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C - China

View Related Topics

August 2, 2000, Wednesday, Late Edition - Final

SECTION: Section A; Page 1; Column 1; Foreign Desk

LENGTH: 1650 words

HEADLINE: Scientists Warn of Inaction As **AIDS** Spreads in **China**

BYLINE: By ELISABETH ROSENTHAL

DATELINE: BEIJING

BODY:

During all the years that Yang Zhiyin was selling his blood, he had never heard of **AIDS**. All he knew was that he was desperately poor, and selling blood on the black market was what farmers did in his village when they needed cash. For much of a decade, Mr. Yang said, he rolled up his sleeve to the blood dealer's needle "many many times."

One of those times, Mr. Yang, now 37, became infected with H.I.V., the virus that causes **AIDS**. Because illegal blood rings often use unsterile collection methods, poor peasants like Mr. Yang are routinely exposed to blood-borne diseases, scientists say. And after Mr. Yang contracted the virus, he presumably spread it unwittingly to dozens of others like himself, who for the most part still do not know that they are infected -- or even that H.I.V. exists.

With the **AIDS** virus skipping silently through **China**, a number of the country's leading medical experts have begun to loudly complain that the government has done too little to determine the extent of the problem and to prevent the spread of the disease. Official inattention and the lack of a national public education program about the disease have already allowed H.I.V. to transform from an fairly rare condition among intravenous drug users in 1990, to a rapidly growing problem that now affects an estimated 600,000 Chinese, the scientists say. And in another 10 years, they warn, **China** could have one of the world's largest populations of H.I.V. carriers, unless the government takes action.

"The spread of **AIDS** is accelerating rapidly and we face the prospect of remaining inert against the threat," states an extraordinarily blunt report by a committee of eminent Chinese experts that was sent to **China's** leaders earlier this year. It adds: "Owing to government indifference, **AIDS** prevention and control is gravely ineffective."

Although Chinese doctors have now started a number of research and education projects, there has been no nationally coordinated effort to determine the prevalence of H.I.V. so that the government has only a vague idea of how and where the disease is spreading, for example. The total budget for **AIDS** prevention last year was only a few million dollars -- far less than that of much smaller countries like Vietnam and Thailand. Local officials often resist efforts to test people in their jurisdiction for the virus, for fear high rates will reflect badly on them. In many cities, billboards promoting **AIDS** awareness or prevention through condoms have lasted only days before they were declared "indecent" and destroyed.

"We've reached the point that if we don't wake up, it will be a national disaster," said Zeng Yi, a leading **AIDS** researcher who was on the committee.

The battle over how **China** should handle **AIDS** generally pits government scientists concerned with a simmering epidemic against socially conservative propaganda, education and health officials, guardians of **China's** image and its moral values. The scientists protest that the conservatives have stymied their efforts to confront the disease, preventing frank discussions of sex and drug addiction, for example, and have even attempted to camouflage **China's** H.I.V. problem.

"The central government doesn't seem to realize how serious this is," said Qiu Renzong, a bioethicist at the Chinese Academy of Social Sciences, with clear exasperation. "We have not yet had an effective risk reduction strategy, because some departments are very conservative. They think chastity is more important than condom use. They say that the only way to prevent H.I.V. transmission is to rely on **China's** traditional values!"

Committee members like Professor Qiu say they intended their report to be a jarring wake-up call -- arguing for national **AIDS** education, condom use and needle exchanges for drugs addicts, for example. And some have been encouraged by the government's prompt initial response: appointing Deputy Prime Minister Li Lanqing to oversee the problem.

"I think the government attitude is changing," said Dr. Zeng, hopefully.

But others remain skeptical. "Yes, there's been big progress, but compared to the speed at which H.I.V. is spreading it's not enough," said Wan Yanhai, a former government health worker, who said he was fired in the mid-1990's for speaking too frankly about H.I.V. "Part of the reason there hasn't been a national survey is that they don't want to know."

Although there are now 17,000 people known to carry the **AIDS** virus in **China**, government officials say that the real figure is probably closer to 500,000 or 600,000. The number is still small compared with **China's** overall population, which exceeds 1.2 billion, but scientists say rates are extraordinarily high in some groups and in some locations. They estimate that the number of cases is now growing by 30 percent a year.

Government officials say intravenous drug users probably account for about 70 percent of H.I.V. in the country. Dr. Zeng and many other experts believe that blood sellers like Mr. Yang may well be the second-largest group.

But the first estimate may be skewed because it is based on the forced testing of drug addicts under arrest. And there is almost no hard information on blood sales, which have been banned since 1998. Prostitutes as well as gay men are also considered at high risk, but there are no reliable figures.

Some surveys have found extremely high rates in localized populations: In the early 1990's more than 80 percent of drug addicts arrested near the Myanmar border were infected, Dr. Zeng said. More recently, a survey in Henan found rates as high as 16 percent in locales where illegal blood selling was common -- until local officials blocked further testing.

But it is difficult to extrapolate from these pockets of high infection to the larger population.

"Because we haven't done the screening that needs to be done, we don't really know the size of the problem," said Dr. Zeng. "That means that when the government confronts it, they think the problem's not

too big."

In fact, Mr. Wan said, some of the most worrisome survey results have been kept secret. "A lot of people still feel quite safe -- they think H.I.V. is a disease of foreigners," said Mr. Wan, who now runs a web site about H.I.V.

The true picture will never be clear without very aggressive government intervention, experts said.

Individuals from high-risk groups often do not realize they are in danger -- and have little incentive to be tested since treatment options for the disease in **China** are extremely limited.

The medicines now widely given to patients in the United States to control the virus are too expensive and not licensed; traditional medicines have not yet proven effective.

Also, although laws prohibit discrimination against people with H.I.V., harassment is the rule.

