance of heterosexual transmission of HIV could be expected to continue in the foreseeable future. With a greater number of women and children being infected by HIV, more services catering for their health care needs should be developed. The demand for social support to affected families is expected to increase and non-government organisations should be encouraged to supplement the psychosocial services available from the government.

To reduce the strain on the hospital service and to reduce the overall treatment cost, community care for HIV/AIDS should be further developed. This would require improved coordination of the clinical and social services now provided by the public and private sectors as well as the non-governmental organisations. With reduction in discriminatory attitude within the community through legislation and public education, more patients could openly express their views on the best model of clinical service and participate in the decision process of their own treatment.

The AIDS Services Development Committee reviewed the clinical services for HIV/AIDS patients in Hong Kong in 1994 and stated the following recommendations: that services for HIV/AIDS patients should be integrated into the existing social and health care system, that a community based approach should be adopted, that a non-discriminatory attitude should be fostered, that consumer participation should be encouraged, and that coordination at the policy and operation should be reinforced [10]. Apart from these measures, commitment from policy makers and active participation by all health care workers would be vital to ensure that the high quality of clinical service could be maintained when the number of AIDS patients escalated.

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4. DEVELOPING AN ALTERNATIVE SYSTEM OF CARE

O C Lin
Abstract

It has been ten years since the first case of HIV infection was reported in Hong Kong. In these ten years, much effort has been devoted by both the Government and AIDS specific non-governmental organisations in promoting awareness in the community and providing care to people infected or affected by the virus.

In terms of care provided to people with HIV/AIDS, it is noticed that a great variety of services have been developed by different agencies. It is especially reassuring to find that the evolution of the system of care is directed towards improvement on the clients' quality of life. In line with the six domains proposed by the World Health Organisation in maintaining an individual's quality of life (namely physical, psychological, level of independence, social relations, environment and spiritual), the development of the care system in Hong Kong is reviewed and analyzed. Using the experience of service development of the care system in Hong Kong AIDS Foundation, the influence contributed by cultural and social factors are also discussed.

While it is encouraging to find innovation and enthusiasm in service provision for those affected or infected, it is felt that further refinement and improvement according to the changing need of the clients is essential. With a team of dedicated workers in the AIDS field, it is believed that the unfortunate members of the society can eventually be assured of a quality life in the very near future.
Introduction

Since the discovery of the first case of HIV infection, much resources have been devoted to helping those infected, especially through research on treatment. Unfortunately, the advancement has been very slow. As from the latest report presented in the 11th International Conference on AIDS, it is still a long way from a complete cure from the diseases. What can be offered at the present moment is only prolonging the life of those infected. While delighted at the latest advancement, albeit insufficient, people started to ask whether simple prolongation of life will lead to prolongation of suffering at the same time. Obviously, research on curative treatment of HIV/AIDS is important. However, effort should also be spent on creating a favourable environment for the infected so that the quality of their life can be maintained even with the disease.

According to the World Health Organisation, six areas, or named as domains, should be attended in considering an individual's quality of life. These domains are: physical, psychological, level of independence, social relations, environment and spiritual [1]. To achieve satisfaction on these six domains, hence improving the quality of life for people with HIV/AIDS (PWHIV/AIDS), we must not only focus on clinical areas. Development of a comprehensive system of care is also essential so as to reduce the agonies of those affected.

Historical Review

Quite unlike other places in the world, AIDS programme in Hong Kong was first initiated by the Government. Apart from educating the public and promoting awareness on HIV/AIDS, the Hong Kong Government also started providing care to those infected. It was not until 1990 that the first AIDS specific non-governmental organisation (NGO), the AIDS Concern, was established in Hong Kong. A year later, with the assistance from the Government and the Jockey Club Charities Foundation, the Hong Kong AIDS Foundation, another major AIDS specific NGO, was formed. Subsequent to these, more and more NGOs targeting different populations were formed.
When HIV/AIDS was first discovered, people’s attention were focused on medical areas, including advancements in drugs, treatments and immunisation. The need of people infected, other than treatments, was neglected. Areas like psychological aspect, social aspect or familial aspect were not properly addressed. The same phenomenon happened in Hong Kong. The insufficiency of this imbalanced approach towards HIV/AIDS was noticed when discrimination and undue sufferings caused to PWHIV/AIDS were disclosed. People were alerted by the need of attending to the basic quality of life in providing care to PWHIV/AIDS. This awareness had brought about an entirely new picture to AIDS specific service provisions. In other words, an alternative system of care has gradually evolved.

Provision of Care to People with HIV/AIDS

As mentioned above, care of people with HIV/AIDS is incomplete without attending to their quality of life. In Hong Kong this belief was realised through the development of a comprehensive system of care. Programmes aimed at improving different domains of client’s life have been developed. Most of these programmes are provided by AIDS specific NGOs which are playing a significant role in the provision of care to PWHIV/AIDS in Hong Kong.

Apart from medical services provided by the Hospital Authority and the Department of Health, other alternative therapies are also available for PWHIV/AIDS in taking care of their physical health. One AIDS specific organisation, the AIDS Concern, provides referral services for clients who seek alternative therapies. They refer clients to traditional Chinese medicines, aromatherapy or massage. In addition, the Hong Kong AIDS Foundation runs neo-linguistic programming and meditation courses for clients. In 1995, a new organisation started to provide home nursing care and residential hospice care for people with AIDS. Obviously, the establishment of this Service has started a new page on the system of care for PWHIV/AIDS in Hong Kong.

In the psychological aspects, counseling for PWHIV/AIDS and their families has been available since the commencement of medical service. The scope of psychological care was expanded considerably in recent years. Services aiming at
Developing an Alternative System of Care

helping PWHIV/AIDS to cope with the illness, to re-establish self-respect, and to continue with the hope for life were developed. Apart from services provided by medical social workers of related hospitals or clinics, NGOs in Hong Kong are also actively involved in the provision of counseling services. In the Hong Kong AIDS Foundation, a good variety of service programmes helping clients in the psychological aspects are provided. Activity based support groups are formed for clients with different needs. Through the activities, mutual support among participants are established, thus reinforcing their psychological strength in facing the disease.

HIV/AIDS causes gradual decrease in the level of independence of an individual. By level of independence it means the extent to which the clients can manage their daily life without relying on others. Being able to be independent implies that an individual can have full control on his or her life. This belief is essential in helping clients to sustain confidence and self-respect. It is under this rationale that different agencies in Hong Kong started new services include financial support; supply of physical mobility aids; transportation service; and employment referral service. All these activities have been devised for maintaining the level of independence of the clients.

As a human being, sense of relatedness is a necessary ingredient in maintaining our morale and interests in life. To PWHIV/AIDS, this aspect is even more important because there is, unfortunately, a strong linkage between HIV/AIDS and some moral judgment. People tend to relate HIV infection to minority or marginalised groups and because of rejection to these groups, people with the virus are liable to lose the social relations which they badly need. The understanding of the importance of social relations has urged different agencies in Hong Kong to develop service programmes that help PWHIV/AIDS to have normal friendship. Buddy service provided by AIDS Concern, the home and hospital visits organised by the Hong Kong AIDS Foundation are typical examples. Through the concern and support from the volunteers, PWHIV/AIDS are reaffirmed of their own identities as friends of someone else.

A comprehensive system of care cannot be achieved without attending to the environment. This environment may have direct or indirect relationship with the clients. Simple as the physical setting within which the client is living or complicated as the society as a whole, the environment is essential in enhancing the quality of their
lives. In this respect, different agencies are playing different roles but targeting at a common goal, i.e. to create a favorable environment for people infected or affected by HIV/AIDS. Services range from offering assistance to people to settle down in a reasonably comfortable setting to promoting acceptance and understanding in the community. It is clear that great effort has been made by both the government and non-governmental organizations in improving the “environment” of the PWHIV/AIDS.

Finally, significance of spiritual support cannot be ignored. From patients' perspective the influence of spiritual power is sometimes greater than that of medical treatment. Apart from respecting clients’ religious belief, some agencies have also developed programmes targeting specifically their spiritual needs. The Christian Fellowship and a support group “Spiritual Support” are new developments of the Hong Kong AIDS Foundation aiming at taking care of some clients' specific needs.

Cultural and Social Considerations

Having reviewed the development of the system of care for PWHIV/AIDS in Hong Kong according to the six domains proposed by the World Health Organisation, it is interesting that the approach seems to be different from that of western countries. On further consideration, culture and social background may have contributed to the development and refinement on the system of care. In this section the experience of the Hong Kong AIDS Foundation in developing support groups will be used to illustrate the influence caused by cultural and social factors.

Support groups have long been used as an alternative social outlet for people facing similar situations. For PWHIV/AIDS, it is believed to be a very valuable means for attaining internal support among the members. Through group interactions members are encouraged to share their feelings and living experiences and, more importantly, to build up their mutual support network.

At the Hong Kong AIDS Foundation, a small group of clients turned up at their group meeting regularly initially, but most of the time the participants were involved only passively. After a few sessions, the number of participants decreased.
The participants confessed that they were not used to talking about their emotions and feelings or to sharing openly, even with those who faced the same problem. Also, they believed that they should count on their family members for assistance first before seeking help from outsiders. They considered it shameful if they could not obtain assistance from their family. Of course, the agony of witnessing someone suffering from the same illness to go through the dying process is another factor deterring them from joining the support group. After all, they believed that they had to rely on themselves for handling the upcoming problems. All these practical experiences indicated that the expected goals could not be achieved by running support groups in the "conventional" manner because the participants were influenced by their own background, including the cultural and social aspect.

Chinese people are taught that they should keep their emotions to themselves. Hiding the emotions seem to be the Chinese norm. They were trained, since childhood, that they should avoid bothering others with their own problems as far as possible. Even with problems they could not deal with, they should approach their families for assistance and the problem should not be made known to others or the family's reputation will be damaged [2].

From a social perspective, Hong Kong is well known for its very basic social welfare system. Citizens are encouraged to turn to their kin for assistance and government's or social agencies' assistance should be the last resort [3]. With this mentality, most Hong Kong people are reluctant to make use of available social services. The same applies to PWHIV/AIDS. They perceive themselves to be under the worst situation when they seek assistance from welfare agencies. They prefer not to get associated with any welfare agencies as long as they can tolerate. They do not approach social welfare agencies unless they have no other options. Moreover, people in Hong Kong are very pragmatic. Once they approach welfare agencies, they often expect to have something tangible, to have the problems solved. Many do not prefer support groups because they feel that sharing cannot help them out. They feel that they face the same verdict - the impending death.

Further, HIV/AIDS is still perceived as something related, though not only, to marginalised groups. PWHIV/AIDS are especially sensitive to having any connection with an AIDS specific organisation. Even among PWHIV/AIDS, many have very
mixed feeling getting along with other PWHIV/AIDS. Some of them feel that they are more innocent and should be distinguished from other PWHIV/AIDS.

With the above observation and understanding, the Hong Kong AIDS Foundation has modified its service provision. An activity centre was set up and regular activities were commenced, e.g. Japanese learning class; Karoke Group and some other interest classes. The main aim is to provide normalising activities for PWHIV/AIDS. They also organised regular large scale outdoor activities during which clients, their family members, volunteers and staff could take part. It was through this soft approach that relationship was built up and clients have become more spontaneous in sharing among themselves. The aim of attaining mutual support was thus achieved.

The AIDS Foundation also runs groups focusing on different areas, such as Tai Chi Class, Spiritual Support Group, Christian Fellowship and a Carer's Group. All these groups are more activity-based. For example, in Tai Chi Class, participants perform exercises under the guidance of a tutor; in Spiritual Support Group, members learn meditation or how to deal with stress; in Christian Fellowship, they may have religious discussions, Bible reading or group prayer while in the Carer's group, members may share cooking or other domestic skills. People become more forthcoming because they perceived themselves as joining activities. Sharing was made while something tangible took place at the same time. They were more comfortable in talking with each other when activities took place. They could also achieve a temporary relief from the worries over the illness.

HIV/AIDS, because of the stigma associated and the nature of the disease, has created suffering that is far greater than those caused by the disease itself. It is understandable that support from others is essential in going through the agonies. However, conventional support group is not that effective in our community because of the cultural and social background of people in Hong Kong. The failure of the past experiences and the success of the revised programme has alerted workers in the AIDS field on the importance of attending to social and cultural factors in developing service programmes. With incessant changes taking place all over the world, it is impossible to write up a formula or blueprint on services for PWHIV/AIDS. However, awareness of social and cultural factors is definitely crucial in helping PWHIV/AIDS re-establish a dignified life which they are entitled.
Conclusion

"Enthusiastic" and "innovative" may be the words to describe the development of care to PWHIV/AIDS in the past ten years in Hong Kong. Front-line workers in the AIDS field had commonly experienced certain degree of difficulties in establishing a system of care that could render the clients with greatest assistance. Due to the shortage of previous experience in helping people with similar problems and the ever changing face of the issue, practitioners found it extraordinarily difficult in developing a protocol of care. Fortunately, we have a group of workers in Hong Kong who are willing and eager to devote to the improvement of care for PWHIV/AIDS. With their effort and the experiences accumulated they are confident that the standard of care will be improved.

The observations made upon the responses of the clients had clearly shown that consideration of the various aspects under specific social and cultural background is necessary in accomplishing a quality care system. The development in the past has reflected an attempt to realise the emphasis on the six domains related to quality of life. However we must not stop at this point. More vigorous work in improving the quality of life for the PWHIV/AIDS must be done before we can assure those unfortunate members of the community with a genuine quality life.

References


5. CHILDREN LIVING WITH HIV IN HONG KONG

Y L Lau

with contributions by
Peter WH Lee and Maureen McGinley
Abstract

Paediatric HIV/AIDS has fortunately remained at a low level in Hong Kong, limited to the 21 haemophilic children diagnosed to have HIV infection under 13 years of age and the 3 perinatally-infected babies, up to June 1996. However, HIV infection was spreading into the heterosexual female population and it was projected by year 2000, up to 100 babies might be infected perinatally. Effective means to reduce maternal-infant transmission by two-thirds is available but the ethical and logistical issues of implementing an effective intervention programme abound. Nevertheless different disciplines in Hong Kong have risen to the challenge of caring for this small group of HIV-infected children. A clinical psychologist and a voluntary AIDS worker share their perspectives in the care of children living with HIV.
Introduction

From the beginning of the HIV/AIDS pandemic until January 1, 1996, it was estimated that 3.2 million children world-wide had been infected with HIV.[1] Of these 3.2 million infected children, 0.38 million were in Southeast Asia and 0.206 million already had AIDS.

In Hong Kong, despite its strategic geographical location in Southeast Asia, the prevalence and incidence of HIV/AIDS still remain relatively low compared to neighbouring countries such as Thailand and India. The magnitude of the paediatric HIV/AIDS caseload has therefore been fortunately low so far. However there is no room for complacency as there is evidence of spread of HIV infection into our local heterosexual female population in recent years. With time the HIV infection will spread into the paediatric population. Indeed the first case of perinatally acquired HIV infection in Hong Kong was reported in June 1994 with two further cases reported in 1995. Nevertheless the majority of the children infected with HIV were still haemophiliacs having received contaminated Factor 8 concentrates back in the 1980's. There were 21 children aged less than 13 years old infected with HIV through the use of contaminated blood/blood products reported to the Department of Health.[2] They form at present the major paediatric HIV/AIDS caseload for the health care community.

The HIV-Infected haemophiliac child

These victims of the double tragedies of haemophilia and HIV/AIDS are being looked after in various paediatric units of the major Hospital Authority hospitals, with no more than a few cases in each unit. The doctors in charge of these cases are usually paediatric haematologists/oncologists who are familiar with issues related to chronic diseases, necessitating a multi-disciplinary approach. The in-patient and outpatient care of these children will therefore be mingled with those of children suffering from other blood diseases and cancer. It is indeed impossible for Hong Kong to have a dedicated paediatric HIV/AIDS unit even at this moment. Therefore there is still no uniformity in the approach for management of this group of HIV-infected children.
Back in the mid-1980's when this group of children were identified to be infected with HIV, the paediatric health care community was quite unprepared in providing a comprehensive and tailored programme for them. It is quite understandable as the whole world was quite unprepared for this HIV/AIDS pandemic and the process of development of care was a bit of struggle of finding answers to a lot of difficult questions both at the bedside and in the community.

The initial hurdle was how to break the news to the parents that their haemophiliac sons were infected with yet another life-long and ultimately fatal disease, with all the societal prejudices attached to it. It is even more difficult to break such news to a growing-up child-patient. Not infrequently the diagnosis was not revealed to the patients initially, who might find out at a later stage that they were infected with HIV through less formal routes. For example in the very early days of the HIV/AIDS era, the practice of having the label of “HIV” by the bedside has been followed in some wards, and an older child might be smart enough to find out what the three letters mean. Of course it will be outrageous for any health care unit to so blatantly ignore patients’ confidentiality nowadays. Those were the days when the whole health care system muddled through the process of finding how to care for these unfortunate children.

The paediatricians are learning with the rest of the medical profession in how to deliver the optimal care to these children. Even with easy access to the world literature and the relatively socialistic medical delivery system in Hong Kong, it is sometimes quite difficult to judge on the best course of action. For example, the prophylactic use of intravenous immunoglobulin, the timing of when to start anti-retroviral therapy, the choice of switching to another anti-retroviral drug or combination therapy as well as frequency of monitoring of immune status are some of the difficult issues which seem to have changing answers through these years, not to mention the recent issue of monitoring viral load. It is therefore not surprising for our HIV-infected haemophiliac families to query why the medical care could vary so much from one hospital to another. Nevertheless the essence of a good and caring programme hinges not so much on just technical and clinical aspects, but on the ability in spinning a flexible network of support systems, including the medical social worker, clinical psychologist, voluntary AIDS worker, hospital school system, community service and the in-patient medical and nursing care support. It has been difficult in the early
days to get co-operation from certain sectors due to unfounded fears secondary to ignorance and prejudice. For example, the Red Cross Hospital School Service had been adamant in refusing to provide education for some of these hospitalised children in the early 1990's despite repeated explanation on the routes of transmission of HIV. Prejudice could not be easily dispelled by objective knowledge alone. However, most of the professionals in Hong Kong have risen to the challenge of providing care to these children. When these children reach the terminal phase of their illness, the acute paediatric ward has even functioned as an “open-door hospice” for them and their family to drop in for a few days and weeks when they could not cope with all the problems in the community and respite care was urgently needed.

The support from other disciplines in caring for these children has been tremendous. The perspectives of a clinical psychologist and a voluntary AIDS worker in providing care for these children are recorded at the end of this chapter. It was also gratifying, despite considerable delay, that in April 1993 that the government had delivered financial assistance ranging from HK$0.3 to $1 million to these patients and their families, in recognition of their special circumstances in contracting the HIV infection.

