

Assessing HIV/AIDS Initiatives in China

Persistent Challenges and Promising Ways Forward

A Report of the CSIS Task Force on HIV/AIDS

Author
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Center for Strategic and International Studies
1800 K Street, N.W.
Washington, D.C. 20006
Tel: (202) 887-0200
Fax: (202) 775-3119
Web: www.csis.org

Contents

Acknowledgments	IV
Executive Summary	v
Background to the Report	XI
The HIV/AIDS Situation in China	1
Changing HIV/AIDS Response: From Indifference to Action	3
Persistent Challenges and Gaps	6
Poor Coordination within and across Relevant Agencies and Actors	6
Lack of Financial and Human Resources	7
Blood Supply: Better, but Still Question Marks	8
HIV Education, Awareness, Prevention, and Testing Still Lag Behind	9
Role of Nongovernmental Organizations and Civil Society	10
Drug Resistance	11
Addressing the Needs of Marginalized Groups	11
Major Chinese and International Initiatives	17
Chinese Government Programs	18
International Initiatives	18
Productive Practices, Innovative Strategies	21
Methadone Replacement Therapy	21
Expanding Voluntary Counseling and Testing (VCT) and Peer Education	23
Condom Promotion	25
Comprehensive Drug-dependence and Rehabilitation Services	26
Access to Antiretroviral Therapy	28
Recommendations: Comprehensively Meeting the Needs of At-risk Populations	29
Annex: Key International Actors Funding or Implementing HIV/AIDS Programs in China	35
About the Author	37

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The views expressed in this report are the author's and do not necessarily reflect the views and policies of the underwriters or interlocutors in China.

Executive Summary

The HIV/AIDS Situation in China

Since China's first reported indigenous case of human immunodeficiency virus (HIV) was identified in Ruili City, Yunnan province, in 1989, HIV has spread numerically and geographically throughout the country. Today, HIV-positive persons are present in all 31 provinces and municipalities of China. As of the end of 2005, the Ministry of Health estimated that approximately 650,000 persons could be infected in China.

Although the new estimate of 650,000 cases is lower than that previously believed, the rate of infection is rising, with an estimated 70,000 new cases per year as of 2005. In addition, the government acknowledges that it has confirmed only 144,089 cases of HIV infection in China, a more than 60 percent increase from the 89,067 confirmed cases reported the year before. The new estimated figure of approximately 650,000 HIV-positive persons, while lower than previously reported, still means that some half a million or more persons in China, or about 80 percent of those HIV positive, do not know their status and the government does not know who they are. This has obvious implications for the continued spread of HIV in the country.

The data are more worrisome among certain at-risk groups. Official data as of the end of 2005 show that prevalence among injection drug users (IDUs) has tripled from 1.95 percent in 1998 to 6.48 percent in 2004, and from 0.02 percent in 1996 to almost 1.00 percent in 2004 among commercial sex workers (CSWs), a remarkable jump of nearly 50-fold. Among pregnant women in high-risk areas, HIV prevalence has also grown substantially, from nil in 1997 to 0.26 percent in 2004.

In addition, several emerging factors—the increase in China's sex trade, increasing premarital and extramarital sex, greater social tolerance for homosexuality and men having sex with men (MSM), and risky behavior in the “floating population” of migrant workers—could serve as a bridge to spread the epidemic into the general population.

Persistent Challenges and Gaps

Despite major increases in new resources, the establishment of new programs, and an unambiguous shift in the central government's stance toward dealing with the disease, significant gaps in capabilities and policies exist and formidable challenges lie ahead.

Poor Coordination within and across Relevant Agencies and Actors

Combating HIV/AIDS is still largely seen as a “health problem” to be tackled by the bureaucratically weak and poorly funded Ministry of Health, rather than a broader socioeconomic challenge requiring a more comprehensive and coordinated response from across the governmental and nongovernmental spectrum. China's government system is highly “stovepiped,” with each government unit operating within its own vertical command chain, frustrating coordination between departments and across bureaus.

Lack of Financial and Human Resources

A debilitated and dysfunctional public health system, particularly in rural areas where HIV is hitting hardest, undermines an effective response to HIV/AIDS. The vast majority of HIV-positive persons and those at highest risk of contracting HIV live in some of the poorest and most remote regions of the country—such as in Yunnan, Guangxi, Sichuan, Henan, Anhui, and Xinjiang provinces—further complicating an effective response. Overall, resources and capacity are lacking at many levels. Medical professionals lack the expertise and necessary incentives to treat HIV/AIDS patients, as well as the necessary equipment and technologies to properly diagnose, counsel, treat, monitor, and care for them. Ancillary treatment, counseling, and social services are not sufficiently available to those in need.

Blood Supply: Better, but Still Question Marks

Since the mid-1990s, the government has stepped up its efforts to regulate the commercial blood supply, a move that has reduced the threat of spreading HIV through unsanitary blood collection methods. In addition, in certain parts of the country, the government has suspended mandatory blood collection quotas. Relying on voluntary donations will improve the chances of avoiding tainted blood supplies. Yet these government efforts may have driven the practice of commercial blood donation underground with potentially greater risks to donors and recipients. In March 2004, a CCTV report exposed the mismanagement of a plasma collection station in Deqing county, Guangdong, where techniques used were similar to those that caused the spread of HIV in the early to mid-1990s in central China. Reports indicated that by 2003, 15 percent of the blood used in China was collected from sellers and that some 50 illegal blood stations had to be closed down in late 2004.

HIV Education, Awareness, Prevention, and Testing Still Lag Behind

Greater emphasis is needed on HIV education, awareness, prevention, and testing. Stigma associated with HIV/AIDS as well as with behaviors that spread HIV remains a major barrier to successful implementation of many programs—including lingering stigma even among health care workers.

Encouraging advances have been made in treating HIV/AIDS among rural farmers who contracted HIV through plasma donation and in preventing the further spread of HIV through illicit blood donation. However, the government remains poorly equipped to deal with those who are most at risk of contracting and spreading HIV/AIDS, particularly highly stigmatized and marginalized populations. HIV-testing capacity is severely stretched.

Role of Nongovernmental Organizations and Civil Society

Nongovernmental organizations (NGOs), both domestic and international, continue to walk a fine line in China and need to be constantly cautious and restrained in their activities to avoid political, legal, and financial complications with local and central authorities. Although there clearly are bright spots and encouraging preliminary results from many pilot projects, few have “scaled up” or expanded to provide services to a wider population.

Drug Resistance

Chinese officials and medical experts need to study more seriously the social and political ramifications of widespread drug resistance and treatment failure under the current national treatment program.

Addressing the Needs of Marginalized Groups

Much of China's HIV/AIDS challenge will arise from within hard-to-access, at-risk groups that are socially and economically marginalized. There is a great need to reorganize the national response in a way that more effectively addresses the needs of these groups—such as drug users, sex workers, economic migrants, and ethnic minorities—to stem and prevent the spread of HIV. Ethnic minorities, especially those in southern and western China, are disproportionately affected by HIV/AIDS, presenting special linguistic and cultural challenges to public health authorities.

Productive Practices, Innovative Strategies

A more comprehensive, coordinated, and concerted national and international response to China's HIV/AIDS challenge is still at a relatively early stage. As this response expands and evolves, many “best practices” and innovative strategies have emerged. Five key programs have demonstrated some preliminary success and, if expanded in a coordinated and effective way, will have a significant impact on the prevention of HIV/AIDS in China.

Methadone Replacement Therapy

The introduction in 2004 of 8 pilot methadone clinics in Beijing and southwest China provided a moderate number of opiate addicts with the opportunity to break their addiction and potentially access HIV-prevention information, testing, and possibly antiretroviral therapy. The Ministry of Public Security and its associate bureaus at provincial and local levels have frequently stated that they are not inherently supportive of substituting one drug with another but have increasingly seen the clinics as an effective way to reduce heroin use and local crime associated with addiction. The support of the public security apparatus has been a critical factor in the success of the pilot program. It is not clear if the same kind of support can be expected in other parts of China, such as in Xinjiang.

The Chinese Ministry of Health has ambitious plans to expand the number of clinics from 128 at the end of 2005 to 800 by the end of 2007. The methadone program expects to build the capacity to treat 300,000 addicts, representing almost half of the current number of registered drug addicts. The introduction and expansion of methadone clinics will make a substantial contribution to China's effort to prevent and control the spread of HIV/AIDS among the intravenous drug-using community.

Expanding Voluntary Counseling and Testing (VCT) and Peer Education

HIV testing has significantly increased recently in China. As testing expands and more people know their status, there is growing need for peer support and peer education, both to support those who are HIV positive and negative and to reach out, identify, and

educate at-risk people in the community, particularly those who are reluctant to directly engage with authorities.

Overall, the willingness of some government agencies to incubate peer groups appears driven by a need to reach into marginalized high-risk populations. For the successful expansion of VCT and peer education in combating HIV/AIDS, the role of local NGOs and peer groups, especially those associated with or made up of at-risk and stigmatized populations, will need to be clarified and better integrated into the broader anti-HIV effort.

Condom Promotion

In spite of a number of challenges, condom distribution and promotion is expanding with condoms increasingly available in hotels, “entertainment establishments,” and vending machines. NGOs are playing a significant role in marketing condoms in tandem with prevention information, particularly among the most at-risk individuals who are wary of interacting with government authorities and representatives.

The availability and widespread use of condoms is unquestionably an important component of a comprehensive HIV/AIDS-prevention campaign. Affordability and quality, widespread availability, and awareness of the importance of condom use are critical to assure the successful control of HIV/AIDS. Condom availability and use is vitally important in areas where HIV is concentrated and where high-risk behaviors take place, such as in “entertainment establishments.” It is critical that condom use increase among commercial sex workers and their clients, particularly in areas where intravenous drug use is common and where significant numbers of drug users earn money through commercial sex. Condom use at the nexus of these high-risk behaviors can prevent HIV from bridging into the general population. Additionally, international organizations are introducing new approaches to “social marketing” of condoms, finding particular success in jurisdictions where the local government is active in HIV/AIDS prevention, fostering a positive environment for such work.

Comprehensive Drug-dependence and Rehabilitation Services

Organizations are addressing voluntary drug addiction rehabilitation in programs in a variety of settings, some incorporating intense therapy, counseling, self-help groups, and programs to help former addicts gain skills to reintegrate into society. Voluntary detoxification services operate mostly in urban areas where drug addicts can afford to check themselves in and pay daily fees. Stays are short, lasting only a week or two. Methadone and buprenorphine are available in some centers, along with Chinese medicines that help ease withdrawal symptoms, and counseling takes place between in-house physicians and patients. These voluntary centers focus on drug detoxification, rather than on long-term rehabilitation. There are very few residential drug rehabilitation centers in China, but there are existing, albeit expensive, models that demonstrate promise.

Unfortunately, the government has not revealed plans to expand comprehensive drug rehabilitation services, despite its potential to break the cycle of drug addiction. While resources for fighting drug abuse and HIV/AIDS are increasingly available, the government has not made comprehensive, residential substance abuse rehabilitation a

priority policy for preventing the spread of HIV. This gap in potentially valuable services could be filled by international charities with expertise in delivering similar services.

Access to Antiretroviral Therapy

Access to effective, affordable antiretroviral therapy has been shown to help HIV-prevention efforts by encouraging otherwise reluctant HIV-positive and at-risk individuals to identify themselves and engage in HIV-education, awareness, and prevention activities. China's national treatment program remains at an early stage and faces a number of challenges, but if properly expanded, it could serve as a critical component of the national HIV/AIDS-prevention and control strategy.

The national HIV-treatment program is welcome and has made encouraging progress, but much more needs to be done. Now that the program is moving from an "emergency response" to a more standard treatment program, it will need to be more fully integrated into the spectrum of patient management and linked closely with other components of a successful strategy, including prevention education and awareness, harm reduction, testing, and other social services. This will require an even greater commitment of political will and financial resources to solidify and build on the gains achieved thus far.

Recommendations: Comprehensively Meeting the Needs of At-risk Populations

Given the HIV/AIDS situation in China, the persistent challenges that confront the fight against the disease, and the emergent best practices in the country, the following broad recommendations point to a promising way forward.

- **GIVE PRIMARY FOCUS TO KEY MARGINALIZED AND AT-RISK POPULATIONS.**

Thus far, much of China's government response to HIV/AIDS has focused on the plight of the rural villages and farmers that were so hard-hit by HIV as a result of the illicit blood donation schemes of the mid-1990s. Nevertheless, owing to stigma, official obfuscation, and a lack of resources, it took many years for an effective response to take shape to address those persons and families in central China who became afflicted with HIV.

Looking ahead, the Chinese authorities and the international community will need to increasingly focus their attention on HIV-infected and at-risk populations that are even more difficult to access, inform, treat, and care for. By China's official estimates, well more than half of the country's HIV-positive population comprises IDUs, CSWs, and MSM, with the percentage perhaps as high as 60 to 75 percent. In addition, a large proportion of these groups—especially within IDUs and CSWs—comprises ethnic minorities. For a variety of reasons—political, cultural, legal, linguistic, and for practical reasons of accessibility—Chinese authorities and international organizations have been slow to focus HIV-prevention, control, and treatment efforts on these groups.

