GLOBAL AIDS POLICY

Douglas A. Feldman

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In order to keep this title in print and available to the academic community, this edition was produced using digital reprint technology in a relatively short print run. This would not have been attainable using traditional methods. Although the cover has been changed from its original appearance, the text remains the same and all materials and methods used still conform to the highest book-making standards.

To my good friend
Steven Hersh
(1947–1992)
who died of AIDS

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Preface

This volume of original, never previously published chapters grew in part out of two seminars that I chaired: "Issues in Planning and Evaluating AIDS-Related Interventions in Africa and Asia" at the March 1991 Society for Applied Anthropology meetings in Charleston, South Carolina, and "Global AIDS Policy" at the November 1990 American Anthropological Association meetings in New Orleans. Several of the chapters, however, were initially developed specifically for this volume.

All of the chapters were peer reviewed prior to acceptance, and I would like to cordially thank our distinguished panel of external reviewers: Dr. Ralph Bolton (Pomona College), Dr. Robert G. Carlson (Wright State University), Dr. Michael C. Clatts (Narcotic and Drug Research Inc.), Dr. Francis P. Conant (Hunter College, CUNY), Dr. Stephen L. Eyre (University of California, San Francisco), Dr. Vincent E. Gil (Southern California College), Dr. Janis Hutchinson (University of Houston), Dr. Carl Kendall (Tulane University), Dr. Norris G. Lang (University of Houston), Dr. Susan McCombie (University of Pennsylvania), Dr. Michael Melody (Barry University), Dr. Robert Porter (Porter/Novelli), Dr. Michael D. Quam (Sangamon State University), and Dr. Priscilla Reining (University of Florida). I would also like to thank Jean Dingee, Jonathan Bellman, Armando Castro, and Dieter Fredericks for editorial assistance, and Donna Rayburn and Maggie Dominguez for secretarial assistance.

The reader should keep in mind that AIDS-related events and circumstances change rapidly, and that the contributors to this volume maintain perspectives valid at the time their chapters were written. It is not the intention of this volume to be comprehensive on the topic of global AIDS policy. Indeed, volumes have already been written on this subject. How-

ever, the viewpoints expressed here are primarily based upon empirical social science research and theory.

While it was not my original intention necessarily to edit a volume that emphasized strong critiques of existing global AIDS policy, most of the chapters turned out this way. It is now clear that this development was not by chance. Rather, the overall direction of global AIDS policy through the 1980s and early 1990s has been essentially misguided, and serious rethinking of AIDS as a public health and social issue is now necessary. It has become obvious to most of the contributors of this volume, and to myself, that a restructuring of AIDS/HIV prevention programs, services for persons living with AIDS/HIV, and social institutions relating to all aspects of health is crucial on an international scale if there is to be any chance for success in our global struggle against AIDS. It is my hope that this volume will assist in showing us the way.

1

Introduction

Douglas A. Feldman

As we look back at the social, cultural, and political dimensions of AIDS in the 1980s and early 1990s, it seems as though we have come so far in so short a time. From a virtually unknown disease in 1981, AIDS has become undoubtedly the most discussed, most thought-about, and most feared pandemic of our time. Few human activities generate as much concern and ambivalence as do sex and death, and AIDS links sex and death in our consciousness as has no other disease in the modern era. AIDS has had a profound influence in numerous aspects of our lives, especially in many developed nations. From the media to the workplace to health care to our educational systems, AIDS discourse has increasingly grown in importance in recent years.

AIDS has become a major concern in many aspects of public policy. Whether or not to have sex education and AIDS education in the classroom is no longer the issue in much of North America and Europe. The question has become to what extent abstinence or safer sex practices should be emphasized. The enormous economic impact of AIDS upon the health care system in the United States has forced us to begin seriously to plan for a fundamental restructuring of this previously intransigent social institution. Human resource managers are increasingly becoming more experienced in handling employment-related issues of their employees with HIV-spectrum disease. Major newspapers, newsmagazines, and television networks have devoted substantial resources and staff to cover various issues and perspectives of AIDS. For a virus that had infected only an estimated 13 million people by 1992, or a mere 0.25 percent of the world's 5.3 billion people, HIV has had a more pivotal effect on health research, health education, and the global biomedical infrastructure than any other single disease in this century.

Yet when we look at what has actually changed, at what behaviors have been fundamentally altered, and at what social institutions have been restructured as a consequence of AIDS, it is striking how little has been accomplished in terms of getting the pandemic under control through effective prevention programs and of ameliorating the social, cultural, political, and personal impacts of AIDS. In most of the developing countries where HIV is already rampant, while sexually active teenagers and adults may be very worried about getting AIDS, there is usually little or nothing that they are doing to change their sexual behavior to prevent HIV infection. In those African cities where one of every four sexually active adults is currently HIV seropositive, the alarming reality remains that only a tiny minority of the population uses condoms properly and regularly during sexual intercourse. The vast majority do not use condoms at all. Few individuals utilize other forms of safer sex, such as interfemoral sex, to reduce HIV risk. In those same African cities where funerals for persons who have died of AIDS have become commonplace, where the managerial sector of key industries has been especially hard hit by personnel losses due to AIDS, and where the number of AIDS-related orphaned children continues to climb more rapidly than the resources of either society or government to cope with the needs, AIDS is still viewed much as it was a decade ago. It remains a highly stigmatized disease that few care to talk about in public.