With the advent of viral-loading monitor and anti-retrovirals combination, it is essential to ask the question whether the HIV could ever be eradicated from the HIV-infected haemophiliac children. Since this group of children seems to have the slowest rate of disease progression and many of them are long-term non-progressors [3], their HIV viral load should be relatively low and if anti-retrovirals combination could effect a “cure”, if it is ever at all possible, it will probably be in this group of patients. According to Dr. David Ho’s (New York, USA) HIV modelling data, a completely inhibiting regimen of anti-retrovirals would have to be given for 1.5 to 3.0 years before each compartment of HIV burns out; though HIV sanctuary sites might complicate this model. At the moment the paediatricians looking after this group of children are gathering baseline data on their treatment and immune status before embarking a discussion on what should be the next phase of treatment for them.
Perinatal HIV infection

The HIV prevalence rates in Hong Kong have remained low: <0.01% among blood donors and <0.1% among patients with sexually-transmitted diseases and drug users.[4] Since unlinked anonymous screening (UAS) was introduced in November 1990, several thousands of cord blood samples have been tested for presence of HIV antibody and only one was positive in 1995. These surveillance studies and UAS confirmed the relatively low HIV prevalence rate in Hong Kong. However there is unrefutable evidence that the HIV infection is spreading into our heterosexual female population. Of the 67 females infected with HIV who were reported to the Department of Health between 1986 and 1995, 60 occurred in the last 5 years and of these 60 females, 57 contracted HIV infection via the heterosexual route. The implication of this is that HIV infection will then spread to the newborns via the perinatal route.

Up to June 1996, three babies have been reported to have contracted HIV infection through perinatal transmission, of whom two have developed AIDS. There are a few more HIV-seropositive mothers who have either elected abortion or delivered babies who turned out not to be infected. The care of these infected babies and sero-reverted babies are again dispersed among the various Hospital Authority hospitals. The uniformity of care of this small group of babies has to certain extent been assured by the introduction of the revised Guidelines on management of HIV infection in children by the Advisory Council on AIDS in 1995. However, as in the case of the HIV-infected haemophiliac children, the more difficult aspect of the care is to generate an efficient and caring network of support systems for this small group of families, who will be facing problems even greater than that of the haemophiliac families, such as parents dying with AIDS. The number of HIV-infected babies through the perinatal route has been projected by Professor James Chin (California, USA) to be less than 100 by the end of year 2000. This figure may fortunately still be an over estimation.

Since the publication of the ACTG (AIDS Clinical Trials Group) 076 trial in 1994, there is now effective means to reduce the perinatal HIV transmission rate by two-thirds.[5] However the operational hurdle is how to identify the HIV infected pregnant mothers early enough to implement the intervention programme. The HIV prevalence rate among the 70,000 pregnant mothers each year in Hong Kong is likely
to be less than 0.1%. It is therefore debatable whether one should implement a universal screening programme for all pregnant women on logistical ground, let alone the ethical issue of such screening programme. However selective screening depends heavily on the awareness and initiative of all health care providers in the antenatal clinics as well as the pregnant women. The process of education will take a long time and need to be reinforced regularly to achieve any effect. It is difficult to make a final judgement but constant review of the need of a universal screening programme should be made, depending on the trend of perinatal HIV infection. It is nevertheless interesting to note 82.3% of pregnant women in a study in Tsan Yuk Hospital agreed to universal antenatal HIV antibody test. [6] Emerging data on risk factors of perinatal HIV transmission rate which can be altered may also influence future obstetric practice. For example it was reported that prolonged rupture of membrane was associated with a higher maternal-fetal transmission of HIV [7] and babies of HIV-infected mothers should probably be delivered within four hours of rupture of membrane.

**Training of paediatricians**

The Hong Kong College of Paediatricians have established *Guidelines on Postgraduate Training and Accreditation* in which emphasis on the management skill of paediatric HIV infection has been mentioned under two disciplines, i.e. Immunology and Infectious Diseases. However it is envisaged that the relatively low caseload of paediatric HIV/AIDS will not be able to sustain adequate level of exposure for a thorough training in the practical aspects of care of such children. It is therefore very much dependent on the individual paediatricians who have an interest in the care of such children to constantly update their knowledge base on the changing standard of care for these patients. These paediatricians include those who are in the disciplines of haematology, immunology and infectious diseases. It will be important for them to organise regular seminars to share their experience and update the collective knowledge base.
A psychologist's perspective

Peter W H Lee

The lay adult's view of AIDS is very much that of a disease of the homosexuals or of individuals with immoral character. For the child-patients, however, they are equally shunned but for a different reason. They are avoided and stigmatised not so much for their "immorality" but rather for their infectivity projected more from imagination than from reality. It is often the case that when facts conflict with biases, the former lose out particularly when fear is an underlying factor.

In working with the HIV positive child, the sunny child's image is one of the guiding principles. There is more to a child's life than merely one of hanging in there, hoping for no more pains and sufferings, or the ever present brush with inevitable death. The child's quality of living is what we should be aiming to do the utmost. The doctors will be busy saving the child's life. The psychologist's task is one of making the most opportunistic use of the child's remaining functions and capabilities to help him/her fulfill the most wanted but reachable wishes. The wishes that brighten up the painful little eyes may be so simplistic to many as not even worth a mention. It may be one of going to the Ocean Park, but having to be carried on the back. It may be one of having an extra mechanical robot to fit together before it might be too late. It may be seeing the mother's face during an earlier hospital visit.

Sensitivity and flexibility are the two key elements in the psychological helping process. Sensitivity is demanded as the child's physical and mental states may vary ever so quickly, particularly in the last days of his/her life. Sensitivity is essential for knowing what is not appropriate for the moment as much as knowing what is. An example calls to mind when I was dealing with a dying child with AIDS. Professionally what I was taught was that the psychologist should unravel and handle the child's fears of death and separation. However, the actual scenario of the child's confrontation with impending death can be very far away from the dictates of professional training. The child may be simply too weak (physically and mentally) to deal with any big issues that may as well be fantasies in the professional's minds. The child's wishes at such a time may have so regressed that his major source of gratification may be one of simple immediate reduction of tension - the simple joys of seeing mother's face earlier than expected, being able to swallow without feeling the pain in the throat.
being able to watch television with a better physical support of the bony aching body. It would not only be unhelpful but harmful if one were to thrust down unwanted discussions of vague concepts of death and how best to handle it with the dying child. To be sensitive is to be able to see what really helps, regardless of one’s professional training. To be sensitive is also to be able to see and feel and understand from the child’s personal point of view. The operational implication of sensitivity is often one of flexibility. When one is intent to really do good, when one is intent to really understand and serve in areas where it is most required, flexibility and often moving into uncommon behaviours are required. How can one help better than simply helping to facilitate the buying of a toy robot when this is the most hoped for at the moment?

To be truly helpful, one has to see these children as fellow human beings, to feel their pains, to see the world through their eyes, and to touch them with naked hands and sensitivity rather than in plastic gloves and thickened senses. Let’s hope their plight and sufferings are redressed in a different time and space........

A volunteer’s experience

Sister Maureen McGinley

As adults we sometimes forget that young people are very aware of themselves in their own environment, in their experience and in their own feelings. They may not always be able to name how they feel, but they can tell you something about it. I believe that we also forget that, even though they have a more limited experience of life, they have the ability to create a world for themselves that makes it possible for them to deal with the hardships and sadness that can affect them.

That is my experience of getting to know two young boys, both haemophiliacs, both of whom died of AIDS. I first met Ah Kit and Ah Ming almost 2 years before their deaths. At age 14 they had spent the major part of their lives in and out of hospitals, attending clinics, always being forced to face the fact that they had 2 major illnesses, haemophilia and AIDS. At the time of meeting them they had no personal friends, except adults, were unable to lead a very active life, and the pressure of their HIV status on their families was showing in their relationships and daily family life.
Their haemophilia apart, what was most difficult for them was the reaction of others towards the fact that they had become infected with HIV. Their extended family members could not be told; they no longer had school friends; one was barred from attending the hospital school and the other barred from attending the local primary school; medical students would meet them dressed in caps, gowns, masks and gloves (they refused to speak to them until they disrobed).

I am a trained nurse, with experience of HIV/AIDS, but I met them as a volunteer. My medical background helped me understand and deal with the disease process, but what was more important was my ability to become their friend. They had to learn to trust me, and that took time. They were not the most verbose of young boys, but did have many interests, a really good sense of humour, and a great sensitivity towards their families. Being their friend meant that it was important that I offered them an opportunity to enjoy life and life’s little pleasures. We did not talk about their illness, or make much of their difficulty; we did not talk about hospitals and drugs. Instead, we visited shopping malls, restaurants, went for trips to the beach or the countryside. We sat at home and watched T.V. together. We constructed model cars and ships and made jigsaw puzzles. In other words, we shared ourselves and our time with each other and developed our friendship.

Who wants to talk about sickness, who wants to be reminded that they have a terminal disease? People would ask me if they had spoken about their impending deaths. They knew they were dying, they knew that their families were sad and they could see their own bodies changing. They mentioned it once or twice, to make sure that I understood. Afterwards, they avoided the conversation as their way of making the most of the time left. They looked forward to the good days when they had energy, rather than dread the final outcome.

Many children with AIDS have already had to cope with personal rejection and discrimination. They face society’s misunderstanding and for these two boys it was often expressed verbally and in the media. What they could not understand was that society fears the disease, and it was not rejection of themselves as people. How could they learn that? More than the pain and suffering due to the disease, this was the hardest burden to bear. They were expected at times to have adult emotions and understandings, whilst dealing with the events as a child. They were also expected to
deal with the physical suffering in a stoical way as in, “you must be accustomed to it by now”!

As the disease progressed they created a world for themselves where they felt safe and accepted. Both boys claimed more of their parents’ time and support. They trusted them, distrusted many others. Welcoming volunteers into this tight circle seemed to be privilege as we became close friends. It also became important that those of us who cared for them, in turn made efforts to enable others to understand the whole experience of a child living with AIDS, while trying to live the normal life of a 14-year-old.

Accompanying a child at this stage of their life does indeed demand sensitivity, and a great selflessness. Dealing with them as an equal is their expectation; showing normal feelings, saying ‘no’ when necessary, silently holding and comforting them is a real need. It is AIDS that brought us together, but it was as mutual friends that we developed our relationship, and indeed our love for each other.

A sick child with AIDS can watch your every movement, your every expression. They may read expressions wrongly, as many adults also do, but they are hypersensitive to rejection and others’ expression of distaste or fear. Ah Kit would refuse to speak to anyone who seemed to show that they were reacting to his physical appearance or to the fact that he had AIDS. Ah Ming became severely depressed and withdrawn, refusing to go outside in case others should see him and somehow know that he had AIDS. He refused to get out of bed in the hospital ward after some mothers refused to allow their children to associate with him. Without his glasses his sight was quite poor. To shut out the world he would take off his glasses and lie back in the bed and create a quiet, accepting world for himself. If I visited, he would whisper “why do they not like me?” How do we answer such questions?

As they both neared death, they wanted me to touch them more, hold them, take away some of their fear. Helping their parents to cope with their child dying was also part of my role. It was heart-rending for me to watch them deteriorating and suffering, how much more so for their loving parents? As individuals each parent dealt with the situation out of their own pool of inner strength and ability. Together, it was sometimes difficult as they were shy of showing their feelings to each other.
Their love was evident, but they too needed the extra strength and support that we could offer as they extended such love and care for their sons. Having a child dying of AIDS often sets them apart from their own family and friends.

As AIDS was the cause of death of both Ah Kit and Ah Ming, both they and their families were denied the normal outpourings of sympathy and support from the community and extended family. Do they then just become forgotten people?

As professionals, and as volunteers allowed to come into the world of these two young boys, it enabled us to witness to their courage and their ability to live life despite AIDS - an uplifting experience. As professionals we come with set rules and regulations, as volunteers we want to help, but it could be a little overpowering. Accompanying these young boys afforded the opportunity to walk alongside them, share our own life with them and in return share some of theirs. AIDS does not need to separate us, but it can bring us together.

A parent’s wish

“I hope all of us, whether they have or have no sons or daughters, infected or not infected with HIV, could love and care for these less fortunate children, fight discrimination and win over support from all walks of life”.

References


6. IMPACT OF AIDS ON THE SOCIAL WORK FIELD

Billy Ho
Abstract

Social work is a profession to render assistance to those least able to help themselves in order to restore the latter's social functioning. People with HIV/AIDS (PWAS) who have to face tremendous psycho-social impacts are among the most vulnerable potential target of social work intervention. The growing epidemic has created a growing need for social work involvement in fighting AIDS.

Social workers are challenged by different facets of the epidemic. They should equip themselves to face the future challenges, such as complex psycho-social issues, limit of confidentiality, prejudice towards sexuality, social segregation etc. All these call for professional knowledge and skills to effect intervention.

Social workers' competency and adequacy in these areas are being challenged. In Hong Kong, social work response to HIV/AIDS is still at its beginning phase. More have to be done to enhance the interest of social workers to involve themselves in this field. Considering the strength and advantageous position of the social work profession, social workers should secure themselves in the battle against AIDS in roles as significant health promoters, psycho-social counsellors, AIDS specific service providers and anti-oppressive practitioners. However, the lack of specialised training and insufficiency of community resources may become the main obstacles for achieving greater involvement of the social work field.
Introduction

Over the years, HIV (human immunodeficiency virus) has been spreading to every corner in this world since its inception in the United States in 1981, and Hong Kong is no exception. In the last decade, the number of HIV infection and AIDS has been increasing steadily in Hong Kong. At the beginning, the AIDS crisis, regarded as a medical issue, has drawn the attention of government authorities and health care professionals to curb the spread of the infection.

With a better understanding of the modes of transmission of this disease, its impacts on the society and the infected persons, HIV/AIDS is no longer someone else’s or individual problem, nor is it a purely medical issue, but that it has become a social problem as well. Not only has it aroused intense social unrest and panic but it also exerts great psycho-social stress which hampers the social relationship of the infected persons. The social work profession is designated to help those miserable and deprived groups to optimise social functioning and normal living in the society. It has been, like other disciplines in the community, challenged by the HIV/AIDS epidemic during the last decade.

In this paper, the impacts of AIDS on the social work field in the last decade is examined, with special reference to the context in Hong Kong. Such factors as the attitudes of social workers towards AIDS clients, their knowledge of the disease and their readiness to provide services to HIV/AIDS patients are explored. Lastly, the dilemma and difficulties faced by the social work field in developing services to HIV/AIDS patients is discussed.

Social Workers are Challenged by HIV/AIDS

Social workers, similar to other health care professionals, are challenged by HIV/AIDS during recent years. The challenges are multi-faceted. They emerge from the growing epidemic, the nature of the disease, psycho-social impacts on the infected persons and the specific issues relating to the HIV epidemic.
A. Growing Epidemic

As in other countries, AIDS was first discovered in some sectors of the community in Hong Kong. These include homosexuals, haemophiliacs and intravenous drug users. HIV infection seemed to be confined in a small sector in the community. Obviously, this is not true.

HIV infection is a sexually transmitted disease. Today, heterosexual transmission has become the dominant route of spread of the virus. More women and young adults are getting the virus through unprotected sexual intercourse with an infected partner. Every member of the society is exposed to the risk of infection if they have practised unsafe sex irrespective of their age, sex and ethnicity.

The phenomenon that men and women in Hong Kong are becoming sexually active at a younger age is another important factor to be considered. It is clear also that pre or extra-marital sex is not uncommon. On the other hand, some may have changed their sex partners a number of times before entering into steady intimate relationship while others may have been involved in commercial sex.

Although the awareness of the community to HIV/AIDS during the recent years is increasing, the unwillingness to or constraints of practising safer sex is a major obstacle in sex education. The sexual attitude of the young population is also becoming more and more open, and they are rather permissive to pre-marital sex. Much worry is aroused by the research finding which revealed the reluctance of young people in using condoms due to peer influence and their perceived reduction of sensitivity and pleasure by using condom during sexual intercourse.

Though the HIV incidence in Hong Kong is still not very high, the vulnerability to HIV/AIDS will be increasing in parallel to the heterosexual spread and the openness in sexual attitude in the community. According to an estimation, the cumulative number of HIV infection is projected to reach 8,000 to 12,000 at the turn of the century.[1] Hence, all sectors of the community are susceptible to HIV infection once unsafe sex or other high risk sexual behaviour prevails.
Social workers deal with a diverse clientele such as young people, family, offenders, drug abusers, disabled persons, elderly etc., and they are working in different sectors in the community. They have to work with clients who have higher susceptibility to HIV infection, such as marginal youth, offenders, sex workers, drug abusers, and some may need to work with people infected with HIV or their family members. With the increasing number of HIV infection and the growing epidemic, coupled with the unique nature of social work in intervening at different levels, social workers have higher chances to encounter enquiries or problems concerning HIV/AIDS from their clients. Against the background of the rapid development of social welfare services in Hong Kong, it is essential for social workers to equip themselves with the appropriate skills and knowledge, and be prepared to face the AIDS challenges in the years to come. This is in line with the professional mission to provide high calibre services in observance of the principles of equality, equity, efficiency and confidentiality.

B. Psycho-social Issues

Social workers who work with people infected with HIV are challenged by the demand of professional knowledge and skills in helping their clients to cope with the diverse and complex psycho-social issues.

Due to social rejection and stigmatisation, the psycho-social impacts of HIV/AIDS on any infected individual is tremendous. The impacts may be characterised by a deep sense of experiencing multiple losses: health, physical strength, job, financial autonomy, standing in the community, family, friends and social support [2]. No matter how psychologically well-prepared a person might be, a positive HIV antibody test or appearance of symptoms is likely to cause feelings of shock and disbelief. Confusion, bewilderment, and fear are other normal reactions to be expected. Shock may persist and become generalised as do confusion, despair, emotional fluctuation, morbid concern for the future, and self-denigration [3].

It is necessary for social workers dealing with clients at this initial acute phase to provide emotional and psycho-social support, and to propose realistic actions at such time of crisis. Assisting clients in accepting, assessing, and acting upon the
realities is critical. [2] Social workers are therefore in need of specialised training in acquiring knowledge and skills in handling such crises, and to get themselves prepared to address the various psychosocial issues that affect the clients and their support systems. [4]

Due to the short history of HIV/AIDS, there has been a vacuum in professional training relating to HIV/AIDS in the formal social work curriculum in the tertiary institutions in Hong Kong. Social workers are challenged by the feeling of being inadequate and incompetent to educate and counsel clients about the difficult subjects in relation to the causes and effects of the infection. Unfortunately, the current literature on HIV/AIDS in the Chinese society and in the local context is still scarce. Fundamentally, therefore, the social work profession in Hong Kong is in need of knowledge, skills and information in addressing psychosocial problems faced by people with HIV and their support systems.

C. Special Issues arising from HIV/AIDS in Social Work Field

The magnitude of the AIDS crisis is so great that it poses a number of unavoidable challenges to the social work profession, among them limits of confidentiality versus “duty to protect” third parties; social segregation versus integration; mandatory versus voluntary HIV testing; and “prejudice” towards sexuality. Self-reflection over their professional stance and values towards these issues by social workers has become crucial for the development of commensurate service for this clientele. Failing that, social workers may find themselves caught in difficult positions when their own values come into conflict with the PWAS’s needs or if they cannot accept the values of these clients.