- **WORK TOWARD A MORE COMPREHENSIVE, "FULL-SPECTRUM," PATIENT-MANAGEMENT APPROACH.**

In bringing greater focus to these marginalized and at-risk groups, these efforts will require a more comprehensive and "full-spectrum" approach that strategically and

deliberately links together best practices and innovative interventions across a continuum of patient management. Such an approach reflects the complexity of China's HIV/AIDS challenge, begins to address the gaps that have frustrated a more effective response, and focuses on the patient and on case management. Ideally, once an at-risk individual is identified, a full spectrum of coordinated services would become available as needed, including testing, prevention education, counseling, harm reduction, treatment and care, and social services designed to reintegrate the individual into society as a productive and contributing member.

▪ **INTENSIFY ENGAGEMENT WITH NONGOVERNMENTAL PLAYERS.**

In introducing a more forward looking and comprehensive system of best practices that targets marginalized and at-risk groups, it is clear that there will be a far greater need to engage both domestic and international NGOs.

Marginalized groups by their nature are more difficult for government agencies to access and serve. They are far more likely to respond to appeals and programs that emanate from or are closely associated with their own groups. In addition, the comprehensive, full-spectrum approach requires a broader range of expertise than any single government agency or major international NGO can deliver. As such, the Chinese government and international NGOs need to consider how to effectively and acceptably increase the participation of NGOs in a comprehensive anti-HIV strategy.

▪ **DEEPEN COORDINATION ACROSS GOVERNMENT AGENCIES AND KEY ACTORS.**

This more strategic and comprehensive approach, drawing together and gaining synergies from a greater range of inputs and actors, will absolutely require a far greater degree of coordination across government agencies and among key actors than has been the case. Coordination among NGOs is often lacking as well, which undermines the very purposes and goals that like-minded organizations seek to achieve. Most importantly, for an effective, comprehensive, patient-centered approach to work within marginalized and at-risk populations, a far more strategic and regularized coordination mechanism should be instituted at local levels where programs are being implemented.

Background to the Report

“AIDS prevention work is an issue relating to the quality of the population, economic development, social stability and the rise or decline of the country.” —Chinese Minister of Health Gao Qiang, November 30, 2005¹

Since 2002, the Freeman Chair in China Studies at the Center for Strategic and International Studies (CSIS) has closely observed the HIV/AIDS response in China. We have conducted numerous research visits and organized senior-level delegations to China, while also hosting many visiting Chinese officials, experts, and policymakers in Washington, D.C., including two Chinese ministers of health. Between June 2002 and December 2005, Freeman Chair staff members have made more than 25 separate trips to China, logging some 300,000 air miles in travel to Yunnan, Sichuan, Anhui, Hubei, and Xinjiang provinces, as well as to Beijing and Shanghai, to understand and assess the HIV/AIDS situation in the country. This work has resulted in two major reports and numerous other monographs, research articles, congressional testimonies, policy briefings, and essays in both Chinese and English.²

With the support of generous sponsors and in cooperation with the CSIS HIV/AIDS Task Force, this work has offered a rare and valued opportunity to watch and take part in the remarkable expansion in the Chinese and international response to the country’s HIV/AIDS challenge. This report reflects on those efforts and seeks to answer the question, “What has worked best in addressing the persistent HIV/AIDS challenges in China, and what are some of the most promising ways forward?”

Given the vastness of the country, its rapidly evolving policy environment on HIV/AIDS issues, and the increased international and domestic attention focused on HIV/AIDS in China, an exhaustive and up-to-date survey and assessment of “who is doing what where” on HIV/AIDS in China posed a difficult challenge. To narrow its scope but provide a useful survey and analysis, the report focuses on programs addressing HIV/AIDS where the disease presented the toughest immediate and long-term challenges—primarily in Yunnan, Sichuan, and Xinjiang—and where the success or failure of those interventions would ultimately shape and determine the future course of the HIV/AIDS epidemic in China.

This research focused most heavily on prevention efforts rather than treatment (though recognizing that the presence and integration of both is absolutely necessary for overall success). Particular attention was devoted to international implementers and their partners on the premise that their experience might bring time-tested and innovative strategies, technologies, and productive practices that would hold promise for the broader national response, especially as they are translated into real local capacity on the ground in China. This report highlights the findings and observations from this research.

¹ Gao Qiang, quoted in “China to Unveil 5-year AIDS Control Plan,” *Xinhua* (Beijing), November 30, 2005.

² To access the work of the Freeman Chair in China Studies on China’s HIV/AIDS situation, go to <http://www.csis.org/china/hivaids/>.

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The HIV/AIDS Situation in China

Since China's first reported indigenous case of human immunodeficiency virus (HIV) was identified in Ruili City, Yunnan province, in 1989, HIV has spread numerically and geographically throughout the country. Today, HIV-positive persons are present in all 31 provinces and municipalities of China. As of the end of 2005, the Ministry of Health (MOH) estimated that approximately 650,000 persons could be infected in China, with about three-quarters of these persons living in five Chinese provinces: Yunnan, Henan, Xinjiang, Guangxi, and Guangdong.¹

Although the new estimate of 650,000 cases is lower than previously believed, the rate of infection is rising with an estimated 70,000 new cases per year as of 2005.² In addition, the government acknowledges that it has confirmed only 144,089 cases of HIV infection in China, a more than 60 percent increase from 89,067 confirmed cases reported

¹ See People's Republic of China Ministry of Health, Joint United Nations Program on HIV/AIDS, and World Health Organization, *2005 Update on the HIV/AIDS Epidemic and Response in China* (Beijing: National Center for AIDS/STD Prevention and Control, January 24, 2006), p. i. See also "China Has 135,630 Cases of Reported HIV Infection," Xinhuanet.com, November 28, 2005. The figure of 840,000 HIV-positive persons in China was reported a year earlier in: China State Council Working Committee on AIDS and United Nations Theme Group on HIV/AIDS in China, *A Joint Assessment of HIV/AIDS Prevention, Treatment, and Care in China (2004)* (Beijing: State Council AIDS Working Committee Office and UN Theme Group on HIV/AIDS in China, December 1, 2004).

² See People's Republic of China Ministry of Health, Joint United Nations Program on HIV/AIDS, and World Health Organization, *2005 Update on the HIV/AIDS Epidemic and Response in China* (Beijing: National Center for AIDS/STD Prevention and Control, January 24, 2006), p. 1.

the year before.³ The new estimated figure of approximately 650,000 HIV-positive persons, while lower than previously reported, still means that some half a million or more persons in China, or about 80 percent of those HIV positive, do not know their status and the government does not know who they are. This has obvious implications for the continued spread of HIV in the country.

The data are more worrisome among certain at-risk groups. Official data as of the end of 2005 show that prevalence among injection drug users (IDUs) has tripled from 1.95 percent in 1998 to 6.48 percent in 2004, and from 0.02 percent in 1996 to almost 1.00 percent in 2004 among commercial sex workers (CSWs), a remarkable jump of nearly 50-fold. Among pregnant women in high-risk areas, HIV prevalence has also grown substantially, from nil in 1997 to 0.26 percent in 2004.⁴

In addition, several emerging factors—the increase in China’s sex trade, increasing premarital and extramarital sex, greater social tolerance for homosexuality and men who have sex with men (MSM), and risky behavior in the “floating population” of migrant workers—could serve as a bridge in spreading the epidemic into the general population.⁵ In some provinces, such as Yunnan, Henan, and Xinjiang, HIV-prevalence rates exceed 1 percent among pregnant women and among persons who receive premarital and clinical HIV testing. This meets the criteria of the United Nations Joint Program on HIV/AIDS (UNAIDS) for a “generalized epidemic.”⁶ The figures cited in the previous paragraph for increased prevalence among CSWs and pregnant women are especially important indicators that the disease is probably spreading into the wider, “mainstream” population.

The source of HIV infection is another indicator of how the disease may be moving toward a more generalized epidemic in China. For example, past estimates suggested that over two-thirds of Chinese HIV cases were contracted through injection drug use (IDU) with infected needles. Data in 2005, however, show that of all persons living with HIV in China today, about 44.3 percent were infected through injection drug use, 43.6 percent were infected through sexual contact, 10.7 through tainted blood or blood products, and 1.4 percent through mother-to-child transmission. More recent data for those who were infected in 2005 indicate that while IDU infection accounts 48.6 percent of HIV infection, sexual transmission for the first time accounts for more infections, at 49.8 percent. Mother-to-child transmission also appears to be increasing as part of the overall epidemic.

With much of the illegal and unsanitary blood collection practices shut down in China but with commercial sex and extramarital sex on the rise in that country, the percentage

³ *Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, 2004 Update: China* (Geneva: United Nations Joint Program on HIV/AIDS, 2004).

⁴ See People’s Republic of China Ministry of Health, Joint United Nations Program on HIV/AIDS, and World Health Organization, *2005 Update on the HIV/AIDS Epidemic and Response in China* (Beijing: National Center for AIDS/STD Prevention and Control, January 24, 2006), p. 4.

⁵ Bates Gill, J. Stephen Morrison, and Andrew Thompson, *Defusing China’s Time Bomb: Sustaining the Momentum of China’s HIV/AIDS Response*, CSIS HIV/AIDS Task Force Report (Washington, D.C.: Center for Strategic and International Studies, June 2004).

⁶ See People’s Republic of China Ministry of Health, Joint United Nations Program on HIV/AIDS, and World Health Organization, *2005 Update on the HIV/AIDS Epidemic and Response in China* (Beijing: National Center for AIDS/STD Prevention and Control, January 24, 2006), p. 5.

of persons contracting HIV through unsafe sex will increase in the years ahead. According to the Chinese vice minister of health, Wang Longde, these figures indicate that the “epidemic is spreading from high-risk groups to ordinary people, and that China is in a critical period for AIDS prevention.”⁷

Changing HIV/AIDS Response: From Indifference to Action

From the discovery of the first cases in 1989 through the early 2000s, the Chinese authorities were slow to respond to HIV/AIDS. Poor monitoring, surveillance and reporting, suppression of what was considered “bad news,” and widespread stigma thwarted an earlier and more candid Chinese reaction. As a result, HIV spread steadily among intravenous drug users who shared needles, among poor farmers who donated plasma under medically disastrous and corrupt conditions, and among persons who had unprotected sex. It was not until the summer of 2001 that the Chinese minister of health acknowledged that China’s HIV-positive population was possibly as high as 600,000 persons.

China’s response to HIV/AIDS was significantly expanded in 2003, following increased international attention, the outbreak of severe acute respiratory syndrome (SARS), and the rise to power of new leadership under President Hu Jintao and Premier Wen Jiabao. In 2003, new leaders were placed in charge of the Ministry of Health, and national and provincial budgets for HIV/AIDS were enlarged. A high-level interagency body—the State Council Working Group on HIV/AIDS—headed by Vice Premier Wu Yi, was established in 2003 to better coordinate the national response.

The national budget allocation for combating HIV/AIDS was increased from RMB100 million (approximately \$12.5 million) in 2002 to RMB800 million (approximately \$100 million) in 2005. Local government budgets provide an additional RMB280 million (approximately 34.7 million) per year. At the end of 2005, it was announced in official newspapers that the national HIV/AIDS budget would be nearly doubled, for 2006 and 2007, to RMB1.5 billion (approximately \$185 million).⁸ The central government took a highly visible interest in HIV/AIDS and mobilized the bureaucracy to mount a more effective response. A national treatment program was initiated, and high-profile official appeals such as “four frees and one care” were promoted.⁹

The national treatment program, known as China CARES (China Comprehensive AIDS Response), was initiated in 2003, supported by central government funding and a grant from the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund). By June 2005, 19,456 patients had been cumulatively enrolled in the China CARES program to receive free antiretroviral (ARV) therapy; of this number, approximately 16,000 have

⁷ See “China Has 135,630 Cases of Reported HIV Infection,” Xinhuanet.com, November 28, 2005.

⁸ “Spending on HIV/AIDS Prevention Set to Double,” *China Daily* (Beijing), December 28, 2005.

⁹ “Four frees and one care” refers to free antiretroviral treatment for farmers and indigent AIDS patients, free HIV testing, free prevention of mother-to-child transmission of HIV, free schooling for AIDS orphans, and care for families affected by HIV/AIDS.

continued treatment.¹⁰ At the end of 2005, the number of patients who had been enrolled in China CARES reached 20,453 in 605 counties within 28 provinces.¹¹

Awareness and education programs have been expanded. According to official reporting, by the end of 2005, more than 120 million HIV/AIDS information, education, and communication materials had been published, and 34.9 million persons had received face-to-face information and education. Surveillance sites have been expanded, and plans are afoot to introduce more aggressive interventions to stem the spread of HIV among certain marginalized populations such as IDUs and CSWs, including condom promotion and distribution, needle and syringe exchange programs, and methadone replacement therapy to help get addicts off of heroin.

HIV testing at local levels has been expanding rapidly. Very large batches of hundreds of thousands of tests have been carried out in Henan province, where most HIV cases are former plasma donors, and in Yunnan province, where most HIV cases are IDUs. For instance, Yunnan carried out 418,630 HIV tests in 2004, compared to the cumulative 980,000 tests carried out between 1989 and 2003. Both testing campaigns revealed significant increases in new cases, with Yunnan province doubling its number of cumulative registered cases. Yunnan province has an estimated 80,000 HIV-positive individuals, with slightly more than one-third having been identified. The National Center for HIV/AIDS at the Chinese Center for Disease Control and Prevention (CDC) completed a massive testing program in the summer of 2005, testing two million individuals in central Chinese provinces who had taken part in blood and blood plasma donations in the mid- to late-1990s.

