

8 GOVERNING SEXUAL HEALTH IN THE PEOPLE'S REPUBLIC OF
CHINA

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China's post-1978 shift from a planned to a market economy has been accompanied by the withdrawal of the Party-state from much of its previous commitment to social welfare provision. This situation has not only heightened people's vulnerability to basic risks, but also generated new expectations that individuals will become more self-regulating in areas such as health management, education and job creation (Hyde 2007 151–2; Saich 2004: 1–27). In China today, as in many western societies, health increasingly is viewed as a commodity — something that can be bought and sold through privatized healthcare programmes or the consumption of health products — and as an individual goal — it is an individual's moral and social responsibility to be healthy and to remain healthy. In other words, health is not just a 'base or default state'; it is something to be monitored, protected and worked toward via the maintenance of a healthy life-style, both for the sake of oneself and for the good of society as a whole (Clarke *et al.* 2003: 162, 171–2).

Although the government-led promotion of public health has an established history in the People's Republic of China (PRC), this concern now extends to the new arena of sexual health. Sexual health comprises a recent object of governmental concern due to the early Communist Party's successful eradication of active venereal disease from 'New China' by the mid 1960s (Abrams 2001: 429–40). Following its assumption of national political power in 1949, the Chinese Communist Party (CCP) declared that syphilis and gonorrhoea were preventable social diseases stemming from the exploitation of man by man: their root causes being 'poverty, prostitution, ignorance, and the subordinate status of women' (ibid.). Through a combination of campaigns involving mass education, the virtual eradication of the prostitution industry and the large-scale provision of costly penicillin, the CCP announced to the World Health Organization (WHO) in 1964 that active venereal disease no longer existed in China, i.e., it no longer constituted a public health problem (Abrams 2001: 429–40; Chen *et al.* 2007: 132–8; Horn 1974; Remez 2000: 141; Zhang *et al.* 2004: 41).

Since the mid 1980s, the PRC Government has acknowledged not only the rapid resurgence of prostitution and sexually transmissible infections (STIs),¹ but also accepted that the PRC's revolutionary history has complicated initial responses, with no doctor under the age of 45 to 50 having even seen a case of active syphilis or gonorrhoea until the 1980s (Abrams 2001: 429–40; Rosenthal 1999). Yet the incident rate of STIs in China has risen sharply over the last twenty years and STIs now rank among the PRC's most prevalent reportable infectious diseases. 703,001 cases were registered in 2005, compared to 461,510 cases in 1997 and 5,838 cases in 1985 (Rosenthal 1999; Zhang *et al.* 2004; Chen *et al.* 2007). Among the most common STIs

in China today, non-gonococcal urethritis/cervicitis has the highest reported incidence (19.8 per 100,000), followed by gonorrhoea (13.0 per 100,000), condyloma acuminata (10.2 per 100,000), syphilis (8.7 per 100,000) and genital herpes (2.1 per 100,000) (Xing ai zhongxin 2006). Health officials further suggest that under-reporting makes these figures highly conservative, since STI patients frequently seek treatment from private — commercial, unlicensed and often illegal — clinics in order to avoid the social stigma associated with contracting an STI and having their details registered with government authorities (Detels *et al.* 2003: 803; State Council 1998; Zhang Kong-Lai *et al.* 2004: 41).

Concerns about sexual health in present-day China relate to the resurgence of standard STIs *and* the new threat posed by HIV/AIDS, a focus premised on the understanding that individuals with a current or past history of STIs are more likely to contract or transmit HIV than those without (Abrams 2001: 429–40; Chen *et al.* 2005: 853–4; Detels *et al.* 2003: 803; State Council 1998; World Bank 1999). Scholars usually divide the spread of HIV/AIDS in the PRC into four stages (Avert.org 2007; Smith 2005: 66–8; Zhang *et al.* 1999; Zhang *et al.* 2004: 39–40). Stage One (1985–8) began with the identification of China's first AIDS case in Beijing in 1985 and was followed by the identification of 22 more 'imported' cases. These cases mainly involved overseas Chinese and 'foreign' residents in China and were located in coastal cities that had been opened to export-orientated economic development and foreign investment. Stage Two (1989–93) relates to the identification of HIV-infected persons among intravenous drug users in southwest China (Yunnan Province and Guangxi Autonomous Region) and in the far western region of Xinjiang. Such cases are linked via their geographical location

with drug-using cultural practices among ethnic minorities. Stage Three, starting in late 1994, is associated with commercial plasma donors or the practice of contaminated blood being circulated to original donors and the recipients of blood transfusions (Anagnost 2006: 509–29; Avert.org 2007; Gu and Renwick 2008: 89–91). By 1998, HIV infection had been reported in all of China's 31 provinces, autonomous regions, and municipalities, with over 70 per cent in the countryside (Avert.org 2007; 'China AIDS survey' 2003; Zhang *et al.* 2004: 39).

Since 2001, the spread of HIV/AIDS in China has reached a Stage Four pattern in that the rate of domestically generated HIV infections has increased and many new cases are linked to sexual transmission (Avert.org 2007; Smith 2005; Zhang *et al.* 2004). Figures published by the PRC Government, along with WHO and UNAIDS, in January 2006 suggest that 650,000 people are now living with HIV in China, including about 75,000 AIDS patients (Avert.org 2007). The majority of this group are young people, with 60 per cent of China's total HIV population being between 15 to 29 years of age and the second highest group being between 30 and 39 years of age ('China AIDS survey' 2003). China has a huge youth population of 15–24 year olds, an estimated 217 million young people in 2004 or 18 per cent of the total world youth population (Tang 2006). Many such youth are sexually active but have limited knowledge of STIs and HIV/AIDS. The nationwide promotion of sex education and condom use consequently is seen as essential for averting an epidemic (Kaufman 2005; Tang 2006).

