Opportunistic Infections:
The Governance of HIV/AIDS in China

Final Report to the
UC Irvine Chew-Liang Chinese Rural Development Research Program

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I. Background

According to UNAIDS, the total number of people living with HIV in China at the end of 2009 was 740,000. The primary route of infection is through heterosexual transmission, although the rate of infection from homosexual transmission is increasing, reaching 14.7% in 2009 (UNAIDS 2011).[1] Antiretroviral therapy (ART) is nationally available, and is provided by the government under the Four Frees and One Care policy. By August 2010, the cumulative number of people on ART had reach 95,631 (ibid). However, in some areas, drug resistance is increasing, and it is estimated that up to 10,000 people will need second line drugs in the coming years.

In 2002, the government began piloting the free distribution of ARV drugs before rolling out the national policy to the rest of the country a year later. By the end of 2003, the Four Frees and One Care policy had been introduced, providing (1) free ART to rural residents of those with financial hardship in urban areas; (2) free voluntary counseling and testing (VCT) services; (3) free drugs to HIV infected pregnant women and testing for newborns; (4) free schooling for AIDS orphans. In addition to this national policy, most places also adopted local policies to supplement these entitlements, such as economic assistance or subsidized health care.

II. Findings

Using ethnographic methods, the preliminary findings from this research highlight two main points: (1) how these policies mediate access to resources and in turn, generate inequalities within communities; and (2) how these inequalities lead to the commodification of HIV/AIDS. In most places, local government will design their own policies to further protect and mitigate the suffering of people living with HIV/AIDS. These policies and entitlements vary from place to place, but often include economic assistance and subsidized medical care and treatment for opportunistic infections. In some communities, these policies are an important part of the everyday lives of people living with HIV/AIDS, lessening their daily burdens, especially in terms of medical care. At the same time, these policies tend to exclude non-HIV infected people, including those with other chronic illnesses, from benefiting from these entitlements. For some non-infected people, this means that they must pay out-of-pocket for healthcare expenses; even with insurance, the benefits for people living with HIV/AIDS are more generous than insurance. Moreover, non-infected people are unable to access economic assistance benefits. These policies, therefore, mediate access to resources and these resources are in turn, determined on the basis (or lack thereof) on a biological disease. In some ways, the policies have produced a kind of illness triage that prioritizes HIV/AIDS over other diseases, and in doing so, ascribes a higher value to the lives of people living with HIV/AIDS.

This kind of inequality is especially acute in rural communities, where households are equally beset by poverty and struggle to afford basic healthcare services. These boundaries of exclusion not only create tension within communities, but also provoke non-infected people to redefine their identity from non-HIV to person living with HIV in order to lay claim to these resources. To do this, non-infected people will develop strategies of collusion in response to their exclusion. For instance, in some cases, people will purchase an HIV infection, that is, some form of record that indicates an HIV status. Others will simply borrow the ID card of an HIV positive person. In each case, non-infected people must produce an illness that doesn't exist, and perform their HIV

[1] UNAIDS 2011. Key Data. Electronic document, http://www.unaids.org.cn/en/index/page.asp?id=197&class=2&classname=China+Epidemic+%26+Response, accessed September 2, 2011.

positive status to be able to benefit from the policies. In part, these strategies reflect the deep inequalities that have been engendered through the policies, and the impact they have had on communities. At the same time, these policies have created a space where being HIV positive has become a mode of survival, one that requires the production and performance of an imagined disease.

It is this production of HIV/AIDS that, in many ways, has transformed it into a commodity in certain communities. For non-infected people to access entitlements, they must *become* HIV positive. In doing so, the disease becomes something that is manufactured, bought, sold, traded or exchanged for different purposes. For instance, the HIV infection can be bought by a person in order to collect on benefits; it can be sold for a profit; it can be traded for services, such as using an HIV infection (or the perception of one) to avoid confrontations; it can be exchanged between infected and non-infected people. The manufacturing of HIV/AIDS ensures a person's inclusion and access to benefits otherwise denied to them. The commodification of the disease becomes a way for non-infected people to reconcile their own lives and exclusion to the policies.

III. Conclusion

The epidemic in China offers a useful lens into understanding the impact of public health policies once implemented on the ground, the effects they have on intended and unintended populations, and the implications of these policies on a broader scale. Although meant to mitigate the suffering of people living with HIV/AIDS, these policies often lead to unintended consequences that further exacerbate the conditions for non-infected people. The preliminary findings from this project indicate that the effects of these policies are more acute on the non-infected population than the intended beneficiaries, and have created more inequalities within communities. In response to these inequalities, people must redefine their own identities and use different strategies to ensure their inclusion in and access to basic resources. Thus, inasmuch as the policies have protected people living with HIV/AIDS, in other ways, they have done so at the expense of others.

Figure 1: The exterior of a village clinic.