A national HIV test of the prison system took place between November 2004 and March 2005. While national results have not been reported, Shandong province reported in July 2005 that 72,801 tests were conducted throughout the provincial prison system, revealing 221 cases. In August 2005, Beijing municipal authorities did not reveal the results of their survey but announced that routine compulsory HIV tests will be conducted on all prisoners in the future. On June 3, 2005, the Ministry of Health gave notice to all departments to gradually begin institutionalizing routine testing for drug users entering detoxification centers throughout the country.

In January 2006, the State Council announced long-awaited HIV/AIDS regulations that will come into effect on March 1, 2006. The new regulations cover seven chapters—general rules, publicity and education, prevention and control, cure and relief, guarantee measures, legal responsibilities, and supplementary articles—and are important for bringing greater national attention to the plight of those who have contracted HIV, while also codifying antistigma and discrimination rules. The regulations also stipulate the role of different government agencies at national and local levels and spell out the rights and obligations of HIV-positive persons and their families.

¹⁰ National HIV/AIDS Treatment Program director Zhang Fujie presentation in Beijing, August 18, 2005. Of the 19,456 persons enrolled for treatment, about 8 percent eventually dropped out of the program and about 10 percent passed away after treatment began.

¹¹ People's Republic of China Ministry of Health, Joint United Nations Program on HIV/AIDS, and World Health Organization, *2005 Update on the HIV/AIDS Epidemic and Response in China* (Beijing: National Center for AIDS/STD Prevention and Control, January 24, 2006), p. ii.

Greater responsibility for carrying out HIV prevention, treatment, and care will fall to county-level governments. The regulations suggest grassroots organizations and citizen groups should also cooperate with government authorities to help combat the disease. According to the regulations, work units cannot discriminate against people living with HIV/AIDS, and the rights to marriage, employment, medical care, and education are to be protected. Full implementation and enforcement of the regulations will need to be followed, but they mark a step in the right direction.¹²

Importantly, since 2003, China has been more open to the assistance of international nongovernmental organizations, the private sector, and numerous governments—such as the Global Fund, multinational corporations, international foundations, the governments of Australia, the United Kingdom, the United States, the European Union, individual European governments, and others—that have become increasingly active in addressing HIV/AIDS in China. According to Chinese vice minister of health Wang Longde in late 2005, international cooperation programs to combat HIV/AIDS have been carried out in 27 of China's 31 provinces, autonomous regions, and major municipalities, contributing RMB1.867 billion (approximately \$229 million).¹³

International funding for HIV/AIDS is increasingly reaching implementers on the ground in central and southwest China where the epidemic is growing fastest. Importantly, local budgets are increasing in anticipation of even more funds reaching local levels as provincial and county-level governments build capacity to absorb these funds. Notably, funding has begun to flow from the Global Fund. The Global Fund approved \$98 million in funding in 2003 and \$64 million in 2004 for HIV prevention, treatment, and care in China. China is seeking an additional round of funding from the Global Fund that will focus on men who have sex with men (MSM), people living with HIV/AIDS, rural-to-urban migrants, and sex workers in seven provinces. The five-year, \$28-million application aims to prevent the epidemic among these high-risk groups from evolving into a generalized epidemic. This “Round 5” application (submitted in June 2005) foresees a dramatic increase in the amount of funding earmarked for use by nongovernmental organizations (NGOs) and civil society organizations (a requirement of the funding), particularly NGOs led by people living with HIV/AIDS so they can carry out epidemiological and behavioral studies and provide some prevention services. In particular, it is expected that increased support will be channeled to groups working with CSWs and MSM in China.¹⁴

The U.S. Agency for International Development (USAID) has funded HIV/AIDS projects in Yunnan and Guangxi provinces amounting to \$1 million in FY 2002 and \$2 million in FY 2003. Total U.S. government commitments to China for HIV-related work amounts to approximately \$35 million over five years, mostly flowing from the National Institutes of Health and the U.S. Centers for Disease Control and Prevention (CDC). The UK government-funded China-UK HIV/AIDS program in Yunnan and Sichuan is

¹² “艾滋病防治条例” [“Ai zi bing fangzhi tiaoling,” “HIV/AIDS Prevention Regulations”], State Council order no. 457, issued January 18, 2006, accessed at <http://www.chinaids.org.cn/zhq/ShowContent.asp?lm=011&sn=3658>.

¹³ “New Rules to Combat AIDS Spread,” *China Daily* (Beijing), October 28, 2005.

¹⁴ To see the Chinese application to Round 5 of the Global Fund, see <http://www.china-aids.org/gf5/china-aids-gf5-final.pdf>.

expected to terminate funding in 2006, although the UK foreign aid agency, the Department for International Development (DFID), is currently considering options to continue funding programs that support and complement Global Fund–sponsored programs in seven southwestern provinces. In addition, it was announced in May 2005 that Merck & Co., the U.S. pharmaceutical company, will work with the Chinese Ministry of Health to implement a five-year, \$30-million program of comprehensive HIV/AIDS patient management, to include elements of education, awareness, prevention, health care worker training, treatment, care, HIV-drug research, and job training programs for recovering drug users.

This international support, while delivering valuable funding and technical assistance, also provides an increased profile to HIV/AIDS issues at local levels and pushes officials outside the health sector to take increasing notice of public health issues and commit greater local resources.

Persistent Challenges and Gaps

Despite, however, major increases in new resources, the establishment of new programs, and an unambiguous shift in the central government's stance toward dealing with the disease, significant gaps in capabilities and policies exist and formidable challenges lie ahead.

Poor Coordination within and across Relevant Agencies and Actors

Combating HIV/AIDS is still largely seen as a “health problem” to be tackled by the bureaucratically weak and poorly funded Ministry of Health, rather than as a broader socioeconomic challenge requiring a more comprehensive and coordinated response across the governmental and nongovernmental spectrum. China's government system is highly “stovepiped,” with each government unit operating within its own vertical command chain, frustrating coordination between departments and across bureaus.

For example, the Chinese government—not unlike others around the world—grapples with how best to deliver preventive interventions to certain at-risk groups such as IDUs. Differences persist across China between local public health and public security authorities over the appropriate response, ranging from officially supported needle exchanges and methadone replacement therapy to “strike-hard” campaigns of incarceration and cold-turkey detoxification. Such differing approaches across the Chinese bureaucracy undermine the government's ability to deal with the task at hand: stemming the spread of HIV/AIDS.

Because government-implemented programs are relatively independent, there is frequently inadequate oversight. Accountability within government organizations is often difficult to assure, sometimes leading to inefficiencies, waste, and possibly fraud. With the new HIV/AIDS regulations issued in January 2006, greater day-to-day responsibility for implementing prevention, treatment, and care will fall to county-level governments, which may exacerbate existing problems of implementation, oversight, and accountability.

Lack of Financial and Human Resources

A debilitated and dysfunctional public health system, particularly in rural areas where HIV is hitting hardest, undermines an effective response to HIV/AIDS. The vast majority of HIV-positive persons and those at highest risk of contracting HIV live in some of the poorest and most remote regions of the country—such as in Yunnan, Guangxi, Sichuan, Henan, Anhui, and Xinjiang provinces—further complicating an effective response. Overall, resources and capacity are lacking at many levels. Medical professionals lack the expertise and necessary incentives to treat HIV/AIDS patients as well as the necessary equipment and technologies to properly diagnose, counsel, treat, monitor, and care for them. Ancillary treatment, counseling, and social services are not sufficiently available to those in need.

Since the reform and opening period began in 1978, government financing of social systems, health care in particular, has not kept pace with economic development and social changes. The share of public expenditure on health, as a proportion of GDP, has been declining (from 1.30 percent in 1982 to 0.86 percent in 1992 and 0.82 percent in 2002).¹⁵ Today, private, out-of-pocket spending on health care represents almost twice as much as public health care spending as a percentage of GDP.¹⁶

According to a 2005 report released by China's State Council Development Research Center, the country's medical insurance system currently covers less than half of urban residents (approximately 100 million people) and only 10 percent of the rural population. The same report also notes that "China's medical reform has been unsuccessful because it has become unbearably expensive to patients and many dare not go to the hospital when they fall ill."¹⁷ The steady trend toward health care privatization, combined with a general lack of health care insurance, results in disincentives for the provision of preventative and medical services to the poor and indigent.

The disparity in government health care spending between urban and rural areas is stark and increasing. United Nations' data show that in 2002 the average level of per capita health spending in urban areas was more than twice the national average and 3.5 times the average health spending level in rural areas. China's medical resources have been mostly allocated to benefit urban areas and to government departments or state-owned units. Meanwhile, the lack of funding in rural areas means poor and declining health services over time. Additionally, the central government has placed increasing responsibility for financing health care on local authorities. HIV/AIDS, however, is most prevalent in some of the poorest and most remote parts of China, where there is the least financial capacity to address HIV/AIDS prevention and control.

For example, in one hard-hit county that needs to address its escalating HIV problem, not more than 10 to 12 percent of its entire countywide operating budget is generated from local economic activity. To tackle the myriad issues a county must address, let alone

¹⁵ United Nations Development Program, *People's Republic of China United Nations Development Assistance Framework (UNDAF) 2006–2010*, March 2005, p. 5, <http://www.undp.org/cn/downloads/keydocs/undaf2006.pdf>.

¹⁶ United Nations Development Program, *Human Development Report 2005*, http://hdr.undp.org/reports/global/2005/pdf/HDR05_HDI.pdf, accessed January 23, 2006.

¹⁷ "The Medical Reform Controversy," *Beijing Review* 48, no. 38 (September 2005).

HIV/AIDS as its own issue, this county falls far short of much-needed resources and is heavily reliant on national and provincial assistance. Moreover, the central government has eliminated many rural taxes in an attempt to increase farmers' incomes, further eroding the ability of rural counties to legitimately raise revenues.

All these factors contribute to the inability of local governments to fund social programs that are mandated by the central government, making them dependent on outside resources such as (often questionable or exorbitant) user fees, poverty grants from the central or provincial governments, or international donors. This chronic shortage of funds and insecurity about consistent future funding creates an atmosphere that is not conducive to effectively addressing the complex, long-term social and medical challenges presented by HIV/AIDS.

The chronic underfunding of social systems also creates human capacity gaps at many levels. Rural and poor areas in particular suffer from brain drain because of limited opportunities for talented individuals. Because of fiscal decentralization, the central government distributes less wealth to poor areas, exacerbating income disparities, driving the talented and ambitious to migrate to other areas—especially cities and the more prosperous coastal areas—where they can seek greater opportunities. Even when funds are made available in poorer areas to combat HIV/AIDS, such as a major World Bank loan or a grant from the central government, there is no assurance that the resources will be spent efficiently by local government officials, and there is always the possibility that funds for one project will be diverted to fund a different program that lacks resources and is determined to be a higher priority.

As trained officials and technical experts leave poor areas, remaining staff are not always up to the task of implementing complex projects with technically challenging requirements. Attracting and retaining qualified and motivated staff in poor areas with little infrastructure is a universal challenge.

As greater resources have begun to flow into China's anti-HIV effort, both from domestic and international sources, there is also an increased need for program management expertise. Much of the responsibility for overseeing these new monies and the establishment of major new programs, however, has fallen to medical personnel and technicians who have little to no management experience. Looking ahead, increased funding should also be more judiciously targeted and not simply spread thinly across countless "priorities."

Blood Supply: Better, but Still Question Marks

Since the mid-1990s, the government has stepped up its efforts to regulate the commercial blood supply, which has reduced the threat of spreading HIV through unsanitary blood collection methods. In addition, in certain parts of the country, the government has suspended mandatory blood collection quotas. Relying on voluntary donations will improve the chances of avoiding tainted blood supplies.¹⁸ Yet these government efforts may have driven the practice of commercial blood donation underground with potentially greater risks to donors and recipients. In March 2004, a

¹⁸ "Beijing Terminates Blood Donation Quotas," Xinhuanet.com, March 29, 2006.

CCTV (China Central Television) report exposed the mismanagement of a plasma collection station in Deqing county, within Guangdong province, where techniques were used similar to those that caused the spread of HIV in the early- to mid-1990s in central China.¹⁹ Reports indicated that, by 2003, 15 percent of the blood used in China was collected from sellers, and some 50 illegal blood stations had to be closed down in late 2004.²⁰

In 2005, the government claimed that some 95 percent of clinical blood was donated, not bought. This same report, however, notes that “problems are still existing in blood safety and voluntary donation. For instance, acts of paid blood collection are still seen in parts of the country and some local governments set quotas for voluntary donation.”²¹ As long as commercial blood sales remain an important channel for China’s blood supply, the country could see a repeat of an epidemic that spread among blood donors in Henan in the early 1990s.

HIV Education, Awareness, Prevention, and Testing Still Lag Behind

Greater emphasis is needed on HIV education, awareness, and prevention. The stigma—even among health care workers—associated with HIV/AIDS as well as with behaviors that spread HIV remains a major barrier to the successful implementation of many programs.

Encouraging advances have been made in treating HIV/AIDS among rural farmers who contracted HIV through plasma donation and in preventing the further spread of HIV through illicit blood donation. The government, however, remains poorly equipped to deal with those who are most at risk of contracting and spreading HIV/AIDS, particularly highly stigmatized and marginalized populations and including men who have sex with men and persons outside of the formal economy engaged in illegal activities, such as injection drug users and commercial sex workers.