Acknowledging the potential for an HIV epidemic, China's State Council issued a circular in 1998 stating that the unchecked spread of STIs-HIV poses a serious public

health problem which could threaten national socio-economic development (State Council 2004; Pan and Huang 2006). A 2001 UNAIDS report on China's AIDS situation more dramatically describes it as a 'titanic peril', claiming that the country is poised 'on the verge of a catastrophe that could result in unimaginable human suffering, economic loss and social devastation' (UNAIDS 2002). In fact, although China's HIV infection rate among adults is low by world standards (less than 0.1 per cent) (Zhang *et al.* 2004: 39), the United Nations (UN) estimate that 10 million people in China will be infected with HIV by the year 2010 ('China aware of threat to vast population' 2000; Smith 2005: 65).

Domestic and international concerns over China's soaring rate of STIs-HIV/AIDS have prompted demands for immediate government action and encouraged a new focus on individual 'risk-taking' behaviours, especially needle-sharing among intravenous drug users and engagement in unprotected heterosexual and homosexual intercourse (Detels *et al.* 2003: 803; Smith 2005: 67–8; State Council 1998). This emphasis mirrors dominant paradigms in international social research vis-à-vis the prevention of HIV/AIDS and associated intervention programmes, which stress the identification of risk-taking behaviours and the subsequent provision of surveillance and education so that individuals can learn how to modify and self-regulate those behaviours (Altman 1999: 559; Smith 2005: 65–80). This focus is far from a neutral reflection of 'reality', irrespective of how that term is understood. The evaluation of risk rationalizes surveillance and surveillance works to standardize and calculate risk more precisely, with certain subpopulations and individuals being judged in terms of their perceived degree of risk, i.e., whether they are at 'high' or 'low' risk. Measures for calculating risk

are therefore normalizing techniques; they attempt to assure the life of the population by setting standards of appropriate behaviour (Clarke *et al.* 2003: 172).

This chapter examines the emergence of ‘sexual health’ and the nature of its governance in present-day China with reference to Michel Foucault’s concept of governmentality (Foucault 1991 [1978]: 87–104). Defined as ‘the conduct of conduct’, that is, any more or less calculated means of directing how we behave and act, the concept of governmentality is concerned with the ‘how’ of governing: how we govern; how we are governed; and the relation between the government of the state, the government of others and the government of ourselves (Dean 1999: 1–3). Accordingly, the first section examines how the concept of sexual health is being developed and circulated in China today, noting its links to normative conceptions of appropriate sexual behaviour and threats of disease. It then explains how governmental concerns over the spread of STIs-HIV/AIDS have been transformed into a focus on the risk-taking behaviours of those categorized as members of potentially vulnerable subpopulations. Section two discusses how concerns about STIs-HIV/AIDS transmission from potentially vulnerable subpopulations to the general population have led to the establishment of a comprehensive but somewhat problematic surveillance system. The third section examines how sexual health awareness is being popularized in China by comparing two different examples of STIs-HIV/AIDS education, one aimed at young people through the education system, and another directed at (migrant) sellers and buyers of commercial sex through low literacy intervention programmes. In conclusion, we argue that the example of sexual health demonstrates that government in China has shifted towards the construction of individual subjects who are capable of exercising self-

government, albeit a moral form of self-government premised on the cultivation of self-respect and the exercise of self-control.

Conceptualizing sexual health in the PRC

Xingjiankang — the Chinese term for sexual health — emerged into public discourse in the 1990s and is a literal translation from the English. Although the term has yet to be included in a Chinese dictionary, it contains two components: *xing* (sexual) and *jiankang* (health). ‘Health’ is usually defined as ‘the normal functioning of all the physical mechanisms of the person, without any disease or deficiency’ (*ren de yiqie shengli jineng zhengchang, meiyou jibing huo quexian*) (Zhongguo shehui kexue yuyan yanjiusuo 1998). However, in recent years, medical experts and the Chinese mass media have begun to promote and popularize WHO’s broader understanding of health as referring to ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (World Health Organization n.d., 2006). The adoption of this understanding in China marks a shift away from a biomedical model of health towards one that is based on a combination of social, psychological and biological factors.

The sex-related component of the Chinese term ‘*xingjiankang*’ has three broad connotations. First, health educators use the term in relation to discussions of reproductive health (*shengzhi jiankang*), which is another new and imported phrase in the Chinese health lexicon. Sexual health in this context is understood as involving a safe and satisfying sexual life, based on an equal relationship between husband and wife,

and without any sexually transmissible infections (STIs), unwanted pregnancies, or associated problems that may cause physical, psychological or social harm to the individuals concerned ('Shenme shi xingjiankang' 2005).

Second, China's health educators use the term '*xingjiankang*' to refer to a broader combination of reproductive, physical and psychological health. Sexual health in this sense refers to a human being with not only a 'healthy' physical body and sexual desires, but also a 'healthy' and educated understanding of emotions, love, social morality, social behaviors, and social relationships. In particular, 'healthy' means having a sexual relationship that can be characterized as 'mature, responsible, monogamous, and honest', that 'conforms to accepted standards of social and individual morality', and that is not marred by 'harmful feelings of shame or sinfulness' (ibid.). The term *xingjiankang* thus variously refers to notions of reproductive health and well-being, both of which are underpinned by morally-based conceptions of the appropriate nature of legitimate sexual relationships, i.e., they should be monogamous, heterosexual and preferably marital (see also Sigley 2006: 49–52).

Finally, the term '*xingjiankang*' is usually associated in both popular and medical discourses with sexual ill-health or medically-based efforts to cure apparent or perceived problems such as sexual dysfunction, impotence, loss of libido, and premature ejaculation (McMillan 2006: 124–38; Pan and Emil 2001). With the introduction of health promotion programmes and the commercialization of STI clinics, it also has become associated with the prevention of STIs and HIV/AIDS. This link has reinforced the popular equation of sexual health with disease, even though discussions of sexual

desire and sexual pleasure can be found on the Chinese internet and the commercial sale of 'adult goods' is increasing (McMillan 2006: 124–38).