"H.I.V. is like having leprosy in the 1930's," said Mr. Yang, the former blood seller who contracted the virus, and who said he would only speak if his home province was not identified. "I have only told my immediate family." Mr. Yang only learned he was infected after a researcher wanting to test a new herbal medicine came to test blood sellers in his village.

But perhaps the greatest obstacle is local officials who do not want to admit that prostitution, drug abuse or blood selling are occurring on their watch. They are particularly resistant to surveys of blood sellers, scientists say, since the practice was outlawed in 1998.

Although there is a national network of blood banks that screen for H.I.V., blood shortages are common and illegal blood sales continue. Government scientists estimate that there are five million Chinese who regularly provide blood for pay.

Doctors say H.I.V. rates in this group are probably very high because of the collection methods commonly used by the blood gangs, who buy the blood from farmers and then sell it to individual patients or small-town doctors.

At illegal collection stations, blood is collected from a number of peasants with the same blood type at one time. The blood is then pooled, spun down to separate out the components needed for medical use, and the remainder is divided up and re-infused into the original donors. In this way, people like Mr. Yang are exposed to blood of 6 to 12 others every time they sell, experts say.

The risk to hospitalized patients is probably not great, Dr. Zeng said, because hospitals generally screen blood products for the virus -- although in emergencies or in rural hospitals and clinics, there is evidence that the system can break down.

Researchers and even government bureaus have initiated dozens of projects to educate citizens about H.I.V. But these are often privately funded and nationwide efforts have been hampered by lack of money and a strong puritanical streak.

"When H.I.V. became a problem in the West, there were huge education campaigns," said Dr. Zeng, who has himself raised money for and organized a large traveling scientific exhibition on H.I.V. "We talk about it openly one day a year -- on Dec. 1 -- International **AIDS** Day. That is not enough."

Last Dec. 1, for example, the State Family Planning Commission unveiled new television advertisements promoting the use of condoms to thwart H.I.V. By the next day they were ordered off the air by the State Administration for Industry and Commerce, which said they violated a law against advertising sex-related products.

In June, a billboard advocating condom use in Wuhan was ordered removed just 22 hours after it was posted.

"If you promote condoms among youth, it would lead to a great deal of sexual license and abandonment of sexual morality," said Zhu Qi, a government consultant who believes that the best answer to H.I.V. is chastity.

It is an attitude that exasperates Professor Qiu. "There is an old Chinese saying," he said. "People don't shed tears until they see the coffin."

<http://www.nytimes.com>

GRAPHIC: Photo: Condom-dispensing machines like this one in Beijing have been installed in some Chinese cities, but they remain a source of contention. (Agence France-Presse)(pg. A8)

LANGUAGE: ENGLISH

LOAD-DATE: August 2, 2000

FOCUSTM
Search: General News;AIDS, China

To narrow this search, please enter a word or phrase:

FOCUS

Example: House of Representatives

Sandra Thurman 03/25/98 05:22:25 PM

Record Type: Record

To: Todd A. Summers/OPD/EOP
cc:
Subject: Fwd: China's HIV/AIDS Epidemic

----- Forwarded by Sandra Thurman/OPD/EOP on 03/25/98 05:24 PM -----



Big Bob411 <BigBob411@aol.com>
03/25/98 12:35:22 AM

Record Type: Record

To: See the distribution list at the bottom of this message
cc:
Subject: Fwd: China's HIV/AIDS Epidemic

Return-path: <mddc2@info.iuol.cn.net>
Received: from relay29.mx.aol.com (relay29.mail.aol.com [172.31.109.29]) by air09.mail.aol.com (v40.16) with SMTP; Tue, 24 Mar 1998 04:48:46 -0500
Received: from info.iuol.cn.net ([202.96.26.245]) by relay29.mx.aol.com (8.8.5/8.8.5/AOL-4.0.0) with SMTP id EAA01240 for <bigbob411@aol.com>; Tue, 24 Mar 1998 04:48:34 -0500 (EST)
Received: from mddc2 by info.iuol.cn.net (SMI-8.6/SMI-SVR4) id RAA22143; Tue, 24 Mar 1998 17:47:31 +0800
Date: Tue, 24 Mar 1998 17:40:48 +0800
From: "MDDC2" <mddc2@info.iuol.cn.net>
Subject: China's HIV/AIDS Epidemic
To: <bigbob411@aol.com>
Message-id: <199803240947.RAA22143@info.iuol.cn.net>
MIME-version: 1.0
X-Mailer: Microsoft Internet Mail 4.70.1157
Content-type: text/plain; charset=US-ASCII
Content-transfer-encoding: 7bit
X-MSMail-Priority: Normal
X-Priority: 3

Dear Mr. Fogel,

I'm very pleased to receive your email dated on February 25, 1998 referring to the HIV/AIDS control in China. I'm sorry that I couldn't reply to you at an earlier time.

The AIDS epidemic appeared in China in 1986. Since then, it has been preading rapidly, with all the 31 provinces except Qinghai province reporting 8,303 HIV infections, including 209 AIDS cases, by the end of

October, 1997. Taking the so many risk factors, such as the increase of IDUs, STDs, floating population etc. into consideration, experts conclude that the AIDS epidemic has come into a phrase of fast acceleration. Our Government has paid more and more attention to the AIDS prevention and control. We also benefit from international cooperation with UN agencies, EU and other organizations, such as Save the Children. However, as the potential for further spread of HIV/AIDS in China is enormous, much more financial support and technical assistance, both from international and domestic, are required for this work. We have published a document named ~{!0~}China Responds to AIDS~{!1~}which covers all the detailed information. If you could give me your address, I can send a copy to you for your reference.