HIV-testing capacity is severely stretched. By the end of 2005 there were 3,756 HIV-screening labs and 63 confirmation labs currently in operation, causing multimonh delays between blood being drawn and results being returned to the units conducting the testing. Extensive waste will occur as contact with suspected cases is lost by the testing unit, resulting in individuals being tested multiple times by different units, particularly in areas where the epidemic is driven by highly mobile drug users and sex workers. Aside from the waste of scarce resources, an additional result will be the overestimation of cases in areas where the epidemic is concentrated, potentially leading to a misallocation of resources to those areas at the expense of areas where prevalence is lower, but where incidence is increasing steadily.

Compulsory premarital health checkups were eliminated on October 1, 2003, with the promulgation of a new marriage law, resulting in rates of premarital health checkups dropping to below 10 percent nationwide (and as low as 1 percent in some areas). In

¹⁹ “Plasma Unit Negligence Sparks AIDS Concerns,” *South China Morning Post* (Hong Kong), March 22, 2004, p. 7.

²⁰ “China Shuts Down Illegal Blood Stations,” *China Daily* (Beijing), October 21, 2004, accessed at http://www.chinadaily.com.cn/english/doc/2004-10/21/content_384165.htm.

²¹ “Donation contributes to 95 percent of clinical blood use in 2005,” Xinhuanet.com, February 24, 2006.

Beijing, only 5.03 percent of new couples had health checkups in 2004, though 13.6 percent of those tested were found to have an infectious disease, including sexually transmitted diseases (STDs).

Several provinces are now in the process of preparing legislation reinstating mandatory premarital health checks. If central government authorities apply pressure to provinces to reinstate premarital health checks, it would generate potentially useful surveillance data in the general population, which is undersampled by the current surveillance system.

Role of Nongovernmental Organizations and Civil Society

Nongovernmental organizations, both domestic and international, continue to walk a fine line in China and need to be constantly cautious and restrained in their activities to avoid political, legal, and financial complications with local and central authorities. While there are clearly bright spots and encouraging preliminary results from many pilot projects, few have scaled up or expanded to provide services to a wider population.

Additionally, many government officials are wary of NGOs, not necessarily because they could undermine the leadership of the Communist Party, but because NGOs and private organizations compete with the government to provide services such as health care and education. Government officials in many jurisdictions do not understand the concept of “nonprofit,” instead determining that any organization that generates revenue potentially takes revenue away from a government organization that provides a similar service, or is inherently profit making. It is also true that for reasons of saving face local governments may have trouble fully accepting outside expertise and technical leadership. As a result, NGOs often have antagonistic relationships with government officials, creating a challenging environment in which to operate.

International NGOs, while actively implementing programs directly and partnering with Chinese organizations, often face challenges operating in China, particularly when they attempt to run programs from a distance. Oftentimes, coordination between international organizations is lacking. In some instances, multiple NGOs support the same local implementer, concentrating resources and capacity in one individual or organization. From a distance, it appears that there are many organizations out there. But in fact, many outside donors support the same implementation site, resulting in a gap between the actual and perceived capacity on the ground. This lack of coordination also reduces the opportunities for a community to build and expand its indigenous NGO sector. Because international NGOs build capacity among local partners, enabling them to seek additional resources, failing to expand the number of partners concentrates the capacity in one organization or individual that is unlikely to have the ability to single-handedly serve the needs of an affected community.

International and domestic NGOs also face resource challenges, particularly as they operate in an environment where polices and services are dominated by the government, and in many instances, civil society is viewed with some distrust by authorities. Many smaller international NGOs lack long-term access to resources, which poses significant challenges for building a significant presence in the field and building capacity to address HIV/AIDS over the long term. Relationships between projects and the government can be

strained, reducing long-term chances for success. Additionally, many smaller projects are unable to effectively address the broader challenges that are faced by the populations they serve.

A newer concept in the fight against HIV/AIDS in China is the introduction of public-private partnerships. These efforts seek to join the talents and resources of private entities, such as a business, with the central and local government authorities. Groups such as the Global Business Coalition on HIV/AIDS have been active in promoting such initiatives. The concept, which is somewhat contrary to Chinese development aid practices in the past, is slowly catching on but will take time to be fully understood and leveraged as Chinese government and private-sector actors work out their respective roles and responsibilities within such a framework.

Drug Resistance

As of June 2005, the head of the national HIV-treatment program claimed that some 20,453 HIV-positive persons were enrolled in the national drug treatment program known as China CARES. A number of difficulties attend this program, however. The China CARES program initially introduced a first-line drug therapy that is poorly tolerated by patients, is difficult to adhere to, induces serious toxic side effects, and in the end is not as effective against the virus as other first-line therapies used elsewhere in the world. The principal reason China CARES chose this particular regimen—either AZT + ddI + nevirapine or AZT + d4T + nevirapine—is because these drugs are produced as generics in China. Beginning in early 2005, China CARES introduced more effective anti-HIV compounds purchased from abroad into the first-line therapy: 3TC and efavirenz. According to the head of the China CARES program in mid-2005, about 20 percent of enrollees received the more effective therapy, and he expects to increase the use of 3TC and efavirenz in the future.

Data presented in late August 2005 in Beijing by Chinese HIV doctors show that on average, between 45 and 80 percent of patients treated begin to harbor a resistant virus and start to fail. In other settings, and especially in the West, when a patient begins to fail, the treatment is adjusted to a second-line therapy against which the virus is not resistant, in order to drive the viral load back down again. As of early 2006, China did not have a second-line therapy under the China CARES program. Once a China CARES patient has a resistant virus, there are no treatment alternatives within its national treatment program.

Chinese officials and medical experts have not seriously studied the social or political ramifications of widespread drug resistance and treatment failure under the China CARES program. It is important to note, however, that with just over 3 percent of suspected HIV-positive persons enrolled in the program, antiretroviral drugs are not available to the majority of those who may need them.

Addressing the Needs of Marginalized Groups

Much of China's HIV/AIDS challenge will arise from within hard-to-access, at-risk groups that are socially and economically marginalized. There is a great need to reorganize the national response in a way that more effectively addresses the needs of

these groups—including drug users, sex workers, economic migrants, and ethnic minorities—to stem and prevent the spread of HIV. Ethnic minorities, especially those in southern and western China, are disproportionately affected by HIV/AIDS, presenting special linguistic and cultural challenges to public health authorities.

IDUs

Some steps have been taken since 2004 that will create a somewhat more flexible and pragmatic approach to harm reduction in an effort to stem the spread of HIV/AIDS emanating from drug users and IDUs. These measures endorse needle and syringe exchange programs and methadone replacement therapy. Chinese public security and public health officials have traveled to the United States and elsewhere to learn more about such programs as well as to consider buprenorphine replacement therapy.

As of June 2005, some 2,000 drug users had been enrolled in nine methadone clinics, each paying RMB10 per day or less for a daily dose of methadone. With an expanded budget and a clear mandate from the State Council, the methadone maintenance program was expected to expand to 34 clinics by the end of June 2005 with a goal of establishing 100 clinics by the end of 2005. Longer-term goals include establishing up to 1,500 clinics over the next three years, servicing a projected 200,000 to 300,000 clients, representing about one-third of the registered heroin abusers.²² As of the end of 2005, China had obtained approvals for 128 methadone replacement clinics and established 91 needle and syringe exchange pilot sites.²³ The ambitious plans to expand these programs will be limited by funding constraints and a lack of trained personnel, especially in resource-poor parts of China.

Perhaps the biggest problem in stemming the IDU-driven HIV epidemic, however, is the disconnect between public health and public security approaches to dealing with IDUs and the HIV/AIDS epidemic. Harm-reduction programs face continued resistance from local communities as well as local public security and law enforcement bureaucracies, which prefer arrest and detention of drug abusers over prevention and harm-reduction programs. The fundamentally contradictory approaches taken by public health and public security departments are unlikely to resolve themselves in the foreseeable future.

For example, in April 2005, politburo member and Minister of Public Security Zhou Yongkang announced a people's war on drugs, formalizing a crackdown on drug trafficking and drug use that have been escalating since mid-2004.²⁴ Because of the historical legacy of drug abuse in China, officials and communities are even intolerant of casual drug use. Stigma and discrimination against drug abusers is high, amplified by most users' arrest records, and compounded even further by fear and prejudice related to HIV/AIDS. The government's zero-tolerance approach to drug abuse contributes to an environment that is particularly challenging for public health officials and

²² Presentation by Wu Zunyou at the Center for Strategic and International Studies, Washington, D.C., June 6, 2005.

²³ People's Republic of China Ministry of Health, Joint United Nations Program on HIV/AIDS, and World Health Organization, *2005 Update on the HIV/AIDS Epidemic and Response in China*, p. ii.

²⁴ Drew Thompson, "The People's War against Drugs and HIV/AIDS," *China Brief* 5, no. 14 (June 21, 2005). See also, "China Wages 'People's War' against Drugs," Xinhuanet.com, April 4, 2005.

nongovernmental organizations attempting to implement HIV/AIDS programs targeting the drug-using community.

The National Narcotics Commission has submitted draft legislation that is expected to be promulgated in 2006. Key provisions in the new drug law reportedly will make drug taking (not just possession) a crime, threatening to drive drug users further underground, which makes them less accessible for public health interventions.²⁵

Beginning in late 2004, public security authorities launched a “strike-hard” crackdown against drug use that has seriously undermined the environment for carrying out harm-reduction activities. Interviews with international NGO implementers reveal that there have been numerous police actions in the vicinity of harm-reduction sites (drop-in centers) as a result of stepped-up activities by the police. Reportedly, as a result of increased funds provided for HIV/AIDS, public security authorities in several provinces have engaged in building new detention facilities and are now arresting drug users in order to populate these newly built facilities. According to a limited-distribution report by an international bilateral development agency, “The operation is being implemented on different schedules in each of the provinces and is seen as ‘harm reduction,’ in that it stops public drug use and therefore prevents users from ‘harming’ themselves. There are now over eighty of these detention centres in operation in Yunnan with inmate numbers estimated at 30,000.” There are plans afoot in Yining, in far western Xinjiang province, to build new detention centers to house up to 10,000 IDUs.

The resources being committed by the public security authorities to the recent antidrug campaign is significant. Goals are high, including, unrealistically, the incarceration of all of the nation’s drug users. Funding has gone not only to the construction of new detention facilities, but large budgets are available to pay informants who turn in drug users and drug dealers. Local-level security officials are committed to the strike-hard campaign against drugs and are under direct instructions from Ministry of Public Security headquarters in Beijing, which gives them very little leeway when dealing with international or domestic NGOs carrying out harm-reduction activities. Public security authorities also remain uninterested in actively cooperating with international partners to work on rehabilitation or methadone treatment within the detention and involuntary detoxification system. The investigators have noted only one or two occasions during their visits in Hubei, Sichuan, Xinjiang, Yunnan, Shanghai, and Beijing over the past three years where there were concrete and effective efforts underway—beyond the usual rhetoric—to forge cooperative links between health authorities and the public security apparatus in order to better combat HIV/AIDS.

International NGO implementers reported to the authors that peer-education and outreach efforts have also suffered, partly because of increased police activities but also reflecting the fundamental challenges faced by implementers dealing with drug users. One drop-in center implementer reported that needle exchange visitors dropped from 2,000 to 200 per month, because IDUs were too afraid to visit the center as they would likely be arrested a few blocks from the clinic. Another international NGO implementer reported that several peer educators who go to neighborhoods with clean needles to

²⁵ “China Drafts Antidrug Law,” Xinhuanet.com, July 14, 2005. See also, “Law to Make Drug Taking Criminal,” *China Daily* (Beijing), June 23, 2005.

exchange with hidden users were arrested, reportedly because they were also carrying drugs that the police suspect they were selling along with the clean needles.

The net result of these stepped-up police activities will likely have a negative impact on HIV/AIDS prevention activities throughout the southwest, regardless of increased international funding and support for these activities.

Commercial Sex Workers

Aggressive suppression campaigns following the Communist victory in 1949 nearly eradicated commercial sex work in mainland China. Commercial sex work reappeared, however, and has grown more and more evident since the reform and opening period began in 1979. The loosening of former taboos, greater social mobility, and economic development have been factors in the rapid expansion of commercial sex in China.

Today, there is a greater social and legal tolerance for commercial sex work, compared to illicit drug use or male-male sex behaviors. In many urban areas in China, commercial sex solicitation is openly conducted with many cities and even smaller county seats sprouting informal red-light districts. Growing numbers of travelers engage in sex tourism, visiting certain areas for the purpose of engaging in commercial sex. Although female commercial sex work is the dominant form, male commercial sex work is increasing, particularly among impoverished urbanites or young men from rural areas who are induced to travel to cities to become “money boys.”

There are widely varying estimates of the actual numbers of women who engage in commercial sex work, with estimates ranging between 3 million and 5 million. Because many women engage in commercial sex on a temporary or sporadic basis, it is extremely difficult for public health and public security authorities to determine either the cumulative or current number of commercial sex workers.

All concerned observers agree, however, that people who engage in commercial sex work are at an increased risk of the sexual transmission of HIV and other sexually transmitted infections (STIs) for both biological and social reasons. In particular, many studies show inconsistent and low condom use among commercial sex workers, heightening the risk for HIV transmission. In many cases, commercial sex workers state that it is difficult to impossible to convince their sexual partners to consistently use condoms and becomes a particular problem when clients are adamant or offer more money, or when the sex worker is afraid to propose condom use to a regular partner. Additionally, some sex workers and their clients lack education on and awareness of the importance of condom use and therefore do not use them.

