The China-Gates Foundation HIV Prevention Cooperation Program

Program Synopsis

September 2013

The China-Gates Foundation HIV Prevention Cooperation Program was the first large-scale public health partnership between the Bill & Melinda Gates Foundation, the government (Ministry of Health [now National Health and Family Planning Commission], Sate Council AIDS Working Committee) and social organizations (Chinese Preventive Medicine Association, Chinese Association of STD/AIDS Prevention and Control, community-based organizations) in China. The US$50 million, six-year program was launched in November 2007 to demonstrate the feasibility of scaling up HIV prevention in 14 large Chinese cities (Beijing, Changsha, Chongqing, Guangzhou, Harbin, Hangzhou, Kunming, Nanjing, Qingdao, Shanghai, Shenyang, Tianjin, Wuhan, Xian) and Hainan Province, targeting persons most vulnerable to HIV infection – men who have sex with men (MSM), female sex workers (FSWs), injecting drug users (IDUs) – and people living with HIV and AIDS (PLHA).

The core of the program utilized a "**Test and Treat**" public health infectious disease control model to reduce HIV transmission. The main components of this model were:

- **Increase case detection for prevention among high-risk populations (test)** – Scaling up community-based outreach, testing and counseling to identify and prevent new infections among the MSM, FSW and IDU populations.
- **Improve case management for prevention among infected individuals (treat)** – Scaling up community-based test results notifications, counseling, health monitoring and treatment adherence support for PLHA to prevent further transmission.

The program placed strong emphasis on supporting community-based organizations (CBOs) to complement the work of the local branches of the Chinese Center for Disease Control and Prevention (CDC) and hospitals.

Program Design

The program was designed to address the following four key problems China was facing in 2007:

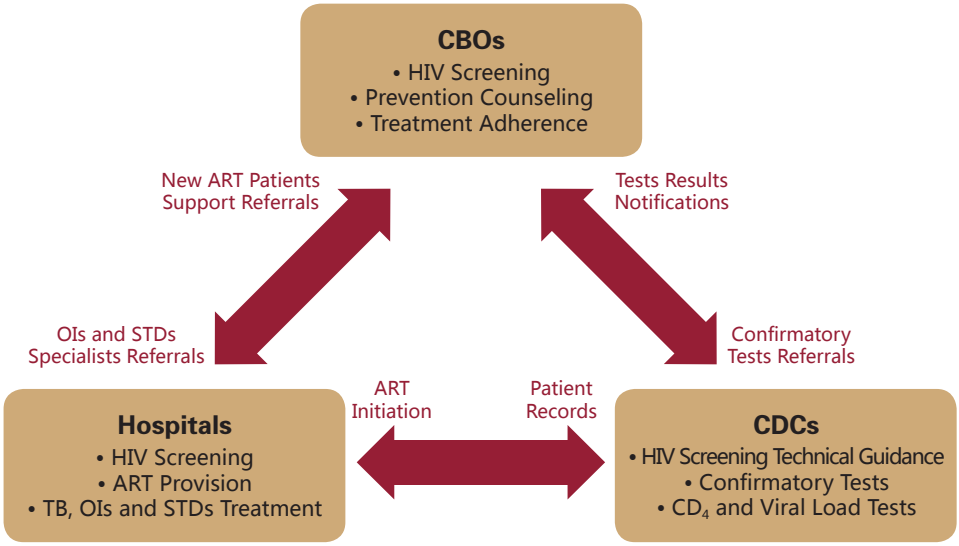
- **Low level of case detection** - Due to low rates of both testing and positive results notification, less than 15% of the estimated 650,000 infected persons in 2005 knew their positive status, leaving the majority of infected individuals unaware of their positive status posting substantial public health risks to the rest of the general population.
- **Rising HIV prevalence among MSM** – Government sentinel surveys showed the HIV epidemic among the MSM population was escalating rapidly with prevalence rising from 1% in 2003 to 3% in 2006 and exceeding 10% in some key urban areas in the Southwest. The main focus of the government's HIV services until then had been setting up the health service infrastructure to provide drugs for antiretroviral therapy (ART) to AIDS patients, rolling out harm reduction programs (Methadone and clean needles and syringes) to IDUs and promoting condom use among FSWs. MSM, due to social stigma and limited political

support (MSM not a target population in the country's National AIDS Action Plan 2006-2010), was largely hidden from government HIV services.

- **Inadequate attention paid to testing and treatment as transmission reduction strategies** – Despite years of raising awareness and promoting condom use by international cooperation programs, condom use among the MSM population was still stubbornly low in 2006. This called for a more comprehensive transmission reduction approach that would go beyond awareness raising and condom promotion but still building on the civil society foundation laid by previous international cooperation programs – a community-based "Test and Treat" public health approach that engages CBOs in the government's testing and treatment services to reduce infectivity at the population level.
- **Inadequate attention paid to program impact and performance** – In 2007 most HIV programs in China did not include outcome-oriented targets, such as number of new positive cases found and number of PLHA receiving pre-ART CD_4 tests, with most of their budgets typically driven by input targets such as number of outreach sessions and condoms distributed. Many of these programs were also quite relaxed about linking funding continuity to performance in meeting targets. The combination of soft targets and a general absence of performance-based financing meant CBOs' ability to demonstrate their potential contributions to government services – detecting positive cases among the hidden MSM population and following up on positive cases with further pre-ART tests and treatment – was quite limited.

Program Implementers

The diagram below summarizes the typical roles and responsibilities of the three implementing partners in each of the 15 program sites. Collaboration areas between them that received special attention by the program are also highlighted as arrows in the diagram.