As far as I know that there have been some collaboration in the field of public health between China and the United States through the Protocol between the Department of Health and Human Services of the United States of America and the Ministry of Public Health of the People's Republic of China for Cooperation in the Science and Technology of Medicine and Public Health, but unfortunately none for HIV/AIDS prevention and control. Being the first AIDS report country in the world, the United States has invest heavily/greatly in research of actiology, behavior intervention, vaccination, drug development as well as clinical and community service for people living with HIV/AIDS, and obtained substantial experience and achievements, some of which are great contribution to the human being. I hope that we could collaborate in this field so as to exchange information and share experience. For this purpose, I would like to take this opportunity to offer the following suggestions for your consideration:

1. Research on AIDS actiology with high techniques;
2. Development of AIDS vaccine;
3. Production of effective anti-viral drugs and development of Chinese traditional medicine promising for AIDS treatment;
4. Hospital-based and community-based medical service and health care for people living with HIV/AIDS;
5. Health education and behavior intervention for targeted population, such as harm reduction among IDUs;
6. Surveillance and effective management of STD.

And I think it would be helpful if the AIDS prevention and control could be integrated into the above-mentioned Protocol for Cooperation in the Science and Technology of Medicine and Public Health which is going to be extended for a longer period of efficacy.

I hope that we could have further discussion about this issue, and if you have any further requirement, please do not hesitate to contact with me.
Thank you.

With best regards,

Message Sent To:

GlobalAIDS @ aol.com
VCB3 @ CDC.GOV
Sandra Thurman/OPD/EOP
Cowals @ UNAIDS.org
heymannd @ who.ch



Tsummers @ aol.com

07/28/98 10:55:21 PM

Record Type: Record

To: Todd A. Summers/OPD/EOP

cc:

Subject: Fwd: Quick Spread of AIDS Alarms China

Return-path: <AOLNews@aol.com>

Date: Tue, 28 Jul 1998 22:40:18 EDT

From: AOLNews@aol.com

Subject: Quick Spread of AIDS Alarms China

MIME-version: 1.0

Content-type: text/plain; charset=US-ASCII

Content-transfer-encoding: 7BIT

Quick Spread of AIDS Alarms China

.c The Associated Press

BEIJING (AP) - Chinese authorities urged greater efforts to slow the spread of AIDS as the official tally of people infected with the virus that causes the disease topped 10,000, an official newspaper said Tuesday.

The newspaper said the actual number of people infected with HIV may be as high as 300,000 - 100,000 more than previous estimates.

That figure could pass 1 million by 2000 if more is not done to check the spread of HIV, Xiao Yan, an official with the Department of Disease Control, told state television.

Local health authorities have been ordered to speed up education and prevention campaigns, the newspaper said.

The disparity between official numbers and estimates is likely due to underreporting, the lack of government resources to perform tests and the stigma attached to acknowledging HIV-infection.

AP-NY-07-28-98 2237EDT

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March 30, 2000

NOTE TO SANDY THURMAN FROM PETER HARTSOCK,

Re: **INITIATION OF NEW AIDS RESEARCH PROJECT IN CHINA**

Sandy:

I have just been successful in developing and funding a large study of the epidemiology AIDS and drug use, and related intervention policies, in China. You may have seen the attached map in the March 6th *Washington Post* science section. It describes the heroin routes of the Golden Triangle in southeastern Asia and the co-occurring routes for HIV. The project I have just gotten going is centered in the bull's eye of the attached map—Kunming—and the project also covers a good deal of the map. Note Kunming's key position in both the more local, larger map and in the smaller map which shows the drug and HIV routes across southeast Asia, through China, and to portions of the former Soviet Union. Andrei Kozlov and I are talking about bringing Chinese researchers to his annual conference. Our Chinese project has great potential and I'll keep you posted on developments. My Chinese colleagues were so delighted to be notified of their getting funded on St. Patrick's Day that they called to wish me Happy St. Patrick's Day! I told them that the luck of the Irish was with them!

