policy

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CHINA

HOW THE DECLINE IN PEPFAR FUNDING HAS AFFECTED KEY POPULATIONS

Brief

The Issue

Due to social and political barriers, many governments have been slow to directly support HIV services for key populations (KPs)—men who have sex with men (MSM), sex workers, people who inject drugs (PWID), and transgender people (TG). This hesitation has historically led donors to provide the bulk, or in some instances all, of the funding for KP-specific programs. As donor budgets for HIV have flat-lined, funding for HIV services and programming has decreased, particularly in countries with higher income status and concentrated HIV epidemics. This trend has left key populations especially vulnerable.

Ahead of many other countries, China saw a withdrawal of most of its international HIV donors between 2010 and 2013, including USAID. For this reason, China presents a unique opportunity to examine the effects of a donor phase-out on KP-programming, both in terms of coverage and quality. In 2015, in order to examine the implications for key populations of reduced donor funding in China and to provide guidance for future transitions, the USAID- and PEPFAR-funded Health Policy Project (HPP) conducted a desk review and interviewed 48 key informants from civil society, local government, and international donors. The resulting case study offers lessons learned on how donors can ensure the resiliency of HIV programming for key populations while undergoing funding transitions.

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The Context

China's HIV epidemic is concentrated both geographically and among MSM and PWID. Just over 83 percent of people living with HIV (PLHIV) reside in 12 (out of 31) provinces, with the highest rates in southwestern provinces of Sichuan, Yunnan, and Guangxi (NHFPCPRC, 2015).

In unpublished studies conducted in 2011, China estimated that there were 2.76 million PWID, 2.47 million FSW, and 3.83 million MSM residing in the country. There are no HIV prevalence or population size data pertaining to TG, and a corresponding dearth in targeted programming. In recent years, HIV prevalence has decreased among FSW and PWID, but increasing HIV prevalence among MSM, particularly young MSM, is a cause of concern in China. In 2014, over a quarter (28.4%) of new HIV infections occurred among MSM, compared to only 2.5 percent in 2006. Further, it is estimated that HIV prevalence among MSM could be as high as 17-18 percent in certain urban areas and 26.2 percent in Sichuan province (HIV and AIDS Data Hub for Asia-Pacific, 2015). There has also been a rapid increase in same-sex relations as a reported mode of transmission (Figure 1), however, many cases reported as heterosexual transmission may be non-disclosing MSM.

China-at-a-Glance[1]

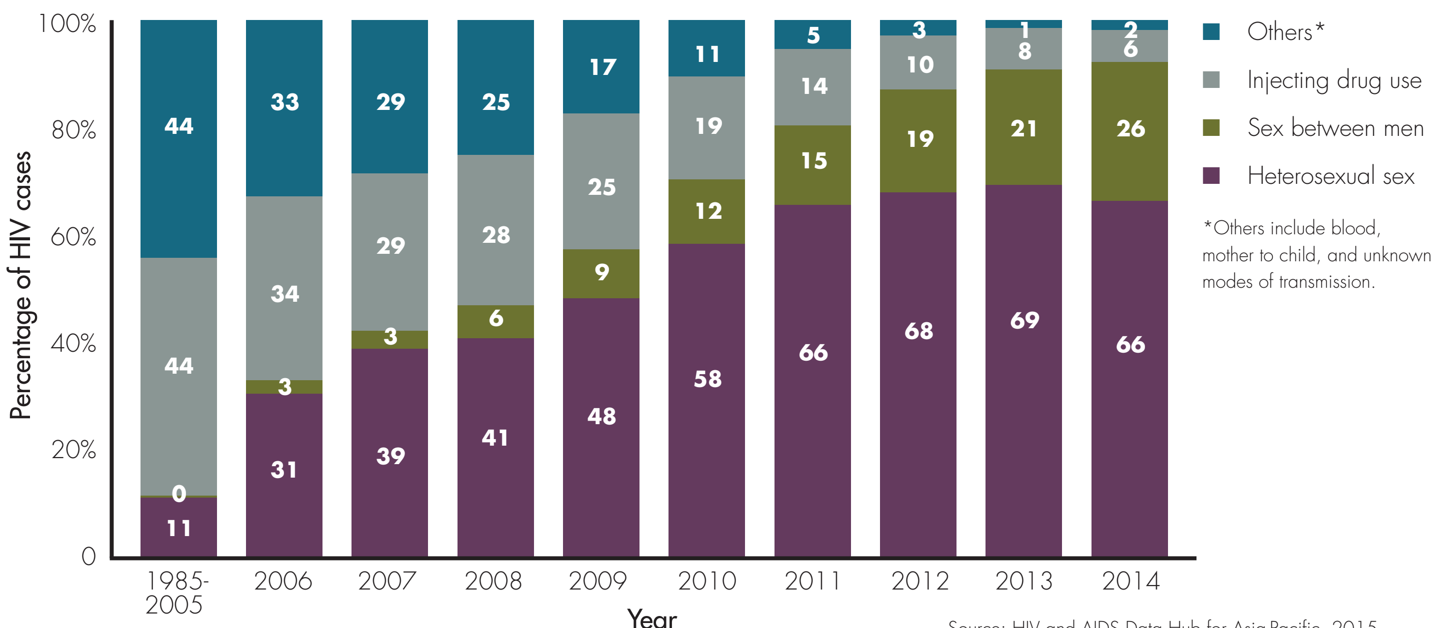
Population: 1,364,270,000
GDP per capita (current US$): 7,590
HIV epidemic type: Concentrated
Number of PLHIV: 501,000
HIV prevalence:
- Total population (all ages): 0.037%
- FSW: 0.2%
- MSM: 7.7%
- TG: No data available
- PWID: 6.0%