According to the United Nations and the Chinese government, “approximately 127,000 sex workers and their clients are living with HIV/AIDS, accounting for 19.6 percent of the total number of estimated HIV cases.” Government figures also show that estimated prevalence among sex workers has dramatically increased, from 0.02 percent in 1996 to 0.93 percent in 2004.²⁶ In areas where HIV is more prevalent, particularly in

²⁶ People’s Republic of China Ministry of Health, Joint United Nations Program on HIV/AIDS, and World Health Organization, *2005 Update on the HIV/AIDS Epidemic and Response in China*, p. 4.

southwest China, HIV prevalence among CSWs is higher, reaching 11 percent in sentinel surveillance sites in Guangxi province and 5 percent in Yunnan province in 2002.²⁷

Beginning in the late 1990s, international organizations and governments began to address more seriously HIV/AIDS prevention activities among female commercial sex workers. Efforts have focused on outreach and education and, most importantly, on ensuring access to condoms and the knowledge to use them. Several programs have worked in “entertainment establishments” with sex workers and their managers. Other programs have focused on “condom social marketing” by creating an environment where condom use is encouraged through creating a conducive environment.

Condom “social marketing” has been comprehensively introduced in some parts of China, involving technical and financial support for condom distributors, government policies requiring hotels and entertainment establishments to make condoms available, and opening community-based drop-in centers where local commercial sex workers can purchase condoms before work and receive training and regular medical checkups. These drop-in centers are particularly effective for building community-based, peer-advocacy networks, which is particularly important because of the high mobility and turnover among sex workers. While these interventions are generally considered successful, it is difficult to accurately measure how often condoms are used, because self-reporting of condom use can be highly inaccurate. By some estimates, increases in condom sales are a good indication of growing coverage, though most interventions to date have measured their success through limited surveys and self-reporting, rather than through more objective measures such as local reductions in reported STIs.

Perhaps the greatest challenge to HIV/AIDS programs targeting CSWs occurs in areas where intravenous drug use is prevalent and drug users are forced to support their habits through transactional sex. Of particular concern is the possibility that drug-using clients transmit HIV to sex workers and vice versa, generating a dangerous synergy. It is estimated by researchers that commercial sex workers in China average slightly less than one client per day, meaning there is great pressure on drug-addicted sex workers to secure a client every day in order to support their habit. Drug-addicted sex workers have little bargaining power to refuse clients who will not use a condom. Because of this dependency and the subsequent need for daily income, drug-addicted sex workers are at significant risk of inconsistent condom use.

Men Who Have Sex with Men

Even though the social stigma against MSM is significant, the policy environment for addressing the health needs of MSM has begun to improve in China. Homosexuality is not illegal in China, following the abolition of the 1997 criminal code that included sodomy in the same clause as “hooliganism.” In 2001, the Chinese Psychiatric Association delisted homosexuality from the list of mental disorders. Regardless, until recently, MSM as a group have been largely ignored by public health authorities. Today, Chinese health

²⁷ Joan Kaufman, “HIV/AIDS in China: Can Disaster Be Averted?” (testimony before the Congressional-Executive Commission on China, Washington, D.C., September 9, 2002).

authorities estimate there are approximately 5 million to 10 million men who have sex with men in China and about 1.35 percent of them are HIV positive.²⁸

The political and social environment for addressing the risk of HIV among the MSM community, however, is rapidly evolving and becoming more favorable for implementing interventions. Public health authorities are visibly mobilizing personnel and resources to target MSM, while various media, including TV and print media and the Internet, are increasingly carrying stories and providing information about MSM and the risk that HIV poses to the community and other important information to society.

In early June 2005, the Ministry of Health and the Chinese Center for Disease Control issued a policy document instructing provincial and local centers for disease control to form teams of experts to carry out research, outreach, and interventions among high-risk groups, including MSM. On June 6, 2005, the Chinese vice minister of health in charge of HIV/AIDS, Wang Longde, affirmed that the Ministry of Health had identified MSM as a population at heightened risk of HIV infection, requiring an increased study of the population and the design of appropriate interventions. Vice Minister Wang admitted that there had been misperceptions in the past that homosexuality and MSM behavior did not take place in China, but there was the recent realization that many MSM are also engaged in heterosexual relations and therefore pose the risk of spreading HIV to low-risk partners. By late July, the Ministry of Health had allocated RMB6 million for grants to nongovernmental organizations to carry out studies and provide prevention education to the MSM community.²⁹

A major indication in the evolution of the Chinese government's strategy to address HIV/AIDS among the MSM population is the significant increase in resources that will ultimately be allocated for programs targeting the population. After steadfastly refusing to include MSM as a target group in previous applications, China's June 2005 Round 5 application to the Global Fund will focus on MSM and other high-risk groups (see discussion above). This significant injection of resources will have a significant impact in the level of knowledge about MSM behavior, boost the capacities of organizations working with MSM, and greatly increase the profile of MSM throughout the bureaucracy and civil society networks.

There has been significant growth in the number of governmental and nongovernmental organizations working with MSM groups in the health sector. There are numerous MSM hotlines operated by hospitals, local health authorities, and private groups to provide counseling and prevention information to MSM. Self help groups and Web sites tailored to address issues within the MSM community abound, with an estimated 300 MSM-themed Web sites hosted in China.

Since August 2005, there have been a growing number of MSM-related stories in the Chinese media, including the press and CCTV, indicating a relaxation of previous strictures. One of the first substantive programs that discussed HIV/AIDS and MSM aired on CCTV on August 9, 2005, and included interviews (showing faces) with an

²⁸ "Chinese Gay Population Announced for the First Time," *China Daily* (Beijing), April 5, 2006, accessed at http://www.chinadaily.com.cn/hqylss/2006-04/05/content_560655.htm.

²⁹ Presentation by Vice Minister of Health Wang Longde at the Center for Strategic and International Studies, Washington, D.C., June 6, 2005.

HIV-positive MSM and other MSM.³⁰ Although some producers and editors have been criticized by propaganda authorities for exceeding undefined boundaries, the punishments have been perfunctory and the environment is clearly trending toward a more open and frank discussion of these issues in public.

Additional indications that the gay community is emerging from the shadows are cropping up across China, from university courses in homosexuality at prominent universities, to gay kite festivals in Shenyang and Fuzhou,³¹ to gay and lesbian film festivals in Beijing.³² These activities, however, remain under watch by authorities, especially to monitor whether they are too political.³³ China's first major gay and lesbian film festival, slated to take place in Beijing in December 2005, was shut down by public security authorities before it could open. Police claimed that the organizers did not have permission to hold the event.³⁴

Migrant Population

Paradoxically, even though migrants are highly visible, well studied, and accessible in all cities, because they do not fall under the jurisdiction of local health authorities, they are rarely the target of consequential HIV/AIDS prevention education, testing, or treatment efforts. Despite being visible everywhere, government public health organs can rarely find migrants. Although various government departments have made some passive efforts, such as posters and condoms distributed at railroad stations, no sustained program of any significant size has been implemented to address the migrant population.

With their low wages and willingness to take on hard and dirty work, migrants are fueling China's roaring economic growth, while at the same time being left behind. Stigma toward migrants is very high in urban areas. Epithets to describe migrants are commonly used by urbanites, and migrants are frequently blamed, often unjustly, for urban problems such as crime and litter. Migrants live in the cheapest possible housing (even with low wages, the bulk of their income is sent home), further isolating them from urban society. Without social insurance or legal residence, they often have little access to public medical or education services where they work. For migrants most at risk of HIV, such as intravenous drug users in urban areas without official residence, they are not allowed to access methadone clinics. Prevention within this population is critical, but their mobility, isolation, and social status present enormous challenges for governments that are already struggling to provide services to their permanent residents.

Major Chinese and International Initiatives

Given these positive developments and persistent challenges, what has been the response from Chinese authorities and major international partners?

³⁰ “新闻调查 以生命的名义” [“News Investigation: The Name of Life”], CCTV News, August 9, 2005.

³¹ Carrie Yang, “Rainbow Kites Carry Gay Pride,” *South China Morning Post* (Hong Kong), June 14, 2005.

³² “Homosexual Film Fest to Open in Beijing,” *Shenzhen Daily*, April 20, 2005.

³³ *Restrictions on AIDS Activists in China* (New York: Human Rights Watch, June 2005), accessed at <http://hrw.org/reports/2005/china0605/>.

³⁴ “Police Call Halt to China's First Gay Cultural Festival,” *London Times*, December 17, 2005.

Chinese Government Programs

China's national response to HIV/AIDS is dominated by large, government-led programs. Major programs supported by outside donors also require close cooperation with the Chinese government for their implementation. The Ministry of Health in Beijing, the provincial health bureaus, and their associated public health departments (variously referred to as centers for disease control or antiepidemic stations) play the leading role of implementing the majority of interventions that reach affected and at-risk populations.

Other parts of the Chinese government, such as the State Population and Family Planning Commission, and social organizations, such as the China Youth League and the Women's Federation, also play important roles in education and prevention. Other key agencies, such as the Ministry of Education, the Ministry of Public Security, and media and propaganda bureaucracies, could significantly expand their roles in making a positive contribution to combating HIV/AIDS in China.

The Ministry of Health and the Chinese Center for Disease Control and Prevention have taken the lead on such large programs as the China CARES national treatment plan, large-scale HIV-testing efforts in 2004–2005 of some 2 million persons aiming to narrow the gap between the estimated number of HIV carriers and those who are confirmed and identified by public health authorities, and a national effort to clean up and improve the testing capacity of blood banks and blood donation operations. There have also been massive investments at local levels to improve basic HIV surveillance, testing, and monitoring, particularly in laboratories run by the Ministry of Health system at the central and provincial levels and by the Chinese Academy of Medical Sciences (CAMS), and to begin ramping up HIV-related training for local health care workers.

The Chinese government has also promoted the policy of “four frees and one care.” Introduced in late 2003, this national policy calls for free antiretroviral drugs for rural AIDS patients and for urban AIDS patients facing financial difficulties; free voluntary counseling and testing services in high-prevalence areas; free education for children orphaned by AIDS; free voluntary counseling and testing as well as services to prevent mother-to-child transmission of HIV for pregnant women; and care of AIDS patients and their families facing financial difficulties. Less clear is how well this overarching policy mandate is implemented, especially in parts of the country with limited financial resources and trained personnel.

International Initiatives

Numerous international initiatives of both private and governmental nature also operate major programs in China. These organizations almost invariably work with the blessing of national authorities. They either provide funding directly to the government—as in the case of the Global Fund—or they closely align, coordinate, and work with local government bureaus, particularly the health-related bureaucracy, in partnerships where the local government is the actual implementer. In other cases, these organizations can operate under a mutual agreement, where the government accepts their presence and either actively supports them or simply allows them to carry out activities somewhat independently from local government agencies.

The Global Fund has become a major international partner for the Chinese government in its fight against HIV/AIDS. China twice applied to the Global Fund for a grant to address HIV/AIDS before being awarded their first HIV/AIDS grant as part of the Round 3 funding cycle. Grants for the Round 3 proposal began flowing to the Chinese Center for Disease Control in 2004 to fund the “China CARES” first-line antiretroviral treatment program in 56 central China counties where HIV spreads primarily through illicit blood and blood plasma donation practices: Anhui, Hebei, Shandong, Henan, Hubei, Shanxi, and Shaanxi. The five-year program is to be funded with some \$97.888 million.

In 2005, the Chinese government successfully applied for a five-year, \$63.742-million grant in the Round 4 cycle, which will be used by the Chinese CDC to implement programs targeting IDUs and CSWs in 37 highly affected prefectures in seven provinces and autonomous regions: Yunnan, Xinjiang, Guangxi, Sichuan, Guizhou, Hunan, and Jiangxi.

China has submitted a proposal to the Round 5 process, which will expand prevention programs targeting at-risk populations, including sex workers, migrants, men who have sex with men, and people living with HIV/AIDS in Chongqing City as well as in Liaoning, Heilongjiang, Jilin, Inner Mongolia, Ningxia, and Gansu provinces. With the expected funding for the Round 5 proposal, Global Fund support will flow to 21 of China’s 31 provinces, autonomous regions, and major municipalities.³⁵

Notably, in Rounds 3, 4, and 5, Global Fund proposals submitted by Chinese nongovernmental organizations (NGOs) have been allocated a portion of the budget in order to carry out interventions among marginalized populations. It remains to be seen, however, how effectively these monies are spent and whether Chinese NGOs are given sufficient funding and independence as envisioned in the Global Fund applications.

One of the first major international programs in China to address HIV/AIDS was initiated by the United Kingdom’s Department for International Development. Known as the China-UK HIV/AIDS Prevention and Care Program (simply referred to as “China-UK”), the project was initiated in August 2000 and programmed to run through July 2006 with a total budget of £19.9 million (approximately \$36.5 million). It was subsequently extended for one year by DFID. Focusing on Yunnan and Sichuan provinces, the China-UK program is primarily implemented in the target provinces by the central and local centers for disease control, which provide treatment and care. In addition, the Futures Group has been contracted by China-UK to promote the social marketing of condoms and other prevention work, such as assisting in the establishment of gay HIV/AIDS information hotlines and other education programs in the gay community. Numerous other organizations have provided technical support and specialized services to this program.