Policy decisions are being made throughout the world on how to best handle the AIDS crisis. Areas of policy formulation include such issues as mandatory or voluntary HIV reporting, mandatory or voluntary HIV testing, priorities in AIDS health and social services funding, quarantining and immigration restrictions, screening blood supplies in developing nations, effective strategies for HIV prevention, and HIV-related discrimination and neglect.

In general, politicians and biomedical administrators have set the direction for global AIDS policy until now. By and large, this policy has failed, and failed miserably. It is the premise of this book that to effectively accomplish the control of HIV on a global scale, it will be necessary to replace political considerations and a biomedical approach with a public health and social science approach. Needle exchange programs are a good example of the need to reformulate policy. Political considerations in the United States and elsewhere have prevented needle exchange programs from being implemented. Conservative politicians and some religious and African-American leaders have opposed needle exchange programs, asserting that they promote drug use. Those who favor a biomedical approach have been reluctant to support any program that will facilitate the use of a harmful narcotic. However, public health and social science research has demonstrated that such programs reduce HIV seroprevalence in an injecting drug-using population and do not promote greater drug use.

Vincent E. Gil's chapter ("Behind the Wall of China: AIDS Profile, AIDS

Policy") looks at AIDS in the world's most populous nation. HIV is spreading rapidly through injecting drug use in China's rural southern Yunnan Province and is also showing signs of nascent growth through sexual transmission in major urban centers. Restrictive attitudes toward sexuality and antidemocratic policies may hinder HIV prevention and control in China during the 1990s. Certainly, Asia is the continent to watch during the next few years. It has been projected that the number of new HIV infections in Asia will overtake the total number of persons with HIV in Africa by the year 2000. HIV transmission is increasing rapidly in India and Thailand, and it is likely that this pattern will soon occur in other neighboring countries as well.

Richard G. Parker ("Public Policy, Political Activism, and AIDS in Brazil") points to the dismal lack of achievement by the Brazilian government in handling its AIDS crisis. Poor planning, lack of governmental coordination, inadequate funding, and disinterest on the part of most Brazilian politicians concerning HIV prevention and AIDS services have led to the current disastrous situation in Brazil. Conditions that have contributed to the spread of HIV in Brazil include a large but politically unorganized gay community, rampant poverty where countless street children often turn to prostitution, a vast bisexually active population of married men who do not see themselves at risk, and poor sanitation in the *favelas* (slums) that promotes the proliferation of cofactor pathogens.

The problem of governmental neglect or incompetence is certainly not restricted to Brazil. Indeed, most of the governments in Latin America, the Caribbean, Asia, the Middle East, and Africa have performed poorly in their handling of the AIDS crisis. There are exceptions, Costa Rica and the Commonwealth of Puerto Rico in Latin America and the Caribbean, Uganda and Senegal in Africa, and Thailand and Australia in Asia and the Pacific, for example, where governments have made a sincere attempt to work against the epidemic through the provision of HIV prevention and AIDS health and social services within their borders. But even in these few countries where stigma, shame, fear, denial, corruption, and inaction do not shape AIDS/HIV policy, severe budgetary limitations in developing nations often delimit what such governments can do. It is interesting, though unfortunate, that the one developing country that spends the most funds on persons living with HIV on a per capita basis, Cuba, has developed the most draconian measures of incarceration of all HIV-positive citizens in several quarantine camps. Allocation and availability of resources by a government clearly do not necessarily mean that prudent choices will be made in the struggle against HIV.

Pamela Hartigan ("The Response of Nongovernmental Organizations in Latin America to HIV Infection and AIDS: A Vehicle for Grasping the Contribution NGOs Make to Health and Development") looks at the role that NGOs, national AIDS programs, and donor organizations have in

working together to strengthen broad-based HIV prevention and AIDS care programs. Hartigan shows us some of the difficulties encountered by various kinds of NGOs in Latin America, which have led to inefficiencies and inadequacies of HIV-related services and prevention.