International HIV funding: US$8.87 million
- PEPFAR funding: US$1.5 million

Domestic HIV funding: US$989.14 million
Existence of laws criminalizing:
- Any aspect of sex work: Yes
- Consensual same-sex relations: No
- Drug use: Yes

[1]All data are for 2014; Population and GDP data come from World Bank, 2015; PEPFAR funding data come from RDMA, 2015; All other data come from NHFPCPRC, 2015; International funding includes UNAIDS, World Health Organization, United Nations Populations Fund, United Nations Children's Fund, PEPFAR, US-CDC, and Merck & Co.

Figure 1. Proportion of Annual HIV Cases by Reported Mode of Transmission, 1985-2014



Source: HIV and AIDS Data Hub for Asia-Pacific, 2015

Conversely, the proportion of new HIV infections among PWID decreased from 34.1 percent in 2006 to 6.0 percent in 2014, but like MSM, prevalence among PWID remains high in some areas; 25.6 percent in Kunming, the capital of Yunnan, and 37.2 percent in Urumqi, the capital of the Xinjiang Uyghur Autonomous Region (HIV and AIDS Data Hub for Asia-Pacific, 2015).

The legal and social context

Drug use and sex work are both criminalized in China, although sex work is better tolerated than drug use, which is highly stigmatized. While same-sex relations are not criminalized, MSM and TG individuals also suffer from significant stigma, and there are no laws that protect gender or sexual minorities against discrimination.

Civil society organizing is tightly managed and controlled by the Chinese government. Most HIV civil society organizations (CSOs) in China are founded and managed by local government officials; others more closely resemble loose groups of community volunteers or working groups, rather than autonomous organizations. Although donor influence significantly increased the number of HIV CSOs operating in China, the difficulty of CSO registration has been a consistent barrier toward formal funding and continued sustainability. Unregistered CSOs are required to receive funding through government management partners, which exercise varying levels of influence over program management. The lack of a robust civil society in China complicates reaching key populations, who are highly stigmatized, criminalized (in the case of sex work and drug use), and therefore are often reluctant to engage in government-sector services. Community-based services for key populations, provided through peers, are often the preferred service delivery point for these hidden and hard-to-reach populations.