Cc: C. Bauerle
S. Holewinski

March
6, 2000

Lookheed SCIENCE

AIDS Outbreaks Follow Asia's I

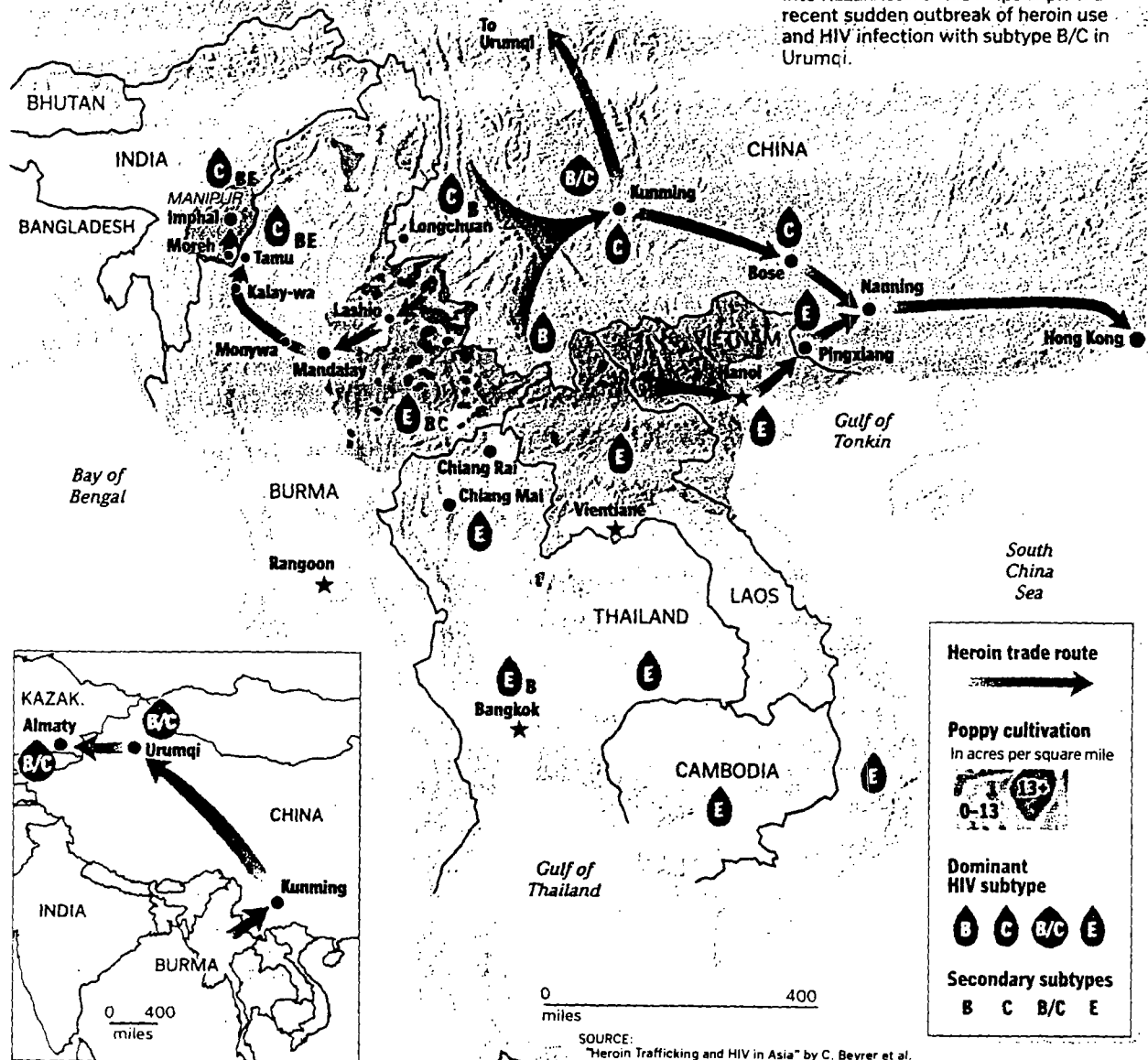
Heroin flows from northeast Burma into China through Kunming, and then east to Hong Kong through Nanning. Researchers have discovered that, along this route, HIV strains called subtype C and a hybrid strain dubbed B/C dominate.

From Mandalay in central Burma,

heroin from the northeastern part of the country is trucked to Manipur, an isolated border state in northeastern India. Despite being an insurgent area that the Indian government has closed, Manipur has India's highest HIV rates. Viral strains detected in the area include subtype C—the dominant strain in India—and subtypes B and E, Southeast Asia's major strains.

Burmese heroin reaches the Chinese border town of Pingxiang via a route that traverses Burma, Laos and northern Vietnam. HIV subtype E dominates this route.

A fourth, previously unrecognized route runs hundreds of miles—north from Kunming into Urumqi in China, then west across the Chinese border into Kazakhstan. This helps explain a recent sudden outbreak of heroin use and HIV infection with subtype B/C in Urumqi.



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Submitted to Dr. Peter *Hertzberg*

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& NAME: YANG, XIUSHI

APPL NO:1 R01 DA13145-01A1

AIDS/EXPED

COUNCIL: 01/00

DUAL:

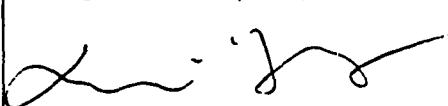
RCVD:09-01-99

IRG: ZRG1-AARR-7(1S)

CE/SOG

Follow instructions carefully.

Do not exceed character length restrictions indicated on san.

1. TITLE OF PROJECT Community-Based Study of Mobility, Drug Use, and AIDS			
2. RESPONSE TO SPECIFIC REQUEST FOR APPLICATIONS OR PROGRAM ANNOUNCEMENT ☒ NO ☐ YES (If "YES," state number and title) Number: Title:			
3. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR		New Investigator ☒ YES	
3a. NAME (Last, first, middle) Yang, Xiushi	3b. DEGREE(S) BS MA Ph.D	3c. SOCIAL SECURITY NO. Provide on Form Page KK.	
3d. POSITION TITLE Associate Professor	3e. MAILING ADDRESS (Street, city, state, zip code) Department of Sociology and Criminal Justice College of Arts and Letters Old Dominion University Norfolk, VA 23529		
3f. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT Sociology and Criminal Justice			
3g. MAJOR SUBDIVISION College of Arts and Letters			
3h. TELEPHONE AND FAX (Area code, number and extension) TEL: (757) 683-3809 FAX: (757) 683-5634	E-MAIL ADDRESS: xyang@odu.edu		
4. HUMAN SUBJECTS ☐ No ☒ Yes	4a. If "Yes," Exemption no. or IRB approval date 7/15/99	☒ Full IRB or Expedited Review	4b. Assurance of compliance no.
5. VERTEBRATE ANIMALS ☒ No ☐ Yes		5a. If "Yes," IACUC approval date	5b. Animal welfare assurance no.
6. DATES OF PROPOSED PERIOD OF SUPPORT (month, day, year - MM/DD/YY) From 05/01/00 Through 4/30/05	7. COSTS REQUESTED FOR INITIAL BUDGET PERIOD 7a. Direct Costs (\$) \$125,000	7b. Total Costs (\$) \$173,934	8. COSTS REQUESTED FOR PROPOSED PERIOD OF SUPPORT 8a. Direct Costs (\$) \$725,000 8b. Total costs (\$) \$950,108
9. APPLICANT ORGANIZATION Name Old Dominion University Res. Foundation Address PO Box 6369 Norfolk, VA 23508-0369		10. TYPE OF ORGANIZATION Public: ☐ Federal ☒ State ☐ Local Private: ☐ Private Nonprofit Forprofit: ☐ General ☐ Small Business	
		11. ORGANIZATIONAL COMPONENT CODE 20	
		12. ENTITY IDENTIFICATION NUMBER 546068198 DUNS NO. (If available) 077945947	
13. ADMINISTRATIVE OFFICIAL TO BE NOTIFIED IF AWARD IS MADE Name Jackie Royester Title Grants & Contracts Admin. Address Old Dominion University PO Box 6369 Norfolk, VA 23508-0369 Telephone (757) 683-4293 ext. 611 Fax (757) 683-5290 E-Mail jroyester@odu.edu		14. OFFICIAL SIGNING FOR APPLICANT ORGANIZATION Name Bob E. Wolfson Title Executive Director Address ODU Research Foundation Norfolk, VA 23508-0369 Telephone (757) 683-4293 ext.500 Fax (757) 683-5290 E-Mail bwolfson@odu.edu	
15. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR ASSURANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. I agree to accept responsibility for the scientific conduct of the project and to provide the required progress reports if a grant is awarded as a result of this application.		SIGNATURE OF PI/PPD NAMED IN 3a. (In ink. "Per" signature not acceptable.) 	DATE 8/31/99
16. APPLICANT ORGANIZATION CERTIFICATION AND ACCEPTANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge, and accept the obligation to comply with Public Health Service terms and conditions if a grant is awarded as the result of this application. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil or administrative penalties.		SIGNATURE OF OFFICIAL NAMED IN 14. (In ink. "Per" signature not acceptable.) 	DATE 8/31/99