Program Management

The delivery of the program relied heavily on three critical program management components:

- **Collaboration between CBOs, CDCs and hospitals** – To promote collaboration between local CBOs, CDCs and hospitals, the program: (1) Advocated directly to local government officials at both city and district levels to highlight the importance of collaboration between the three implementers, particularly CBOs case detection and case management roles in complementing existing government HIV services; (2) Designed the performance-based management system to explicitly embed collaboration in case detection and case management roles and targets of each implementer to ensure the three implementers working together to deliver on targets and receive continuous financial support from the program; (3) Trained all three implementers to improve working relationships between them by highlighting mutual understanding of respective working principles, particularly CBOs' communications skills with local CDCs and hospitals; and (4) Annual workshops to allow implementing partners to learn from each other to improve performance.
- **Outcome-oriented targets and performance-based financing** – To hold implementing partners accountable to meeting targets and encourage them to innovate, the program put in place: (1) Outcome-oriented targets that directly contributed to government testing and treatment services (individuals from targeted populations tested, individuals tested positive, individuals followed up with CD_4 tests); and (2) Performance-based financing that linked funding continuity to meeting targets of previous periods of typically three to six months and encouraged those performing well to innovate and aim for higher targets in the next period.
- **Program data quality control** – To minimize double reporting and assure high-risk populations were targeted, the program put in place: (1) Cross-checks of newly diagnosed cases reported by implementing partners against the national infectious disease database to eliminate double reporting; and (2) Comparisons of HIV and syphilis positive rates of cases reported by an implementing partner against averages of the program site to identify and terminate contracts with persistent under-performers.

Achievements

Through six years of implementation, the program successfully demonstrated the feasibility of scaling up case detection (MSM, hospital patients) and case management (PLHA). The program also contributed towards important shifts in government HIV policies.

- **Case detection scale-up**

  MSM confirmed positive – Seven-fold increase from 646 in 2008 to 4,536 in 2012

Hospital patients confirmed positive – Five-fold increase from 1,636 in 2008 to 8,416 in 2012

- **Case management scale-up**

  Pre-ART PLHA tested for CD_4 – Seven-fold increase from 3,576 in 2008 to 24,838 in 2012

  PLHA on ART – Ten-fold increase from 1,284 in 2008 to 12,850 in 2012

- **Policy influence**

  Expansion of testing and treatment – The National AIDS Action Plan 2011-2015 highlighted the scaling up of both testing and treatment as key prevention strategies demonstrating the government's commitment to go beyond awareness raising and condom promotion towards the more comprehensive "Test and Treat" public health approach to control the spread of HIV.

  MSM as a target population – The National AIDS Action Plan 2011-2015, for the first time, included MSM as a target population for prevention. This provided the much-needed political foundation for local governments across the country to roll out prevention programs among the MSM population.

  Formal recognition of CBOs – In addition to being recognized for their prevention roles and contributions, CBOs were also highlighted by the National AIDS Action Plan 2011-2015 to be given service contracts by local governments to complement government testing and treatment services at the local level. In November 2012, then Vice-Premier (now Premier), Li Keqiang, publicly acknowledged the indispensable role that social organizations play in HIV control efforts and pledged more support for them to fight HIV.

  Outcome-oriented targets and performance-based financing – Encouraged by their program experience and results, local governments of many program sites decided not only to continue purchasing HIV services from CBOs upon the end of the program but also adopted the program's management (outcome-oriented targets) and financing mechanism (continued funding tied to performance) in their CBOs service contracts procurement and management systems. This suggests the program not only had successfully reinforced these local governments' trust in CBOs but also provided a practical management framework for them to work with CBOs.

Lessons Learned

Two key lessons emerged from six years of program implementation:

- **The importance of outcome-oriented targets, performance-based financing and quality control in working with CBOs** – A key advantage of using outcome-oriented targets and performance-based financing and quality control was this approach's ability to differentiate CBOs based on their program performance. This was instrumental in eliminating non-

performing ones, including those with little community roots, and holding other under-performing ones accountable to improve, while supporting and pushing those performing well to innovate. Another advantage of this approach was it allowed local CDCs to clearly see the contributions of competent CBOs as outcome-targets adopted by the program were both measurable and explicitly designed to complement government HIV services. This helped lay the foundation for collaboration and trust between local CDCs and CBOs. The third advantage of this approach was it provided CBOs a transparent and measurable framework to demonstrate to both the government and the community their contributions. Despite initial resistance and misunderstanding of this novel approach, many CBOs in the program eventually came to realize by demonstrating their program performance they were constantly innovating to deliver better services and find new ways to improve communications and collaboration with local CDCs. This helped build local governments' trust in CBOs and led to many of them adopting the program's approach in managing their own service contracts with CBOs in the future.

- **The importance of evidence-based evaluation and program adjustment flexibility to maximize program efficiency** – During the first two years of implementation, the number of HIV tests done among IDUs and FSWs were consistently much larger than that for MSM. This was partly due to these two populations were easier for local CDCs to reach via cooperation with police as both drug use and sex work are considered illegal while sex between men is legal. Despite homosexuality being legal, the widespread social stigma against it meant the MSM population was largely hidden from local CDCs. After the 2010 program review, which showed while investments had been the lowest amongst the three MARPs the rate of testing positive among MSM was much higher than those of IDUs and FSWs, the program dropped the IDU and FSW populations from the case detection component of the program in 2011 (low cost effectiveness in case identification and relatively stable new infections as compared to the MSM population) and channeled these resources to expand MSM case detection and PLHA case management. Despite initial resistance from local CDCs, the use of objective program evidence (hard targets) and program's flexibility to reshuffle resources were both critical in convincing local CDCs to drop relatively easy work (IDUs, FSWs) and move into unfamiliar but critical territories (MSM) to ensure the case finding objective of the program would be met.