1. Limits of Confidentiality versus “Duty to Protect”
Social workers are always torn between the clients’ right to confidentiality and the rights of third parties, such as lovers, girl/boy friends or sexual partners who may be at risk because of their sexual relationship with their clients. Unfortunately HIV/AIDS is still an incurable disease. Is the responsible social worker obliged and or has he/she a duty to inform third parties of the clients’ HIV status without
their consent? What is the limit of confidentiality in social work in context of HIV/AIDS? Under which circumstances can social workers breach the right of confidentiality to protect the “innocent” third parties? All these are controversial issues often quoted in the social work profession concerning handling PWAS.

2. **Social Segregation versus Integration**

   Social workers have to face the social attitude of intense panic and irrational fear towards HIV/AIDS from the community. Social ostracism and rejection from the public is mainly due to their misunderstanding and misconception towards the nature and modes of transmission of the infection. Social work is an anti-oppression practice which prevents its service clients from being marginalised and discriminated. Its value base and orientation require a commitment to social justice and social integration, to enhancing the quality of the life of individuals, families and groups within communities, and to a repudiation of all forms of social discrimination. [5] Following this line, social welfare personnel have an obligation to ensure a non-discriminatory and non-segregation policy for PWAS.

   The challenges to social work come from two fronts: First, anti-oppression practice is not an easy task as social workers have to face not just heavy social pressure, but unsupportive or even discriminating manner from public towards the provision of HIV/AIDS services. The recent protest by local residents of Richland Garden in Hong Kong against the setting up of a health centre for PWAS is a good example. Secondly, social rejection exists within the profession itself, as research revealed that the attitude of some helping professionals were negative in rendering services to PWAS. In recent years, some PWAS have been refused home help service by different non-government agencies for fear that the helpers might get infected. Social work practitioners should re-examine their attitude and belief towards HIV/AIDS while committing to be helpers of sufferers.
3. **Mandatory versus Voluntary HIV Testing**

With the growth of the HIV/AIDS epidemic, the number of PWAS and their needs for social welfare services are increasing. Services such as home help, counselling and supportive groups, residential care and other social support services are some of the demands. Some social service personnel and agencies are proposing the need for mandatory HIV antibody test for prospective clients prior to service provision. The rationale is to ensure all clients are free from the infection so that service deliverers, care-givers or other users of these services (such as other inhabitants of an institution) can also be free from the infection risk. Obviously, safety of and the duty to protect other clients and helpers become the primary concern of these agencies.

On the other hand, it is also clear that mandatory testing has the demerit of forcing high risk individuals to go underground, adding more difficulties to prevent the spread of the disease. From the public health perspective, HIV testing should be conducted in voluntary and self-determined basis to protect the rights of the individuals and to ensure effective prevention.

4. **Prejudice towards Sexuality**

Social workers involved in the arena of HIV/AIDS usually have to work with people with different sexual preferences - homosexuals, bisexuals, 'promiscuous' persons, people having extra or pre-marital sex etc. Attitudes and values of the social workers are challenged as these may affect their relationship with HIV/AIDS clients and their commitment in the field. It is particularly important for social workers in the Chinese society where sex is still very much a personal, sensitive and taboo area. Open discussion for self-reflection on one's sex values is difficult. They should sensitively observe the possible impacts of their own attitudes and values on their practice and their relationship with PWAS.
Social Work Response to the HIV/AIDS Epidemic

Social work response to HIV/AIDS is varied. Many social workers feel that they do not have the knowledge or skills to work in an area they see as highly specialised, while others suggest that, at a professional level, there is little difference between working with PWAS and people suffering from other life-threatening illnesses such as cancer and other chronic illnesses. Practitioners already involved in the field agree that social workers should be aware of their possible responses to the issues involved and to their potential clients, which may be living with HIV/AIDS. As HIV/AIDS becomes more widespread, the probability of social workers encountering a HIV positive client and the need to discuss with clients about sex, sexually transmitted disease (STD) and AIDS increases. Social workers should therefore equip themselves to meet the future challenges in these aspects.

A. Readiness of the Social Work Profession

A local survey on knowledge and attitude among social welfare personnel towards HIV/AIDS [6] reported that as compared with the general public, social workers have better knowledge in the disease. They were knowledgeable about the mode of transmission and the nature of the disease. However, knowledge on the biomedical aspects such as the latency and window period of HIV infection and probability of transmission via blood donation is far from adequate. Besides, social workers are found to be more sympathetic towards HIV infected persons. In general, the social work profession shows willingness to provide AIDS-related services. Their perceived difficulties in the provision of such services rest in inadequate skills and knowledge in working with HIV/AIDS clients, and insufficient material and human resources. These hamper the participation of the social work profession in the HIV/AIDS field. A majority of the respondents feel an urgent need of receiving further training to enhance their knowledge and skills in working with these clients.
Another local study on the readiness of social workers in providing services to PWAS involved interviews of several medical social workers working with HIV/AIDS patients [7]. It was revealed that some have higher acceptance towards the "innocent victims" such as infants and haemophiliacs but are less accepting towards "the guilty" such as commercial sex workers, homosexuals. Some of them still have fear of contagion and have the feelings of incompetence due to the lack of knowledge. Such attitude may impede the empathic and competent service delivery to clients.

To conclude the findings from these two local studies, the readiness of the social work profession towards HIV/AIDS epidemic is still at its infancy. Fear and misconceptions towards the disease are not uncommon among social workers in Hong Kong. They lack adequate training on the knowledge and skills on working with HIV/AIDS clients. This impedes their competency and commitment in this field. Fortunately, social workers, in general, are willing to serve the HIV/AIDS clients. If more resources are available, the involvement of social workers in this field can be enhanced.

B. Social Work Response in the Local Context

Social work response to HIV/AIDS in Hong Kong is not vigorous. In late 1993, the Social Welfare Department appointed a half-time medical social worker on secondment to the Department of Health to render medical social work services to HIV/AIDS patients. Tangible services, such as financial aid, housing, home help service have been provided. It is enlightening to see that the scope of services has been widened from tangible services to intangible counselling, from casework to professional education and group work. It is in fact the Department of Health which involves the medical social worker in various tasks, such as: to perform a psycho-social assessment on clients; to assist in educational seminars on AIDS for professionals; to join their research team; and to prepare a handbook for social workers. The Department of Health has taken much initiatives in the field while the Social Welfare Department and other social work agencies are less active in this regard.

In 1994, with the support of AIDS Trust Fund, the Hong Kong Council of Social Service, which is an umbrella organisation for all the non-government
organisations in the social welfare sector, started a pilot AIDS project to coordinate all relevant tasks among its member agencies in the area of HIV/AIDS to enhance and enrich the quality of life for HIV/AIDS patients. Interdisciplinary training programmes and dissemination of information and knowledge of AIDS were held for staff in the welfare sector. This became a new leap in the social welfare field in response to AIDS. It also set the agenda for the future involvement of the social welfare sector in this field.

Subsequently, under the auspices of the AIDS Services Development Committee, a Manual on HIV/AIDS for Social Welfare Personnel was published in 1995 [8]. This manual has been distributed to all social welfare service units in the territory and every social worker was given a synopsis of the publication. Such a move has aroused the concern of the profession to a greater extent. With the improvement of the knowledge and skill level on HIV/AIDS among the profession, it is speculated that the readiness of social workers in responding to this epidemic will advance.

In June 1996, the Social Welfare Department released its departmental policy on AIDS and general guidelines on working with PWAs to uphold the principles of non-discrimination and non-segregation in service provision. Operational guidelines on referring PWAs for other services have also been clearly given. This reflects an enhanced involvement of the Government in helping PWAs, and commitment of the social welfare sector in responding to the epidemic.

**Future Development**

_A. Social Workers' Roles_

Social workers start to gain awareness of their roles in providing information and counselling to PWAS. They also find that their participation in the promotion of safer sex and safer drug use is indispensable in the course of promoting and maintaining the behavioural change. Considering the different phases of development of the HIV epidemic and the different targets for prevention, social workers would allow greater room for enhancing their roles in meeting the AIDS challenges. The social worker's
roles at different stages of development and their targets of intervention are summarised in table I.

Such a conceptualisation on social workers’ roles in HIV/AIDS is an attempt to give a quick reference to local social workers in preparing for the AIDS challenge and such roles are deemed applicable in the Hong Kong context.

Table I: Social work and tasks in HIV/AIDS

<table>
<thead>
<tr>
<th>Stages of Development/Targets</th>
<th>Social Workers’ Roles &amp; Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. AIDS Patients</td>
<td>Roles: counsellor, resource mobiliser, carer</td>
</tr>
<tr>
<td></td>
<td>Tasks: providing social support services, hospice care, home help, residential services, preparing for death</td>
</tr>
<tr>
<td>II. HIV infected persons</td>
<td>Roles: counsellor, group worker, information giver, resource mobiliser, advocate</td>
</tr>
<tr>
<td></td>
<td>Tasks: running self-help groups, providing volunteer service, buddy service, information - giving on current medication, safer sex education, advocating for non-discriminatory policy</td>
</tr>
<tr>
<td>III. High risk individuals such as: drug abusers, marginal youth, offenders, homosexuals</td>
<td>Roles: educator, counsellor, information giver</td>
</tr>
<tr>
<td></td>
<td>Tasks: AIDS education, pre &amp; post-test counselling</td>
</tr>
<tr>
<td>IV. General public</td>
<td>Roles: educator, advocate, organiser, researcher</td>
</tr>
<tr>
<td></td>
<td>Tasks: AIDS education, anti-discrimination advocacy, promoting caring &amp; supportive attitude, arousing awareness on HIV/AIDS</td>
</tr>
</tbody>
</table>

B. Social Work Relationship - Partnership

In working with PWAS, the concept of partnership should be applied in building up relationship with the clients. Social workers should work collaboratively with their clients to fight AIDS. The professional mandate should not be dominant in the helping process. The concept of “walking with the clients” or “standing by their sides during the different phases of the disease” should be emphasised. The dignity of the clients should be respected and the quality of life at the late stage of the disease should be upheld.
C. Health Promotion

AIDS cannot be cured to date, but it can be prevented. With a better understanding of this disease, effective prevention strategies should be formulated on different target groups so as to curb the spread of the infection. As they have a wide contact with different types of clientele in the community, social workers should be more aware of their roles in the dissemination and publicity of information on HIV/AIDS to their clients.

Condom education has become a key issue in the prevention of and education about AIDS. In Hong Kong, social workers still hold great reservations in ways to teach young people how to use condoms in sexual intercourse, as many have doubts on whether such a move would indirectly encourage engagement in pre-marital sexual activities. With the growing epidemic, the lives of thousands of people at risk, can we downplay the moral concern in promoting condom use to protect people at young age? More in-depth reflection and discussion of such issue is required in order to arrive at an appropriate sex education approach to accommodate the upcoming challenges.

Conclusion

Upon reflection, it is crystal clear that the social work profession in Hong Kong is challenged by the growing HIV/AIDS epidemic. Social work response is still at its beginning phase. More need to be done to prepare the profession in meeting the future challenges. Evidently, it can be seen that HIV infection is spreading to people of younger age and of various classes in Hong Kong. There are growing opportunities for social workers to involve themselves actively and to contribute in the fight against AIDS. More resources have to be mobilised to improve the education of social workers, so that they can command a better understanding of the infection and develop skills required in working with HIV/AIDS patients. The interest and concern of social workers to work for PWAS should also be aroused. This emerges as a prominent trend that the social work professionals are securing themselves in the battle against AIDS in roles as health promoters, psycho-social counsellors, service
providers. If they are to fight AIDS effectively, social workers should engage themselves in anti-oppression practice as the essential task will be to reduce the social stigma of this disease in the community.

References


7. TRACKING AWARENESS AND ATTITUDES TOWARDS AIDS AND RELATED ISSUES IN HONG KONG

Joseph T F Lau
Abstract

This chapter summarises the up-to-date situations and changes of the community's response on various AIDS-related issues in Hong Kong. Some favourable changes have been observed. In particular, the public has attained a good level of knowledge about the basic modes of HIV transmission. The education programmes have also successfully removed doubts about the chance of HIV transmission through social interaction such as ordinary body contacts and sharing meals. These may have resulted in less discriminatory attitudes. There are areas of change that correspond quite well to specific programming efforts. In areas which have not been emphasised by the programmers, such as efficacy of condom use, changes were not observed. The lesson is that specific messages on targeted changes should be explicitly expressed by education programmes in order to be picked up by the public.

Four important tasks are identified in this review: (1) promoting the interest and awareness of the public towards AIDS and its related issues; (2) dealing with discrimination against people with HIV/AIDS; (3) helping women exercise control in protecting themselves against infection via their spouses; and (4) convincing the public about the efficacy of using condoms to prevent HIV infection. Finally, future research should continue to track the patterns of public awareness and attitudes in order to evaluate the effectiveness of the programmes.
Background of KABP Studies

Different studies on knowledge, attitudes, behaviour and practice related to AIDS have often been put under the embracing term of KABP. These studies have become popular in the AIDS research literature since the mid 80s [1-7]. Launched as one of the initial responses, KABP studies have aimed at obtaining a general understanding of the community's responses in order to provide directions for programming. They have also frequently been employed as measurements to evaluate programme effectiveness [8,9].

When the World Health Organisation (WHO) designed its core KABP questionnaire on AIDS, social theories such as the health belief model [10], reasoned-action theory [11], and social cognitive theory [12] had been adopted to build up the theoretical frameworks for investigating the complex inter-relationships between knowledge, attitudes and behaviours [13]. The theories hypothesised that the provision of knowledge should result in risk reduction behaviours. Empirical results have however been mixed [14]. Other KABP variables such as risk perception, perceived efficacy of interventions like condom use and reduction of sex partners, were reported as significant predictors of behavioural changes [15-18]. Furthermore, KABP studies have identified strong relationships between discrimination and misconceptions about HIV transmission. Though research on AIDS soon goes beyond KABP studies, they are still important in monitoring societal responses and in assessing programme effectiveness. While answers to some of the KABP questions are quite consistent, others may exhibit some patterns of changes. The continuous tracking of the patterns are hence useful to find out what has and what has not been achieved. Such tracking is in place in Hong Kong.

A few KABP studies of smaller scale were conducted in the late 80s in Hong Kong [19]. The first landmark KABP Study was completed in December 1992 [20]. In 1994, the Community Research Programme on AIDS was established with a grant from the Council for the AIDS Trust Fund. One of the tasks was to monitor changes in AIDS awareness. Over the years, a number of surveys have been carried out,
including the Community Awareness Survey carried out in August 1994 and October 1995 which targeted the general public (a third wave is to be launched in October 1996) and other studies on specific subpopulations, including married persons, secondary school principals, teachers, students, social workers, health care workers, and heads of the personnel departments of business establishments (see Appendix). These studies had covered a wide spectrum of respondents with total sample size of over 14,000. Like putting pieces of puzzles together, a summary gives a meaningful picture of the local context within.

Aims of the Chapter

This chapter attempts to review and synthesise the main results of the aforementioned studies, with a view of identifying areas of improvement and weakness. Discussions are centred on the following topics:

1. The general awareness of the public.
2. Knowledge and beliefs related to the nature, modes of transmission and common misconceptions about HIV infection.
3. Discriminatory attitudes toward people living with AIDS and HIV (PWA/HIV) of the public, service providers and employers in the workplace. The relationship between discriminatory attitudes and misconceptions is also discussed.
4. The perception of susceptibility to HIV infection and women's exposure to risk of infection.
5. The perception of the effectiveness of using condoms.

Definition of the Problem at Present and in Future

Members of the general public may not regard AIDS to be an immediate threat, though in their mind, it is certainly something that is getting big. From the 1994 and 1995 data, only about one-third of the respondents thought that AIDS is ‘currently’
Tracking Awareness and Attitudes towards AIDS and Related Issues in Hong Kong

(at the time of survey) a serious problem in Hong Kong [Table I], while about three quarters of the respondents in 1994 and 1995 thought that AIDS would become a 'serious' or 'very serious' problem a decade later. [Table II] Women, persons above age 40, those who did not attain secondary education and the 1994 respondents were more likely to think that AIDS was not serious at present. The viewpoint that AIDS would become serious after ten years was more homogeneous among members of the public - besides the observed sex difference, people with different socio-economic backgrounds held similar views.

Responses to the questions in the 1992 KABP Study are also given in Table I; strict comparisons are however not possible since they were phrased differently (see footnotes of Tables I & II). However, a lower percentage (62.5%) in the 1992 survey considered the future situation to be 'a threat' to Hong Kong. If this is roughly comparable to the 'serious' or 'very serious' options taken by 75.5% and 73.5% of the respondents in the 1994 and 1995 surveys, it is possible that more people are holding the belief that “AIDS” is becoming a serious problem.

Since AIDS has not been perceived as an immediate threat, it is not surprising to find relatively low enthusiasm among the public in getting relevant information or participating in relevant activities [Table III]. Younger respondents (below age 40) and those with tertiary education were generally more interested. A similarly low level of concern was reported in the family members of the respondents. Less than 10% of the respondents had discussed about AIDS with some family members in the last 3 months.

The relatively low level of concern is possibly related to the common perception that AIDS is not an immediate problem. The 1994 and 1995 Community Awareness Surveys reveal that perceived immediate seriousness is associated with interest in getting information and participating in AIDS-related activities. This is consistent with the health belief model which suggests a positive relationship between perceived severity of the disease and resultant risk reduction behaviour. The observation is important in planning education strategy in the future.
Table I: The general public's perceived seriousness of AIDS nowadays

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<tr>
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<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Very serious/serious</td>
<td>30.9</td>
<td>33.2</td>
<td>32.0*</td>
</tr>
<tr>
<td>Average/some threat</td>
<td>66.9</td>
<td>65.5</td>
<td>66.2</td>
</tr>
<tr>
<td>Not serious/not serious at all</td>
<td>2.2</td>
<td>1.2</td>
<td>1.7</td>
</tr>
<tr>
<td>Number of respondents</td>
<td>1155</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 In the 1992 KABP Survey, the question was: "How threatening is AIDS in Hong Kong nowadays?"

2 In the Community Awareness Survey of the general public in 1994 and 1995, the question was: "How serious is AIDS in Hong Kong nowadays?"

3 Responses to the 1992 KABP Survey and 1994 and 1995 Community Awareness Survey were not strictly comparable because of different response options provided. In 1992, the response categories were 'no threat', 'some threat', and 'very large threat' and in 1994 and 1995, they were 'not serious at all', 'not serious', 'average', 'serious', and 'very serious'.

# Significant difference among the years (p < .05, by the χ² test for association)

* Significant sex difference within the year (p < .05, by the χ² test for association)

Table II: The general public's perceived seriousness of AIDS in future

<table>
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<tr>
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<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Very serious/serious</td>
<td>59.8</td>
<td>65.4</td>
<td>62.5*</td>
</tr>
<tr>
<td>Average/some threat</td>
<td>38.7</td>
<td>33.6</td>
<td>36.2</td>
</tr>
<tr>
<td>Not serious/not serious at all</td>
<td>1.4</td>
<td>1.1</td>
<td>1.3</td>
</tr>
<tr>
<td>Number of cases</td>
<td>1155</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 In the 1992 KABP Survey, the question was: "How threatening is AIDS in Hong Kong in future?"

2 In the Community Awareness Survey of the general public in 1994 and 1995, the question was: "How serious is AIDS in Hong Kong ten years from now?"