The U.S. government actively funds HIV/AIDS programs through the USAID, the U.S. CDC’s Global AIDS Program (GAP), the National Institutes of Health (NIH), and the Department of Labor. USAID’s HIV/AIDS programs concentrate on HIV-prevention

³⁵ As of the end of 2005, Chinese jurisdictions as yet not formally designated for HIV-related support from the Global Fund are Beijing City, Shanghai City, Tianjin City, Zhejiang, Jiangsu, Fujian, Hainan, Qinghai, and Guangdong provinces, and the Xizang (Tibet) autonomous region.

initiatives targeting at-risk persons in the Mekong provinces of Yunnan and Guangxi. The GAP, formally established in October 2003, pledged more than \$15 million over five years and seeks to improve China's HIV-surveillance system, develop prevention activities, including expanding voluntary counseling and testing services (VCT), and support programs that train medical workers to more effectively treat HIV/AIDS. GAP's activities take place in multiple provinces throughout the country. The National Institutes of Health, through the China Integrated Program for Research on AIDS (CIPRA), will provide \$14.8 million over five years to help the Chinese CDC carry out a range of research on HIV treatment, surveillance, data management, and at-risk behaviors. The U.S. Department of Labor provided \$3.5 million for an HIV workplace education and prevention program in cooperation with the International Labor Organization. The United States also provides significant in-kind assistance by seconding four to five NIH and CDC personnel to work within the Chinese Ministry of Health bureaucracy such as within the Chinese CDC.

The Australian government, through its Agency for International Development (AusAID), has initiated a number of HIV-related programs in China. In Xinjiang, AusAID has pledged a contribution of AUS\$14.46 million (approximately \$10.5 million) for 2002–2007 to help build capacity for Xinjiang health authorities to combat HIV/AIDS, including training and advice to the local CDC and other organizations in harm reduction, condom promotion, and needle and syringe exchange programs; nurse training; doctor training; mosque/imam training; condom promotion among CSWs; and an IDU information hotline. In Tibet, for 2004–2009, AusAID contributes AUS\$17 million (approximately \$12.4 million) toward a health care promotion program, which includes a component to improve the capacity of the local government to respond to the increasing threat of HIV/AIDS in Tibet. Health-related support, including addressing HIV/AIDS, will remain one of three major priorities for AusAID programs in China.

There are several significant private-sector HIV/AIDS initiatives operating in China. The Clinton Foundation formalized its cooperation with the Chinese Ministry of Health in an April 2004 memorandum of understanding and works most closely with the Chinese CDC, CAMS, and AusAID as well as with the U.S. CDC's GAP. In China, the Clinton Foundation has deviated from its standard international practice of facilitating negotiations between drug and equipment suppliers and national treatment programs. Instead, the foundation has focused on providing various kinds of technical and in-kind assistance. For example, it assisted the Chinese CDC in producing an antiretroviral therapy manual, provided funds to purchase drugs to treat HIV-positive children, and helped expand ARV treatment and HIV-related doctor training, especially in poorer parts of China.

In May 2005, Merck & Co., Inc., signed a memorandum of understanding with the Chinese Ministry of Health to form a five-year, \$30-million partnership to comprehensively address HIV/AIDS, beginning in the Liangshan prefecture in Sichuan province, where 50 percent of the province's HIV cases reside. This was the largest public-private partnership to date aimed at combating HIV/AIDS in China. This program aims to develop an integrated model for prevention and patient care and to include a range of interventions such as education, counseling, testing, harm reduction, treatment,

care, and other social services. This initiative also includes a health care worker HIV training program, which began in December 2005.

Project HOPE, a U.S.-based philanthropy, carries out a significant number of HIV-related health care worker training programs in Hubei province in central China. The first program, in 2001, involved training doctors for the care of HIV infection in adults, which reached 450 physicians. The second, in October 2003, addressed the care of HIV infection in children (pediatric care) and involved 85 physicians and nurses. The third program, using a “train the trainers” model, began in 2004 and involved the preparation and training first of 8 master trainers, followed by the training of an additional 68 participants. These 68 trainees conducted further follow-up training sessions in their local areas, with oversight and assistance of the master trainers and Project HOPE staff who make regular visits out to the countryside locales to ensure that the training is conducted effectively and to learn of particular local conditions and casework. As of November 2004, this program had trained 4,000 health care providers: 1244 doctors, 839 nurses, 370 technicians, 1,675 other health care workers, and 617 general community members.

In November 2004, the Bill and Melinda Gates Foundation conducted an assessment of the HIV/AIDS situation in China in preparation for a possible HIV-prevention project in the country. The foundation has previously funded various reproductive and rural health projects in China that have HIV/AIDS-related components and also supports work on sexual and reproductive health targeting urban young people.³⁶

There are numerous other international organizations actively confronting HIV/AIDS in China. Organizations such as UNAIDS and the World Health Organization (WHO) play a major leadership and coordination role. Several governments such as Germany, Sweden, and the European Union have bilateral HIV/AIDS programs with Chinese partners. Numerous international charities, foundations, nonprofits, and companies have programs and projects that make an important impact in the communities where they operate by providing technical advice, education, and awareness programs; harm-reduction interventions; health care worker training; media training; and peer group counseling programs; and by providing funds directly to local implementing agencies.

Productive Practices, Innovative Strategies

A more comprehensive, coordinated, and concerted national and international response to China’s HIV/AIDS challenge is still at a relatively early stage. Nevertheless, as this response expands and evolves, many best practices and innovative strategies have emerged. The following pages highlight five key programs that have demonstrated some preliminary success and, if expanded in a coordinated and effective way, will have a significant impact on the prevention of HIV/AIDS in China.

Methadone Replacement Therapy

The introduction in 2004 of eight pilot methadone clinics in Beijing and southwest China provided a moderate number of opiate addicts with the opportunity to break their

³⁶ “Joint Programme Highlights Sex Education,” *China Daily* (Beijing), March 29, 2006, accessed at http://news.xinhuanet.com/english/2006-03/29/content_4357408.htm.

addiction and potentially access HIV-prevention information, testing, and possibly, antiretroviral therapy.

The Ministry of Health initially established these pilot sites in part to demonstrate their effectiveness to the communities in which they operate. In doing so, the Ministry of Public Security came to support the pilot program and subsequently signed agreements with the Ministry of Health to jointly oversee the program and help ensure that officers do not harass IDUs seeking methadone at the clinics. While the Ministry of Public Security and its associate bureaus at provincial and local levels have frequently stated that they are not inherently supportive of substituting one drug for another, they have increasingly seen the clinics as an effective way to reduce heroin use and the local crime associated with addiction. The support of the public security apparatus has been a critical factor in the success of the pilot program. It is not clear if the same kind of support can be expected in other parts of China, such as in Xinjiang.

Nevertheless, the MOH has ambitious plans to expand the number of clinics from 128 at the end of 2005 to 800 by the end of 2007. The methadone program expects to build the capacity to treat 300,000 addicts, representing almost half of the current number of registered drug addicts. Funding for this expansion will come from provincial and central government budgets and from the Global Fund Round 4 grant. Additionally, methadone clinics charge patients up to RMB10.00 per day (approximately \$1.25), which contributes to their sustainability, but clients are charged a fee primarily to ensure that they develop a sense of the value of the program and build their self esteem. Policies have been standardized to ensure that only verified addicts are able to access the methadone clinic services. Clinic clients must be over 18, legal residents, and have been detained in detoxification centers at least twice before.

The introduction and expansion of methadone clinics make a substantial development in China's effort to prevent and control the spread of HIV/AIDS among the intravenous drug using community. By weaning addicts from opiates and bringing them into regular contact with the public health community, methadone therapy opens the door to numerous interventions targeting IDUs. In addition, there is some evidence in certain locales in China that the introduction of methadone maintenance therapy has been a factor in the reduction of thievery and petty crimes. Accessing the IDU community on a regular and systematic basis and reducing the life-disrupting effects of heroin addiction also make ARV treatment more feasible for HIV-positive addicts. Some jurisdictions have already begun integrating medical services provided by the CDC with methadone clinics (also operated by the CDC), introducing innovative policies such as waiving the residence requirement for HIV-positive IDUs, enabling them to access methadone as well as free antiretroviral drugs.

Methadone clinic sites present immense HIV-prevention and treatment opportunities at this point, many of which have yet to be realized. A suite of on-site prevention interventions could be introduced and sustained, including voluntary HIV testing, counseling, prevention education, condom distribution, and even the provision of additional services such as job- and life-skills training. Methadone clinics can act as a hub for coordinating these services as well as a base for organizing self-help and peer-support groups or peer-outreach programs. The clinics have the potential to expand their footprint to service rural communities through mobile clinics or shuttle buses.

Although the methadone pilot clinics show promise, they face significant challenges. Drop-out rates are high, frequently because many methadone patients continue to use opiates (though often at much reduced volumes than pre-methadone enrollment). This results in the subsequent detention of many methadone patients testing positive for opiates and the reincarceration of these patients in detox centers, prisons, or labor camps. Public Security Bureau officers operating detox centers report that inmates coming off methadone suffer from greater withdrawal symptoms than heroin addicts. Increased training for methadone clinic operators (as well as greater experience) can potentially improve their ability to correctly estimate dosage, which can potentially reduce the addict's need to supplement their methadone regimen with opiates. Improving interaction and communication between clinic operators and patients as well as establishing ancillary services such as counseling, peer-led therapy, and job training, will likely improve the overall results. In addition, although the fee charged for methadone treatment may seem nominal, it may be prohibitive to some IDUs, especially those who, because of their condition, arrest record, and other factors, have a more difficult time securing employment.

Expanding Voluntary Counseling and Testing (VCT) and Peer Education

HIV testing has significantly increased, recently, in China. As the testing program expands, a number of counseling and innovative outreach techniques utilizing peer groups to identify and engage marginalized, high-risk persons have demonstrated some success.

HIV testing is extensive throughout China and is on the rise. Individuals are tested for HIV in numerous settings, often without their knowledge, such as when persons apply for civil service jobs, seek surgical treatment, or wish to deliver a baby in a hospital. Public health officials are, however, increasingly seeing the value of expanding voluntary counseling and testing, or VCT. While many health workers sometimes confuse the “c” for “coercion,” other public health workers are counseling at-risk persons about the consequences of their behavior with compassion and convincing them to get tested as part of a prevention and education process. The advent of free ARV therapy enhances this practice, increasing the willingness of at-risk persons to participate, knowing that there is accessible treatment available if they need it. As testing expands and more people know their status, there is growing need for peer support and peer education, both to support those who are HIV-positive and negative and to reach out, identify, and educate at-risk people in the community, particularly those who are reluctant to directly engage with authorities.

The MOH and the Ministry of Finance drafted national VCT guidelines and regulations in 2004, strengthening the implementation process for free testing set out as part of the “four frees and one care” policy. The CDC has carried out massive testing campaigns of high-risk populations, including large cohorts of former plasma donors in Henan province, IDUs in Yunnan province, and incarcerated populations in prisons and detoxification centers. Effectively capturing the data generated by testing is extremely valuable to epidemiologists who track the epidemic and inform policymakers who must allocate resources and plot strategies to prevent and control the spread of HIV. VCT testing policies are now widely promoted in bright yellow posters featuring celebrity

spokesperson Pu Cunxin, highly visible in public health clinics and even in the departure halls of the Beijing airport.

HIV testing is offered at many hospitals and clinics as well as CDC sites, but the quality, availability, and affordability of testing is inconsistent from place to place. Despite a policy of free testing, many venues still charge fees, and others only provide free testing during promotional campaigns. Health care workers are often unaware of the need for confidentiality in counseling, while most lack the training to effectively convey important knowledge to at-risk persons. Local clinics tend to be passive about testing, waiting for people to come in for testing on their own accord, rather than proactively conducting outreach to at-risk persons. This is partly due to the lack of political or financial incentives for clinics to expand free services. Finalizing fund allocation and reimbursement policies for clinics will improve the application of VCT and allow for the expansion of services to a larger segment of the population. As the capacity to expand testing occurs, however, identifying and reaching out to those in need of testing will require the greater involvement of the community, including peer- and NGO-driven outreach. But the willingness of all government authorities to allow a greater role for NGOs and other peer groups varies widely across different parts of the country.

The health bureaus in many provinces with concentrated HIV/AIDS epidemics have actively encouraged people with HIV/AIDS to form mutual support groups. Under the close supervision of health authorities, these groups are generally provided with meeting space, which is used for training and sharing information and other social activities. Some clinics have made use of peer educators to reach out and identify IDUs and distribute clean needles. Unfortunately, although these programs are very useful, they remain relatively small scale—estimates vary, but there may be as many as a million or more IDUs sharing needles in China today—and will not make a significant impact on the national scale of the spread of HIV unless such programs are dramatically expanded. Needle exchange is often not supported by communities or the police, and peer educators carrying needles and narcotics have reportedly been arrested in some areas. Health authorities, however, have more strongly encouraged peer outreach activities that serve less controversial purposes.

The Ministry of Health and the CDC are demonstrating their support for the peer-driven delivery of a variety of services. Government-controlled funds are being made available to NGO groups as part of each Global Fund grant. The Round 5 grant is to train 540 peer educators and 1,440 health counselors per year, over five years, in VCT services in order to reach 777,000 CSWs and economic migrants. Other funds have been made available to peer groups seeking to reach MSM and IDU populations.