Norris G. Lang ("HIV, Immigration Policy, and Latinos/as: Public Health Safety versus Hidden Agendas") discusses the history and inequities of U.S. immigration policy as it relates to HIV and Latin America. It is peculiar that the United States, a nation that contributed heavily to global HIV transmission during the 1980s through international tourism and that has such a large population with HIV, is so restrictive against immigration by persons testing HIV positive. If this model of exclusion were adapted universally, no one with HIV would be permitted to migrate to any other nation. Since most HIV transmission is preventable, policies based on exclusion of infected persons, rather than behavioral change, are unnecessary and unfair. By the early 1990s this policy of exclusion led to the virtual stranding at a U.S. military base camp next to Cuba of HIV-positive Haitians who were otherwise eligible to come to the United States. It took a court decision, ruling this policy to be inhumane, to permit some of the Haitians to be brought over to a detention center in Miami.

Sub-Saharan Africa has so far been the region most deeply impacted by the AIDS pandemic. In spite of the imminent threat to their lives, most Africans remain wary of using condoms. Charles B. Rwabukwali and colleagues ("Culture, Sexual Behavior, and Attitudes toward Condom Use among Baganda Women") conducted a study among Baganda women in Uganda to find out how they feel about using condoms. Among the findings, quite remarkably, is that most of the women who have extremely negative feelings toward condoms have never even seen a condom, let alone used one. Successful behavioral change requires more than education. Fundamentally, long-term behavioral change may inevitably be dependent on much-needed structural changes in the political economy of developing nations in order to reduce relentless poverty, dichotomous income inequality, and the second-class status of women. In the short term, however, skills building, role playing, desensitization to discussing sex and handling condoms, and personal empowerment counseling are necessary tools for promoting safer sex behavior.

The lessened value of women in contemporary African societies may explain why female prostitutes in Ghana were seen as the source of the HIV problem in that country. Robert W. Porter ("AIDS in Ghana: Priorities and Policies") shows us the cultural biases of epidemiologic data and demonstrates how the HIV prevention priorities for this nation were wrongly constructed based upon a false foundation.

In South Africa political conservatives have mobilized antigay and antiblack bigotry to support an intentionally lethargic AIDS agenda. Virginia van der Vliet ("Apartheid and the Politics of AIDS") analyzes the political

processes at work in that nation. The potential impact of AIDS in South Africa cannot be overstated, and van der Vliet is correct in stating that "AIDS will become one of the most important factors shaping [that nation] within the next ten years."

Dana Raphael ("The Politics of International Health: Breastfeeding and HIV") addresses the risk of breastfeeding among HIV-positive mothers in developing nations. She points to what she sees as the hypocrisy of international organizations that have one standard for developed nations and another riskier standard for developing nations. The question of HIV and breastfeeding raises some essential ethical dilemmas that need further examination.

This volume attempts to be truly global by including public policy concerns within the United States, where much of the work on HIV by social and behavioral researchers has been conducted. Michael D. Quam ("AIDS Policy and the United States Political Economy") assesses the status of HIV in relation to socioeconomic factors within the United States at the close of the Bush administration. Writing prior to Clinton's national health program, he is on target when he indicates, "We have no national health policy and we have no national strategy for funding such a policy. The AIDS crisis has exposed the brutal failure of the current health establishment."

In the United States millions of gay and bisexual men, both those who are HIV positive and those who are HIV negative, have been irrevocably affected by the pandemic. The gay community of the 1990s has been transformed quite dramatically since the advent of AIDS. With hundreds of thousands of gay men ill (or dead), the scourge has not only been devastating on a personal level, but has had a profound influence on the social and economic infrastructure and cultural norms of the gay community itself. In many respects, however, AIDS has strengthened the gay community. Political coalitions and demonstrations, gay economic development, and cultural activities have markedly grown. M. E. Melody ("Acting Up Academically: AIDS and the Politics of Disempowerment") describes some of the growing pangs of the gay community. Melody takes us from the reaction of the Reagan conservatives to the rise of ACT UP, an activist organization that has had a pivotal influence upon HIV public policy.

Robert G. Carlson, Harvey A. Siegal, and Russel S. Falck ("Ethnography, Epidemiology, and Public Policy: Needle-Use Practices and HIV-1 Risk Reduction among Injecting Drug Users in the Midwest") look at the cultural ecology of injecting drug use in two Ohio cities. They observe that the term *needle sharing* is a misnomer, since the process of needle transfer from one user to the other does not involve a communal sense of, or desire for, social sharing. When needle transfer does occur, it is out of necessity, rather than as a function of social solidarity within the injecting drug-using population. Indeed, the general availability of clean needles and syringes in Ohio has resulted in a very low rate of HIV seroprevalence among users.

Michael C. Clatts and colleagues ("AIDS Risk Behavior among Drug Injectors in New York City: Critical Gaps in Prevention Policy") review the findings from several studies conducted among drug injectors in New York City where needle transfer is common due to the scarcity of available unused needles. The authors conclude that knowledge about risk does not result in behavioral change among many of those involved in drug injection, and that condom use appears to be determined by a host of social and economic factors that compete with concerns about risk for HIV.