3 Responses to the 1992 KABP Survey and 1994 and 1995 Community Awareness Survey were not strictly comparable because of different response options provided. In 1992, the response categories were ‘no threat’, ‘some threat’, and ‘very large threat’ and in 1994 and 1995, they were ‘not serious at all’, ‘not serious’, ‘average’, ‘serious’, and ‘very serious’.

# Significant difference among the years (p < .05, by the χ² test for association)

* Significant sex difference within the year (p < .05, by the χ² test for association)

Table III: The general public's interest in AIDS-related matters

<table>
<thead>
<tr>
<th></th>
<th>1994</th>
<th>1995</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>You are interested in knowing more about AIDS prevention</td>
<td>64.6</td>
<td>65.0</td>
</tr>
<tr>
<td>You are interested in joining AIDS-prevention activity</td>
<td>34.3</td>
<td>30.5</td>
</tr>
</tbody>
</table>

1 Sources were the 1994 and 1995 Community Awareness Survey of the general public.
How Good is the Public's Knowledge?

The public's knowledge of AIDS has been maintained at a relatively high level, as evidenced by the studies in 1992, 1994 and 1995 [Table 4]. Over 90% knew that HIV could be transmitted via unprotected sex, sharing contaminated needles and vertical transmission. They were also aware that HIV could be transmitted by a healthy looking person. The members of the public were, however, less clear about the long incubation period of HIV infection, e.g. only 46% answered correctly in 1992 [Table IV].

Misconception about AIDS has improved over the years. During the three years from 1992 to 1995, more members of the public have accepted that ordinary body contact (from 82.4% to 90.0%) and sharing meals with PWA/HIV (from 68.3% to 86.3%) would not result in HIV infection. It should be noted that the Government of Hong Kong had released several APIs during the same time period with special reference to these two points [Table IV]. On other aspects, especially when body fluid is involved, such as the questions on transmission via kissing, coughing and sneezing or toilet seats used by PWA/HIV, misconceptions are still very common. In the 1995 survey, percent of correct responses to these items were only 29.2%, 66.6%, and 65.1% respectively. Misconceptions are not uncommon even among professionals. For example, only about 50% of the teachers surveyed in 1993 believed that HIV could not be transmitted by kissing, while only 51% of the teachers and 67% of the nurses believed that HIV could not be transmitted via mosquito bites [21].

It is disturbing to see that a majority of the respondents in the 1994 and 1995 surveys believed that there was some risk of infection when one donated blood to others (the question was “Whether someone can get infected by giving blood to others?”). The reasons are unclear, but when social workers were asked a similar question in 1995, only 49.2% of the social workers answered ‘correctly’. The phenomenon cannot be explained by the mere misinterpretation of the question. Instead, it may be related to the confusion arising from the deep root of misconception while body fluid, blood in this case, is involved. Such observation is important as misconceptions are considered to be related to discriminatory attitudes and behaviour [1,5].
In sum, members of Hong Kong’s public have attained very good knowledge about the asymptomatic nature of HIV transmission and its major routes of transmission. The local AIDS programmes have also done very well to ensure the public that sharing meals and ordinary body contacts with PWA/HIV would not transmit the virus. Some misconceptions, mostly about the risk of infection in contacting some forms of body fluid, remain very persistent from changes. Front-line professionals are not totally convinced about these facts and may result in negative impacts.

### Table IV: The general public’s knowledge and beliefs about the nature and transmission of HIV/AIDS (% of correct responses)

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>All</td>
</tr>
<tr>
<td>1) Asymptomatic</td>
<td>92.6</td>
<td>92.5</td>
<td>92.5</td>
</tr>
<tr>
<td>2) Long incubation period</td>
<td>47.0</td>
<td>44.8</td>
<td>46.0</td>
</tr>
<tr>
<td>3) Vertical transmission</td>
<td>82.8*</td>
<td>78.8</td>
<td>87.0</td>
</tr>
<tr>
<td>4) Sharing needle</td>
<td>94.1</td>
<td>96.8</td>
<td>95.4</td>
</tr>
<tr>
<td>5) Body contact</td>
<td>81.7</td>
<td>85.2</td>
<td>82.4</td>
</tr>
<tr>
<td>6) Sharing meals</td>
<td>66.8</td>
<td>69.8</td>
<td>68.3</td>
</tr>
<tr>
<td>7) Toilet seat</td>
<td>na</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>8) Kissing</td>
<td>27.0*</td>
<td>33.7</td>
<td>30.2</td>
</tr>
<tr>
<td>9) Coughing/sneezing</td>
<td>55.9</td>
<td>57.3</td>
<td>58.7</td>
</tr>
<tr>
<td>10) Donating blood</td>
<td>69.3*</td>
<td>59.3</td>
<td>64.4</td>
</tr>
</tbody>
</table>

### Notes:

1. Sources were the 1992 KABP Survey and 1994 and 1995 Community Awareness Survey of the general public.

2. The original questionnaire items abbreviated by the key words were:
   1. “One with HIV, even looks healthy, can still transmit HIV to others” in the 1992 Survey and “one who looks healthy can transmit HIV to others” in the 1994 and 1995 Survey.
   2. “One who looks healthy can transmit HIV to others” in the 1992 Survey and “One with HIV looks healthy even after being infected for a long time” in the 1994 and 1995 Survey.
   3. “A female person with HIV can transmit HIV to her fetus during pregnancy or delivery.”
   4. “Injecting with syringes used by AIDS patients can infect one with HIV.”
   5. “Having ordinary body contact with persons with HIV cannot lead to infection.”
   6. “Sharing meals with persons with HIV cannot lead to infection.”
   7. “Using toilet seats used by persons with HIV cannot lead to infection.”
   8. “Kissing mouth-to-mouth with persons with HIV cannot lead to infection.”
   9. “AIDS patients can transmit HIV to others via coughing or sneezing” in the 1992 survey and “persons with HIV cannot transmit HIV to others via coughing” in the 1994 and 1995 survey.

3. Questions not asked in the survey.

4. Significant difference among the years (p < .05, by the \( \chi^2 \) test for association).

5. Significant sex difference within the year (p < .05, by the \( \chi^2 \) test for association).
Discriminatory Attitudes against PWA/HIV

The four items in Table V are used as indicators to assess the extent of discriminatory attitudes against PWA/HIV [1,5]. In the 1994 survey, 37.6% of the respondents chose to avoid making contacts with an HIV-positive friend and 21.8% thought that HIV-positive persons should move out of their families’ residence. Similarly, about 16% to 25% thought that infected children should not continue to study in their original schools and that HIV-infected persons should quit their jobs. These reflected the profound fear felt by the public.

On the positive side, the 1995 figures in Table VI are lower than those of 1994, especially in avoiding HIV-infected friends and keeping HIV-infected persons in their families. A similar question about avoiding infected friends was asked in 1992, and stronger discriminatory attitude was seen (see Footnote 2 of Table V). Some incidences may have accounted for the positive changes. Firstly, misconceptions about the risk of casual social contacts had diminished substantially over the period; secondly, the Hong Kong AIDS Foundation launched a campaign on “family and AIDS” in 1994 which worked intensively on these subjects and thirdly, the successful Announcement of Public Interest (API) on television featuring a late AIDS patient (J.J.) was launched in 1995, which focused on the importance of the family’s support. However, at least 20% to 30% of the respondents in the community still displayed discriminatory attitudes as recorded in the 1995 survey. In fact, such discriminatory attitudes outburst in Hong Kong in 1996 when the residents of a community protested strongly against the establishment of a clinic, which will be used by some HIV-positive persons, in their neighbourhood. This illustrates the potential conflict that may arise when the number of HIV or AIDS cases increases.

As discussed earlier, persistent efforts to remove misconceptions is a promising way to reduce discrimination as the two are strongly associated. This is supported by our results. Logistic regression analysis consistently shows that persons under age 40, persons with tertiary education, higher income and the 1995 respondents were less likely to be discriminatory in the four aspects, while females were less likely to avoid HIV-positive friends but they were more likely to demand HIV-positive children to leave their original schools. Dissemination of information to members of lower socio-economic groups may hence be useful.
PWA/HIV have to face direct acts of discrimination when they are receiving some services or when they function in the workplace. It is alarming to find out that one-fourth to one-third of the social workers and health care workers were unwilling to provide services to HIV-infected patients or clients. There are considerable variations among different types of social workers and health care workers. Home helpers were most reluctant to serve PWA/HIV (51.4%) and they had the least knowledge and, for other categories of social workers, 14 to 25% would avoid clients who were PWA/HIV [22]. Among the health care workers, those having received less training, nurses and radiographers were also more likely to show avoidance, while public doctors showed the least avoidance tendency [21]. It is interesting to note the perceived susceptibility of home help service providers (29.6%) and health care workers such as medical students (44.2%), nurses (41.4%), doctors (22%), laboratory technicians (38.5%), and radiographers (31.8%). Their perceived risk of infection when providing services explains their reluctance to serve HIV-infected clients or patients [21,22].

Among the business establishments with 100 employees or more in Hong Kong surveyed in 1996, about 26% would dismiss HIV infected employees and another 14% transfer them to other posts against their will. A majority of heads of personnel departments expected staff panic when an HIV-infected employee was identified (81.9%) and about the same percentage (76.6%) stated that dismissal would be justified to avoid staff unrest [23]. To reduce discrimination in the workplace, education must therefore be directed to all members in the staff fonce. The assurance of employees about the inability for HIV to transmit via social contacts would remove fear and give confidence to the management to implement non-discriminatory policies. Unlike the experience in the United States and other western countries, mandatory blood testing of existing or prospective employees is not a heated issue in Hong Kong, as very few (<2%) of the establishments were going to screen the HIV status of their employees. Another striking feature is the relatively high percentage of the public who believed that employers had the right to carry out mandatory testing in a recruitment exercise (50%).
Tracking Awareness and Attitudes towards AIDS and Related Issues in Hong Kong

Table V: The general public's discriminatory attitudes toward HIV-positive persons

<table>
<thead>
<tr>
<th></th>
<th>1994</th>
<th>1995</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male %</td>
<td>Female %</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Would avoid contacts with an HIV-infected friend</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Absolutely likely</td>
<td>11.6</td>
<td>13.8</td>
</tr>
<tr>
<td>Most likely</td>
<td>27.5</td>
<td>25.4</td>
</tr>
<tr>
<td>Not know</td>
<td>4.4</td>
<td>5.1</td>
</tr>
<tr>
<td>Most unlikely</td>
<td>37.7</td>
<td>42.1</td>
</tr>
<tr>
<td>Absolutely unlikely</td>
<td>18.8</td>
<td>21.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>An HIV-infected person needs to move out from the family</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>7.2*</td>
<td>5.3</td>
</tr>
<tr>
<td>Agree</td>
<td>15.2</td>
<td>16.1</td>
</tr>
<tr>
<td>Average</td>
<td>6.8</td>
<td>4.4</td>
</tr>
<tr>
<td>Disagree</td>
<td>39.0</td>
<td>45.1</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>31.8</td>
<td>28.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>An HIV-infected student should not continue to study in the original school</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>7.5*</td>
<td>11.1</td>
</tr>
<tr>
<td>Agree</td>
<td>15.2</td>
<td>16.4</td>
</tr>
<tr>
<td>Average</td>
<td>5.5</td>
<td>5.1</td>
</tr>
<tr>
<td>Disagree</td>
<td>47.0</td>
<td>49.5</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>24.6</td>
<td>17.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>An HIV-infected person should not continue to go to work</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>4.7*</td>
<td>6.5</td>
</tr>
<tr>
<td>Agree</td>
<td>9.4</td>
<td>10.3</td>
</tr>
<tr>
<td>Average</td>
<td>3.3</td>
<td>3.5</td>
</tr>
<tr>
<td>Disagree</td>
<td>52.7</td>
<td>57.6</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>29.9</td>
<td>22.9</td>
</tr>
</tbody>
</table>

1 Sources were the 1994 and 1995 Community Awareness Survey of the general public.
2 A similar question was asked in the 1992 KABP Survey which found that 70.2% of the male, 68.3% of the female, and 69.3% of all respondents would avoid contact friends with HIV in daily life.
# Significant difference among the years (p < .05, by the χ² test for association)
* Significant sex difference within the year (p < .05, by the χ² test for association)
Risk Perception and Susceptibility to HIV Infection

It was reported in the 1992 KABP Study that at least 7.6% of the 18-54 years old males (95% confidence intervals: 5.5%-9.7%) and 2.3% of the females of the same age range (95% confidence interval: 1.4%-3.0%) were considered to be at moderate to high risk of HIV infection. Single men and those who were divorced, separated or widowed, those who expressed sexually permissive attitudes, and those with experience of living abroad in countries other than mainland China were more likely to be at risk [20]. Such self-reported data were expected to be underestimated.

In 1994, 8.5% of the males and 5.5% of the females perceived themselves being somehow susceptible to contracting AIDS (reporting 'an average', 'large' or 'very large' chance of contracting AIDS in future) while the figures were 7.9% for males and 8.1% for females in 1995 (Table VI). Reports on the increasing prevalence of HIV in women may also have heightened their awareness. Younger women below 31 of age, and those who did not attain secondary education perceived a higher risk of infection.

Women's risk of HIV infection deserves additional attention. When interviewed, a high percentage of members of the public regarded the chance for a women to contract HIV from her husband to be high or very high (43.7% in 1994 and 41.8% in 1995). While over 90% of the married people surveyed in 1994 and 1996 believed that women should insist on using condoms if they suspected their husbands to have another sex partner, only some 53% felt that women could actually put that to practice. Married persons of 31-40 years of age, those having attained secondary or tertiary education were more likely to feel that they should insist on using condoms whenever in doubt. However, there was no socio-economic difference in the perceived feasibility for insisting on condom use. On the other hand, about 90% of the respondents in the 1994 and 1995 surveys believed that use of commercial sex in mainland China by men from Hong Kong was common or very common. In fact, attitude towards the use of commercial sex by males has been rather open in Hong Kong. Data from the 1992 KABP Study showed that only 51.4% of the respondents objected to use of commercial sex by single males. Besides, there were daily columns in some of the major Chinese newspapers that served as guides for commercial sex visits [24]. It is important to know that males in Hong Kong do not perceive the risk for contracting AIDS from commercial sex to be particularly high. 70.6% in the 1994 data and 77%
in the 1995 data perceived high probabilities of HIV infection when using commercial sex in China. However, only around 55% thought that there was a high probability of infection if the acts were performed in Hong Kong. Given the recent reports of the large influx of imported commercial sex workers from mainland China and Southeast Asia, there is little ground to assume that it is 'safer' to practise commercial sex in Hong Kong. However, such an assumption may be translated into unsafe sex behaviour which in turn exposes women to an increased risk of HIV infection.

Table VI: The general public's perceived chance of contracting HIV in future

<table>
<thead>
<tr>
<th></th>
<th>1994</th>
<th>1995</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male %</td>
<td>Female %</td>
</tr>
<tr>
<td>Very high</td>
<td>2.5*</td>
<td>1.3</td>
</tr>
<tr>
<td>High</td>
<td>2.1</td>
<td>1.4</td>
</tr>
<tr>
<td>Average</td>
<td>3.9</td>
<td>2.8</td>
</tr>
<tr>
<td>Low</td>
<td>10.4</td>
<td>8.8</td>
</tr>
<tr>
<td>Very low</td>
<td>81.0</td>
<td>85.6</td>
</tr>
</tbody>
</table>

1 Sources were the 1994 and 1995 Community Awareness Survey of the general public.
# Significant difference among the years (p < .05, by the χ² test for association)
* Significant sex difference within the year (p < .05, by the χ² test for association)

Perceived Efficacy of Means of Risk Reduction and Effectiveness of AIDS-Prevention Programmes

Perception of efficacy generally correlates with behavioural changes. A majority agreed that having fewer sex partners was an effective means to reduce the risk of infection. However, members of the public have not been convinced about the efficacy of protected sex. In the 1992 survey, while only 60.3% of the respondents believed that using condoms was effective, 37.2% doubted about their effectiveness when used in sexual intercourse with HIV-infected persons. Both the 1994 and 1995 surveys showed that only 58% of the respondents believed that the effectiveness of using condoms was high or very high [Table VII]. Females, those who did not attain secondary education and those with low family income (less than HK$20,000 per month) were less likely to hold such beliefs. In another survey of secondary students,
a similar percentage (about 50%) did not believe in the effectiveness of using condoms to prevent AIDS. Among the 20% of students with self-reported sexual experience, 27% had unprotected sex for more than once [25].

While use of condoms has been promoted in some of the APIs in Hong Kong, its efficacy has not been emphasised explicitly. It is encouraging to note from the 1996 Family Survey that about 65% of the married respondents did not object to teaching about condoms in schools [16]. Educators have, however, always been more reserved on the subject.

In general, the public believes that the government and NGOs could do better. [Table VIII] Only 40.1% of the respondents felt that AIDS-prevention activities were effective in 1994 and this dropped to 34.0% in 1995. Almost 40% thought that it might be difficult for infected persons to receive treatment and about 31% believed that it might be difficult for citizens to obtain information or counselling. 50% to 60% of the respondents thought that the Government and the NGOs had not been doing enough in both the 1994 and 1995 surveys.

### Table VII: The general public's perceived effectiveness of using condoms, reducing the number of sex partners

<table>
<thead>
<tr>
<th></th>
<th>1994</th>
<th>1995</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td><strong>Effectiveness of using condoms</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very high</td>
<td>19.7*</td>
<td>16.8</td>
</tr>
<tr>
<td>High</td>
<td>44.1</td>
<td>34.9</td>
</tr>
<tr>
<td>Average</td>
<td>15.2</td>
<td>19.8</td>
</tr>
<tr>
<td>Low</td>
<td>15.7</td>
<td>22.3</td>
</tr>
<tr>
<td>Very low</td>
<td>5.2</td>
<td>6.3</td>
</tr>
<tr>
<td><strong>Effectiveness of reducing the number of sex partners for preventing HIV infection</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very high</td>
<td>56.3</td>
<td>53.4</td>
</tr>
<tr>
<td>High</td>
<td>29.3</td>
<td>31.0</td>
</tr>
<tr>
<td>Average</td>
<td>5.0</td>
<td>5.2</td>
</tr>
<tr>
<td>Low</td>
<td>8.3</td>
<td>4.7</td>
</tr>
<tr>
<td>Very low</td>
<td>3.1</td>
<td>2.7</td>
</tr>
</tbody>
</table>

1. Sources were the 1994 and 1995 Community Awareness Survey of the general public.

# Significant difference among the years (p < 0.05, by the χ² test for association)

* Significant sex difference within the year (p < 0.05, by the χ² test for association)
Table VIII: The general public’s perceived inadequacy in AIDS-related services

<table>
<thead>
<tr>
<th></th>
<th>1994</th>
<th>1995</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>AIDS-prevention activities are not effective</td>
<td>38.7</td>
<td>41.3</td>
</tr>
<tr>
<td>Government’s effort is too little</td>
<td>48.1</td>
<td>54.7</td>
</tr>
<tr>
<td>Non-government organizations’ effort is too little</td>
<td>55.6</td>
<td>64.1</td>
</tr>
<tr>
<td>Difficult to obtain Information about AIDS</td>
<td>29.6</td>
<td>26.9</td>
</tr>
<tr>
<td>Difficult to have a blood test</td>
<td>14.6</td>
<td>15.3</td>
</tr>
<tr>
<td>Difficult to receive counselling</td>
<td>29.4</td>
<td>29.5</td>
</tr>
<tr>
<td>Difficult to obtain treatment</td>
<td>43.9</td>
<td>45.3</td>
</tr>
</tbody>
</table>

1 Sources were the 1994 and 1995 Community Awareness Survey of the general public.

# Significant difference among the years (p < .05, by the \( \chi^2 \) test for association)

Summary and Discussion

The chapter summarises the up-to-date situations and changes of the community’s responses to AIDS and various related issues. Some favourable changes have been observed. In particular, the public has attained a good level of knowledge about the basic modes of HIV transmission. The education programmes have also successfully removed doubts about the chance of HIV transmission through social interaction such as ordinary body contacts and eating together. These may have resulted in less discriminatory attitudes, represented by responses to questions such as avoiding HIV-positive persons or demanding them to move out of their families’ residence. The public has also received the message that AIDS will become a more serious problem ten years from now.