The linking of concepts of sexual health with infirmity or disease has been augmented by claims that the PRC is facing an HIV/AIDS epidemic, one that will spread from those subpopulations designated as most 'at-risk' to the general population via sexual transmission (Zhonghua renmin gongheguo weishengbu 2005). China's government initially was slow to respond to the policy imperatives of HIV/AIDS, regarding it as a 'foreign import' and the product of a 'too liberal' western sexual culture ('China AIDS survey' 2003). But it now acknowledges that the spread of HIV/AIDS in China is driven by multiple domestic factors and has become actively involved in prevention work (ibid.). Until recently, needle-sharing among intravenous drug users was considered the major cause of HIV/AIDS transmission in the PRC (Fu 1990), which contrasts with the initial focus of western societies on sex-related transmission among and between the homosexual and heterosexual communities. However, in 2005, an estimated 49.8 per cent of new HIV infection cases in China were reported as stemming from sexual contact, which is higher than the figures for drug-related transmission in that year (Zhonghua renmin gongheguo weishengbu 2005).

Following the established parameters of international HIV/AIDS prevention programmes, government officials and health authorities in China have become concerned about the potential spread of STIs-HIV/AIDS from localized at-risk groups into the general population via the behaviours and practices of members of so-called bridge populations. Bridge populations include: long-distance truck drivers; intravenous

drug users; former blood donors; sellers and buyers of commercial sex; people who engage in casual, premarital, extramarital or non-monogamous sex; and men who have sex with men, that is, men who engage in sexual behaviors with other men, but who do not necessarily self-identify as 'gay' or 'bisexual'. These groups are categorized as most at-risk and major routes of STIs-HIV transmission due to China's relatively low rate of condom use (Choi *et al.* 2003; Pan 2004).

Concerns over the spread of STIs-HIV/AIDS from at-risk subpopulations to the general population also have geographical dimensions in China. In underdeveloped and ethnic minority areas such as Guangxi, Yunnan and Xinjiang, where needle-sharing among intravenous drug users is relatively common, new incidences of HIV infection are connected to heterosexual sexual transmission from persons already infected with HIV/AIDS to their previously uninfected partners. However, the reported incidence of new infections among men who have sex with men is said to be high in major cities such as Beijing (Zhang Chunmei 2007: 5; see also Bates *et al.* 2007: 21–4).

International and domestic concerns over China's rising rate of STIs-HIV/AIDS have further encouraged a focus on perceived risk-taking behaviours among members of China's rural migrant population (Anderson *et al.* 2003: 177–85; Detels *et al.* 2003: 803–8; Smith 2005: 65–80; Zhao *et al.* 2005: 848–52). The relationship between increased rates of mobility and the spread of STIs-HIV has been examined in many contexts around the globe (Herdt 1997; Hugo 2001; Skeldon 2000; Mann and Tarantola 1996, Wolffers and Fernandez 1995; Yang *et al.* n.d.). Such research suggests that certain migrant groups are susceptible to risk-taking behaviours and represent one of the

potentially most dangerous 'bridge populations' in terms of the transmission of STIs-HIV from localized at-risk groups to the mainstream population (Smith 2005: 68–9). Given that China has experienced a population transfer of unprecedented proportions throughout the 1990s and into the new millenium, with an estimated 130 to 140 million people, mostly from rural areas, migrating to cities and towns in search of work, the broad parameters of such studies have been applied to an examination of the Chinese case ('China AIDS survey' 2003; Bates *et al.* 2007; Hyde 2007: 19–20).

Certainly, numerous English-language studies somewhat erroneously suggest that rural migrants labouring in China's cities are more likely to engage in high-risk activities and behaviours than permanent residents of both rural and urban areas (Anderson *et al.* 2003: 177–85; Bates *et al.* 2007: 24–7; Detels *et al.* 2003: 803–8; U.S. Embassy 1977; Zhao 2005: 848–52). A standard claim is that rural migrants working in urban centres are predominantly young, poorly educated and sexually active men, who are not only socially isolated and far away from family constraints, but also have little knowledge of STIs-HIV/AIDS, and virtually no access to preventative education or regular health care. Consequently, they are vulnerable to behaviours that place them at risk of acquiring STIs and HIV, such as intravenous drug use involving sharing needles and engaging in unprotected sexual intercourse, whether heterosexual, homosexual, or commercial, with multiple partners. Moreover, they are unlikely to abstain from further unprotected sexual contact or seek appropriate medical treatment if they acquire an STI ('China AIDS survey' 2003; Yang Hongmei *et al.* 2005: 270–80). Concomitantly, the majority of China's estimated three to 10 million illegal sex sellers are said to be young, uneducated, female migrants, who are highly mobile (Anderson *et al.* 2003: 177–8;

‘China Aids Survey’ 2003; Yang Hongmei *et al.* 2005: 270–80). Recent studies therefore conclude that China’s STIs and HIV/AIDS prevention strategies need to target (migrant) sex sellers and their clients, particularly those who also inject drugs (Chen *et al.* 2005: 853; ‘China AIDS survey’ 2003; Zhou Jinghao 2006: 255).

Although international agendas encourage the targeting of most at-risk subpopulations, there is little reliable evidence to support such a governmental focus in China to date. A report from the HIV/AIDS Prevention and Control Work Committee Office of China’s State Council to the United Nations (UN) in 2005 indicates a low HIV infection rate of 0.5 per cent among female sexual service providers, 0.2 per cent among male buyers of commercial sex, and 1.5 per cent among men who have sex with men in Beijing (Guowuyuan 2005b; Yang *et al.* n.d.). A 1999–2000 nationwide survey of sexual behaviours in China suggests that men with money and power, as opposed to poor migrant workers, may constitute a neglected vehicle of disease transmission, since urban businessmen and government officials are far more likely to purchase commercial sexual services than migrant laborers (Pan 2004). And, a recent survey of young rural migrant women working in urban-based factories indicates that they have an effective knowledge of the utility of condoms in terms of STI and pregnancy prevention (Qian *et al.* 2007). Results from these surveys imply that government-led efforts to promote sexual health and STIs-HIV prevention in China might be better focused on urban rather than rural areas, and at population groups in addition to (poor) female sex sellers and male migrant workers (Smith 2005: 70).