The struggle over AIDS policy is a microcosm of the essential political and social struggles currently raging within societies on a global level. Broadly speaking, AIDS spotlights the dysfunctional inadequacies and anachronisms of our times. AIDS forces us to revive our commitment to social, political, and economic change throughout the world. In responding to the challenge of AIDS, we undoubtedly will continue to encounter change-resistant forces that may seem formidable. Our role must first be to develop AIDS policy that is sound, reasoned, based upon research and evaluation, and not compromised by the omnipresent change-resistant forces, and then to implement well-financed, effective programs that will convert policy into action. It is urgent that we not waver from this approach. AIDS is giving us the opportunity to correct the structural and attitudinal discontinuities of modern social life and to guide the direction of rapid social and cultural change in virtually every nation. Equally as important, there are simply too many lives at stake. We cannot let them, and indeed ourselves, down. The new AIDS policy makers need to remain firm and uncompromising. History will judge us harshly if we fail.

2

Behind the Wall of China: AIDS Profile, AIDS Policy

Vincent E. Gil

China has both fascinated and alarmed the West for centuries. Called the Middle Kingdom—Zhongguo in Mandarin—China has had the ability to remain enigmatic to most of the world, seeping out self-perceptions with measured restraint and as global opinion has required (Mosher 1990). Yet the universal human condition of our era cannot be divorced from the experiences of China's more than 1.16 billion people, nearly a quarter of the human population.[1]

As China has emerged from isolation and attained for itself a more comfortable global platform, it has been pressed to address issues that come from openness and reform. Such issues are no longer simply ideological or technological; they are also epidemiologic and medical. China's nascent HIV infection is already moving the country from being a poorly understood nation to one deserving once more a center position on the global stage.

Sadly, news of China's HIV infection has crept out slowly and cautiously. Initially given little press by official news agencies, it was later overshadowed by the more pressing economic reforms of 1988 and by the dramatic political events of 1989. The emerging pattern of infection led to China's classification by the World Health Organization (WHO) as a "Pattern III" country (Chin and Mann 1988), where infection rates are low and predominantly heterosexual or of unspecified origin. Viewing China's infection through the WHO taxonomy has also worked against understanding any unique dimensions of China's own HIV epidemic.[2] As will be discussed later, there are relevant differences in the Chinese case that merit specific attention.

This chapter is the result of fieldwork in China by the author, undertaken as part of a collaborative technical exchange and at the invitation of the

Chinese Medical Association. Fieldwork presented a rare opportunity to go "behind the Wall" and openly assess HIV/AIDS in most of its complexity. In developing countries such as China, multifactorial issues hinder prevention efforts and complicate epidemiologic forecasting (Alexander, Gabelnick & Spieler 1990; Feldman 1990:46). In this chapter I elaborate those cultural, social, and political elements involved in China's attempts to manage its growing HIV epidemic. Epidemiologic data from field visits conducted in Beijing, Chengdu, and Kunming summarize the status of the epidemic to date. Select data from the First Sino-American Management of HIV Disease Symposium (held in Beijing during 1990), to which I was a delegate, are also blended with the ethnographic material to further clarify present conditions.[3]

Particular attention is being devoted to understanding China's emerging HIV/AIDS policies. Attempts to clarify these policies and the issues they pose for Chinese socialism are framed within the tensions of prevention. HIV prevention in China cannot be easily divorced from political philosophy or from human rights issues. Containment of HIV thus poses an unrelenting challenge for China to transform its traditional treatment of sexual expression and—consequently—of people.

A report such as this is both necessary and timely, because China's HIV record should be kept distinct from the HIV/AIDS phenomenon in other countries totally unlike China. Today, with its ideology in flux, with its commitment to halting HIV formed under unique traditions and a socialist philosophy that is quintessentially Chinese, China is rapidly developing its own prevention system. Any effort to delineate just what that system is—or what it may become—must be to some degree hesitant, preliminary, and limited. This chapter is a first step toward understanding China's HIV problem and its unfolding policies and procedures to halt infection.

CHINA'S HIV/AIDS HISTORY

Growth in international contacts eventually enabled the transmission of HIV to within China's borders. In 1984 an American foreigner was identified as being seropositive and was quickly deported (Zeng 1988). Shortly thereafter, the government commissioned seroepidemiologic studies on a wide scale. In 1985 Factor VIII sera produced in the United States were found to have infected four Chinese persons with hemophilia (Zeng 1990). There was now sufficient reason for the government to begin coordinated screening of potentially at-risk populations. In April 1986 several hospitals in Beijing and the Institute of Virology, Chinese Academy of Preventive Medicine, began screening sexually transmitted disease (STD) and other select outpatients.

Sexual transmission was discovered in January 1988 in a Chinese male

who presented with penile erythema and atrophic lesions. Western blot and ELISA tests confirmed that the patient was HIV seropositive (Quin *et al.* 1990). The patient acknowledged that during the previous September he had had homosexual contacts with foreigners.