In reviewing results of the many studies conducted in the past, four important tasks are identified. Firstly, the interest and awareness of the public have to be promoted and such work should be sustained. Some results suggest that public awareness may be gradually falling. In fact, the level of concern has not been high all along and education programmes are not highly regarded by the public. It is necessary to convince the public that AIDS is not only a problem to be dealt with in future, and though with relatively low prevalence today, it is important to act promptly. The public, in general,
is not knowledgeable about the long incubation period of AIDS. More emphasis on this aspect may link the present to the future and may promote the sense of relevance of the present situations.

The second task is the urgency to deal with discrimination against PWA/HIV. While educating administrators of organisation to adopt anti-discriminatory policies, we have to reassure them that panic would not arise among the employees if such policies are in place. One suggestion is to work on the removal of misconceptions associated with such specific areas as the use of toilet seats, coughing or sneezing, and even kissing. The public knows better about how HIV can be transmitted than how it cannot be transmitted. The terms in the Disability Discrimination Ordinance concerning dismissal and transfer of positions should be made clear to the administrators. It is not acceptable that a high percentage of the service providers are reluctant to deliver services to PWA/HIV. Training on effective infection control procedures as well as removal of misconceptions is important to alleviate the high level of perceived susceptibility to infection.

The third task is to empower women to exercise more control in protecting themselves from HIV infection contracted via their sex partners. The recent heightening of awareness of the risk is encouraging. To work on the male side is of equal importance. In particular, they should be reminded of the risk of HIV infection when casual or commercial sex is practised. The release of figures about HIV prevalence among commercial sex workers in Hong Kong, mainland China, and other neighbouring countries may serve as an effective reminder.

The fourth task is to convince the public about the efficacy of using condoms to prevent HIV infection. This is an important and underemphasised area of AIDS prevention in Hong Kong. The situation has not improved from 1992 to 1995. To work with school children in sex education classes would be an ideal start. It may boil down to simple statements such as "condoms have been proven to be one of the most effective means of AIDS prevention". Parents have been shown to be supportive.

In sum, it seems that the levels of awareness and attitudes regarding HIV/ AIDS in Hong Kong have been quite stable in the past few years. From the years' experiences, the lesson is that specific messages on targeted changes should be
explicitly expressed in education programmes in order to be picked up by the public. Future research should continue to track the patterns of public awareness and attitudes, in order to test the effectiveness of strategies. Some hypotheses need to be verified, which are: the removal of misconceptions would alleviate fear and discriminatory attitudes, promotion of the relevance of AIDS as both a current and future problem would increase public support, etc. The use of condoms, such as perceived efficacy, factors affecting practices and behavioural changes in condom use, and women's role in AIDS prevention are other important issues to be researched. Finally, periodic reviews are important to remind us of our progress and inadequacy.

References


### Appendix: Background information of different studies summarised in this chapter

<table>
<thead>
<tr>
<th>Name of survey</th>
<th>Target population</th>
<th>Age</th>
<th>Sample size</th>
<th>Sampling method</th>
<th>Data collection format</th>
<th>Time of completion (year, month)</th>
<th>Response rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) KABP Survey on AIDS in Hong Kong</td>
<td>General public</td>
<td>18-56</td>
<td>1245</td>
<td>Random address from census</td>
<td>Face-to-face</td>
<td>92.12</td>
<td>42.9</td>
</tr>
<tr>
<td>2) Community Awareness Survey</td>
<td>General public</td>
<td>18-50</td>
<td>1519</td>
<td>Random telephone numbers</td>
<td>Telephone</td>
<td>94.8</td>
<td>57.6</td>
</tr>
<tr>
<td>3) Community Awareness Survey</td>
<td>General public</td>
<td>18-50</td>
<td>1601</td>
<td>Random telephone numbers</td>
<td>Telephone</td>
<td>95.10</td>
<td>55.0</td>
</tr>
<tr>
<td>4) Family Survey on AIDS</td>
<td>Married people</td>
<td>18-60</td>
<td>793</td>
<td>Random telephone numbers</td>
<td>Telephone</td>
<td>94.6</td>
<td>47.6</td>
</tr>
<tr>
<td>5) Family Survey on AIDS</td>
<td>Married people</td>
<td>18-60</td>
<td>800</td>
<td>Random telephone numbers</td>
<td>Telephone</td>
<td>96.3</td>
<td>48.0</td>
</tr>
<tr>
<td>6) Survey of Attitudes toward HIV/AIDS Related Social Services</td>
<td>Social workers</td>
<td>&gt;18</td>
<td>1103</td>
<td>All family, outreaching, and drug-related workers</td>
<td>Mail</td>
<td>94.11</td>
<td>57.9</td>
</tr>
<tr>
<td>7) Survey on HIV/AIDS Training and Patient Care among Health Care Workers</td>
<td>Health care workers</td>
<td>NA</td>
<td>4624</td>
<td>All doctors, nurses, final year medical students, and allied health professionals</td>
<td>Mail</td>
<td>95.7</td>
<td>21.9</td>
</tr>
<tr>
<td>8) Survey of Need Assessment in the Workplace</td>
<td>Companies with staff size &gt; 100</td>
<td>NA</td>
<td>299</td>
<td>All companies with staff size &gt;100, answered by heads of personnel departments</td>
<td>Mail</td>
<td>96.6</td>
<td>16.7</td>
</tr>
<tr>
<td>9) Surveys of Education Programs on AIDS in Secondary Schools</td>
<td>Secondary schools principals, teachers, and students</td>
<td>NA</td>
<td>97 principals 864 teachers 1190 students</td>
<td>Random schools and classes from Secondary 4 to 7</td>
<td>Mail and self-administration</td>
<td>94.4</td>
<td>64.7 for principals 50.0 for teachers</td>
</tr>
</tbody>
</table>

NA: not applicable

Sponsoring or collaborating organisations:
1) Hong Kong AIDS Foundation, Hong Kong Polytechnic University; 2) & 3) Council for the AIDS Trust Fund
4), 5) & 6) Hong Kong AIDS Foundation; 6) Council of Social Service
7) & 9) Scientific Committee on AIDS, Advisory Council on AIDS.
8. AIDS AND THE MEDIA IN HONG KONG —
THE ENGLISH MEDIA’S CONSTRUCTION OF A
SOCIAL PHENOMENON IN THE PAST TEN YEARS

Diana Yeung
Abstract

This paper looks at how AIDS has been stigmatised in Hong Kong and how the English press has contributed to that process.

AIDS is highly stigmatised and is unique when compared to other chronic or terminal diseases, due to both its medical characteristics, and associations with pre-existing social and cultural beliefs. Themes like gender and sexuality had been central to coverage of AIDS in the media. Beliefs on such themes had been constantly reproduced over the slightly longer than one decade of AIDS history in Hong Kong and had strengthened the stigma associated with AIDS.
Introduction

Hong Kong news media have played an important role in disseminating information on AIDS as it first came to the territory. While news reports on new diseases are strongly dependent on how much scientific information or facts are available, they are also products of cultural beliefs already existing in society. When such new diseases are already strongly stigmatised due to their medical nature and social implications, like AIDS, there is notably more tension between the role of news media to report accurate information on the one hand, and controlling biases from news-makers themselves that may penetrate into the coverage of AIDS on the other.

This paper looks at how English daily newspapers in Hong Kong had strengthened stigmatisation of HIV/AIDS, people affected by it, and related issues. Most reports were found to be supporting existing ideologies of gender and sexuality by repeating existing stereotypes. Some exceptions may indicate potential value change in Hong Kong society.

This analysis is only a beginning of looking back at how HIV/AIDS had been portrayed in the past decade specifically in English news. It is not to say ONLY the English press contributed to constructing AIDS as a particular social phenomenon in Hong Kong. Rather, their coverage on AIDS was a window through which one gets a glimpse of pre-existing beliefs in society, and how other forms of the mass media, through similar processes, might have done the same. For a more comprehensive, if not complete, picture of what HIV/AIDS means for Hong Kong people, there should also be analyses of newsmaking processes in Hong Kong, including beliefs and practices of people who make news, all the way from the highest quotable sources to newspaper readers, and editorial staff themselves.

Stigmatisation of AIDS

In analysing the media's response to AIDS, it is crucial to note that stigmatisation plays a central role. AIDS is highly stigmatised and in unique ways. Why is that? Ervin Goffman defined stigmatisation as a process of discounting certain
undesirable attributes in a person and treated them as equating to the person's whole identity [1]. It is not the attributes that matter (although Goffman noted traits that were more universally undesirable and discrediting than others), but how they are related to their stereotypes in particular social and historical contexts and within particular webs of social relationships.

People infected with HIV/AIDS go through a unique process of stigmatisation in a number of ways. AIDS is historically linked to gayness, an undesirable attribute in Western societies like the United States, where the spread of AIDS was first noticed. Douglas Crimp noted [2] the infections probably didn't even start among gay people.

Stigmatisation within the infected population varies, which is also unique to AIDS. Transmission through sexual intercourse and intravenous drug use are more strongly stigmatised than that through blood transfusion and birth. Sexual intercourse itself may not be socially unacceptable in itself, but intercourse that connotes perversion or institutionalisation and commercialisation is. One stereotype relating to unprotected sex which constitutes risk of infection is that it is a measure of how intimate a relationship is. To be infected through sexual intercourse reveals the nature of the relationship, sometimes even raising questions about whether true love is involved. However, stigmatisation of sexual practices seem to work differently in gay communities. Gay people's attraction to "promiscuity" and what society considers "perverted" sexual practices are associated with assertion of male power [3]. Stigmatisation of the infected within gay communities may be less strong than that outside of them. Drug use is also an unacceptable social behaviour. Drug users are stigmatised as weak and unable to fulfill normal social roles. Drug injection is also associated with pollution [4].

Stigmatisation in AIDS also differs from other diseases in terms of the "sick roles" [5] the infected plays. Sick people are generally expected to withdraw from normal social obligations, consult a doctor and cooperate with him and get better. Once the sick roles are fulfilled, the sick get out of them. This process is more complicated for HIV/AIDS patients. Like other chronically and terminally ill, they cannot fulfill the role of getting better: they may get better in terms of their syndromes, but their clinical status of being positive remains. There are different aspects of a sick role on a continuum of activities the infected choose after knowing their medical
status. Their being sick takes on different combinations of definitions of social and medical conditions. Being infected is therefore more a social status than merely a medical condition [figure 1].

Some of these characteristics of stigma associated with AIDS are shared by other terminal and chronic diseases, but it is a unique combination of them in AIDS that makes it different, and perhaps the stigma more complicated to cope with and unpack.

Figure 1: The Meaning of Being Sick for HIV/AIDS Patients

<table>
<thead>
<tr>
<th>SOCIAL STATUS</th>
<th>MEDICAL STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ve, no symptoms</td>
<td>+ve, with symptoms</td>
</tr>
<tr>
<td>status unknown publicly</td>
<td>status publicly known</td>
</tr>
<tr>
<td>continuation of</td>
<td>complete departure</td>
</tr>
<tr>
<td>normal social obligations</td>
<td>from normal social obligations</td>
</tr>
</tbody>
</table>

What Role has the English Media Played in the Stigmatisation of AIDS in Hong Kong?

Herzlish, Claudine and Pierret [6] identified the construction of AIDS in the French press as having two aspects: first, the media is concerned with presenting AIDS "in terms that [has] to do with fundamental social processes and [transforming] this individual event into a collective reality" or a "social phenomenon"; second, information about this social phenomenon is circulated among social groups through the press, making them "feel concerned and mobilise". Relations around AIDS are polarized. These, however, are processes that do not occur distinct from each other, one after the other. Rather, they are products of medical knowledge, public opinion and editorial principles that combine in particular contexts and determine the nature of news products. The end result tells people "not only what to think, but also what to think with, by controlling the type and extent of information available about an issue of which the audience often has no direct experience."[7]
I will argue that reports in the English news media had been strengthening the stigmatisation of AIDS by repeatedly referring to existing cultural and social beliefs in their coverage of AIDS. While there had been exceptions, which may be seen as resistance against dominant ideologies, they occurred in a scattered manner in the texts. I have attempted to look at more than ten years of news coverage as a field of texts with thematic links, instead of sections divided by before and after phenomena in AIDS development, as I believe this is a more faithful expression of reality.

The Hong Kong Government Department of Health figures indicate there are 642 HIV carriers and 175 AIDS patients in the territory up to the end of 1995. [8] As the disease developed from being terminal to chronic with recent medical advancement, attention has gradually been directed to coping with AIDS more as a social than medical problem.

How has the process of stigmatisation occurred in the coverage of AIDS in the English news media?

From Mystery to Medical Reality

The early years of AIDS in Hong Kong portrayed in the English news media had been one of mystery, intensified with fear. Since the identification of the first AIDS patient in February, 1985, stories on AIDS in the English newspapers had been marked by headlines as “AIDS : bid for information” (Feb 26, 1985 South China Morning Post [SCMP]) and “Red Cross says lips are sealed on AIDS victims” (April 20, 1985 SCMP).

From the discourse of yearning for more information, the press turned quickly to admission of the reality of AIDS. Headlines in 1986 and 1987 were marked by warnings of the seriousness of the problem and called to have something done, like “How to stop AIDS spread” (July 16, 1986 SCMP), “AIDS threat sparks action” (Jan 19, 1987 SCMP) and “The Plague Years in HK, AIDS makes its presence felt” (Mar 14, 1987, Standard). These stories, however, quoted statements by medical authorities that underplay the significance of the AIDS threat, such as “Hong Kong is far from having any AIDS epidemic” (May 1, 1986, SCMP). There was tension between
admission of a threat small enough not to cause panic, yet big enough to arouse attention and awareness. Medical authorities took up the role of calming the public, and yet they failed to suggest concrete preventive measures the public could take. However, their omnipotence in dealing with diseases in western medical ideologies was relatively unchallenged because they remained the only source of accurate information for the press. AIDS remained a disease what the medical authorities defined it to be.

One consequence of supporting the authority of medical sciences was further polarisation of concepts of science and rationality versus emotions. AIDS was constructed as an epidemiological reality that can only be dealt with through science. "Overreaction", "hysteria" and emotions in general, were condemned as undermining combat efforts. Reports like "AIDS case turns on chill" (Feb 6, 85 SCMP), "AIDS is now the big frightener" (Jun 22, 85 SCMP) and "AIDS frightened the donors away" (Nov 23, 85 SCMP) equated AIDS with fear. As illustrated by a report headlined "Everybody's fears increase for disease that knows no boundaries" (Mar 15, 87 SCMP), it was not only the spread of the virus that was worrying, but the spread of emotions associated with it.

Meanwhile, medical professionals like Dr E.K. Yeoh were quoted as calling on the public "not to turn the disease into a moral issue, but to recognise it for what it is - a lethal disease that eventually kills." (Nov 8, 86 Standard) Press reports failed to reconcile what AIDS was, defined by medical authorities, and what AIDS was actually thought of by parties involved in newsmaking. Despite later attempts to bring in voices of the infected in articles like "Casting off shackles of HIV shame and fear" (Nov 29, 92 SCMP), the disparity had continued with articles that sensationalised on the one hand, like "New fears over spread of AIDS" (Sep 15, 94 Standard), and "Explosion of sexual disease forecast" (Aug 26 1995 Eastern Express [EE]), and others that called for accepting AIDS as part of life, like "Accepting AIDS instead of denying it" (Dec 1 1994, Standard) and "Inequality 'hinders AIDS fight' " (Feb 17, 95 SCMP). This demonstrates the inadequacy of looking at disease phenomena as decontextualised scientific entities, and assumptions that news reports are "objective" accounts of such realities.
There was also tension between making AIDS a collective social threat by reporting its epidemiological developments, and giving AIDS a specific and personalised face that does not have wide social applicability, a question to be discussed in the next section on people with AIDS in English news reports.

The Sick Role of People with AIDS

AIDS in Hong Kong complicates conventional understanding of sick roles. New definitions of sick roles appeared in the English news media, which challenged stereotypes of what being sick means.

In the beginning of the epidemic, the news media had emphasised that the infected had interests in addition to or other than being sick. Those interests included sexual orientation, gender, occupation, age and ethnicity. The infected were not simply identified as the sick who got well after having consulted doctors and withdrawn from normal social obligations. Instead, their being sick was defined by their other interests and the way they contracted the virus. Some became “sick but good, not threatening, not dangerous and not contagious”, and hence “good” patients.

Being sick is no longer a monolithic and static identity trace which can be taken up and shed away through identical social processes, but takes on different social, political and cultural meanings that in turn define what being sick is. The infected’s medical and social identities reinforce existing stereotypes.

The first AIDS case in Hong Kong was defined as a “46-year-old Chinese seaman”, who “most likely contracted the virus outside Hong Kong as he spent so many years outside the territory.” (Feb 4, 85 SCMP). In the same article, the South China Morning Post quoted then Deputy Director of the Medical and Health Department Dr S.H. Lee as saying “[AIDS], by its nature, could not affect the general population” and that Hong Kong is “very fortunate as [it does] not have a very large homosexual population here”, implying homosexuals are more likely to be hit. It is sexual orientation that defined the early face of AIDS in Hong Kong’s English news media in the beginning.
As the press continued hunting for infected patients, they became labelled as "suspected criminals" (Mar 27, 85 Standard; Jun 2, 85 SCMP; Oct 16, 86 SCMP). The Standard's report on the third official AIDS patient quoted a patient's neighbour's description of the infected:

"The man was pretty tall for a Chinese, about 5 feet 11 inches or six feet. He was in a neat suit with neck tie every time I met him while waiting for the elevator." (Sep 19, 1985) The neighbour went on to say he smelt of disinfectant and that he "had not suspected anything". Identifying who is infected becomes a process comparable to identifying a criminal. The infected took on an identity of being a threat to society.