But other studies insist that regional rates of STIs-HIV infection among those categorized as most at-risk are considerably higher than national averages suggest and that members of such groups seldom use condoms and have limited knowledge of STIs-HIV/AIDS and the nature of their transmission (Bates *et al.* 2007; Chen *et al.* 2005: 853–60; ‘China AIDS survey’ 2003; Holtzman *et al.* 2003; Stenson 2003; Yang Hongmei *et al.* 2007: 270–80). International and domestic concerns over the *potential* risk posed to the national health by individual sexual behaviours have therefore encouraged the PRC Government to establish standardized STI clinical services and develop a national surveillance system based on the governmentalizing logic of global HIV/AIDS governance — the imperative to know those most at-risk — and consequently the targeting of certain designated subpopulations. The targeting of these subpopulations as most at-risk and potentially retarding the general welfare and life of the population highlights an obvious point: ‘the significance of risk lies not with risk *itself* but with what risk gets attached to’ (Dean 1999: 177).

Monitoring sexual health

Government-led efforts to promote sexual health awareness in China have changed dramatically over the last decade, partly in response to perceived changes in the nation’s history of HIV/AIDS transmission. From 1985 to 1993, when HIV/AIDS was viewed as an imported disease, government policies focused on preventing the entry of HIV into China. Strategies based on exclusion included prohibiting or monitoring the importation of blood products into China and requiring long-term visitors from overseas to undertake physical health examinations prior to entry, which theoretically precluded the

issue of visas to people who were HIV-positive (Smith 2005: 66). Domestic prohibitions on the production, sale, dissemination, and use of narcotics, and the organization and facilitation of commercial sexual services, were also viewed as limiting the potential spread of STIs and HIV/AIDS.

Policies based on exclusionary and prohibitory strategies were expanded to include a new focus on STIs and HIV/AIDS prevention work from 1994. In 1995, the Chinese Ministry of Health released an ‘Announcement on Strengthening HIV/AIDS Prevention and Control Work’, which led to the State Council’s establishment of the National Coordinating Committee on HIV/AIDS and STDs in 1996. This committee functioned as the leading governmental body with regard to STIs-HIV/AIDS prevention and resulted in the release of two important guidelines: the ‘Chinese National Medium and Long-term Strategic Plan for HIV/AIDS Prevention and Control (1998–2010)’ and the ‘Five Year Action Plan on Preventing HIV/AIDS in China (2001–5)’ (State Council 1998; *Zhongguo e’zhi yu fangzhi aizibing xingdong jihua* 2002). The introduction of both Plans heralded a shift in governmental thinking away from a focus on exclusionary policies towards a focus on STIs-HIV/AIDS prevention through the provision of sexual health education based on behavioural intervention. It also signified an acknowledgement on the part of the PRC Government that HIV/AIDS presented a problem for governance that could not be effectively redressed without a comprehensive national system and without international cooperation and support.

Since 2003, governmental authorities in China have worked to develop the public health system and establish a comprehensive STIs-HIV/AIDS prevention and intervention

model. In April 2003, the PRC Government introduced a pilot program called the China Comprehensive AIDS Response (China CARES); and, later that same year, it introduced the 'Four Frees and One Care policy' (*si mian yi guanhuai*). 'This broad community-based treatment and care program aims to supply free domestically manufactured anti-retroviral (ARV) AIDS medication to HIV patients who contracted the AIDS virus through tainted blood transfusions', starting in the most affected provinces and then developing throughout China ('China AIDS survey' 2003). The 'four frees' are unified under the general policy of providing care and economic assistance to people living with HIV/AIDS and involve: 1) free ARV drugs to AIDS patients who are rural residents or poor urban residents; 2) free prevention of mother to child transmission; 3) free voluntary counselling and testing; and 4) free schooling for children orphaned as a result of HIV/AIDS. Initially targeting geographical areas characterized by severe poverty, a highly mobile population, and a history of unsafe blood collection practices with a high number of commercial blood donors, the CARES program was implemented with the intention that it would be expanded to cover other regions and other members of the population categorized as most at-risk, such as intravenous drug users and commercial sex workers (Avert.org 2007; Gu and Renwick 2008: 94).

The commitment of China's governmental authorities to developing a comprehensive STIs-HIV/AIDS prevention and intervention based on international best practice and behavioural intervention is underscored by the introduction of more recent measures. These include: the establishment of a national committee on HIV/AIDS prevention and control work in 2004; the introduction in 2005 of a second 'Five Year Action Plan on

Preventing HIV/AIDS in China (2006–10)'; and the promulgation of the PRC's 2006 'Regulations on HIV/AIDS Prevention and Control' (Guowuyuan 2006). All of these measures draw on international experience to establish self-help and care groups for people living with HIV/AIDS, to establish needle exchange and methadone treatment programmes for intravenous drug users, and to promote sexual health education and condom use among sellers and buyers of commercial sex, and men who have sex with men.

The development of a comprehensive prevention and intervention model is based on information derived from national STIs-HIV/AIDS surveillance and information systems. China's HIV/AIDS surveillance system has moved through three different stages ('Aizibing — aizibing zhuan ti peixun' 2004). From 1985 to 1994, it operated on the basis of passive surveillance or the reporting of known cases. Between 1995–8, it operated by using a mixture of passive and initiative surveillance, namely, a combination of case reporting and information derived from sentinel sites targeting certain specified groups. Since 1999, China's STIs-HIV/AIDS surveillance and information systems have adopted what is termed a comprehensive system of surveillance. This system consists of various approaches to data collection, including: mandatory case reporting, national and local sentinel surveillance, behavior surveillance surveys, epidemiological surveys, and testing conducted among target subpopulations (ibid.).

Surveillance initially was achieved via mandatory case reporting from government-run facilities, including STI clinics and designated hospitals and clinics at provincial level.

The Chinese National Centre for STD Control was established in 1986 and was soon followed by the launch of a national STD surveillance system by the Chinese Ministry of Health in 1987 (Chen *et al.* 2007). By 1994, 42 sentinel sites were established in 23 provinces under guidance from WHO with a focus on four groups — patients of STI clinics, intravenous drug users, female sexual service providers, and (male) long-distance truck drivers. By 2003, this system had expanded to 194 sentinel sites, with 72 focusing on patients of STI clinics and collating information from 29 provinces, 49 focusing on intravenous drug users and collating information from 21 provinces, 43 focusing on female prostitutes and collating information from 25 provinces, and 11 focusing on long-distance truck drivers and collating information from 25 provinces.