ORIGINAL

DESCRIPTION: State the application's broad, long-term objectives and specific aims, making reference to the health relatedness of the project. Describe concisely the research design and methods for achieving these goals. Avoid summaries of past accomplishments and the use of the first person. This description is meant to serve as a succinct and accurate description of the proposed work when separated from the application. If the application is funded, this description, as is, will become public information. Therefore, do not include proprietary/confidential information. **DO NOT EXCEED THE SPACE PROVIDED.**

This project examines the social and behavioral correlates of HIV transmission at individual, household, and community levels. We will combine existing data and information obtained from a carefully designed survey to address specifically: (1) the dynamic link between mobility, active drug abuse, and AIDS, (2) the prevalence of drug use and HIV/AIDS among migrants and the general population, (3) the type of drugs most often used and the mode of acquiring them, and (4) the characteristics of migrants, drug abusers, and AIDS cases, including their spatial correlation. Based on the findings, we will discuss strategies to prevent and to combat the spread of illicit drugs and AIDS, emphasizing the outreach of anti-drug and AIDS prevention programs with active involvement of communities and businesses.

Previous research views migration mainly as a vehicle of HIV transmission. We argue that migration is more than a transporter of AIDS; migration needs to be studied in its own right as one of the main causes of risk behavior and HIV/AIDS. We hypothesize that migration creates a growing transient population that is economically marginal, emotionally lonely, and socially detached. Social isolation and economic marginalization greatly limit migrants' opportunities for stable employment and social mobility. Separated from their families and faced with uncertainties in the job market, some migrants may turn to illicit drugs and prostitution as a way to escape the loneliness, frustration, and social isolation. Migrants' vulnerability to drug abuse, prostitution, and HIV infection is further heightened by their lack of social support networks, the limited access to health services, and the erosion of social and normative control over their behaviors. Thus a growing transient population contributes directly to increased risk behaviors and HIV infection; migration in turn creates networks for the spread of illicit drugs and the transmission of AIDS epidemic.

This conceptualization of mobility and AIDS dynamics will be tested in Yunnan province of China, utilizing a unique data set that (1) combines survey and focus group that enable us to identify quantitatively and qualitatively the attitudinal, behavioral, and socioeconomic correlates of drug offenses and AIDS; (2) includes spatial information that allows us to examine the spatial correlation between migrants, active drug abusers, and HIV/AIDS cases; and (3) contains samples of both known cases and the general population and collects data about individual, family, and community that permit multi-level analyses of the determinants of risk behaviors and HIV/AIDS.

PERFORMANCE SITE(S) (organization, city, state)

Department of Sociology
and Criminal Justice
College of Arts and Letters
Old Dominion University
Norfolk, VA 23529

Department of Geography
Yunnan Normal University
Kunming, Yunnan Province
People's Republic of China

KEY PERSONNEL. See instructions on Page 11. Use continuation pages as needed to provide the required information in the format shown below.

Name	Organization	Role on Project
Xiushi Yang	Old Dominion University	Principal Investigator
Valerian J. Derlega	Old Dominion University	Co-Investigator
[David D. Celentano]	Johns Hopkins University	Consultant
Huasong Luo	Yunnan Normal University, China	Principal Investigator of China subcontract
Kai Jing	Yunnan Normal University, China	Co-Investigator

Hartsock, Peter (NIDA)

From: Laura Roberts [L.Roberts@salud.unm.edu]
Sent: Tuesday, March 21, 2000 10:09 PM
To: Hartsock, Peter (NIDA)
Subject: Re:

Hi Peter - I am writing to tell you just how much we loved meeting with you last week. As Teddy told our team about you today, "he exudes a warmth and genuineness that is really rare." So very true. Thank you so much for everything. I'll be in touch, Laura

>>> "Hartsock, Peter (NIDA)" <phartsoc@nida.nih.gov> 03/13/00 12:05 PM
>>>

Laura,

As it stands, I'll be in the office until you call me on Wednesday. It won't take me long to drive down to your hotel. Having dinner there sounds fine and will save time. I'm still pretty wiped out, so the less running around we have to do, the better.

Let me know what you think.