By September 1990 China had identified 446 HIV-positive individuals after an extraordinary effort to test over 300,000 in the population (Chen 1990). The emerging pattern, however, did not forecast HIV transmission through heterosexual contacts as much as it revealed its association with drug use in the southwestern provinces (Dai 1990). Then "Pattern III" characteristics began to weaken. It was obvious to the Chinese, even in 1988, that the Indochinese epidemic was spreading up through Thailand, a consequence of drug traffic in the Golden Triangle.

Most severely affected since 1988 has been Yunnan Province, a predominantly agricultural region bordering Myanmar (formerly Burma), Laos, and Vietnam. Through this region—and inevitably through southern China as well—passes the "opium express," a trafficking complex that since the late 1970s has produced the world's largest tonnage of opium and its derivatives (Inciardi 1986). Since the 1980s drug use has steadily increased in Yunnan and adjoining provinces (Guanxi, Guizhou, Guangdong). For centuries there has been a tradition of smoking opiates in this region, but the recent trend has been toward intravenous use of drugs, particularly heroin (He 1990). Estimates vary, but official reports put the region's intravenous drug users at above 100,000 (Dai 1991). Heroin availability masks the low availability of drug-injecting equipment, and thus promotes the onerous practice of communal use of syringes.

By 1990 Yunnan's HIV-infected accounted for 87.2 percent ($n=389$) of China's total HIV prevalence.[4] Ruili (county) had the strongest concentration of seropositives; 305 (of the then 389) cases living in its Dehong prefecture. This cluster was considered yet another recognizable but rare HIV nidus in a rural region (Peabody 1990). Lushui (county), in Jadi Prefecture, and Gejiu (county), again in Dehong, followed, with 11.4 percent and 4.3 percent of the nation's infected. (Mercifully, the rest of China enjoyed at that time a very low HIV rate, with only Beijing surfacing above the 1–2 percent proportion infected in the samples tested.)

Yunnan's topography and the particular lifestyle of the many minority groups in this region encouraged the consolidation of the epidemic early on. Rugged mountains and deep agricultural valleys dot the countryside. Agrarian populations in Yunnan, consequently, do not travel much or relocate unnecessarily. Even for those addicted, it is often easier to get drugs locally or cross into Myanmar than to travel extensively to cities in the province itself.

Moreover, this region of China is populated by "minority peoples," as the dominant Han Chinese refer to non-Han and related populations. Each ethnic minority group has sufficient lifestyle and historical distinctives to

keep it from readily assimilating. Yunnan's Provincial Health and Anti-Epidemic Center was able to amass enough demographic information early, to clarify local conditions. The Dai, in the county of Ruili, Dehong Prefecture, accounted for 68.6 percent of those infected locally in 1990. Since they were ancestrally related to Thai farmers across the border, most did not even speak Mandarin. The Dai showed the strongest pattern of infection and also drug use (*China Daily* 1991a). However, learning to inject drugs is not part of the cultural legacy of these farmers (87 percent do agricultural work) and this requires needles: needles come from areas where other addicts live—cities and lives well beyond their imagination. The Jingpo, another ethnic minority, accounted for 17.7 percent of those infected in the province in 1990.

In sum, the overwhelming majority of seropositives to 1990 were ethnic minorities (372 of 389) who were occupationally tied to the land, male, young (between the ages of 20 and 39), and involved in parenteral drug use.

Yunnan women presented a low incidence rate at the 1990 juncture. The ratio of men to women infected was 76:1. Only two spouses of HIV seropositive males were identified as seropositive, and they were both Chinese. There were nineteen women of Myanmar origin living in this region identified as HIV seropositives. It was unclear from available data whether these Myanmar female cases were drug-use related. In 1990 it was also too early in China's epidemic to know whether women who were tested, and found seronegative, would seroconvert later on. The exact number of infected women in Yunnan is still not knowable, and is presumed by all forecasts to be higher than the 1990 statistics represent (Zhao 1990).

A significant difference emerged in the ensuing three years of the epidemic, between 1990 and 1993. Growth in seropositive cases between 1990 and 1992 more than doubled to 932 cases, making the growth rate for the period 206.5 percent. AIDS cases also grew from 2 to 11 in the same period (Ministry of Public Health 1992).

In 1990, those non-Han minority groups delineated above and residing in Yunnan, farmers and manual laborers who also drug injected, comprised the bulk of cases. By 1992 the distribution includes expatriate Chinese, prostitutes and their clients, hotel attendants, spouses and relatives of former HIV seropositives, persons with hemophilia, prisoners, those with other sexually transmitted diseases, homosexual men, and populations in the border regions with Tibet and southeast Asia. Drug injection users continue to be well represented (677) but now comprise 72.6 percent of the infected total. Eighty-four percent of medical and epidemiology personnel I interviewed in 1992 (n=69/82) agreed that most new HIV cases are discovered in residents that are not from the province where they were tested and found seropositive. Interviews also confirmed that increases in travel,

especially foreign travel, and exposure to HIV through sexual contact abroad were implicated in the increase (n=80/82, or 97 percent of those interviewed were in agreement).