By 2005, and flowing from the expansion of HIV/AIDS sentinel sites which commenced in 1995, China's national sentinel surveillance system had expanded to 329 national and 400 provincial sites (Zhonghua renmin gongheguo weishengbu 2005; see also Bates *et al.* 2007: 6). This system now targets seven subpopulations with 120 sites focusing on patients of STI clinics; 77 on intravenous drug users; 66 on women-in-prostitution; 25 on long distance truck drivers, 37 on pregnant women; three on men who have sex with men, and one on male prostitute clients. Data for 2005 was obtained from 93,067 people across these seven groups (Xing ai zhongxin 2006). China's first sentinel site for pregnant women was established in Yining City, Xinjiang province in 1997, leading to the establishment of 89 national sentinel sites collating information from eight provinces by 2003 (Chen, K. 2005: 1282–3). By 2005, there were three national sentinel sites focused on men who have sex with men. The first was established in 2003 in Harbin City (Heilongjiang Province) and was followed by the establishment

of sites in the cities of Hefei (Anhui Province) and Zhengzhou (Henan Province) respectively (Xing ai zhongxin 2006; Zhang and Chu 2005).

But the development of an extensive surveillance system has not necessarily resulted in more accurate information about STIs and HIV/AIDS trends across China's population. Results are skewed by the focus on those groups already categorized by WHO as most at-risk and by the way data about them is obtained in China. For example, although information about HIV infection among pregnant women comes from antenatal clinics, data about STI and HIV infection among intravenous drug users is derived from information about people who have been apprehended as drug users by the Chinese police and then sent to compulsory detoxification and rehabilitation centres. Likewise, data about STI and HIV infection among women-in-prostitution is usually derived from information about women who have been apprehended by the Chinese police as sellers of commercial sexual services and then sent to re-education centres. Drug users are often apprehended for involvement in petty crime and women apprehended as sex sellers tend to be from the lowest stratum of China's prostitution hierarchy, i.e., streetwalkers or women who work low-grade facilities, and who command a low fee for engagement in the prostitution transaction (Jeffreys 2004: 172–3).

The PRC's current surveillance system is thus biased in that it targets sections of those subpopulations already designated as at-risk by international organizations rather than obtaining more representative information about STIs and HIV/AIDS trends across China's population. Surveillance sites are also predominately located in southern China and along the southeast coast, that is, in more economically developed areas, with little

information being available about the prevalence of STIs and HIV infection in China's western and less developed interior (Jing Jun 2005). In addition, the number of surveillance sites is limited, particularly in relation to target groups such as men who have sex with men and male prostitute clients.

To offset some of these problems, China's health authorities, with assistance from various international organizations, have put in place a national behaviour surveillance survey system (BSS) and attempted to standardize STI clinics and the services they provide (State Council AIDS Working Committee Office and UN Theme Group on HIV/AIDS in China 2004). The BSS was established in 2004 and includes 42 sites from 19 provinces. It aims to monitor behaviour changes among designated at-risk groups by focusing on six target subpopulations: 1) patients at STI clinics; 2) intravenous drug users; 3) women-in-prostitution 4) male long-distance truck drivers; 5) men who have sex with men; and 6) university/college students. BSS information is intended to complement the existing sentinel surveillance system by facilitating the prediction of future trends and the interpretation of data obtained from the national sentinel surveillance system.

In 2005, standardized STI services were adopted by clinics affiliated with the World Bank's China Health Nine Project. Standardization is meant to facilitate more efficient monitoring and evaluation practices, such as case-reporting, clinical practice, laboratory diagnostics and health care, and the formation of routine work plans, training courses, and evaluation protocols within STI clinics (Xing ai zhongxin 2006). To facilitate better

record keeping, and therefore better control the spread of STIs, a real-name system of network reporting was established in 2005 (*ibid.*).

As with the development of an extensive surveillance system, the establishment of standardized STI clinics has not necessarily resulted in more accurate information about STIs and HIV/AIDS trends across China's population. Standardized STI clinics are usually government-sponsored, staffed by qualified medical personnel and provide cheap and reliable services, whereas private clinics are renowned for being more expensive, using unqualified staff (i.e. staff who do not possess a medical degree or diploma), and providing unreliable and often fraudulent treatments. But many people prefer the services of private or commercial clinics because standardized clinics are part of the national sentinel system and they are concerned that information about their activities may come to the attention of government authorities or work colleagues and family members (Detels *et al.* 2003: 803; State Council 1998; Zhang Kong-Lai *et al.* 2005: 41). Consequently, and in accordance with the principles of global HIV/AIDS governance, health authorities in China have begun to popularize sexual health awareness via campaigns that stress not only STIs-HIV/AIDS prevention, but also the professional and strictly confidential nature of standardized STI clinical services.

The next section of this paper compares the different forms of sexual health and HIV/AIDS education programmes that are provided to China's youth and to those categorized as (migrant) female prostitutes and male prostitute clients. The former offers an example of mass education and the latter an example of low literacy interventions aimed at bridge populations. Campaigns to promote HIV/AIDS education

and sexual health awareness in China now focus on youth and migrant populations with the eventual goal of reaching 70 per cent of the national population and 80 per cent of those subpopulations defined as most at-risk. These interventions illustrate how the biopolitics of health in China, as in other parts of the world, is increasingly shaped by what might be termed ‘neoliberal’ strategies of government in that ‘individuals are exhorted to assume responsibility for insuring, monitoring, and acting upon their own health statuses’ (Nadesan 2008: 108).