This stance reflects the government's growing awareness that they cannot find these marginalized groups and must rely on grassroots organizations to conduct outreach and provide prevention education and counseling. Some peer groups have demonstrated innovative outreach and VCT activities, such as one MSM group that hosts tea parties for MSM in the community to disseminate prevention information, condoms, and lubricants and to collect blood samples that are numbered and sent to CDC labs for HIV testing. The CDC provides the test results back to the peer group, which then contacts the individuals to inform them of the results. This process creates a welcoming and sensitive environment and helps ensure confidentiality for the tested person.

Efforts to expand VCT and peer education are welcome and much needed but face many obstacles. While the government officially encourages peer participation and the establishment of NGOs for HIV education and prevention work, these groups must walk a careful line and avoid operating outside of accepted (but unwritten) political boundaries. Although there is the desire for peer groups to conduct behavior studies and provide counseling and prevention education, there is resistance to decentralizing the actual HIV-testing process. Likewise, there is concern at local government levels that peer groups, including groups of people living with HIV/AIDS, could attempt to expand their role and engage in advocacy and possibly criticize or challenge the government in an organized fashion. In addition, the government has not yet elucidated a clear strategy for peer groups to mobilize society and influence and shape opinions in the community to reduce stigma and discrimination. Because stigma and discrimination regarding HIV/AIDS is so serious in China, it inhibits the successful implementation of many interventions. Civil society and peer groups are well positioned to engage in stigma reduction and antidiscrimination and possibly HIV-testing, but they are currently underutilized.

Overall, the willingness of some government agencies to incubate peer groups appears driven by a need to reach into marginalized high-risk populations. For the successful expansion of VCT and peer education in combating HIV/AIDS, the role of local NGOs and peer groups, especially those associated with or made up of at-risk and stigmatized populations, will need to be clarified and better integrated into the broader anti-HIV effort.

Condom Promotion

Condom distribution and promotion is expanding with condoms being increasingly available in hotels, entertainment establishments, and vending machines. NGOs are playing a significant role in marketing condoms in tandem with prevention information, particularly among the most at-risk individuals who are wary of interacting with government authorities and representatives.

The availability and widespread use of condoms is unquestionably an important component of a comprehensive HIV/AIDS-prevention campaign. Affordability and quality, widespread availability, and the awareness of the importance of condom use are critical to assure the successful control of HIV/AIDS. Condom availability and use is vitally important in areas where HIV is concentrated and where high-risk behaviors take place, such as in entertainment establishments. It is critical that condom use increase among commercial sex workers and their clients, particularly in areas where intravenous drug use is common and where significant numbers of drug users earn money through commercial sex. Condom use at the nexus of these high-risk behaviors can prevent HIV from bridging into the general population.

China has made progress promoting the use of condoms, and in many ways, the government is well suited to promoting condom use and is leveraging its strength to do so. Propaganda departments are well versed in mass communication and have been successful in increasing HIV/AIDS awareness and condom use through high-profile appearances by politicians and celebrities, street rallies, posters, pamphlets, and billboards. Government-dominated television has also played a role in raising awareness

and reducing stigma about HIV/AIDS by broadcasting HIV/AIDS-related programming. Government economic planning ensures that condoms are produced and widely distributed, while market forces drive the retail distribution of branded condoms.

The State Population and Family Planning Commission as well as the government health system have actively distributed condoms through traditional channels, including clinics, neighborhood committee offices, and increasingly, vending machines. Local government departments, often in cooperation with international NGOs, have begun implementing “100 percent condom use” programs in several urban areas. Those programs seek to saturate entertainment establishments in neighborhoods where commercial sex commonly takes place with condoms and information pamphlets. Although the goal of the project has been to reduce the incidence of sexually transmitted infections among sex workers, there has been limited independent research conducted to assess the effectiveness of the programs. Program administrators have reported decreases in sexually transmitted infections among CSWs and increases in condom sales in areas where the pilot programs have been implemented.

Additionally, international organizations are introducing new approaches to the social marketing of condoms, finding particular success in jurisdictions where the local government is active in HIV/AIDS prevention and fostering a positive environment for such work. Increasing numbers of jurisdictions have begun requiring that hotels and entertainment establishments make condoms available for sale. NGOs specializing in social marketing provide technical support to condom distributors, facilitating the regular supply of condoms to retail outlets, including hotels, bars, karaoke parlors, and bathhouses. Additionally, NGOs have opened outreach facilities in neighborhoods where commercial sex workers congregate and work, providing CSWs a place to meet and socialize, receive prevention education and information, purchase or receive condoms before the start of the working period, and even seek medical consultation from visiting health care workers.

In spite of the potential shown in condom promotion, however, this approach to HIV prevention and control faces a number of challenges in China. Despite increased awareness about HIV, there has been reluctance to address the causes of HIV/AIDS, the modes by which the virus is transmitted, and other sensitive and related issues such as homosexuality, drug use, and condoms. Moreover, as in other countries, women and CSWs face difficulties in negotiating the use of condoms. More widespread awareness and the destigmatization of condom use, improved condom availability, affordability, and quality, and greater knowledge and empowerment of women and CSWs to negotiate condom use will have a major impact on reducing the spread of HIV in China. A more comprehensive approach would link condom awareness and availability to other HIV-related prevention and treatment services.

Comprehensive Drug-dependence and Rehabilitation Services

Organizations are addressing voluntary drug addiction rehabilitation in programs in a variety of settings, some incorporating intense therapy, counseling, self-help groups, and programs to help former addicts gain skills to reintegrate into society.

Intravenous drug use and the sharing of injection equipment between addicts is the most efficient means for transmitting HIV and has been the most common means of HIV transmission in China. Although the Ministry of Public Security stated that there are close to 1 million registered drug addicts, other experts estimate that the actual number of drug users might be three to six times higher.³⁷ Additionally, the Ministry of Health estimates that as many as 30,000 young people become addicted to heroin every year. Although Chinese authorities have invested heavily in the punishment of drug dealers, in the detention and detoxification of IDUs, and in raising awareness about the consequences of drug use, and in spite of demonstrated successes on a small scale, there is inadequate investment in drug rehabilitation services.

There are scores of detoxification centers—basically prison facilities for drug addicts—operated by local public security authorities throughout China. There are also voluntary centers operated by hospitals and other governmental organizations. Involuntary detoxification centers are essentially short-term, low-security prisons where inmates are cut off from drug supplies and forced to quit cold turkey. Detention terms vary from 3 to 12 months, and inmates are lectured about the dangers of drug use and HIV/AIDS. Living conditions are Spartan and detention centers vary in their capacity, depending on the relative wealth of the county. Some detox centers in poor counties charge inmates daily fees and fines in order to cover operating costs. Recidivism rates associated with involuntary centers are estimated to be around 90 percent, demonstrating that the involuntary detox centers are, at most, successful in getting drug users off the street rather than off drugs.

Voluntary detoxification services operate mostly in urban areas where drug addicts can afford to check themselves in and pay daily fees. Stays are short, lasting only a week or two. Methadone and buprenorphine are available in some centers, along with Chinese medicines that help ease withdrawal symptoms, and counseling takes place between in-house physicians and patients. These voluntary centers focus on drug detoxification rather than on long-term rehabilitation.

There are very few residential drug rehabilitation centers in China, but there are existing, albeit expensive, models that demonstrate promise. One drug rehabilitation organization operates both street-level needle exchange and outreach as well as long-term residential rehabilitation services. For individuals who can afford to pay for room and board, the facility provides a drug-free home based on the therapeutic community concept, which is a highly structured family environment with considerable peer interaction and group therapy. Residents engage in regular peer-support activities, contribute labor to the maintenance and operation of the facility, and are also involved in job training and skills building to facilitate their reintegration into the community. Regular psychosocial counseling, peer counseling, and a positive, nonjudgmental, structured environment contribute to relative success in getting clients off drugs and in significantly reduced recidivism rates. Comprehensive substance-abuse rehabilitation services are expensive, however, and at the moment, are limited to those drug addicts

³⁷ Tuofu Zhu et al., “High Risk Populations and HIV-1 Infection in China,” *Cell Research* 15, no. 11 (November 2005): 852–857.

who have a significant outside source of income (such as families) that can pay for the costs of admission to the program.

The government is allocating significant funds to address drug abuse and is expected to increase funding in the near future. Public security bureaus are building new detoxification facilities in many jurisdictions, greatly increasing capacity to handle larger numbers of inmates, though there has been no indication that those centers will have greater capacity to provide substance-abuse counseling or medical services. Many of the new facilities will reportedly have segregated facilities for HIV-positive drug users, but it is unclear if the public security authorities will provide for necessary medical treatment and other services for HIV-positive inmates. This expansion and the Public Security Ministry's increasing realization that HIV/AIDS directly affects their work and responsibilities, however, presents opportunities for other organizations to partner and improve the delivery of services such as ARV treatment and HIV-prevention education to high-risk persons and HIV-positive persons.

Unfortunately, the government has not revealed plans to expand comprehensive drug rehabilitation services despite its potential to break the cycle of drug addiction. While resources for fighting drug abuse and HIV/AIDS are increasingly available, the government has not made comprehensive, residential substance-abuse rehabilitation a policy priority for preventing the spread of HIV. This gap in potentially valuable services can potentially be filled by international charities with expertise in delivering similar services.

Access to Antiretroviral Therapy

Access to effective, affordable antiretroviral therapy has been shown to help HIV-prevention efforts by encouraging otherwise reluctant HIV-positive and at-risk individuals to identify themselves and engage in HIV-education, awareness, and prevention activities. China's national treatment program remains at an early stage and faces a number of challenges but, if properly expanded, could serve as critical component of the national HIV/AIDS prevention and control strategy.

The Chinese national treatment plan began with a free antiretroviral therapy pilot program in late 2002 in Shangcai county, a locale in southern Henan province hard-hit by HIV through illicit commercial blood plasma collection activities. In July 2003, the formal national program for free antiretroviral therapy, China CARES, was launched, targeting certain areas of central China heavily affected by HIV. By the end of the year, some 7,000 persons were enrolled in the program. With financial assistance from the Global Fund, China CARES was able to ramp up to enroll some 25,000 persons by mid-2006.

Looking ahead, the expansion and improvement of the free national treatment program will need to overcome a number of challenges in order to be a fully effective part of China's anti-HIV strategy. First, although China CARES has made impressive strides to stand up for the national free treatment program, many remain in need of treatment: China officially estimates that about 80,000 persons have AIDS in the country, but the China CARES program has so far reached only about a quarter of them. Second, because of the marketed nature of China's health care system, the provision of drugs for

free lacks the proper financial incentive for doctors and other health workers, particularly those in the more rural and remote parts of China who depend on charges for dispensing drugs and other service fees for their livelihood.

Third, the China CARES program so far has focused primarily on providing treatment to those persons who were infected through illicit blood donor schemes in central China. These persons were more readily identified and accessible by local health authorities, and many in this population had already progressed to AIDS. The vast majority of HIV-positive persons in China are, however, located in other provinces, particularly those where intravenous drug use is more widespread, especially in southern and western China: Yunnan, Xinjiang, Guangxi, Sichuan, Guizhou, Hunan, Jiangxi, and Guangdong. IDUs and CSWs present particular challenges for the national treatment program, as their activities, by their nature, make them less accessible and more reluctant to cooperate with government authorities. Some Chinese national treatment program officials also believe that IDUs in particular, because of their addiction and its effect on behavior, would be less reliable patients.

Fourth, even where treatment is available, problems can arise. Monitoring drug regimen adherence is a challenge as home-based treatment is the norm, and rural localities at the county and village levels lack the professional medical expertise and equipment to assure proper treatment, adherence, and regimen adjustment. Moreover, the Chinese national treatment plan has only seven antiretroviral drugs available (there are over 20 such drugs available in the world). About 80 percent of China CARES patients receive a first-line treatment combination—either AZT + ddI + nevirapine or d4T + ddI + nevirapine—which is known to be less effective and generates severe side effects in patients. As of mid-2006, China CARES does not provide second-line therapy when patients fail on their first-line treatments. These problems strongly suggest the likely emergence of drug-resistant HIV strains in China.

In short, although the China CARES program is welcome and has made encouraging progress, much more needs to be done. Now that China CARES is moving from an emergency response to a more standard treatment program, it will need to be more fully integrated into the spectrum of patient management and linked closely with other components of a successful strategy, including prevention education and awareness, harm reduction, testing, and other social services. This will require an even greater commitment of political will and financial resources to solidify and build on the gains achieved thus far.

Recommendations: Comprehensively Meeting the Needs of At-risk Populations

Given the HIV/AIDS situation in China, the persistent challenges that confront the fight against the disease, and the emergent best practices in the country, the following broad recommendations point to a promising way forward.

- **GIVE PRIMARY FOCUS TO KEY MARGINALIZED AND AT-RISK POPULATIONS.**

Thus far, much of China's government response to HIV/AIDS has focused on the plight of the rural villages and farmers that were so hard-hit by HIV as a result of the

illicit blood donation schemes of the mid-1990s. Nevertheless, owing to stigmatization, official obfuscation, and a lack of resources, it took many years for an effective response to take shape to address those persons and families in central China who became afflicted with HIV.