I also collected ethnographic data in 1993 through convenience interviews (n=147) of medical doctors, provincial epidemiology station personnel, family planning and STD clinic personnel, and local subjects in five provincial urban centers. All confirmed the effects of mass movements of persons in China during the past three years on HIV transmission and the widening sociogeographic distribution that the virus now shows. This point is worth elaborating.

Since 1989, China increasingly liberalized its policies on employment and thus on where people could relocate. A liberal policy enabled mass movements of peasants, especially from the southwest countryside (from provinces like Yunnan) to come to the burgeoning metropolises of China. The appeal to seek new fortunes in "open cities" like Guangzhou, Shanghai, and in Special Economic Zones (SEZs) like Shenzhen, Zhuhai, became irresistible (Morrison and Dernberger 1989). These are exactly the places where new HIV prevalences have been documented between 1990 and 1992. Moreover, expatriate Chinese during these years continued to travel freely between Hong Kong, Malaysia, Thailand, Macao, and the mainland. Thus, businessmen and wealthy overseas Chinese entrepreneurs are over-represented in the 1992 HIV positive expatriate population. Many expatriates combine business with pleasure, as evidenced by their engagement of call girls and occasional male homosexuals at hotels and exclusive discos in the mainland (Gil 1991). It is not surprising, then, that the number of expatriate Chinese who have been found to be HIV positive is also high in developing and SEZ cities: Yunnan (Sichuan), Beijing, Guangzhou (Guangdong), and Shanghai. Similarly, mainland Chinese who travel abroad are over-represented among the HIV positive cases ("Foreign Exposure" category of Table 2), confirming that their source of infection stemmed from sexual contacts abroad.

Small but visible numbers of the HIV infected in some populations in China now presage the global trend of association among STDs, sex industry workers, clients, and HIV infection (Lewis, Kenney, Dor, & Dughe 1989). In 1990 there were no reported HIV cases among sex industry workers or their clients, nor was a connection between STD patients and HIV seen in the case records (Gil 1991). By the close of 1992 all three groups (prostitutes, clients, and STD patients) show some HIV infectivity. Furthermore, HIV infections also show up among prisoners, as well as among male homosexuals screened for blood in Beijing.

By November 1993, 1,140 HIV seropositive cases were being reported in China, and nineteen patients with AIDS (Zeng 1993). Yunnan Province maintained the highest caseload of HIV/AIDS with 879 infections.

THE GOVERNMENT'S RESPONSE TO HIV

The Chinese perspective on HIV and prevention is best understood within the emic context of China's social, political, and ideologic history. A view from many angles is thus required; only some of these can be fully addressed in this section.

Faced with a small but nonetheless fulminating and deadly epidemic on its soil, the Chinese government has acted quickly and in keeping with its ideological traditions. Essentially, HIV/AIDS required swift political action: new measures to insure that no repudiation of revolutionary ideals would occur while dealing with a crisis that could challenge the fiber of party social thinking.[5] Because HIV was linked early to homosexuality, and later to drug use, laws were enacted by the People's Congress to insure that control measures were framed within appropriate ideologies. The 1982 constitution had already shifted much of the authority for lawmaking and approving to the National People's Congress (Wu *et al.* 1988:47), enabling the passage of new laws within record time.

Two primary goals have thus surfaced in response to the threat of HIV/AIDS in China: (1) to tackle the social contexts in which HIV infectivity is possible; and (2) to generate the appropriate medical-epidemiologic infrastructure needed to prevent its spread. The former goal has required a comprehensive linkage of civil measures with legal and political ones. The latter goal has involved massive and coordinated expansion efforts in education and medicine.

Sociolegal Actions

On January 14, 1988, regulations concerning the monitoring and control of HIV/AIDS were issued by the Ministry of Public Health and seven other ministries, with the approval of the State Council (He 1990). By February 1989 the Law of Preventing Infectious Diseases of the People's Republic of China was passed by the People's Congress (He 1990). Not only does this law require that non-Chinese foreigners coming to stay in China for more than one year bear proof of being HIV negative, but the same regulations are also made to apply to Chinese expatriates returning to China. Thirty-three articles also established a monitoring and control system for "relevant persons" (i.e., those HIV seropositive) and a reporting system that identifies them to the proper authorities. Moreover, under these articles, anyone infected who knowingly transmits the virus to another person could be criminally prosecuted, if identified.

The articles also furnish provinces with the right to restrict the movement of seropositive individuals, enabling local "quarantine" measures for the "provision of medical care to infected persons" (*China Daily* 1990; He 1990). In Yunnan, for example, individual "registration cards" are now

issued to HIV-positive persons in order to trace their movements. No one so identified and tagged can travel without appropriate notification and release from the local epidemiology station (*China Daily* 1990).