Peter

*First Major Research
on AIDS, Stigma, and
Ethics*

THE LANCET

Volume 354, Number 9182

An office on Main Street

Perhaps it was urban dreamers who created the romance of rural medicine. In the USA, as elsewhere in the western world, the notion of the omniscient, tireless, selfless general practitioner is a fixture of lore and the stuff of legend. But, as a recent essay in the *Hastings Center Report* points out, the life of the country doctor is a demanding one that is often not well understood, especially in societies with health-care systems wedded to high-technology practice. And as the popular notion of the country hero, with both rumpled white coat and kindly demeanour, is displaced by the confident, young urban city specialist, the threat to a real understanding of rural practice and its practitioners grows.

The essay—"An Office on Main Street: Health Care Dilemmas in Small Communities" (*Hastings Center Report* 1999; 29: 28-37)—is unusual and noteworthy in its emphasis. One of its strengths lies in the fact that it deals not only with the perfunctory discussion of the difficulties of rural medicine—lack of technology, shortages of trained personnel—but also with the unique and sometimes challenging ethical dilemmas that doctors and nurses must face when practising and living in small towns. Another strength is that its perspective, by Laura W Roberts and colleagues, is from professionals—psychiatrists and ethicists—with clinical experience in rural New Mexico and Alaska.

Some readers may be surprised that an essay on rural medicine comes from an urban nation such as the USA. But demographics tell a commonly disguised story. 45% of the US land mass is considered "frontier" and 60 million of the nation's 250 million citizens live in areas that are either frontier (fewer than 6.6 people per square mile) or rural (fewer than 2500 people per town boundary). The US population density—69 people per square mile—is far lower than medically comparable countries such as Germany (573 per square mile), the UK (609), or Japan (865). Not surprisingly, as the article points out, the medical challenges in rural areas are many. Age-adjusted death rates in US rural areas, for example, are higher than in urban areas. In rural areas, a higher proportion of patients are

disabled or have illnesses such as cancer, heart disease, arthritis, or diabetes. There are more elderly people and more children to care for, and depression, cognitive disorders, and alcohol addiction are also more prevalent in the country than in the city.

There are ethical dilemmas in medical care wherever it is undertaken. But, as the article points out, in small towns the familiarity and closeness of community life can make navigating customary minefields even more treacherous. It is common for caregivers to be looking after friends and family when the community is small; not surprisingly, these interlocking relationships and dependencies of small-town life can make confidentiality nearly impossible. Even the sanctity of the medical chart cannot be guaranteed in settings where care is more likely to be given in a clinic and not in the relative privacy of an individual doctor's office. But good care demands good documentation, and thus the inevitable conflicts arise. It is not hard to see how intensely difficult it becomes for both caregiver and patient when all are called on to discuss or treat openly such sensitive conditions as sexually transmitted disease, abortion, substance abuse, or family violence.

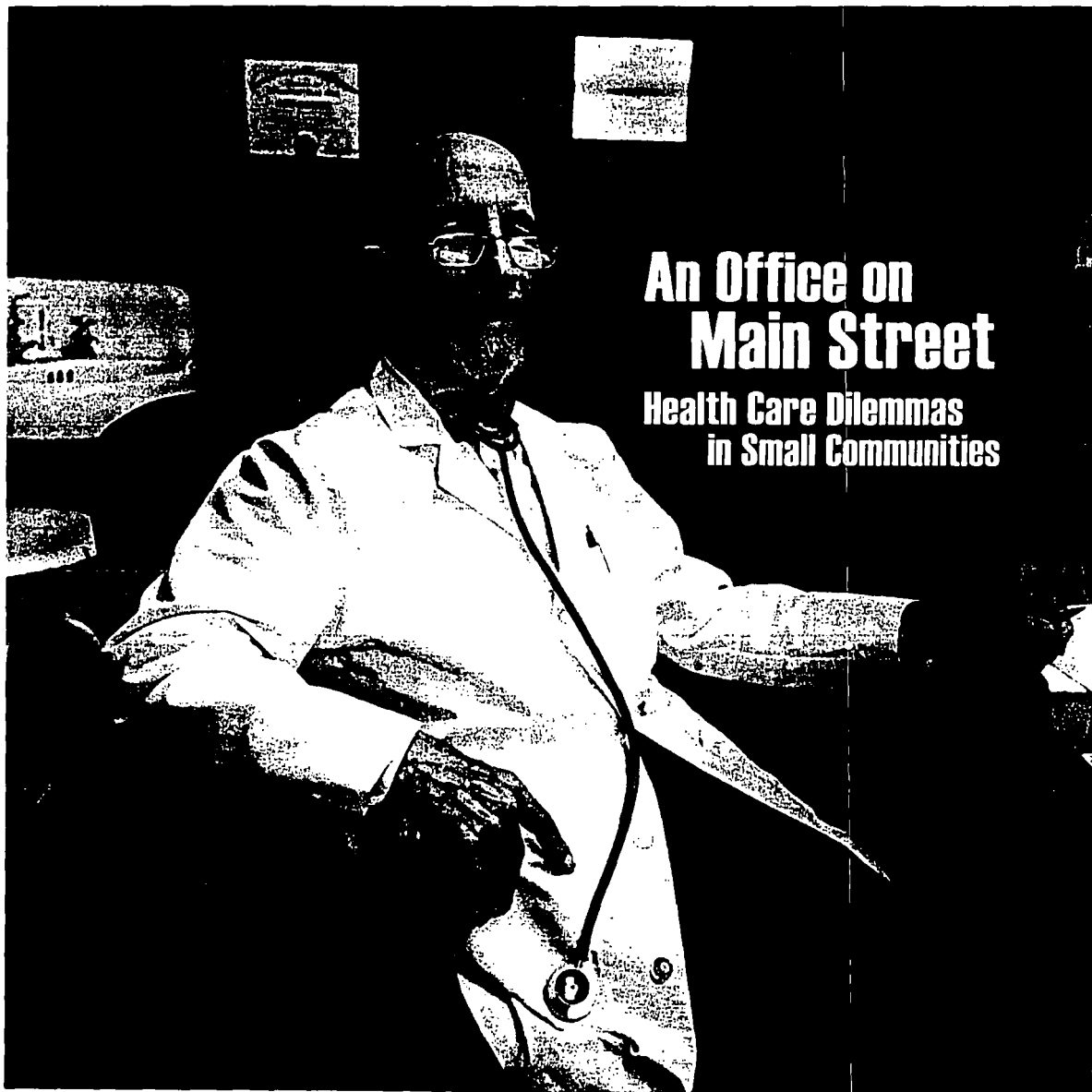
As the authors point out, the country doctor or nurse inevitably becomes the "carrier of every town secret". This burden is significant, especially when added to the already difficult conditions under which rural caregivers must work. And it can have negative consequences. "Rural clinicians may become less socially involved and increasingly withdrawn as their tenure lengthens", the essay reminds us, "until eventually they may feel themselves, ironically, to be outcasts." The message from Main Street is simple: the plight and care of the rural clinician will not be mitigated by machines and technology alone. If nations want to keep competent doctors and nurses in their rural areas, they must also understand the heart and soul of rural practice, and lend support to those who labour to uphold this noble tradition.