Popularizing sexual health awareness

China’s municipal health authorities have responded to international and domestic concerns that sexual contact is a new vector of HIV transmission in the PRC by introducing large-scale, low literacy campaigns aimed at popularizing sexual health education and condom use among the general population. CCP-affiliated mass organizations, such as the All-China Women’s Federation, the All-China Youth Federation and the All-China Federation of Trade Unions, now conduct face-to-face education campaigns that target students, rural women, and migrant workers in urban areas, as part of ‘World AIDS Day’ activities (‘Chinese official stresses China’s role in anti-AIDS effort’ 2004). Members of the PRC’s growing number of homosexual communities have begun to work with municipal authorities, and sometimes in the face of local government opposition, to distribute free condoms, to display STIs-HIV/AIDS awareness posters, and to promote ‘safer-sex’ messages in bars and other venues that are patronized by men who have sex with men (Zhao Chunmei 2007: 5). In addition, China’s STI clinics now offer ‘face-to-face’ counselling and ‘hot-line’ telephone, text

and email services for those who desire information about sexual health and HIV/AIDS (Zhongguo jibing yufang kongzhi zhongxin n.d.; Zhongguo xingbing aizibing fangzhi xiehui n.d.).

Public perceptions of condoms and appropriate sexual behaviours in China are also changing dramatically as programmes to promote condom use and safer-sex displace previous understandings of condoms as a contraceptive tool for married couples. The once common term for condoms — *biyuntao* or avoid pregnancy sheath — highlights the historical link between condoms and (marital) contraception in the PRC. This link stems both from the traditional condemnation of premarital sex and the fact that the PRC Government purchases an estimated 1.2 billion condoms annually, from seven suppliers and more than 500 small manufacturers, with a commercial value of between two to 20 yuan for a 12-pack, to support the goals of the One-child family policy ('What do condoms mean to the Chinese' 2002). These condoms are distributed free of charge to married, government employees in state-owned enterprises as a contraceptive device.

Since the late 1990s, corporate entities such as Futures Group Europe and Horizon Market Research, as part of the China-UK HIV/AIDS Prevention and Care Project, have worked to turn condoms into an 'ordinary' commodity to be consumed by China's huge youth market (APCOworldwide.com 2004). The shift to international cooperation vis-à-vis STIs-HIV/AIDS prevention and increasing dependence on market mechanisms to promote that goal has resulted in the emergence of a new term for condoms in China, namely, *anquantao* or safety sheath. This term highlights the use of condoms in relation to safer sex and disease prevention, rather than strictly in terms of the prevention of

pregnancy. It also highlights a new understanding that monogamous marital sex is not the only legitimate form of sex, as illustrated by the recent provision of condom vending machines on Chinese university campuses and in public entertainment venues (Yang Lifei 2008). Both actions demonstrate a growing acceptance that China's sexual culture is changing rapidly, and that Chinese youth and other sectors of the population constitute necessary targets of government-led sex education and HIV/AIDS prevention programmes.

China's massive youth population is viewed as simultaneously vulnerable to STIs-HIV/AIDS infection, but also as a powerful resource in terms of the dissemination and popularization of public knowledge about sexual health. Following the introduction of the 'Five Year Action Plan on Preventing HIV/AIDS in China (2001–05)' (Guowuyuan 2001), the Chinese Ministry of Education issued a regulation that requires schools, colleges and universities to provide STIs-HIV/AIDS education as part of the standard curricula. This regulation stipulates that, as of 2004, junior high schools should provide six hours of HIV/AIDS education per academic year, senior high schools should provide four hours, high schools focusing on occupational studies should provide between four and six hours, and universities and colleges should provide no less than one hour per academic year. Complimenting these measures, tertiary institutions are encouraged to provide theme lectures on HIV/AIDS and related issues (State Council AIDS Working Committee Office and UN Theme Group on HIV/AIDS in China 2004). Since 2006, organizations such as the China Charity Federation (*Zhonghua cishan zonghui*) and the China Education Association (*Zhongguo jiaoyu xiehui*) have also

implemented an AIDS Prevention Education Project for Chinese Youth (APEPCY) ('AIDS prevention education project for Chinese youth launched' 2006).

While efforts to promote HIV-AIDS awareness among Chinese youth have increased dramatically, the promotion of safer-sex practices is conducted alongside moral education that stresses the importance of cultivating 'self-control' and 'self-respect' (*jieshen zihao*), or avoiding premarital sex, rather than focusing on 'safe pleasure'. As in western societies, some programmes even equate safer-sex with the avoidance of premarital sex and casual sex by intimating that non-marital sexual behaviours will inevitably result in STIs-HIV/AIDS infection, rather than stressing the efficacy of condom use. This follows from the original and American-style ABC strategy (Abstinence, Being Faithful and Condom Use) that informed and underpinned international AIDS campaigns in the early 1990s. However, an important difference in China is that education policies clearly state that sex education for high school and tertiary students should focus on STIs-HIV/AIDS and promote a culture of sexual abstinence among Chinese youth and encourage them to practice monogamy when married. Moreover, Chinese youth are instructed that they have a social responsibility — as the future of the Chinese nation — to practice sexual abstinence ('Qingshaonian' n.d.). Given the documented increase in rates of premarital sex among high-school and university students (Pan and Yang 2004), this injunction introduces a new moral onus on China's youth. It asks them to avoid pre-marital sex not simply out of respect for traditional sexual mores and familial obligations, but also as a patriotic duty.

Campaigns to promote sexual health and HIV/AIDS awareness in China now also target sellers and buyers of commercial sex, even though Chinese law prohibits the formation of a commercial sex industry. Based on the perceived success of Thailand's 100 Per Cent Condom Use Program, which is credited with significant increases in consistent condom use and a declining incidence of STIs (at least in its initial stages), the Chinese Ministry of Health, in conjunction with WHO and the World Bank's China Health Nine Project, implemented pilot programmes in 1999 and 2000 (Disease Control Priorities Project 2006). These programmes aim to prevent the spread of STIs-HIV/AIDS by encouraging a commitment to 100 per cent condom use in all commercial sex encounters on the part of women who sell sex, and by the owners, managers, and employees of venues that facilitate the provision of commercial sex. They offer participatory workshops on the nature of STIs-HIV/AIDS transmission and how to use condoms, and encourage the managers of public entertainment venues to provide visible supplies of condoms and put up 100 per cent condom use posters in their establishments (Population Council 2001). 100 per cent condom use programmes are now being implemented throughout China and are supported by law. The PRC's 2006 'Regulations on HIV/AIDS Prevention and Control' states that condom use is an effective method of preventing sexually transmitted HIV infection and that condom use is to be promoted in order to prevent the spread of STIs-HIV/AIDS from key at-risk groups to the general population (Guowuyuan 2006).