Yet not all the infected were equally "bad" and a threat to social stability. Being sick in a "good" way was dramatically exemplified in British dentist Mike Sinclair's public announcement of his positive status in 1992 (Nov 15, 92 SCMP). His social role as an infected patient went through a transformation process: as an infected dentist, he was a bad patient, because of the challenge he posed to beliefs of the purity and infallibility of medical personnel; as an infected dentist who came out turned him into a brave patient whose "confession" was very much appreciated; and later, as a dentist-turned-activist, he changed from being a cause of contamination to formally recognised as contributing to the prevention of AIDS. His withdrawal from his normal social obligation as dentist was not so that he would get better himself, but society could be protected, a result of social pressure. This contrasts with other sick and disabled people, whose exemption from duties is part of their treatment. His sick role had become one of socially instead of medically "getting well". While reinforcing the "foreignness" of AIDS for Hong Kong, his coming out had also brought out elements of redemption and rehabilitation, as he turned his illness into a resource for public education. There is also a temporal dimension in the analysis of sick roles as there hadn't been so much an exemption from normal social obligations than a CHANGE of such obligations over time, from those incompatible with the sickness itself, to those socially acceptable for an infected patient. New definitions of sick roles in news became resources for public discussion of AIDS for sick roles define the preferred relationship between the sick and the rest of society. Whether these new resources for public discussion yield new understanding of AIDS, and hence value change, is a question I will not go into here.
Sick roles also vary according to the routes of transmission. Those who do not get transmitted through their “wilful acts” were “forgiven” and became good and innocent, while others, bad and guilty. There was marked sympathy towards minor victims, as in South China Morning Post’s April 27, 86 article on the discovery of a seven-year-old’s infection. The article said “AIDS is particularly hard for young children” and that “over-reaction [overseas] has led to children being barred from school and their parents feeling like outcasts among friends and neighbours.” In fact this kind of discrimination is not unique to infected children, but all the infected. Yet the news media chose to show sympathy only to the younger and “innocent” ones, those who were “dependent” on blood transfusions had no control over their plight, as in “An innocent teenager imprisoned by AIDS” (Feb 14, 93 SCMP). This may be partly an extension of western tendencies to idealise childhood as pure and innocent.

The same kind of transformation of sick role also occurred to disc jockey “JJ”, the first Hong Kong Chinese to go public about his HIV status. He was featured in government publicity campaigns, which marked his departure from a suffering patient, through confession of a “life of promiscuity” (May 21, 95 Eastern Express), to a more proactive “good patient” who made an effort to take control of his life.

The Issue of Gender

The picture of AIDS in the English news media is gendered in the sense that the male-female binary opposition, associated with conventional heterosexual characteristics, is constantly used in the classification of patients. Within such classifications themselves are also reinforcements of conventional heterosexual understandings of male-female roles with some exceptions.

First, a look at the classification of infected patients. Infection through intravenous drug use and homosexual activities was given a male face in the news media. Only reports on gays and never lesbians had appeared in news reports so far. From early on when infected homosexuals’ voices were heard, they were marginalised to reinforce the “naturalness” and “correctness” of heterosexuality which was under the perceived threat of a spread of homosexuality: “At first glance, Peter gives the impression he has everything he wants in life. The tall, handsome, well-educated 28-
year-old is receiving a good income and would impress any woman. But Peter is a homosexual who has been exposed to the AIDS virus. So is his lover.” (Nov 3, 1986 SCMP)

Other voices of infected homosexuals had come from “Victim Tom’s brave battle for survival” (Dec 2, 88 SCMP), “I am sick, I have AIDS” (Jul 13, 91 SCMP), and in Mike Sinclair and disc jockey JJ’s coming out. Most reports focus on the before-and-after experience of the infected, as if homosexuality and all the “good things” in life are not compatible and that AIDS destroys all of the “good” things, which are necessarily imbued with middle-class, young, and heterosexual values.

Heterosexual transmission, on the other hand, was dominated by female voices. Married women’s stories were told in articles like “Anguish of AIDS victims hits home” (Apr 18, 95 Standard) in which a 60-year-old woman infected by her husband said she was abandoned, and another emotional account in “AIDS: a husband’s tragic legacy” (May 13, 95 SCMP). There were also reports on men infected through heterosexual activities. But they were reported as objects in the stories more often than subjects with their own voices, as in “AIDS grounds ambitious jet-setter” (Nov 30, 92 Standard) and “Driver with AIDS found at border” (Jun 23, 94 Standard) and “AIDS risk for truck drivers” (Nov 7, 94 EE). This in part reflects the influence of the gendered nature of love [9], a residue of nineteenth century perceived styles of love resulting from a division between home and work place, women and men respectively. Love was identified with what women did at home and associated with “tenderness, powerlessness and the expression of emotion.” [9]. The gendered nature of love was reinforced as traditional roles of women and men were repeated.

Those infected through blood transfusion and birth were relatively androgynous or “genderless” : they were given the face of “haemophiliacs” as in “Haemophiliac AIDS victims ‘persecuted’ ” (Nov 4, 86 SCMP) and “Hope for Haemophiliacs” (Feb 16, 94 SCMP), or “transfusion patients” (Mar 3, 88 Standard) as a whole, or as children with no distinction in gender as in “Identity of AIDS children won’t be given to schools” (May 1, 86 SCMP).
Women and children were further put together to form a different sub-category of the infected, victimised not only by the disease itself, as every infected is, but also the way they got infected. This reflects how traditional western concepts of women being helpless and submissive in sex were projected in beliefs on AIDS.

Male-female division of social roles were also reinforced within those gender categories themselves. Women took on the role of care-provider, who gave unconditional and generous love as mothers. Their care-taking role as a defining characteristic of their moral character or "womanhood" [10] was stressed in such news reports, despite limited coverage of how infected men are also highly emotional outbursts in times of AIDS. Reports like "My husband has given me AIDS" (Nov 30, 91 SCMP), "Husband infecting women with HIV" (Dec 7, 93 SCMP) and "Infected men put wives at risk" (Dec 16, 93 Standard), women were first portrayed as victims of their husbands' infidelity, and then emerged as heroines who were able care-givers as exemplified in the following description: "She prepared his special meals, month in and month out, tended to him when he was sick and was hopeful when he was well." (Nov 30, 91 SCMP)

Sometimes, the news reports sided with the women, as in "AIDS: a husband's tragic legacy" (May 13, 95 SCMP), the infected husband, was described by a nurse as "every ounce a brave widow", looking "small in size", "gentle and soft", but "very strong" and outwardly "calm and collected". There were also "bad" women in news reports - prostitutes, who were singled out as the source of AIDS spread (Sep 3, 90 Standard) as in "New concern over AIDS as first prostitute diagnosed" (Aug 1, 91 SCMP) and "Vice girls ignorant of AIDS" (Feb 2, 1992 SCMP). There was markedly less sympathy for them.

Thus for women, AIDS was tragic not because they were infected, but because they contracted it through men, and heterosexual activities, as in "Wives shy of asking spouses for safe sex" (Aug 24, 94 EE) and "Survey exposes Hong Kong's cheating partners" (Aug 24, 94, Standard), or because women suffer through their infected children, as in "Torment and pain of AIDS baby's mother" (Jul 28, 94 Standard). Their voices are heard through others' ordeals, and in some cases, they become the mouthpiece for the infected's suffering as the mother of the first paediatric AIDS case in Hong Kong said "I am so sad every time I see his face" in the same article.
These reports reinforced ideologies of heterosexuality with women being on the weaker end. Reports on "empowering" women only appeared in the recent one or two years, as in "Giving power to women in the war against AIDS" (Aug 22, 1994 Standard) and "Stronger say for women urged in 'condom politics' " (Apr 18, 95 Standard).

Those in Control: Medical Authorities and Government

The power of medical authorities in Hong Kong has been constantly challenged since AIDS hit the territory: by the press, activists, members of the public, and the clinical facts of the disease itself.

One way by which western authority was challenged was in the problem of courtesy stigma. Doctors themselves were worried about stigmatisation by seeing infected patients. One doctor was quoted in an article headlined “Moral fear of AIDS test still a hurdle” (Aug 25, 85 Standard) as saying “There are very few doctors seeing these clients [homosexuals] and they certainly don’t want to be seen as ‘AIDS’ doctors when the picture in Hong Kong becomes clearer.”

While medical experts issued ample warnings on AIDS spread, as in “AIDS warning as figures rise” (Nov 3, 86 SCMP) and “Warning of rise in AIDS victims” (Jun 3, 94 SCMP), the first real comprehensive “policy” by the government in its combat against AIDS appeared in the press only in 1994 headlined “AIDS policy document to be introduced” (Apr 25, 94 Standard). Before that, the government and medical efforts were portrayed as scattered, individualistic, piecemeal, promising inaction rather than action which are mostly ineffective, e.g. “False negative results leave AIDS test fallible” (Mar 19, 88 SCMP) and “No plans for liberal use of AIDS drug here” (Feb 3, 88 SCMP).

The editorial practice in reporting controversies and conflicts in such actions, rather than how they contribute to stopping the spread of AIDS, facilitated the portrayal of a weak image of medical authorities (Aug 19, 92 Standard; Mar 18, 94 SCMP; Sep 25, 94; Standard Jul 17, 95, EE). Efforts were also personalised to specific medical experts, from Dr E.K. Yeoh, to Dr Patrick Li, and Dr S. S. Lee. They were portrayed as crusaders, “good” doctors, although western medicine may not be invincible in the
combat against AIDS (see “Man with mission to battle AIDS” Dec 17, 89 SCMP and “Going public with AIDS: Doctor leads campaign for compassion” Apr 19, 92 SCMP). Doctors were constantly shifting the burden of care back to patients, in individual efforts to change behaviour, e.g. in “Doctors urge AIDS patients to act early” (Nov 29, 89 Standard) in which doctors blamed late diagnosis on patients. Even medical personnel’s knowledge and “innocence” were in question, as in “Medical professionals need better AIDS education” (Nov 19, 91 SCMP), “AIDS fear prevails in medical circles” (Nov 15, 92 Standard) and “Health workers face HIV rules” (Apr 20, 94 SCMP).

It was only in reports about new drug developments that the authority of medical establishments was reinstated, as in “HK-born scientist reveals HIV hope” (Oct 14, 94 SCMP) although the optimism was greeted by caution, as in “Vaccine for AIDS still years away” (Jul 14, 95 SCMP) and the controversy over faulty HIV test in 1996 (Apr 9, 96 Standard and Apr 10, 96 SCMP).

Conclusion

At times of new diseases or new information, news media are often the first sources of information, and therefore play a very important role in conditioning the public in what to make of the diseases. The impact of the news media in constructing AIDS as a stigmatised social phenomenon is one example. In Hong Kong, the English news media had been strengthening stigmatisation of existing undesirable stereotypes. While there was a serious lack of factual information in the beginning of the epidemic and it would be unfair to account for news reports by mere individual editorial considerations, the media had indeed stirred up much unnecessary hysteria about the disease, effects of which have been difficult to undo.

The intensity of coverage on AIDS has been fluctuating over the past ten years. [figure 2] This is no simple product of balancing editorial decisions and public interests. Rather, AIDS - its medical and social developments - has been, and will continue to be, a window through which cultural values already existing in society are reflected, and at times, tested. Evidence in this analysis is far from comprehensive for drawing conclusions about value change in society, but is a reminder for those in the news
business the importance of being culturally sensitive, and for the government to rethink
its policy of the media in times of epidemics, its duty to disseminate often unproven
scientific information, yet also to avoid unnecessary public panic. This is a difficult
task, but AIDS has and will, most likely, continue to force us to do better.

Figure 2

Number of stories on AIDS and related issues in English daily newspapers in Hong Kong:
1985 to May 1996

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References


9. DRUG ABUSE, RISK BEHAVIOURS AND HIV INFECTION - A HONG KONG PERSPECTIVE

J B Hollinrake
Abstract

Hong Kong has had an opiate addiction problem for the last 150 years and there are currently 40,000 addicts known to the Central Registry, the majority of these taking heroin by injection. The typical profile is that of a young, adult, male, blue-collar worker. Possession of narcotics is an offence and many addicts enter the penal system. Self administration of heroin tends to be a solitary rather than a social activity, which is closely related to the overall economic situation and the relatively high rate of employment. Cheap needles and syringes are readily available and the incidence of sharing such equipment appears to be very rare. Treatment facilities for drug dependency are available within the penal service institutions as well as for the public at large, the latter includes residential programmes as well as non-residential out-patient Methadone distribution. With the advent of HIV/AIDS there was an immediate reaction on the part of the authorities, directing preventive education programmes at the public in general and at the high risk groups in particular, these included the heroin addicts at large in the community as well as those in contact with the various treatment programmes. The incidence of HIV infection among the addict community continues to remain remarkably low, together with a very low rate of progression, and an attempt is made to explain this. Preventive education must continue unabated in order to retain this state of affairs and it is suggested that surveillance should be enhanced as far as possible.
Historical Background of Drug Abuse in Hong Kong

Opiate dependency has a long history in the southern coastal provinces of China, predating but very greatly exacerbated with the arrival of the colonial traders exploiting the demand for high grade opium grown in British India in the early part of the 19th century. But for a brief respite during the Second World War Japanese Occupation, opium addiction prevailed in Hong Kong for a hundred years following its colonial establishment in the middle of the last century. In the 1950’s, with the discovery of its easy conversion and refinement, heroin very rapidly replaced opium, and within a decade, the self-administration of this drug by injection had become commonplace. Over the past three decades, opium usage has become extremely rare, having been replaced almost entirely by heroin.

Prevalence and Demographics

In the 1970’s, the Narcotics Division of the Hong Kong Government established a computerised Central Registry to provide some indication of the prevalence of addiction and to identify changing trends. A wide cross section of Government and non-Government organisations were recruited into furnishing data, and this continues to the present day. Approximately 40,000 heroin addicts are presently known to the Central Registry, the real figure will of course be higher than this, but by how much is a matter of speculation.

Adult, male, blue-collar workers overwhelmingly predominate in the heroin addiction scene, with relatively very few representatives of their female counterparts. Formerly concentrated in the densely populated urban areas, with the progressive and rapid disappearance of the rural hinterland, their distribution is now more or less equal throughout the territory.
Pattern of Drug Abuse

Whereas about 50% of newly reported drug abusers to the Central Registry are taking their heroin by injection, this figure progressively rises so that within the various treatment facilities it is found that between 80-90% of addicts are injectors.

Albeit difficult to substantiate, there are indications that about 70% of opiate addicts will ‘mature’ out of addiction over a period of between 10-14 years, the remaining 30% becoming chronic recidivists. Whereas this might be seen as a positive prospect, it has to be remembered that drug dependence more often than not becomes established in the middle to late teenage years, usually as a result of peer group influence, and thereafter persists throughout the crucial years of early adult life.

Initiation into narcotic usage as stated above, generally takes place as a result of peer influence, with the inhalation of fumes (commonly known as ‘chasing the dragon’). As the habit becomes established, the practice becomes a solitary activity, and this is certainly the case by the time that the addict has graduated into injection usage. Injection equipment, namely disposable syringes and needles are readily and cheaply available at numerous legal outlets throughout the territory.

Heroin addiction, once established, requires the addict to self-administer narcotics three or sometimes four times daily in order to keep withdrawal symptoms at bay…… withdrawal symptoms begin to make their appearance about eight hours after the last dose of heroin. Thus we find that the typical heroin addict will administer his first injection of narcotics soon after he awakes in the morning after which he will set out for work. His second injection of the day will take place during a break from work in the early afternoon, and his third injection after work in the evening. The important aspect to note in this pattern of drug administration is that it is an essentially solitary activity, and not one that takes place in a social group setting. Our enquiries consistently show that the sharing of syringes and needles is very rare, and that it is only resorted to in exceptional circumstances, such as when the addict finds himself without a syringe or needle late at night when the shops are closed. In such a situation he may borrow equipment from an addict friend, but I would stress that these instances seem to be very exceptional.
The Law

Whereas it is not an offence in Hong Kong to be an addict, it is on the other hand, an offence to be found in possession of narcotics, and a person so charged and found guilty may be fined, put on probation or be handed down a custodial sentence, depending upon the magistrate. The prison population of Hong Kong therefore consists of a considerable number of heroin addicts serving sentences, not only by reason of offences against the Dangerous Drugs Ordinance but also on account of other criminal activities.

Economic Factors

Throughout recent decades Hong Kong has enjoyed a thriving and vibrant economy, relatively untouched by the recession that has affected so many other regions of the world. Employment has remained high, and this in turn has benefited the addict population, enabling them to maintain their drug dependency financially. We find therefore that most addicts are in some form of gainful employment, and this important fact has a definite bearing upon the characteristics of the local addict and his personal practices, which differs considerably from his counterparts in other countries.

Drug Addiction Treatment Facilities

The Hong Kong prisons, under the collective name of the Correctional Services Department (CSD) operate a number of institutions specifically dealing with addicts who have been charged with minor drug offences and received custodial sentences through the courts. The Drug Addiction Treatment Centres (DATC’s) operated by the CSD deal with approximately 2,000 cases per year.

For those members of the public seeking residential treatment for drug addiction, the largest provider of such a service is the Society For The Aid and Rehabilitation of Drug Abusers (SARDA) which is a Government subvented organisation, and like the CSD deals with some 2,000 cases annually.
There are about ten religious organisations also providing smaller residential facilities, and about four organisations delivering non-residential services to injecting drug abusers.

For addicts seeking non-residential treatment services, the Department of Health operates a Methadone distribution scheme through twenty four outlets scattered across the territory, which are open every day of the year, and which have an average daily attendance rate of about 8,000.

The Advent of HIV/AIDS

The appearance of AIDS in the early 1980's and the subsequent identification of its causal agent HIV and mode of transmission, immediately alerted the authorities in Hong Kong to the potentially disastrous consequences, given the relatively high number of parenterally administering heroin addicts in the community, and very prompt action was taken to direct preventive education towards this high risk group. This concern was very greatly augmented as reports came through of the rapid spread of HIV infection among the addict populations of other nations and in neighbouring South East Asian regions, and efforts were strengthened, not only in the area of preventive education, but also in determining the best available means of monitoring the ongoing situation in Hong Kong drug addicts.

Preventive Education Campaigns and Drug Abuse

Throughout the past decade preventive education campaigns have been consistently and vigorously directed, not only at the public in general, but also specifically at high risk groups, including the self-injecting drug abusers. Television, radio, posters and Tee shirts, leaflets in cartoon format and highly profiled publicity events have all been used to convey the message of the danger of HIV infection and the precautions which should be observed in order to avoid it. Specifically appointed teams from the AIDS Unit routinely visit prisons and drug addiction treatment centres giving video and verbal presentations concerning the nature and mode of HIV transmission, the situation to avoid and precautionary measures, such as condom
usage and syringe sterilisation. These visits are carried out on a regular basis and conducted in large, open group settings. They continue to be well received by the inmates of these institutions, so much so that there now exists throughout the drug addict community, a very high level of awareness of HIV.

**The Present Position**

Hong Kong presently finds itself in the very remarkable position of having an extremely low incidence of HIV infection among its addict population, associated with an extremely low rate of progression. This calls for some attempt to explain this state of affairs which is at such variance with findings in other parts of the world, where there is a high incidence of HIV infection among addict populations and a concomitantly high rate of progression of transmitted infection among such groups.