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An Office on Main Street

Health Care Dilemmas in Small Communities

by Laura Weiss Roberts, John Battaglia, Margaret Smithpeter, and Richard S. Epstein



Dr. Linda Robinson and patient, Coats Clinic, North Carolina, 1998

The health care needs of rural populations often differ from those of their urban counterparts. And the ethical dilemmas that caregivers face are distinctively shaped in rural settings, not only by resource constraints, but by the nature of life in small, close-knit communities as well.

Photographs by John Moses

Laura Weiss Roberts, John Battaglia, Margaret Smithpeter, and Richard S. Epstein, "An Office on Main Street: Health Care Dilemmas in Small Communities," *Hastings Center Report* 29, no. 4 (1999): 28-37.

It is increasingly acknowledged that individuals who live in remote settings represent a large and underserved patient population in the United States. Many obstacles to rural and frontier health care have been identified, such as poor distribution of care providers and facilities, geographical barriers, and inadequate communication services.¹ What has received little attention, however, are the unique ethical dilemmas encountered in health care in small communities that may significantly influence the delivery of medical services in rural and frontier settings. The aim of this paper then is twofold: to outline the key issues in general health care needs in the rural United States, and to describe the distinct clinical ethical features affecting health care services in small communities. By clarifying these considerations, the care of rural and frontier community residents who suffer from diverse illnesses may be better understood and improved.

Rural and Frontier Health Care in the United States

The United States encompasses 3.6 million square miles and is the fourth largest country in the world. Its overall population density is 69 people per square mile, in dramatic contrast with other industrialized nations such as Germany (573 per square mile), the Netherlands (940 per square mile), Japan (865 per square mile), and the United Kingdom (609 per square mile).² U.S. residents are unevenly dis-

tributed, creating numerous non-metropolitan communities throughout the country. Indeed, roughly 45 percent of the U.S. land mass is frontier, and a total of 25 states have frontier regions.³ It is estimated that more than 60 million individuals, or one-quarter of the U.S. population of 251 million, live in areas designated as *rural* (fewer than 2,500 people per town boundary) and *frontier* (fewer than 6.6 people per square mile).

Concerns have been raised about health care needs in rural areas for several reasons. First, the overall age-adjusted death rate is greater in rural areas (537 per 100,000) than in large (479 per 100,000) and medium to small (517 per 100,000) metropolitan settings.⁴ Second, a higher proportion of rural residents experience chronic illnesses and life-threatening conditions, such as cancer, heart disease, arthritis, and diabetes. They also experience greater limitations on physical activity—for example, in mobility or self-care—than urban residents.⁵ Rural residents' perceptions of their health are also more negative than are those reported by city inhabitants; this is especially true among the rural poor.⁶ Third, rural and frontier areas have a greater proportion of children and elderly residents who generally require more health services. Fourth, rural regions have a greater prevalence of environmental hazards (for example, contaminated water supplies, pollution, pesticides, natural disasters, infectious agents, animal bites) and domestic and occupational injuries (agricultural, forestry/logging, fishing, and mining, etc.).⁷ Finally, mental health concerns in smaller communities are tremendous. Early studies have estimated that 13-19 percent of rural residents experience significant psychiatric impairment. More recent evidence indicates that alcohol and cognitive disorders are higher in rural areas, and depressive symptoms are more prevalent rurally.⁸ Suicide rates, previously higher in urban settings, are now greater in rural regions. Indirect indicators of substance disorders

and mental illness in rural areas are also substantial, as revealed in deaths due to homicide and alcohol-related motor vehicle crashes, in the high rates of fetal alcohol syndrome, child neglect and abuse, and other social problems especially in certain subpopulations of rural dwellers.⁹ For all of these reasons, rural health needs are thus increasingly recognized as among the most pressing of public health issues in this country.