Key informants described China's approach to key populations and its HIV epidemic generally as "pragmatic" and data- and quota-driven. For example, at provincial and municipal levels there are quotas for HIV testing; antiretroviral treatment; and opioid substitution therapy, which China scaled up significantly based on its demonstrated effectiveness and in spite of its controversy in other countries. While the Government of China (GoC) has not prioritized human rights as part of its HIV response, the GoC is willing to implement evidence-based KP programming, including peer approaches, to eradicate HIV. Despite this approach, public health and law enforcement officials are often at odds. Informants reported security personnel waiting outside drop-in centers to arrest FSWs, that both FSWs and PWID are often subject to forced testing, and that PWID may be detained in involuntary detoxification centers even though community-based rehabilitation models have been developed (some PEPFAR supported) (Kamarulzaman and McBrayer, 2015). Further, law enforcement may be alerted through an electronic system any time a former or current drug user shows identification, which serves as a barrier to testing and treatment.

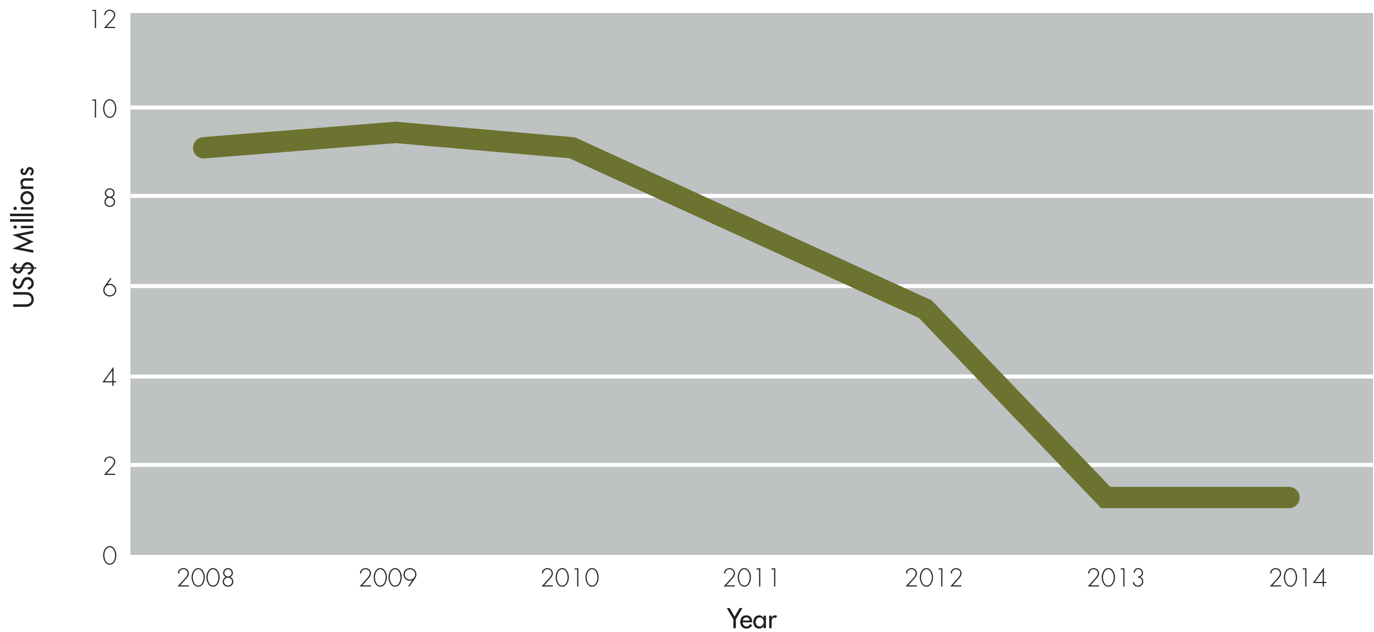
The Funding

Between 2010 and 2013, international HIV funding all but disappeared from China. Prior to 2013, China was one of the largest recipients of funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), receiving US$324 million in HIV funding between 2003 and 2013. However, as an upper middle income country, China was no longer eligible to receive grants under the Global Fund's New Funding Model after 2013. Similarly, the Clinton Foundation stopped funding HIV in China in 2010, the UK's Department for International Development closed its bilateral aid program in 2011, AusAID ended bilateral assistance to China in 2013, and the Bill & Melinda Gates Foundation (BMGF) finished its major HIV investment in China in 2013.

PEPFAR provided modest funding to China from 2003–2013 via USAID and the U.S. Centers for Disease Control and Prevention (US-CDC). US-CDC continues to operate an office in Beijing with an annual program budget of US$1.5 million (see Figure 2).