Sexual health trainings for female sex sellers began in pilot form as early as 2002 but are now being implemented throughout China as part of the 100 Per Cent Condom Use Program. As part of this Program, municipal health authorities — i.e., state-affiliated

organizations — are running free STIs-HIV/AIDS education classes for women who provide commercial sexual services in entertainment venues, providing them with free boxes of condoms and information about who and where to call should they require further information and assistance, i.e., government-sponsored STI clinics and hotlines (Cai and Huang 2006; Condoms mandatory' 2006; 'Condom promotion' 2007; 'Condom use promoted' 2006; 'Ha'erbin shi "xiaojie" peixunban' 2006; Qiu and Wang 2006). Health workers have used a wide range of tactics to ensure attendance at such classes, primarily to limit the potential for low attendance flowing from the fact that the sex industry is banned in China and prostitutes experience social stigmatization. These tactics include: seeking the active support of managers and owners of entertainment venues; asking local police to halt anti-prostitution crackdowns temporarily; ensuring that local police do not arrest recreational enterprise managers who assist with the implementation of 100 Per Cent Condom Use Programs; and attempting to gain the trust of women who sell sex by treating them with respect, taking them out for dinners and providing them with gifts (ibid.).

The PRC's Centre for Disease Control and Prevention, with the assistance of UNAIDS, has also published and disseminated a number of comic books that advise sellers and buyers of sex about the utility of condoms in preventing STIs-HIV/AIDS (e.g. Zhongguo jibing yufang kongzhi zhongxin n.d.; Zhongguo xingbing aizhibing fangzhi xiehui n.d.). These comic books, or low literacy interventions, aim to minimize the effects of limited attendance at formal sexual health classes by encouraging those who engage in the prostitution transaction to share information about STIs and HIV/AIDS prevention among their peers. They not only stress the importance of safeguarding

individual health by refusing to engage in unprotected sex, but also explain how STIs are transmitted, the long-term health implications of untreated STIs, how to use and dispose of condoms, and how to contact health authorities for further assistance.

For example, a booklet that promotes sexual health and STIs-HIV/AIDS awareness for ‘working girls’ (*xiaojie*) begins by stating:

Sisters, be careful! Pay attention to preventing HIV/AIDS. Having multiple sexual partners is the most dangerous; protecting yourself is the most important. Always use a condom; it is very effective in preventing diseases. It also greatly reduces the risk of contracting STIs, HIV and Hepatitis B (Zhongguo jibing yufang kongzhi zhongxin n.d.: 1).

The text uses catchphrases, often in the form of rhyming jingles, to aid memorization of the steps required to reduce the possibility of STIs-HIV infection. It reportedly was designed by speaking to female sex sellers who operate within commercial entertainment venues and incorporating the language that they use to negotiate the prostitution transaction, for example, referring to male consumers of commercial sexual services as *keren* (guests) who are after some ‘fun’ (*wan*) (Qiu and Wang 2006). The pictorial representations in the text also aim to match the sartorial and personal presentation style of the ‘stereotypical prostitute’ — young, pretty, and wearing revealing clothes, short skirts, and lots of make-up and jewellery (*ibid.*).

Most importantly, the booklet has sections that tell ‘working girls’ how to encourage male buyers of sex to use condoms and how to say ‘if it’s not on, then, it’s not on’ (Zhongguo jibing yufang kongzhi zhongxin n.d.: 10–13). Noting that many ‘guests’ will not want to use condoms, the text advises the prostitute-as-reader to say: ‘Try it, its really fun’, and to be prepared to cajole or trick a reluctant ‘client’ into using them. These tricks include having different types of novelty condoms available for use and explaining that condoms not only help to prevent STIs-HIV, but can also prolong the ‘fun’ time expended before ejaculation. If these tactics fail, the prostitute-as-reader is encouraged to act like a spoilt or sulky child to induce compliance, or to state that they do not take the contraceptive pill and are worried about getting pregnant. If these appeals to masculinity and responsibility also fail, then, the prostitute-as-reader is told to remember that their own health is of paramount importance and hence to say: ‘no condom, no sex’ (ibid.). Media reports of the use of this booklet in training classes for female sex sellers conclude that it offers a popular reminder of personal sexual health protection for the more experienced and is an ‘eye-opener’ for the less experienced (Qui and Wang 2006).

The fundamental aim of such a booklet is to empower women-in-prostitution to protect their own sexual health and to encourage peer-sharing of knowledge about the efficacy of condom use in preventing STIs-HIV/AIDS. Unfortunately, it has the simultaneous effect of making female sex sellers responsible for the safer-sex practices of male consumers of commercial sex. In China, as in many countries in the world, the mobility and ‘invisibility’ of male prostitute clients makes them a difficult target of government and other intervention strategies. Original plans to provide simultaneous trainings for

sellers and buyers of sex in China's recreational venues were abandoned due to client mobility and the refusal of targeted men to admit that they actually engaged in the prostitution transaction (Qiu and Wang 2006). In this particular instance, health workers determined to focus their energies on women who provide commercial sexual services and the managers of the commercial venues in which such women solicit their custom.

As a result, low literacy interventions aimed at male buyers of commercial sexual services are primarily targeted at (rural) migrant workers in the (urban) construction industry. Although there is little reliable data on the sexual consumption practices of male migrant workers, a government-sponsored project on 'HIV/AIDS Prevention Among Rural Migrant Workers' was launched in late 2005 (Guowuyuan 2005a). This project states that China has 120 million migrant workers from rural areas aged between 15 and 49 years, who may engage in unsafe sexual behaviours, or drug related needle sharing, due to limited knowledge of HIV/AIDS and sexual health issues. The project therefore aims to popularize HIV/AIDS education among male migrant workers in order to increase their capacity to protect their own sexual health, and to reduce the potential spread of STIs-HIV/AIDS from this particular subpopulation to the general population.