These measures are consistent with China's historical restrictions on individual interests in light of the superseding priorities of the state.[6] Freedom of movement, for example, has been restricted by law since 1958, and mobility is premised principally on the allocation of human resources as the state sees fit. As an HIV control measure, restricting movement of seropositive individuals simply reinforces the argument of selfless sacrifice for the common good (Han and Go 1986). Furthermore, due to its present low level of HIV infection, China has not yet determined the relative risks associated with its infected populations. There are no epidemiologic models that would provide a probabilistic basis from which to predict infectivity and transmission potentialities. HIV transmission remains predominantly rural at this time. Yunnan's villages are the focal points of infection. Restricting movement of those infected from their rural villages is China's hedge against the possibility of HIV transmission beyond the known geographic boundaries of infection.

A high rate of HIV infection among injecting drug users aroused great attention from the Chinese government early on. Laws introduced in 1988 were aimed at strengthening those already in existence to insure that drug dealers, traffickers, and users were swiftly prosecuted (He 1990; Wu *et al.* 1988:46). Not only is drug dealing illegal in China, but so is drug taking. Regulations such as "Strongly Cracking Down on Prostitution, Whoring and Drug Abuse," and "Strengthening the Management of the Public Social Order" (He 1990) express the sentiment that the government will not tolerate what it perceives to be a threat to the society. To this end, the Departments of Social Security, Customs, and Public Security work together with epidemiology surveillance stations and medical establishments as a network. For drug users, rehabilitation centers exist and are operative. These combine detoxification programs with measures for social restoration using work programs.[7]

At other levels, the government has moved to identify at-risk groups beyond drug injecting ethnic minorities. The Asian Games held in 1990 are a good example of what has been happening. Beijing's municipal government intensified surveillance and preventive education in an effort to "encourage people to refuse to be contaminated by evil influence, not to have sexual contacts with [potentially HIV-positive individuals,] and not to engage in needle sharing" (Foreign Broadcasting Information Services [FBIS] 1990b; bracket my translation). Six categories of persons were targeted for special attention: "street prostitutes, upstarts or recently wealthy/aspiring industrialists/businessmen, young women longing for study abroad, teenage [women] who have been raped and thus are indifferent to further sex, young women with [a] vengeance toward men, and

persons who are indifferent to [the risks of] venereal diseases" (*ibid.;* brackets my translations). All of these were presumed risk groups for the spread of HIV.

Categorically, the targets appear predominantly female (at least four of six). Most important in this illustration, however, is the continuation of a socialist ideology about classes of people. That ideology is applied to the HIV/AIDS social metaphor without alteration. Both Sabatier (1988) and Farmer (1990) have illustrated the effects of categorizing individuals believed to be at high risk, resulting often in the accusation of groups because of their presumed potential for transmitting the virus. Here, Chinese socialists evidence their use of "associative logic," a framework that regards classes of people as essentially sharing the same characteristics (Wu *et al.* 1988). Such associations, in turn, promote a particular treatment of the group as a whole.

Epidemiologic and Medical Actions

Stepped up prevention and education activities now underscore China's desire for early precautions. In 1986 the Chinese Ministry of Public Health added HIV/AIDS to the list of diseases requiring notification to health authorities (Zhu and Deng 1988). Monitoring stations were set up in Beijing, Shanghai, Guangzhou, Fuzhou, Hangzhou, Xian, Shengyang, and Nanning. In 1988 Chengdu and Kunming epidemiology prevention stations were added to the list (making them the closest monitoring sites to the sources of infection) and now operate ongoing serosurveillances for HIV (Dai 1990).

The relationship between HIV and other STDs is known and is taken into consideration (Dai 1990; He 1990; Xu and Fan 1990). From 1980 to 1989, 220,222 STD cases were reported in the country, after a previous decade of extremely low incidence (Xu and Fan 1990). In early 1991 the cumulative figure stood at 370,000 (*China Daily* 1991b). Modernization and reforms have had liberalizing consequences, most significantly on the sexual mores of the younger generation (Link, Madsen, and Pickowicz 1989). Premarital intercourse is now known to be higher than ever in China's socialist history (Pan 1989, 1990). Sociologists estimate that between half and two-thirds of all STD cases occur in unmarried individuals. In this population the incidence of STDs has more than doubled since 1989 (FBIS 1990b). Coupled with low levels of contraceptive use by unmarried, sexually active persons, STD infections pose a serious potential route for enhancing HIV transmission in China. Aware of this threat, the National Institute of Virology now coordinates the monitoring of STDs. Screening of groups with high rates of STDs is routine in tourist areas, coastal "special economic zones," and the twelve provinces with epidemiology surveillance stations (Xu and Fan 1990).