After donors withdrew, China had no observable difficulty financing its HIV response given its strong economy. China spends an estimated 5.6 percent of its gross domestic product (GDP) on health expenditures (World Bank, 2013) and the government financed almost all (99%) of its US$987 million in HIV expenditures in 2014 (NHFPCPRC, 2015).

Figure 2. PEPFAR Funding to China, FYs 2008-2014



Source: Compiled by HPP from PEPFAR Country Operational Plans

PEPFAR's Transition

PEPFAR's China program aimed to develop "replicable intervention models that [could] be adopted and financially supported by the Chinese government as part of the national response" (US Mission to China, 2006, p.15). The US-CDC program, which began in 2003, focused on expanding HIV surveillance systems and linking provincial responses to national-level strategy and policy. A year later in 2004, the USAID program was launched to provide technical assistance in only two provinces, Yunnan and Guangxi, focusing on PWID and SWs, and later MSM, in response to China's changing epidemic. USAID did not have national-level programming, but rather focused on the southern provinces due to the high burden of HIV among key populations and the common epidemiologic dynamics and cross-border implications to neighboring countries. This was part of a Mekong regional strategy that included Burma, Laos, Thailand, and Vietnam.

In response to Congressional criticism about providing development assistance to China during the U.S. economic downturn, USAID Washington decided to withdraw HIV programming from China in 2011. However, the Office of the Global AIDS Coordinator at PEPFAR supported a longer transition, allowing a two-year extension for USAID's HIV program. In 2011, when the decision to withdraw was made, USAID had three regional HIV projects operating in China; two of these were scheduled to end in 2012 and the third in January 2016. For this third project, the decision to withdraw resulted in a truncated workplan and only 18 months of project implementation, reducing what the project was able to achieve in terms of capacity building and sustainability. In 2013, as the end of the two-year extension period neared, the China program, which had been planned and reported through a Country Operational Plan, was subsumed within the PEPFAR Asia Regional Operational Plan.

Although USAID had hoped to transition some of the CSOs it had supported to Global Fund grants, the Global Fund withdrew from China soon after USAID. However, some CSOs did secure funding for one year before the Global Fund grant ended.

The decision to withdraw from China was characterized by U.S. government informants as a political "knee jerk reaction" that left them feeling as though "the rug was pulled out from under [their]

feet" (KI, 2015). Informants described USAID's transition from HIV as hasty and without sufficient time to develop sustainable capacity support models or domestic funding mechanisms, particularly given the departure of Global Fund and other donors.

USAID is credited with demonstrating the importance of evidence-based approaches, community involvement, and MSM programming in Yunnan and Guangxi. International donors that channeled funds directly through the GoC at national level, however, may have had more political leverage and influence on GoC programming approaches. The Global Fund, BMGF, and US-CDC all disbursed funding directly to the GoC, which has adopted these funders' quota-based model, under which funding is disbursed based on the number of people tested for HIV. Conversely, USAID focused on developing provincial-level relationships, using evidence of increased testing uptake through peer-based approaches. The agency's minimal presence in Beijing, beginning in 2008, gave USAID some opportunity to gain national-level buy-in for its model approaches, in coordination with US-CDC and the United Nations Joint Programme on HIV/AIDS (UNAIDS).

The Challenges

Due to a weak civil society in China and the historic dependence of most HIV CSOs on international donors, many stakeholders were concerned that the USAID-supported, KP-led CSOs in the two provinces USAID operated in would not withstand the transition. Fortunately, some of the CSOs did survive and continue to provide services with domestic funding, largely due to the high-quality partnerships they developed with local government units. Yet the withdrawal of USAID from China has created some challenges for the country's key populations:

Difficulty in obtaining funding for HIV programming

The GoC developed, and continues to refine, national- and provincial-level funding mechanisms called social service outsourcing (SSO), through which CSOs can apply for HIV program funding. Developing these funding mechanisms takes time, and trial and error and insufficient overlap with donor funding can lead to service provision gaps. While international donors withdrew in 2013, the national SSO mechanism only began accepting applications in July 2015, and funds will not be available until sometime in 2016. The Yunnan SSOs began accepting applications in 2013 and the Guangxi SSO in 2014. One key informant referred to the national mechanism as a "pilot" program (KI, 2015).