It is tempting to attribute this relatively happy state of affairs to the timely action on the part of the authorities in promulgating a campaign of preventive education. Undoubtedly this had a salutary effect on many of the population at large, particularly with the media coverage that was given to AIDS in other parts of the world, and equally undoubtedly the ‘alarm’ factor affected the addict community itself. Although we did not monitor the syringe/needle sharing activities prior to the advent of HIV/AIDS, there are indications, that albeit the incidence was low when we started monitoring, that it has fallen even lower since then, indicating thereby that the addicts are alert to the dangers, and even more disinclined than previously to engage in such high risk activity.

The probability is however that the continuing low incidence of HIV infection among Hong Kong's drug addict population is related not so much to the preventive education measures as to subcultural attitudes and the prosperous economic situation which has long existed and which continues to prevail in the territory.

It is possible for instance that the addicts of Hong Kong have a cultural and deep seated aversion towards the sort of intimacy associated with the sharing of injection equipment, in much the same way as they prefer to retain their own personal eating utensils in a community setting, and that this natural fastidiousness provides a
considerable degree of self-protection against many diseases. Whether or not this is true, the ready availability of cheap disposable syringes and needles has and continues to be major contributory factor against the spread of HIV and other conditions. But more than anything else it is the very 'exclusive' characteristics of the addiction pattern in Hong Kong, which provides the greatest protection against HIV for the addicts, namely the high level of employment, associated with the vibrant economy, and the solitary as opposed to social circumstances of the heroin self-administration. These factors were of course in existence prior to the appearance of HIV/AIDS.

**Conclusion**

In my opinion the fortuitous position in which we find ourselves in Hong Kong, vis-a-vis HIV infection among parenteral heroin abusers, is more attributable to chance than to design; and whereas the foregoing provides us with some measure of explanation, I fear that it offers few lessons which can be emulated elsewhere. Furthermore, being largely speculative in nature, it cannot be used to justify any curtailment of the preventive education programme; on the contrary, public vigilance must be continually refreshed and enhanced without respite until science provides us with dependable immunization and/or treatment.

Concurrently I believe that we should seek every possible means to improve and expand our surveillance programmes, particularly among such high risk groups as the parenteral drug abusers, in order to obtain as accurate as possible assessment of the prevalence of this infection, even at the costs of infringement of individual rights and liberties.

AIDS presents us with a global problem with a potential of very grave consequences, not only as regards personal and public health, but also in areas of national economy, security and even politics bearing in mind the vulnerability of sexually active young adults. The circumstances are such, I believe, that personal rights must be subservient to the good of society as a whole.
10. HIV INFECTION & AIDS PREVENTION PROGRAMME FOR HOMOSEXUALS IN HONG KONG

Andrew Lo
The Beginning

In the late seventies, when the unknown disease was first discovered in a Canadian flight attendant, the name of this new century disease was given as Acquired Immune Deficiency Syndrome - AIDS. At the time, however, it did not create immediate havoc in human society. It was not until 1985 when the famous Hollywood actor Rock Hudson died of AIDS that the disease was widely reported in the news media worldwide. Since then, the AIDS epidemic became a dreaded threat looming everywhere in all contracted sexually, but could also affect innocent children or anyone receiving blood transfusion, or drug addicts sharing syringe.

Since the first AIDS cases were discovered predominately in the homosexual population, there was a misconception that HIV could only be transmitted through anal sex or in those leading sexually promiscuous lifestyles. It was called the Gay Plague which affects only gay people. Since then, crisis groups have been formed in gay communities in the United States and in other western countries. Some gay people were even led to believe that it was God's punishment for their sexual orientation. In order to contain the fear and the threat of the disease, many gay organisations established AIDS units to provide counselling and educate people on AIDS, as well as to give support to people afflicted with the disease. The gay population became the earliest and the most aggressive group to conduct preventive and educational programmes on AIDS.

AIDS Education for Gay Community - The Case of Hong Kong

The situation in Hong Kong is very similar to that of the United States. Gay people in Hong Kong were the first and earliest non-government group to conduct HIV/AIDS prevention and education programmes to the community. In the early eighties, AIDS was still not the hottest issue among the general public, not even within Hong Kong's gay community. As AIDS was unheard of in Hong Kong or elsewhere in Asia, local gays felt that the disease could affect only those living in western countries. This myth was shattered when the first Hong Kong resident died of AIDS in the mid eighties.
The mass media in Hong Kong, in line with those in the West, had widely associated AIDS with gay people. In 1986, the first and only gay organisation - 10% Club (the official name was later changed to HK 10% Club) was established by a young Chinese medical doctor. The primary objective was to fight for the legalisation of homosexuality in Hong Kong, to conduct educational programmes on the correct understanding of homosexuality, and to unite gay people in Hong Kong.

Since 1987, the 10% Club has been invited to discuss AIDS related issues on radio and with newspapers highlighting the concern in the gay community. They wrote articles and published their own newsletters to spread the concept of safer sex, adapting information from gay groups overseas such as GAT in Toronto, GAAT in San Francisco, ACT UP in Boston and New York, etc. This was largely because, at that time, Hong Kong lacked education resources on HIV infection and AIDS.

In 1989, 10% Club organised the first AIDS workshop during which the message of the practice of safer sex was formally delivered. However, the format of presentation was considered too serious and the attendance less than satisfactory. Afterwards, 10% Club adopted the "activities approach" to deliver the safer sex message. Some examples of such activities are Safer Sex Education Camps, Mr. Safer Sex Contest, Safer Sex Boat Cruise etc. These programmes were designed, organised and funded by volunteers of the Club without any government support.

In mid 1990 the new 10% Club Chairman, who had been active in gay movements and AIDS prevention programmes in Boston, USA, introduced new ideas and formed an AIDS Education Division to plan and monitor all AIDS programmes for the gay community in Hong Kong. At the same time, 10% Club also contacted the AIDS Unit of the Department of Health for funding to conduct new AIDS education and prevention activities. With the added support and the funding from the Government, 10% Club successfully produced their first safer sex flyer for the gay community in Hong Kong. The contents included AIDS awareness, teaching people how to practise safer sex and the proper use of condoms. For maximum effect, 10% Club distributed condoms together with the flyers in gay bars and saunas in a campaign. The flyers were also distributed to all health-related institutions, AIDS counselling groups and other concerned organisations in the hope that the message can be passed onto the entire gay community.
10% Club also organised seminars, workshops and discussion groups for members to share their fears and concerns of AIDS, to update knowledge, to advocate the practice of safer sex and performing of HIV blood tests. With the success of the first gay safer sex flyer, 10% Club subsequently produced a safer sex flyer for lesbians for distribution in Hong Kong. In 1994, they produced Hong Kong’s first safer sex video for gay people (available from 10% Club and also AIDS Unit of Department of Health).

Between 1990 and 1992, two other groups were established which serve the gay community - HORIZON and AIDS CONCERN. HORIZON was established in 1992 mainly to provide counselling to gay people on self-acceptance in coming out, AIDS counselling and other personal problems. All of their counsellors have received professional training in AIDS related topics including the basic knowledge of AIDS, safer sex and prevention, referral system and advice. AIDS CONCERN runs a counselling and support group for gay people and the general public. It provides a full range of services including counselling for HIV/AIDS patients, a buddy support programme, and preventive education. There are other organisations such as AIDS Foundation, funding source like AIDS Trust Fund and other groups established to provide different forms of support for HIV and AIDS prevention programmes. The 10% Club, AIDS CONCERN and HORIZON remain the most effective in serving the gay community as regards HIV/AIDS prevention.

Overall, organisers of HIV/AIDS prevention programmes for gay community encounter common difficulties due to:

- Insufficient resources
- Restrictions on promotions imposed by the Government censors
- Lack of full-time trained personnel, educators, medical doctors, consultants and other assistants
- Insufficient channels to deliver the message
- Lack of focused government policy and direction to cope with the crisis
Future Development

From the past development of the HIV Infection & AIDS prevention programme for the gay community in Hong Kong, we consider the Government’s involvement is, at best, half-hearted. The major support had come from the AIDS Unit of the Department of Health, who had put in a lot of efforts to lobby for funding for these programmes. Unfortunately, the Hong Kong Government does not have any long-term planning to organise or assist in any educational programmes, particularly for gay people in Hong Kong. A majority of the activities have been organised solely by the gay organisations themselves.

We are of the opinion that the Hong Kong Government should formally appoint an agent to coordinate AIDS prevention activities for gay community in Hong Kong. It should also instruct other departments to provide support in organising preventive and promotional programmes in the gay community in two aspects.

In the first instance, no matter how many activities are organised by the 10% Club or other gay organisations, it could only reach gay people who have “come out”, estimated at less than 1% of the gay population. With a population of roughly 6 million in Hong Kong, an estimated 10% is thought to be gay in line with Dr. Kinsey’s theory. Even with a network of 5000, the 10% Club could only reach 0.83% of the local gay population. Through adopting a more open minded approach on sexuality issues, the Government could effectively plan for long-term mass media campaigns by putting up posters in prominent public places such as public toilets, outdoor billboards and in selected government publications. In most European and North American countries, governments have been very supportive of such mass media campaigns.

While the 10% Club has a safer sex video, it could only be shown in Gay film festivals or in some small private functions. It is most regrettable as it could again only reach a small percentage of the target population. If only the government could arrange it to be shown in all Hong Kong TV channels during commercial breaks, the message would be delivered to the general public with maximum effect. The government should have no reservations in this regard as the contents of this video is not sexually explicit and would be classified as category II only.
At present, the government APIs (announcements of public interest) only tell people to use condoms. Human behaviour is very complex - people will not use condoms if they are not convinced how they would benefit from such use, or if a powerful message is not delivered on the consequences of not using them. If you ask anyone in the street, one would be shocked to find that very few people would use condoms for the prevention of AIDS. Some APIs are also too threatening, e.g. the black pyramid as a symbol of death. They are liable to inducing an excessive and inappropriate fear of AIDS, causing people to try to escape from it, instead of facing it positively. This is therefore not an effective way to deliver the message nor to bring AIDS to their awareness. They should be informed of how to enjoy sex in a safer way, and provided with a positive yet realistic approach on its practice. This would be an effective method to conduct AIDS education, giving them guidance on self preservation and the enjoyment of life, rather than the negative aspect of escaping from death.

Secondly, resources are simply insufficient to support the gay community to organise AIDS programmes or to provide counselling to the general public. Additional resources should be provided to employ AIDS specialists (e.g. from overseas) to train our local professionals, full-time AIDS educators, counsellors and other personnel and to allocate sufficient funding to support various promotional activities. We understand that Homosexuality may be a sensitive issue for the government as Hong Kong society as a whole still does not embrace this alternative sexual orientation, nor could they appreciate the needs of the minority gay population. However, it is common now to talk of human rights and equal opportunities in Hong Kong. Gays in Hong Kong contribute as much to our society as anyone else. The best way for the government to get involved is to set up a Gay AIDS concern group and resources centre. This is not a new concept as many cities in western countries have been providing funding and support for such programmes. We do not see why Hong Kong, as a major international metropolis, should be different from these other cities.

The advantage of this centre would be to centralise all human resources and funding to plan, organise, implement and monitor all HIV Infection and AIDS prevention programmes and related services, as well as co-ordinating with promotions in the mass media. If the government is not willing to set up this centre themselves, they should allocate sufficient funds for the gay groups which provide AIDS services,
who would be able to train more educators and to employ consultants to establish the system.

Targeting Young People

AIDS education for young people in Hong Kong is grossly inadequate, as reflected in a recent report that an adolescent girl was tested HIV-positive. Knowingly, teenagers today are becoming sexually mature early, and are prone to have sexual relations at an earlier age than before. We cannot risk omitting our youth when educating people on the dangers of AIDS. It is particularly disturbing to know from news report that secondary school children have little ideas or concerns on safer sex, nor do they have sufficient knowledge of AIDS. In this context, we do not consider the government's AIDS prevention programme to be successful. Gay groups in Hong Kong also experience difficulties in reaching gay teenagers. The 10% club has been planning to conduct homosexual and AIDS education in secondary schools and youth centres. Unfortunately, the feedback has been very disappointing as most school principals are very conservative and do not consider the subject suitable for the school settings. However, infection statistics now demand urgent attention in AIDS education for teenagers. If the government is concerned, they should take action immediately.

Among the teenage gays in the 10% club, most are aware of AIDS through gay publications or in other media. They may be fearful of AIDS but have limited knowledge of the subject, and the information they obtain from publications are seldom positive. The existing sex education is too limited and old-fashioned which does not satisfy the increasing sophistication of Hong Kong teenagers. Topics in Homosexuality and AIDS should be routinely included in education programmes for young people.

Conclusion

It can truly be said that the AIDS prevention programmes among the gay community have achieved some desired effect, at least according to recent figures published by the Department of Health that the proportion of reported homosexual infection has fallen, compared with that of the heterosexuals [1]. While the number
of HIV-infected patients may be higher in the gay population, they are also much more aware of their health and concerned about their possible infection and are taking steps to practise safe sex. Their rate of infection has also stabilised, whereas the incidence of HIV infection in the heterosexual population has been rising steadily, and is surpassing that of the gay population.

People may question whether it is worth spending money on the gay community. In the contexts of human rights and equal opportunities, one should understand that human lives are worth much more than the funding. In addition, the proper message is not only for the approximately 600,000 gays in Hong Kong, but the general public as a whole since everyone is potentially at risk. With adequate government support and a more open minded policy in developing closer co-operation with the gay community, we believe a majority of the problems in planning, organising, implementing and monitoring HIV infection & AIDS prevention programme can be overcome, benefiting the entire society in the years to come.

Acknowledgement

The author sincerely thanks Frankie, Jack and all 10% Club members, as well as all who have been supporting the AIDS prevention programme in Hong Kong.

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11. DEVELOPING AIDS POLICY AND EDUCATION IN THE WORKPLACE - A HONG KONG EXPERIENCE

Y C Lo & L C Kwan
Abstract

HIV infection affects largely young people in the working age range. Although HIV cannot be contracted in the normal workplace setting, ignorance, misconceptions and unpreparedness may lead to irrational fear and work disruption. It could precipitate the social death of an individual years before the actual physical death. Pre-employment HIV test is not a solution. With no cure or vaccine immediately available, the only hope companies have to ease the burden and disruption caused by AIDS is policy development and education for all employees.

In Hong Kong, not many companies have drawn up policies on AIDS. On the other hand, both the government and the non-governmental organisations have provided AIDS education in the workplace in various forms over the years. Of these, the Hong Kong Community Charter on AIDS has succeeded in facilitating the development of a more sympathetic environment for people living with HIV/AIDS. Undoubtedly, carefully planning and development of an AIDS policy and education programmes for all employees are key to minimise the disruptive effect on the workplace in the long run.
Introduction

HIV/AIDS is fast becoming one of the most devastating medical and social problems of our time. As the epidemic continues to spread, it has become increasingly obvious that none of us can completely escape its effect, be it direct or indirect. HIV infection affects largely young people in the working age range, who are the most economically productive members of society. It is natural that every workplace may someday be confronted with an HIV-infected employee, client or customer. Although HIV cannot be contracted in the normal workplace setting, ignorance, misconceptions and unpreparedness may lead to irrational fear and work disruption.

In Hong Kong, a majority of people living with HIV/AIDS are aged between 20 and 49. Many survive for years and are able to continue their productive lives despite their HIV status. However, some patients had been forced to quit their jobs once their HIV status was exposed to the administration, even though they were physically fit to work. Such discrimination based on irrational fear is scientifically unfounded. It could precipitate the social death of an individual years before the actual physical death. There have been strikes against AIDS co-workers overseas. Some employers undertake pre-employment HIV tests to avoid employing HIV infected staff. One could figure out that it would be one of most ineffective way of preventing HIV infection. Furthermore, since the prevalence of HIV infection in Hong Kong is low, about 1 in thousand adults, it will consume 1,000 tests to detect one case of HIV infection. For companies with low turn-over rate of new employment, it may take years to prevent employing one case. Further, an HIV negative employee may catch the infection through high risk behaviour after the testing. Routine screening of employed staff for HIV infection on a regular basis could only magnify its cost-ineffectiveness. The cumulative economic loss arising from discrimination acts could be even higher than the total damage done to people living with HIV/AIDS.

The annual health care cost for a person with AIDS has been estimated to be HK$100,000 [1]. There are additional resource implication. For a person with advanced stage of infection, his work performance may decrease and absenteeism may increase. Co-workers' concerns, confidentiality issues and legal matters pose additional problems. All negatively affect productivity and morale within the organisation. With no cure or vaccine immediately available, the only hope companies have to ease the burden
and disruption caused by this disease is policy development and education for all employees. A good policy could prepare a more supportive environment with minimal discrimination to infected workers. Productivity and efficiency of the company could be improved by the elimination of discrimination acts.

**AIDS Policy in the Workplace**

Although public awareness of AIDS is rising, the business world has not been addressing this issue adequately. A survey conducted by the Hong Kong Institute of Personnel Management in 1992 found that only 5.5% of the responding companies had drawn up policies on AIDS such as pre-employment HIV antibody testing, anti-discriminatory practices, special sick leave, counselling service and employee education programmes on AIDS [2].

In 1988, World Health Organisation and International Labour Office [3] made the following recommendations on workplace policy as regards HIV/AIDS -

- On-site education on AIDS for all workers and management personnel should be provided.
- Employment or pre-employment testing for HIV antibody is unnecessary and should not be required.
- Like all medical information, information on whether someone is infected with HIV should be kept confidential.
- There should be no obligation for an employee to inform the employer about his or her HIV/AIDS status.
- HIV infection is not a reason for dismissal.
- Workers who are HIV-infected must be protected from any discrimination or stigmatisation.
- Since HIV infection by itself does not limit fitness to work, no changes in working arrangement are necessary. But if an employee becomes impaired by illness related to HIV, reasonable alternative work arrangement should be made to help the worker stay on the job.
In 1995, the Disability Discrimination Ordinance was passed by the Legislative Council. HIV/AIDS was specially included as one form of disability covered by the new legislation. An Equal Opportunities Commission was established in 1996 to implement the Ordinance. A set of code of practice on employment is under preparation by the Commission to provide guidance on eliminating discrimination on the workplace.

Developing AIDS Education in the Workplace

Realising the importance of alerting the business community to prepare for the impact of AIDS, the Committee on Education and Publicity on AIDS and the Hong Kong AIDS Foundation jointly held a seminar “AIDS and the workplace - sharing the challenge” in March 1992 at the Island Shangri-La Hotel. The panelists shared with participants views from management and staff levels. A video titled “Face to face on AIDS” showing a number of conflicting situations on AIDS in the workplace was presented. The seminar ended with a forum for the speakers and over 200 participants from the business community. Following the satisfactory responses to the first seminar, a second seminar on “Developing AIDS education in the workplace” was organised in May 1993, which aimed at introducing AIDS educational materials in the workplace. It was attended by over 100 participants.