At the medical level, seroepidemiologic, virologic, and clinical research studies are under way (Ji and Su 1990; Wang, Shao, and Zeng 1990; Zeng 1990). Studies have also been undertaken using traditional Chinese medicinal herbs (Su 1990; Wu 1990) and even *qigong* (breathing exercises) (Cui 1990). Some herbal remedies have shown *in vitro* antiviral action against HIV-1, although the scope of this work is very limited at present (Guan 1990; Jin 1990).

China has recently requested assistance from abroad in managing HIV. In March 1990 WHO was asked to help formulate a three-year national program for HIV/AIDS control. The program's aim is to strengthen local efforts while attempting to bring these into conformity with global HIV/AIDS policies and strategies (FBIS 1990a; Peabody 1990). The plan calls for perfecting epidemiologic assays and surveillance work, coordinating established medical resources at the provincial and municipal levels, training health personnel, and targeting populations perceived to be at risk (Zhang 1990). In November 1990 the First Sino-American Symposium on the Management of HIV Disease took place in Beijing. Hosted by the Chinese Medical Association, the symposium brought 148 American delegates with wide-ranging expertise to China for technical exchanges with Chinese counterparts.

Travel throughout China by the author made field assessments of medical facilities and interventions possible. HIV-infected individuals are treated with a regimen of traditional Chinese medicine (TCM) and Western medicine, but this is mediated by a patient's locale, access to medical clinics, and access to available technology. In outlying prefectures little medical intervention is possible. In the West zidovudine/azidothymidine (AZT) treatment is an accessible alternative when a patient is in progressive T4 cell immunosuppression, and clinical programs of ddI, recombinant CD4, and interferon are at least trial options for some. HIV-positive Chinese, however, have none of these. In the clinic as well as the laboratory in China, TCM is increasingly relied on as a feasible therapeutic alternative.[8]

Presently, Chinese medical facilities are not able to provide ongoing interventional medical therapy—in the Western tradition—for HIV/AIDS. Should viral infection grow to any significant extent in the population, resulting in the development of a large AIDS caseload, the medical infrastructure would be hard pressed to deliver medical care by any Western standard. Health care expenditures in China provide an average of only eight dollars per person annually. Hospitals in general suffer from lack of funds, and in some provinces up to one-third are already "bankrupt" (*China Daily* 1991c). The cost of azidothymidine (AZT) and pentamidine alone can average three hundred dollars a month. Moreover, the lack of the medical technology required for the application of aerosol pentamidine for *Pneumocystis carinii* pneumonia and for the administration of various therapies would be compounded by shortages in equipment, laboratories,

and even sterilization methods (Chi 1990; He 1990). Overall, such a shortage of funds, necessary facilities, and testing laboratories, and the lack of experienced public health personnel would severely impede medical interventions.

Inevitably, questions also arise as to how this anomaly of two distinct medical traditions—TCM and Western medicines—can jointly prevail against HIV/AIDS. Policy concerns come clearly into view if one considers the inherent worldview differences these systems represent. Western science underscores empirically tested clinical interventions: technically the goal of Western science is to continually test and modernize, and ideologically to be open to modifications, following the tradition of empiricism. Chinese traditionalism emphasizes subjective therapies and standardization of interventions based on an epistemology of disease that is in harmony with conceptions of the universe, conceptions that are themselves rooted in Chinese mythology. In an herbally rich but technologically and monetarily deficient context, the final outcome of the clash between these two medical systems will only be determined by the pressures that HIV/AIDS itself will impose. Nevertheless, tradition-based thinking is likely to complicate China's ability to move beyond prevention and into effective long-term medical interventions.

PROPAGANDA AS PREVENTION POLICY

Often ignored in studies of HIV-infected societies are ideological differences that exist between Western nations and those professing various forms of socialism. Epidemiology attempts to maintain political neutrality. However, political differences do impose themselves on, and influence, any methodology used to prevent HIV in a population (Mann 1987, 1988; Sabatier 1989). This section deals with prevention education and its complications in Chinese culture, where sexual mores are tied to an "official" and socialist ideology of sex. China's growing modernization has demanded that the vocabulary of Chinese politics be informed by the norms of its evolving popular culture. However, in the arena of sexuality and in light of the exigencies that HIV imposes, dialogue between official perceptions and modern sexual realities is a difficult undertaking.

The government is convinced that appropriate sexual education ("propaganda," as it is nonchalantly called by the Chinese health authorities) is the cornerstone of preventive sexual behavior, and that it will also change behaviors oriented toward high HIV risk (FBIS 1990b; Dai 1990; Tong and Fang 1990). To understand this view of change, one must consider how the state views sexuality and people, and how these perceptions were formulated over time. Such views become critical factors in determining the success of any HIV prevention effort in the Republic of China.

China's epistemology of sexuality is not "scientific" by Western stan-