Looking ahead, the Chinese authorities and the international community will need to increasingly focus their attention on HIV-infected and at-risk populations that are even more difficult to access, inform, treat, and care for. By China's official estimates, well more than half of the country's HIV-positive population consists of IDUs, CSWs, and MSM, with the percentage perhaps as high as 60 to 75 percent. In addition, a large proportion of these groups—especially within IDUs and CSWs—are ethnic minorities. For a variety of reasons—political, cultural, legal, and linguistic, and for practical reasons of accessibility—Chinese authorities and international organizations have been slow to focus HIV-prevention, control, and treatment efforts on these groups.

This is changing, but the change needs to be accelerated. HIV among CSW and MSM populations already appears to be bridging over to the mainstream populations. But these groups, although difficult to access, are often identifiable and, with proper strategies, can be reached with prevention messaging, awareness, treatment, and care. Moreover, many of these groups are geographically clustered in certain parts of the country where anti-HIV efforts can be concentrated more effectively.

It is clear that a key step must be overcoming the political, cultural, legal, and linguistic barriers that have prevented a more serious focus on these groups in the past and to do so as soon and as effectively as possible.

- **WORK TOWARD A MORE COMPREHENSIVE, “FULL-SPECTRUM,” PATIENT-MANAGEMENT APPROACH.**

In bringing greater focus to these marginalized and at-risk groups, these efforts will require a more comprehensive and “full-spectrum” approach that strategically and deliberately links together best practices and innovative interventions across a continuum of patient management. Such an approach reflects the complexity of China's HIV/AIDS challenge, begins to address the gaps that have frustrated a more effective response, and focuses on the patient and on case management. Ideally, once an at-risk individual is identified, a full spectrum of coordinated services would become available as needed, including testing, prevention education, counseling, harm reduction, treatment and care, and social services designed to reintegrate the individual into society as a productive and contributing member.

For example, under the current approach in China, there is little coordination between the agencies that typically are the first to encounter IDUs and CSWs—the local public security apparatus—and local health care or social welfare providers. Public security authorities operate drug detoxification centers where large numbers of drug abusers are detained after testing positive for drug use. CSWs are also sometimes detained and jailed for brief periods. Detainees are not regularly tested for HIV, with only a fraction of the population tested periodically through sentinel surveillance. Officers operating detoxification centers often do not know which detainees are HIV positive because they are not always provided with the test results. Conversely, many Public Security Bureau officers are reluctant to cooperate with health officials and often do not facilitate

counseling for detainees. Record keeping is also very inadequate, with virtually no client data shared between detoxification centers or jails and health departments, and no centralized record keeping between the incarceration facilities, health authorities, and the local police precincts that maintain criminal records and arrest files.

On release from the detoxification center, there is no mechanism for referring the drug user to appropriate drug rehabilitation, methadone replacement therapy, or other medical services (if they exist). Drug users who are eligible for methadone are neither referred to nor actively recruited by health authorities operating the clinics. Conversely, high drop-out rates at methadone clinics are partially due to public security officers detaining methadone clients in detoxification centers. In some areas, there is cooperation between public security agencies and local health care authorities. The observed level of coordination between the two is, however, far from adequate. Improving functional cooperation between these bureaucracies will be a vital component to a comprehensive, full-spectrum, patient-management approach.

In another example, there appears to be inadequate referral systems in place between clinics that focus on STIs and units that treat HIV/AIDS. Within one hospital, the department that handles skin diseases and STIs tests patients for HIV and if a patient tests positive, that doctor simply informs the individual to visit the infectious disease ward that handles HIV/AIDS. Since the majority of persons with an STI usually visit a private clinic in order to receive discreet services, there is no institutional mechanism for referral to specialist services such as prevention counseling and HIV/AIDS treatment services.

Methadone clinics operated by local CDCs and health bureaus do not appear to be used to their full potential as access points to the former IDU community. HIV-testing and prevention counseling is underutilized in many methadone clinics. Although there appear to be solid referral systems between the methadone clinics and the CDC where free ARV medication is distributed, there also appear to be referral gaps in many jurisdictions between the CDC and hospitals where HIV-positive people receive treatment for other ailments. While some CDC-managed clinics will increasingly provide free treatment for opportunistic infections, other clinics lack the funds to provide such comprehensive care. As a result, patients visit the CDC to pick up free antiretroviral drugs, but visit hospitals for other medical care, with no information shared between the two facilities.

In another example, it is understood that many small government and NGO programs have limited resources and therefore must focus on their area of expertise and deliver a limited suite of services. The needs of many at-risk and HIV-positive persons are often broad, however, requiring a comprehensive approach in order to be successful. For example, one program organizes persons living with HIV and AIDS into a self-help group, primarily as a way to coordinate delivery of antiretroviral therapy, nutrition, and medical aid. Such persons have, however, often lost their jobs (or have little hope of gaining employment because of criminal records or stigma), which may present a far more immediate and pressing challenge than HIV infection. An NGO hoping to improve medical care for this group cannot effectively address their medical needs without taking their other needs into consideration. Although a single NGO cannot be responsible for addressing all the social needs of those they serve, effective linkages with other

government departments and NGOs that provide key services is necessary to ensure that comprehensive patient needs are met and a more effective HIV strategy can succeed.

In some cases, bureaucrats from various departments refuse to support HIV-positive and at-risk individuals, because they are already receiving support from well-funded international programs implemented by other government agencies, and therefore consider the individual to be ineligible for support. Breaking through bureaucratic hurdles and ensuring that comprehensive needs are met will ultimately be a key factor for the success of large and small HIV/AIDS projects alike.

Such a comprehensive and full-spectrum approach will require the establishment of a cadre of social services workers who would serve as case managers to monitor and advocate for clients across the spectrum of public services. Professionally trained HIV/AIDS and antidrug counselors would be needed for at-risk individuals. (Such counseling is not the specific responsibility of any government agency at present so tends to be neglected.) A more centralized and dedicated database should be established at the country level for at-risk persons and those receiving services. These records should incorporate inputs from and be available to different ministries, including public security, health, civil affairs, social welfare, and poverty alleviation agencies, and nongovernmental organizations providing similar services.

In addition, this approach should look to more actively incorporate drug detoxification centers and other incarceration sites. Within such facilities, there should be routine or voluntary HIV testing for all detainees with results provided to the centralized record-keeping authority. Coordination will need to be expanded and solidified between local public security agencies in charge of the detox and detainment centers and their public health and social welfare counterparts, in order to integrate on-site HIV-rapid-test technology, enhance counseling for inmates (furthering VCT principles and enhancing HIV/AIDS awareness and prevention), improve overall health care delivery within detoxification centers and other incarceration sites, and refer detoxification center inmates to methadone maintenance on release.

Job training and placement should also be integrated into this system, beginning in the detox centers and continuing through counseling, treatment, and care phases. A residential or semi-residential halfway house arrangement as part of this system would also help reduce recidivism. These kinds of services could be associated with methadone clinics or nearby peer-counseling sites.

A more comprehensive model that recognizes and acts to establish critical links among service providers, both governmental and nongovernmental, will further the ultimate goal of preventing and controlling the spread of HIV/AIDS.

▪ **INTENSIFY ENGAGEMENT WITH NONGOVERNMENTAL PLAYERS.**

In introducing a more forward-looking and comprehensive system of best practices that targets marginalized and at-risk groups, it is clear there will be a far greater need to engage both domestic and international NGOs. This is true for at least two reasons.

First, marginalized groups by their nature are more difficult for government agencies to access and serve. They are far more likely to respond to appeals and programs that emanate from or are closely associated with their own groups. Hence, NGOs such as peer and support groups, social and professional associations, and other community-based

organizations can play a critical role in providing much-needed services such as counseling, harm-reduction activities, in-home treatment and health care, and job training.

Second, the comprehensive, full-spectrum approach requires a broader range of expertise than any single government agency or major international NGO can deliver. This approach will bring in the coordinated expertise of peer educators, social welfare specialists, counselors, medical laboratory technicians, doctors, nurses, employment counselors, foreign experts, public security personnel, hospital and clinical staff, poverty alleviation specialists, and local government officials as well as vendors who can provide the necessary training in many of these areas. This approach will also require significant project management skills at the local level to provide oversight and guidance and to assure overall success.

As such, the Chinese government and international NGOs need to consider how to effectively and acceptably increase the participation of NGOs in a comprehensive anti-HIV strategy. This approach could include an increase in government funding for private-sector implementers and the outsourcing of non-core activities to organizations that have core expertise, such as microfinance and animal husbandry. At a minimum, such an approach calls for a major expansion in the use of peer educators and counselors for IDUs, CSWs, MSM, and people living with HIV and AIDS.

▪ **DEEPEN COORDINATION ACROSS GOVERNMENT AGENCIES AND KEY ACTORS.**

This more strategic and comprehensive approach, drawing together and gaining synergies from a greater range of inputs and actors, will absolutely require a far greater degree of coordination across government agencies and among key actors than has been the case.

Because the needs of high-risk individuals, particularly IDUs, are high, and because such individuals are outside of the formal social and economic systems, they often fall between the lines of responsibility of individual government agencies or NGOs. Drug users who are HIV positive face significant life challenges, often due to deteriorating health, little or no regular income, and the pressures of supporting families and maintaining expensive drug habits. In order to successfully address one need, other needs must also be considered and addressed to ensure the success of any individual program.

Unfortunately, different agencies and initiatives tasked with providing distinct services to at-risk populations fail to coordinate or comprehensively link their activities, and as a result, marginalized individuals do not receive the support that they need, ultimately undermining effective HIV/AIDS treatment and prevention. Poor coordination and weak cooperation is not limited to different bureaucracies or *xitongs*. Disconnects are evident between different elements of the health system, particularly the gap between the government-funded public health system, including the Center for Disease Control and Prevention and antiepidemic stations, and the increasingly privatized medical system of hospitals, local clinics, and doctors' practices.

Coordination between NGOs is often lacking, which undermines the very purposes and goals that like-minded organizations seek to achieve. In one case, an outlet that sells condoms reported a significant drop in sales due to another NGO opening operations in the area and distributing large numbers of free condoms. Additionally, many international

NGOs rush into new programs without accurately surveying what programs already exist, how they operate, and what the organization can do so as to not duplicate services and avoid undermining existing relationships and infrastructure. Government organizations, particularly at lower levels, lack the capacity or incentive to coordinate outside organizations, leading to misunderstanding and gross inefficiencies.

Most importantly, for an effective, comprehensive, patient-centered approach to work within marginalized and at-risk populations, a far more strategic and regularized coordination mechanism should be instituted at local levels where programs are being implemented.

This can happen at two levels. First, local governments, and particularly the provincial, prefectural, and county-level government HIV/AIDS working groups, made up of representatives from all the key agencies and departments concerned with HIV/AIDS, need to be more proactive in coordinating their responses, both within the government and with outside donors. Second, the donors, NGOs, and vendors, at local levels, should form a regularized channel of discussion and coordination among themselves and with the local government. In some cases, one major donor in a locality might take the lead to coordinate and contract the services of local vendors and NGOs, in cooperation with local government agencies.

Annex: Key International Actors Funding or Implementing HIV/AIDS Programs in China (partial list)*

World Health Organization (WHO)

United Nations Joint Program on HIV/AIDS (UNAIDS)

United Nations Development Program (UNDP)

United Nations Children's Fund (UNICEF)

United Nations Population Fund (UNFPA)

United Nations Economic, Social, and Cultural Organization (UNESCO)

International Labor Organization (ILO)

World Bank

Global Fund to Fight AIDS, Tuberculosis, and Malaria

UK Department for International Development (DFID)

U.S. Centers for Disease Control and Prevention (CDC) Global AIDS Program

U.S. National Comprehensive International Program of Research on AIDS (CIPRA)

European Union

Canadian International Development Agency (CIDA)

German Development Bank

Sweden Agency for International Development and Cooperation (SIDA)

Japan International Cooperation Agency (JICA)

AIDS Healthcare Foundation

Médécins Sans Frontières (MSF)

Bill and Melinda Gates Foundation

Ford Foundation

Program for Appropriate Technology in Health (PATH)

Project HOPE

Save the Children

Marie Stopes International

DKT International

Futures Group

* A more comprehensive directory of international and domestic HIV/AIDS organizations active in China was published in 2005 by China AIDS Info, a Hong Kong-based NGO. The directory is available at <http://www.china-aids.org/english/directory2005.htm>.

Family Health International

Population Services International

International Federation of the Red Cross

Daytop Drug Abuse Treatment and Rehabilitation Center, Yunnan

Safe Blood International

Voluntary Services Overseas

Chi Heng Foundation

Aaron Diamond AIDS Research Center

Barry and Martin's Trust

Global Business Coalition on HIV/AIDS

Merck & Co., Inc.

Yale University

Harvard University

Johns Hopkins University

About the Author

Since 2002, **Bates Gill** has held the Freeman Chair in China Studies at the Center for Strategic and International Studies (CSIS) in Washington, D.C. He previously led East Asia-related programs at the Brookings Institution and the Monterey Institute of International Studies and held the Fei Yiming Chair in Comparative Politics at the Johns Hopkins University–Nanjing University Center for Chinese and American Studies in Nanjing, China. His editorial in the *New York Times* (July 2001, with Sarah Palmer) and article in *Foreign Affairs* (March 2002, with Jennifer Chang and Sarah Palmer) helped catalyze greater U.S. and international attention on China’s looming HIV/AIDS challenge.