The AIDS Unit of Department of Health has so far delivered talks to over 400 companies and organisations in Hong Kong. A train-the-trainer approach was adopted to ensure that provision of AIDS education could be facilitated. Hong Kong AIDS Foundation, one of the first non-governmental organisations on AIDS in the territory, has taken an active role in the promotion of AIDS awareness. A booklet “Harmony in the Workplace - dealing with HIV/AIDS” was produced jointly by the Hong Kong General Chamber of Commerce, Hong Kong AIDS Foundation and the Hong Kong Institute of Personnel Management, and was endorsed by the Employer’s Federation of Hong Kong. The booklet has served as a guide for companies and organisations to implementing an effective and rational AIDS policy within the workplace.
In order to facilitate provision of HIV education in the workplace, specific resource materials had been developed by both the government and the community over the years. These have included leaflets, resource kits, mini-exhibition boards and wall charts. Specially produced by the AIDS Unit, the “AIDS and the workplace” resource kit contains a slide set with a synchronised cassette tape and slide commentary, a video, self-assessment on AIDS questionnaires and transparencies, leaflets and other information sheets. All materials are presented in bilingual versions. So far, more than 40 companies or organisations have borrowed the kit and used in their workplace.

The Hong Kong Community Charter on AIDS

The Hong Kong Community Charter on AIDS is an initiative developed by the AIDS Unit of Department of Health and the Lions Clubs International, District 303 - Hong Kong and Macau. The objectives are to enhance AIDS awareness and to foster non-discriminatory attitude towards people with HIV/AIDS in the workplace.

The preparatory phase

In 1993, the idea of using a community charter in promoting AIDS education and adoption of a non-discriminatory policy in the workplace was explored. Advice was sought from various AIDS educators and community leaders. Professor Jonathan Mann of the Harvard AIDS Institute and Dr. Michael Merson of the Global Programme on AIDS, who visited Hong Kong between late 1993 and early 1994 strongly supported the idea. An organising committee was subsequently formed comprising staff of Department of Health’s AIDS Unit and members of the Lions Clubs International. The approach was endorsed by the Right Honourable Christopher Patten, Governor of Hong Kong in his policy address (Figure 1) in October 1994. The Governor has also become the Patron of the Charter.

The content of the Charter was drawn up and publicity materials including introductory leaflets, posters, stickers, invitation letters and Charter booklets were produced. Seven companies and organisations were invited to join as founder signatories of the Charter.
We also have to face the threat of AIDS and HIV infection. So far, the AIDS problem in Hong Kong has been less serious than in many other urban and Asian communities. We can only keep this danger under control if people are well-informed about the problem and avoid taking risks. We will maintain our campaign of public education and ensure that AIDS patients continue to have access to a full range of government and community-based support services. We intend to establish a Community Charter on AIDS to enable business and community organisations to pledge themselves publicly to fight discrimination and prejudice. The Government, as the largest employer, will take the lead by being the first to sign the Charter.

**Launching the Charter**

The Hong Kong Community Charter on AIDS was officially launched on 8 December 1994. It represented another step towards strengthening workplace programmes on AIDS in Hong Kong. The Hong Kong Government, being the territory's largest employer with 180,000 staff and six other companies and organisations were the founder signatories. They signed the Charter at the launching ceremony in the presence of the International President of Lions Clubs International and the Secretary for Health and Welfare of Hong Kong.

Signatories were given a Charter booklet and requested to fulfil three commitments within one year after signing the Charter. The Commitments are (1) actively and openly supporting the Charter, (2) facilitating the provision of HIV education in the workplace and (3) formulating a non-discriminatory policy on HIV/AIDS in the company or organisation. One important issue in the movement is to discourage the practice of pre-employment and routine HIV testing. A Charter plaque bearing the name of the company or organisation is subsequently presented to acknowledge the commitments so demonstrated.
Charter programme gaining momentum

A second signing ceremony was held on 24 August 1995 which marked the beginning of a series of mini-exhibitions at the MTR station concourse. The exhibitions featured highlights of the charter programme. Twenty-five companies/organisations have signed the charter in this ceremony. The Charter celebrated its first anniversary on 9 December 1995. A special plaque presentation ceremony was held in conjunction with the International Night of the 34th Orient and Southeast Asian Lions (OSEAL) Forum. The function was attended by not only local celebrities but delegates from the neighbouring countries. Nine signatories [Table I] which have successfully fulfilled their commitments were presented with a plaque to acknowledge their efforts. As of end of July 1996, 19 months after launching, 55 companies/organisations involving an estimated total of 270,000 employees have signed the Charter [Table II].

Table I. Signatories which have successfully fulfilled the commitments
(End of August 1996)

1. The Hong Kong General Chamber of Commerce
2. Hong Kong Catholic Board of Education
3. Hong Kong Commercial Broadcasting Co. Ltd.
4. Mass Transit Railway Corporation
5. St. Stephen's Society
6. AIDS Concern
7. Hong Kong AIDS Foundation
8. Legislative Council Secretariat
9. Hong Kong Medical Association
10. Dr. Lo Chi Kwong Clinic
11. Lantau Expressway Joint Venture
12. Hong Kong Arts Development Council
13. St. John's Cathedral
14. Action for Reach Out
15. Regional Council
16. The Society for AIDS Care
Table II. The Hong Kong Community Charter on AIDS

List of Signatories (End of August 1996)

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**Accomplishments of Charter Signatories**

Efforts have been made by signatories to provide HIV education and promote awareness in the workplace. These activities took various forms like seminars, exhibitions, distribution of pamphlets, booklets and circulars. The Hong Kong Government, for example, issued a Civil Service Branch Circular “AIDS - Education and Policy in the Civil Service” in bilingual versions to all civil servants in January 1996. The Circular serves to promulgate the civil service policy on AIDS and to recommend courses of action to be taken by departments/branches in respect of education and promotion of HIV/AIDS awareness among staff and the management.

The Hong Kong General Chamber of Commerce has issued a circular to their 4,000 member companies, urging them to sign the Charter. In the March 1995 issue of The Bulletin, the Chamber's in-house magazine, the educational message of AIDS and the workplace was publicised. All staff of the Mass Transit Railway Corporation have been given a two-hour training programme on AIDS and the Corporate policy. In drawing up the workplace policy, the signatories have generally adopted the non-discriminatory approach recommended by WHO and International Labour Office covered in the previous section.

The Charter has succeeded in mobilising resources to fight against AIDS in the community level. It has also facilitated the development of a more concerning environment for people living with AIDS.

**Discussion**

The only effective weapon currently available to fight AIDS is education to bring about behaviour modification. Workplace education is an effective way of communicating with employees [4] which therefore is an important complement to public health HIV/AIDS education efforts. Providing employees with updated, factual information on a continual basis serves to keep them informed and to allay unwarranted fears about acquiring infection in the workplace. Studies reported an association between strong workplace HIV/AIDS education efforts and positive attitudes about HIV/AIDS in the workplace [5,6]. Comprehensive workplace AIDS educational programmes can reinforce employees' knowledge about HIV transmission, thereby
fostering more favourable attitudes towards infected co-workers [7].

Education programmes should be available to all employees. Fundamental education should include HIV transmission, risk reduction and company policy. In addition, managers and supervisors need more in-depth information on company policy, local laws and ways to control rumours and panic when information of an employee’s HIV status is discovered within the workplace.

Development of an AIDS workplace policy should go hand in hand with provision of AIDS education to employees, and that the policy should preferably be implemented before HIV-related problems arise in the workplace. Some of the ways of developing a company policy are: developing a policy specific to AIDS; developing a policy for all catastrophic illnesses; and carefully researching existing policies regarding disabled employees to ascertain that the policy covers all situations that involve employees with HIV/AIDS.

Undoubtedly, careful planning and development of an AIDS policy and education programmes for all employees are key to minimise the disruptive effect on the workplace, and introduction of the Hong Kong Community Charter on AIDS is a good start. Signing the Charter is the first step towards building a supportive workplace environment in anticipation of the growing AIDS epidemic. It nevertheless needs sustained efforts from both the Government as well as the business community. The Chairman of a chain of US department stores had once said “When it comes to AIDS, a good business person may save more lives than a good doctor.” It is crucial to mobilise the business sector to take up the challenge to combat HIV/AIDS now, instead of facing the disruption caused by the disease later.

References


12. AIDS IN CHINA - WHAT IT MEANS TO HONG KONG

K L Zhang
Abstract

Since the identification of the first AIDS case in China in 1985, HIV infection have been reported in 22 provinces, autonomous regions and municipalities under direct control of the central government. As of mid-1996, 3341 persons have been reported with the infection, of whom 117 progressed to AIDS. It should be noted that the number of reported infection has been escalating in recent years. Experts estimated that the actual number of infected individuals approximates 50,000 to 100,000, and the epidemic is rapidly spreading.

Of the multitude of risk factors for HIV infection, the following are speculated to pose significant threat to China: (1) injecting drug use, (2) sexual transmission, (3) iatrogenic transmission. However, the relative contribution of individual factor would need to be studied in better details.

Hong Kong and China have the same historical and ethnic background. We share the same cultural and traditional heritage. The open policy adopted by China in the last decade has greatly enhanced the interchange of the two places in trade, cultural activities as well as tourism. Meanwhile, it has led to new phenomena in the HIV epidemic and hence new problems in its prevention and control.

It is conceivable that there stands in the future a rich prospect of collaboration between Hong Kong and China in AIDS prevention and control. Efforts should be made in those aspects such as experiences exchange between governments and NGOs, and collaborative research covering policy and strategy formulation, social behavioural consideration and analysis of trends of HIV epidemic.
Introduction

Since the beginning of the AIDS epidemic, Hong Kong and China have been working closely together on its control. In 1990, China formulated its first Medium Term Plan on AIDS prevention and control. Upon the invitation of the World Health Organisation, an expert from Hong Kong participated in the drafting of the plan in consultation with officials of the Ministry of Health, Health Bureau at provincial levels, as well as local experts in the country. Good progress has been made in this and subsequent collaborative work. In the last years, delegates from Hong Kong and China participated reciprocally in conferences and seminars held in the two places. Since 1990, government and non-governmental representatives from Hong Kong took part in activities in China covering the areas of social behavioural research, surveillance and counselling. Study tours to Hong Kong have been organised by the government and non-governmental organisations of China. There have therefore been extensive exchanges of views and networking of counterparts in Hong Kong and China which benefits China a great deal in her pursuit of AIDS prevention and control.

Hong Kong and China have the same historical and ethnic background. They share the same cultural and traditional heritage. The open policy adopted by China in the last decade has greatly enhanced the interchange of the two places in trade, cultural activities as well as tourism. It has also led to new phenomena in the HIV epidemic and hence new problems in its prevention and control.

In recent years, although the prevalence is still on the low side, the incidence of HIV infection has increased significantly, with a majority occurring in young or middle-aged adults. Of the reported cases, needle-sharing in injecting drug users remains the predominant route of HIV transmission. Other risk factors are however emerging. The proportion of sexually acquired infection has increased steadily in the last several years. Infection through contaminated blood or blood products is a cause for concern in view of its severity and potential implications. It is becoming evident that the thrust of new infection is now within the local Chinese community instead of the expatriates. As the prevalence of risk factors for HIV spread grows, the task of its prevention and control becomes ever more difficult.
The Distribution of HIV Infection in China

Since the identification of the first AIDS case in China in 1985, HIV infection has been reported in 22 provinces, autonomous regions and municipalities under direct control of the central government. As of mid-1996, 3341 persons have been reported with the infection, of whom 117 progressed to AIDS. It should be noted that the number of reported infection has been escalating in recent years. Experts estimated that the actual number of infected individuals approximates 50,000 to 100,000 and the epidemic is rapidly spreading.

From the geographical point of view, there are two main foci of HIV epidemic in China: the first one is localised in the south-western of the country, which contributes to 70% of total publicised infection, the second is the sporadic infection occurring in the vast areas in other parts of China which accounts for 20% of total infection. A third focal point of HIV transmission through blood or blood products is however beginning to take shape. It comprises people selling blood and those receiving transfusion. The extent of the latter problem is still under investigation. The first two patterns of HIV spread are characterised by their unique feature of being imported from outside the country.

The epidemic in the south-western part of the country is localised in the Dehong district of Yunnan province, with a majority of the infection occurring in injecting drug users. Yunnan borders the “Golden Triangle”, which is the world’s major producer of heroin. It is therefore relatively easy for drugs to be available, thus leading to higher number of drug users in the province. The prevalence of HIV infection is inversely proportional to the distance from the “Golden Triangle”.

The second focus of the epidemic spans over broad areas covering other parts of the country. Sexual, particularly heterosexual contact is the predominant route of transmission. Apart from expatriates, those returning from overseas account for a significant proportion of those infected, the latter include people who have travelled, visited relatives or worked in Thailand, other countries in Southeast Asia and Africa. The remainder comprises people who have used prostitutes in China, few cases of infection linked with infusion of blood products, and some with unknown risk factors.
Major Routes of Transmission of HIV in China

Of the multitude of risk factors for HIV infection, the following are speculated to pose significant threat to China: (1) injecting drug use, (2) sexual transmission, and (3) iatrogenic transmission. However, the relative contribution of individual factor would need to be studied in better details.

Injecting drug use

HIV infection resulting from injecting drug use occurs predominantly in the Dehong region of Yunnan province, which account for 70% of the total reported infection. Because of the high number of infected persons centralised in Yunnan, the province has been a focal point of China's anti-epidemic programme. The number of injecting drug users passing on the infection through sex is also increasing. Within the high prevalence areas in Yunnan, the HIV positive rate of spouses of injecting drug users was 3.13% in 1990, rising three-fold to 9.3% in 1992. However, the chance of the infection spreading to other parts of China is small, in view of the geographical, ethnic and behavioural factors involved. Hong Kong is one of the important centres of international drug trafficking. The issue of HIV transmission in the context of drug use should receive sufficient attention in the territory. A number of research projects can be developed between China and Hong Kong in this regard.

Sexual Transmission

Though only 10% of the overall reported infection had occurred through sexual intercourse, its relative importance has increased significantly since 1991. In 1992, sexual intercourse accounted for 20% of the new infections, spreading over 18 provinces/cities. Except for Yunnan, HIV infection has occurred almost exclusively though heterosexual contacts. It is clear, therefore, that risk factors for sexual transmission of HIV are prevalent in China.

Commercial sex - Statistical data revealed that some 240,000 prostitutes and clients were admitted to institutions in 1992. The figure has shown a yearly increase of 50% in the three year period from 1990 - 1992. About 3-4% have had sexual
contacts with foreigners in the country. The rising number of promiscuous people is becoming one key factor likely to predispose to the spread of HIV.

Changing sexual attitude - Sexual attitude and behaviour are influenced by socio-cultural and environmental factors, the former being determined by changes in the latter. In a study conducted by the Centre for Sexology Research in China, 70% of the university students considered pre-marital sex as normal. Of the people in cities and rural areas, 34% of the men and 16% of the women approved pre-marital sex. In a separate study on senior college students in 50 universities and colleges in Shanghai, the respective figures for male and female students who had sexual experiences were 18% and 17%. According to the data from Ministry of Civil Affairs, of 8000 couples registering for marriage, 21% had history of cohabitation before marriage. Another study revealed that 6% of those interviewed in cities and rural areas admitted having had pre-marital sex. In marriages without love or when problems occur in the relationship of married couples, the proportion approving extramarital sex was high - 53% in cities, 42.9% in rural areas.

In a study conducted by China AIDS Network in 1992, 5% of the taxi drivers in a city interviewed admitted having multiple sexual partners and 13% considered it desirable. On the other hand, 4.5% of the labourers who worked overseas indicated that they might use prostitutes during their stay abroad. These data show that Chinese people are becoming more open on sexual relationship outside marriage. This, together with the knowledge that sexual transmission of HIV is gradually taking root locally, should be considered in designing the appropriate strategy for HIV prevention in China. To a certain extent, the interflow of people between Hong Kong and some nearby regions in mainland also affects the situation of sexual transmission of HIV.

The impact of sexually transmitted diseases (STD) - Since the 1980s, STDs have been spreading in China to the extent that satisfactory control is still not yet possible. Epidemiological data revealed that between 100,000 to 200,000 new cases of STD (eight types) were reported annually. Between 1977 and 1993, a cumulative total of over 1 million cases were reported. The actual number is likely to be much higher, especially in places along the coast and also where injecting drug use prevails. It is clear that the incidence of STD is a good index of the growing HIV epidemic.
HIV spread in neighbouring countries - To date a majority of the HIV infection in China were imported, or through contacts with foreigners. Secondary infection is occurring but the number is still small. Many of the infected persons can be traced to their link with Thailand, other countries in Southeast Asia and Africa. In particular, infection in those returning from Thailand is a cause for concern. Data gathered from several south-eastern provinces and municipalities revealed that till 1993, all of the five cases of HIV infection identified in Hainan Province were due to sexual contact in Thailand. In Guangdong Province, 18 out of 22 reported cases of HIV infection occurred through commercial sex in Thailand. About 30% of infected people in Fujian Province acquired the virus due to sexual intercourse with Thais. In Shanghai, 28% of the reported infection occurred on those returning from Thailand. There are also reports of women who became infected with HIV after being abducted from the frontier regions of Yunnan Province to Thailand for prostitution.

Iatrogenic Transmission

HIV transmission through iatrogenic sources have been widely reported in overseas countries. In China, this has been an unusual cause of HIV infection except for a few cases linked to the use of imported blood products in the treatment of haemophilia. Recently, however, high HIV prevalence has been found in ‘professional’ blood donors in a few provinces. The authority is deeply concerned about the situation, an implication that a potentially high risk of HIV transmission through blood exposure may be emerging.

China has a very high prevalence rate for hepatitis B (HBV) infection. As HIV and HBV share the same routes of transmission, there is every reason that HIV may, in the same way, be spread in the health care settings. In China, 10% of the population or 100 million are asymptomatic HBV carriers, accounting for half of the global total. Twenty million have hepatitis B diseases. If HIV disseminates in the same way as HBV, its dimension can be likened to the grave situation we now have for hepatitis B infection.
The use of unsterilised needles and syringes is the most important cause of iatrogenic transmission of bloodborne infections. Currently, the practice of “one person one syringe and disinfection after each use” can only be strictly enforced in large hospitals in the cities. It is estimated that disposable syringes are used in less than 10% of the circumstances. In China, the number of injections received by children under the age of four is 4 per year. Moreover, the risk of HIV transmission through transfusion should not be overlooked. Of all who give (whole) blood, 45.5% are donors whereas 54.6% sell their blood. Most of these commercial donors are from rural areas where blood donation systems need to be improved. It is speculated that a majority of the infection in these donors are acquired when selling their blood through poorly disinfected syringes. An explosive rise in the incidence HIV infection in rural areas may possibly occur. Hong Kong has successful experiences to share with China in this respect.

The Future

From my personal point of view, there stands in the future a rich prospect of collaboration between Hong Kong and China in AIDS prevention and control. Efforts can be made in the following aspects:

**Collaborative research**

1. Policy and strategies: e.g. towards HIV-infected people, towards drugs abuse.
2. Socio-behavioural aspects: working out relevant and feasible solutions, which may be facilitated by pre-investigation of sensitive issues organised by or participated by NGOs.
Experience sharing

1. Seminars and workshops on special subjects: successful experiences were acquired during HIV Counselling Seminars organised by China AIDS Network in April 1996 with the active participation of experts from Hong Kong.

2. Experience-sharing between governments, NGOs.

3. Information exchange.

4. Long- or short-term exchange programmes for AIDS-related research scholars.
NOTES ON
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The descriptions are valid as of the time of authoring the manuscripts in 1996/1997.

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(b) 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.

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