As with China's youth, male members of China's migrant worker population are charged with protecting the health of the nation, although in this case by being urged to use condoms if they insist on engaging in 'dangerous pleasures'. For example, a comic booklet for male buyers of commercial sex, who are characterized as migrant construction workers, highlights the importance of avoiding unprotected sex in order to protect individual health, the health of one's spouse and one's future children, and

ultimately the health of China's future generations (*Zhongguo xingbing aizibing fangzhi xiehui n.d.*). The text opens with the somewhat improbable image of a group of people who are smiling and holding hands to signify their unity in China's fight against STIs-HIV/AIDS. As they say in unison: 'STIs and HIV/AIDS can be prevented. Having respect for yourself and looking after yourself means protecting yourself'. This group is improbable' because it is comprised of five people who probably would not be smiling in the following circumstances: 1) the head of a migrant worker construction gang; 2) the text's unwitting protagonist — a younger man from the same village as the construction gang head who has joined him to work in the city; 3) the wife of the protagonist (presumably still in the native village); 4) a young female prostitute from the rural hinterland who lives in the city, and whom the protagonist happens to meet and from whom he has contracted an STI; and 5) a female doctor from a government-run STI clinic who treats and cures the protagonist after his male friend persuades him to go to the clinic, and who tells them about the nature of HIV/AIDS transmission and the potential threat that the protagonist's engagement in unprotected sex poses to the health of his wife, his future children, and that the Chinese nation. The text concludes with an equally improbable image — the protagonist and his wife are smiling and standing with their arms around each other, saying: 'Learn how to protect yourself [be faithful or use a condom] and share what you know [about STIs-HIV/AIDS and condom use] with others' (*ibid.*).

The popularization of trainings designed to encourage sellers and buyers of sex to govern their own sexual health is remarkable in the context of China's continued ban on the commercial sex industry. However, in keeping with the focus on protection and

apparent downplaying of pleasure as a determinant of sexual behaviour, such trainings are conducted alongside a broader campaign that stresses the importance of banning prostitution, and ultimately eradicating STIs, as per the historical example of the 1950s. The Yunnan Provincial Government, for instance, released its preferred approach to HIV/AIDS prevention on 1 March 2004, which is described as a ‘One Method and Six [Social Engineering] Projects’ (*yi banfa liu gongcheng*). The six proposed projects for supporting the prevention of HIV/AIDS are: 1) cleaning up the social environment; 2) implementing nationwide HIV/AIDS education and propaganda work; 3) popularizing the use of condoms; 4) promoting clean needles, needle-exchange and methadone programmes; 5) establishing centres for HIV/AIDS support and care; and 6) improving existing surveillance and monitoring systems (Yunnan sheng renmin zhengfu 2004; see also State Council AIDS Working Committee Office and UN Theme Group on HIV/AIDS in China 2004). While not explicitly articulated as such, the aim of the first project — ‘cleaning up the social environment’ — means continuing to crack-down on prostitution, drug use and other behaviours that are both categorized and condemned as social vices and hence in urgent need of corrective programmes of governmental intervention.

The provision of trainings designed to encourage sellers and buyers of sex to govern their own sexual health combined with continued crackdowns on the sex industry is further illustrated by the actions of the Futian police in late 2006. On November 2006, alongside mass media publicity of the 100 Per Cent Condom Use Program, the Futian District police in China’s booming city of Shenzhen held two consecutive public sentencing rallies to illustrate their success in apprehending more than 100 prostitution

offenders, including 10 Hong Kong residents (Cody 2006: A10). This action, as with the policy of the Yunnan Provincial Government, suggests that moral education is viewed as fundamental to the promotion of sexual health and accepted sexual behaviours in China today.

Conclusion

The recent provision of sexual health trainings to Chinese youth, and (migrant) sellers and buyers of sex, is a pragmatic governmental response to the potential threat of catastrophic disease. It turns on the governmentalizing logic of international HIV/AIDS prevention programmes — the imperative to know those most at-risk — with Chinese inflections. International and domestic concerns over the potential risk posed to the national health by the individual behaviours of designated subpopulations have encouraged the PRC Government to develop a national monitoring and surveillance system. The establishment of this system has resulted in the provision of trainings designed to empower those individuals who engage or may engage in ‘risky’ behaviours so that they can better monitor and safeguard their individual health and future. At the same time, it has prompted a focus on (migrant) sellers and buyers of sex, which could function to further marginalize a subpopulation that is already blamed for many of China’s current social problems (e.g. crime), on the grounds that their ‘lack of individual cultivation’ poses a threat to the collective health and wealth of the Chinese nation.

But the example of sexual health also demonstrates that China's old 'socialist arts of government' is being overlaid with new calculations and strategies of government. Sexual health in China today is governed through cooperation with the global HIV/AIDS regime, international organizations, the involvement of diverse state and non-state organizations, such as CCP-affiliated mass organizations, managers of recreational enterprises, and commercial condom manufacturers, and the cultivation by individuals themselves of the capacity to regulate their own health and behaviours. A recent example of this multi-faceted approach to governing sexual health is provided by the 2008 'Life is too good' campaign to promote safer-sex in China featuring celebrity actors Jackie Chan and Pu Cunxin, and soprano Peng Liyuan, and coordinated by the United Nations and the Chinese Ministry of Health through public-private partnerships with the PRC's commercial media and advertisement sector (United Nations in China 2007). The devolving of responsibility for the promotion and enactment of sexual health to both individuals and a diverse array of partnership organizations challenges the widespread view that power is concentrated in a monolithic Party-state, even though the Chinese police continue to govern the realm of commercial sexual relations. It suggests that the act of thinking about and implementing strategies designed to safeguard China's future is also generating changes in the everyday operation of government.

Notes

1. Previously known as venereal diseases and sexually transmitted diseases (STDs), sexually transmitted infections (STIs) are commonly transmitted between partners through forms of sexual activity, such as vaginal, oral or anal sex. In this chapter, we

use the term ‘sexually transmissible infections’ as opposed to ‘sexually transmitted infections’ to denote that sexual contact does not necessarily result in the contraction of an STI. The term STD is used when referring to quotations or organizations that use such terminology, for example, the Chinese Association of STD and AIDS Prevention. However, the term STI is replacing the older imported terminology of STD in China.

Notes

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