Through the SSOs, the government contracts CSOs to achieve service delivery quotas, an approach that limits CSOs' scope of work and ability to innovate. CSO informants stated that funding is only disbursed if the contractor meets the proposed testing quotas (KI, 2015). In the first year, the funding in Yunnan Province only supported direct intervention costs, creating a significant challenge for sustainability, but now some percentage of overhead costs can be covered. Domestically-funded services are also narrower in scope, only including basic, government-approved services. For example, the Yunnan SSO, which is the most mature, does not provide funding for coordination, policy, advocacy, stigma and discrimination reduction, legal support, or other efforts aimed at fostering an enabling environment that could be considered politically-sensitive.

Some previously USAID-funded CSOs continue to provide services supported by this funding mechanism, but less comprehensively and with a reduced scale. For example, sexually transmitted infection facilities in drop-in centers, previously supported by USAID, are not funded under the SSO, purportedly because such services were too expensive. Some CSOs have declined to apply for SSO contracts, fearing a threat to their autonomy; one CSO informant felt it was "more trouble than it was worth," while another worried that it would skew their organization's mission and transform it in unacceptable ways (KI, 2015). While CSOs are not required to register in order to qualify for domestic funding, CSOs are required to have a government management partner—often a provincial- or local-level office of the Chinese Centers for Disease Control (China CDC)— which exert significant control over finances and programming. The SSOs have been criticized as instruments of the GoC to regain control over the HIV response after a period a donor influence (Teets and Jagustzyn, 2016).

Uneven CSO sustainability and capacity

Key informants estimate that the number of HIV CSOs in China dropped by more than two-thirds (from 1,500 CSOs in 2011 to 476 in 2014) after donors withdrew funding. Many of those that did survive were forced to downsize. While KP stakeholders concluded that CSOs closing or downsizing directly reduced intervention coverage, government officials mostly denied this (KI, 2015).

Many informants characterized a CSO's relationship with its government management partner (usually China CDCs) as the most important determinant of sustainability, reflecting civil society's lack of autonomy in China. Smaller and newer groups, those with undiversified funding, less mature leadership, or weaker relationships vis-à-vis their government management partners, were likely to close. In some instances, the loss of international funding changed the fundamental character of CSOs. Many KP groups lost their organizational autonomy as their members became contract employees for the groups' government management partners. Groups that pre-existed the USAID program and those that had diverse funding were also more likely to survive the transition.

In some instances, the impact of USAID support persists. For example, government-operated, non-governmental organizations and KP CSOs in Yunnan and Guangxi continue to employ skills and tools acquired under the USAID program (e.g., the CBO capacity assessment tool and training manuals, outreach and intervention, peer counseling, behavior change communication, rapid testing, and community needs assessment skills). Moreover, SSO application reviewers noted higher-quality proposals from CSOs that had received USAID capacity building in the past.

Decrease in service quality and coverage

CSO informants felt that the focus on community needs, which was a core determinant of USAID's KP program design, no longer exists in China. Multiple civil society stakeholders stated that the domestic funding mechanism is too quota-focused, pays insufficient attention to quality, and may provide a perverse disincentive to appropriate targeting. Informants relayed accounts of professional "testees" who go from one testing site to another, collecting payments and in-kind incentives. So while data may show that HIV testing has gone up, the number of individuals tested may not have increased. In addition, peer workers are now often managed by provincial or local level China CDC offices, which are responsible for the delivery of most HIV services. Income is based on how many people they successfully test, and many key informants felt that little attention is paid to the capacity of the peer workers to deliver interventions effectively and to follow-up with services for people testing positive, both of which affect program quality.

Lack of CSO technical support and coordination

The level and quality of technical support available to CSOs declined post-transition. Government stakeholders expressed an ongoing need for technical support for front-line interventions, while CSOs had more concerns about organizational viability and the need for capacity building. There is a large, outstanding technical support need around addressing the growing epidemic among young MSM. Though some existing mechanisms provide technical support, they are unable to keep up with the need and informants questioned the quality of their capacity building efforts.

Informants also expressed concerns about a post-transition decline in communication and coordination between and among civil society and the GoC. For example, the MSM technical working groups in Yunnan and Guangxi, which had been supported by USAID, no longer effectively supports capacity development or coordination among MSM groups. In Yunnan, the provincial China CDC may shut down the technical working group since it is mostly inactive (KI, 2015).

Lessons Learned

PEPFAR was a relatively small player in the overall HIV response in China in terms of the total budget, and the USAID program only operated in two provinces. Nevertheless, the specialized technical assistance provided through PEPFAR had a significant impact on KP programming, particularly in elevating the role of CSOs; raising awareness about MSM; and launching community-based, peer-driven, MSM-specific programming in the provinces where USAID had programming. Targeted technical assistance can have a major impact, as demonstrated by the rapid decrease in coverage and quality when this assistance ended.

As PEPFAR plans transitions in various countries, a number of important lessons can be learned from the experience in China:

1. **Plan enough time for transition and develop a transition plan that articulates roles, responsibilities, and planning priorities.** Key informants stated in interviews that a five-year transition period for USAID would have been more effective than the two years allocated. As a result, USAID's withdrawal felt rushed and did not provide enough time for transition activities such as capacity development.

   When multiple major donors pull out of a country at the same time, as they did in China, the impact for CSOs can be severe. To mitigate this, donors should coordinate and communicate on transition planning. The transition period should focus on sustainability rather than piloting new interventions. Some models were initiated in China shortly before transition and did not have enough time to become well established. These were never scaled and did not survive the transition, despite development of a handover plan to local government.

2. **Cultivate government buy-in for KP programming throughout the program period.** In China, evidence of intervention effectiveness was critical to making the political case for domestic support of KP programming. GoC officials appreciated the USAID program's robust focus on data. Proof of the effectiveness of community-based, KP approaches may help governments understand the necessity of these programs to reaching epidemic control.

3. **Develop the capacity of civil society and government to work together to provide sustainable services.** KP-led CSOs are weak in many countries and may need support with registration, resource diversification, development of organization policies and procedures, or other areas. It may also be necessary to develop the capacity of government officials and service providers to effectively serve key populations and to work with CSOs. For example, although the GoC recognizes the need to program for key populations, requests for technical assistance to address the growing epidemic among MSM highlight the ongoing technical capacity gaps. In advance of transition in China, capacity gaps among both civil society and government were identified, but the end of USAID programming precluded further capacity development (RTI International, 2009; RTI International, 2012; Jagusztyn et al., unpublished).

4. **Elicit public commitments on domestic funding levels.** Global Fund asked the GoC to commit to maintaining the funding level after Global Fund withdrew, which the GoC did publicly. However, the funding was not directed to the same types of programming that USAID had supported, as evidenced in the short-term reduction in funding to CSOs and a focus on meeting specific service quotas. A commitment to funding a richer model of KP programming that adequately addresses CSO capacity development needs and attempts to build an enabling environment for civil society engagement in the HIV response, could help ensure these groups are not left behind. This sort of commitment could also boost overall program quality and effectiveness.

5. **Support the development of domestic funding mechanisms, which take time to develop, pilot, and refine.** Funding gaps between international and domestic funding have the potential to facilitate epidemic growth. For MSM in China this drop in funding came at a critical moment in the epidemic. Overlap between donor funding and domestic funding can ease the transition. PEPFAR can also help shape new funding mechanisms by providing technical inputs, convening government and civil society to discuss needs, and facilitating collaboration. An exploratory study in 2012 had identified specific recommendations for SSO program design, including capacity development needs, and anticipated some of the challenges to the current SSOs observed by HPP's interviewees (RTI, 2012).

The Project

This case study is one in a series of four from Bangladesh, Botswana, China, and Guyana that seek to examine the implications for key populations of recent decreases in PEPFAR and other donor funding. Each case study is based on desk research and supplemented by key informant interviews with civil society, local government, and international donor representatives conducted in late 2015. Taken together, these case studies seek to provide lessons learned to PEPFAR in ensuring the resiliency of HIV programming for key populations.

For more information on how the decline in donor funding for HIV programming is affecting key populations and to access related case studies, please visit www.healthpolicyproject.com.

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