Distinct Features of Health Care Ethics in Small Communities

Clinical ethics seeks to improve patient care through the process of refining clinical decisions, pursuing empirical inquiry and scholarship, and shaping social policy that is informed by clinical experience and scientific knowledge. Ethical decisionmaking in clinical practice is based on systematic case-based analyses and a foundation of principles and values, such as respect for persons, confidentiality, beneficence, fidelity, clinical competence, and justice.¹⁰ Like their urban counterparts, health care providers in rural communities face dilemmas when clinical issues, ethical principles, and personal, community, and professional values come into conflict. But these dilemmas often take distinctive forms, shaped by several features of rural communities themselves. Moreover, although it has yet to receive systematic empirical study, it appears that such dilemmas may be more likely to arise in rural and remote settings due to the resource constraints of such situations and the limited insights offered by ethics guidelines developed for application in more mainstream, less "closed" settings.¹¹

Special ethical dilemmas encountered in small communities derive from several highly interwoven attributes of health care in these settings: (1) overlapping relationships and conflicting roles among caregivers, patients, and families; (2) challenges in preserving patient con-

fidentiality; (3) heightened cultural dimensions of health care; (4) limited resources and access to health care services and related issues of clinical competence; and (5) exceptional stresses on caregivers in these settings.

Overlapping relationships and conflicting roles. Overlapping relationships are common in small towns: the doctor's kids go to school with patients' kids; the patient is the nephew of the nurse; the office manager and the patient attend religious services together; the patients all talk to one another. Especially in frontier communities, health care providers routinely interact with patients in nonmedical as well as medical roles. For example, Paul Ullom-Minnich and Ken Kallail found that among physicians practicing in communities with fewer than 5,000 inhabitants, two-thirds of their respondents reported that more than 5 percent of their patients interacted with the physician or staff member on a non-medical basis, while nearly half reported that more than 5 percent of their patients were friends or family members.¹²

Overlapping relationships are ethically complex: they enrich the clinical relationship, yet they are also potentially exploitive because of problems related to conflicting roles and their impact on treatment boundaries, the rules and conduct that establish the professional relationship as distinct from other relationships and as fundamentally respectful and protective of patients.¹³ In the context of overlapping relationships, caregivers may more deeply understand and more aptly respond to the well-being and best interests of patients. However, patients' needs at times may be superseded by other concerns determined by the clinician's roles, context, and interests.

Overlapping roles and resulting conflicts of interest may make it difficult to apply ethical principles and uphold legal mandates in rural regions; they also may interfere with seeking and delivering adequate care in these areas. The issues at stake may

The Problems of Rural Care: Four New Studies

Four preliminary studies have begun to characterize a unique constellation of ethical dilemmas and practices encountered in rural health care. In an innovative written survey project, Paul Ullom-Minnich and Ken Kallail studied rural physicians' strategies for safeguarding patient confidentiality.¹ A questionnaire was mailed to all family and general practice physicians in Kansas, and a total of 510 physicians participated (55 percent response rate). Nearly half of the responding physicians (46 percent) practicing in communities of fewer than 5,000 inhabitants stated that more than 5 percent of patients were friends or family members of the physician or staff. Similarly, for 66 percent of respondents in these small communities, more than 5 percent of patients had some interaction with the physician or staff member on a nonmedical basis. In contrast, these two issues affected only 13 percent of the physicians serving communities with more than 20,000 people. The authors concluded that small community size was the first and most objective variable that tends to impede patient privacy. Interestingly, extra measures or techniques used by responding physicians to protect patient confidentiality were: speaking with office personnel regarding the importance of confidentiality of the specific patient (88 percent of respondents), omitting certain details from the official medical record (69 percent), recording the importance of confidentiality in the chart (46 percent), omitting certain details from insurance forms (37 percent), omitting a required notification of local public health officials (21 percent), and purposeful misrepresentation of details in the medical record (6 percent) or insurance forms (5 percent). Women physicians were more likely to record the importance of confidentiality on the chart, whereas male and older physicians were more likely to omit health department notification of a reportable disease. This study clearly demonstrates how the size of a community may influ-

ence patterns of handling sensitive patient information. It also begins the process of documenting novel informal strategies used by physicians to protect patient material, and it hints at factors (e.g., gender, age, practice setting) that may influence these activities.

A second survey study by Helen Robillard and colleagues explored the ethical issues encountered by 702 primary health care providers in Kentucky, including 391 physicians, 100 staff nurses, 93 nurse practitioners, 85 physical therapists, and 33 physician assistants.² Problems identified by a majority of the participants as occurring "commonly" or "occasionally" related to insufficient time with patients, financial problems of patients and of rural systems of care, patient noncompliance, inappropriate patient requests or use of services, lack of continuity of services, complaints about professional incompetence, lack of clinical expertise, and problems with geographical access to health services. Other issues that arose in this study with lesser frequency included ethical dilemmas surrounding confidentiality, informed consent, end-of-life care; complaints of disrespectful conduct toward patients; conflicts with community, patient, or provider values, substance abuse, care of children; and others. On 28 of 36 ethical issues considered, statistically significant differences were found between the perceptions of physicians and nonphysician care providers in the study sample. In addition to its implications for rural health ethical dilemmas, this study clearly affirms the importance of understanding discipline-specific perceptions of ethical issues in patient care.

Ruth Purtilo and James Sorrell performed a pilot, descriptive study focusing on the ethical dilemmas experienced by 125 rural physicians in 1984-1985.³ Through exploratory interviews conducted personally or via telephone, these researchers found that rural physicians dealt primarily with four kinds of ethical is-

be quite serious for patients, physicians, and their communities. In one instance, a primary care physician living adjacent to an Indian reservation discovered that a very powerful tribal council member had sexually abused a number of children in the community. The physician felt clinically and legally obligated to report this finding. He was in a terrible bind, however, because the tribal council and community would be divided about

the decision to report the behavior. Moreover, the tribal council was responsible for approving his annual contract as the community physician. Ultimately, he formally reported the behavior. As a consequence, he lost his position, and he and his family were forced to move from their home of many years in the area.⁴ Because of such pressures in small communities, physicians may serve their own or their family's needs, rather than act

exclusively and faithfully to serve the best interests and concerns of their patients.

Overlapping roles may create clear barriers to optimal care. For instance, in another case a patient drove six hours to Albuquerque to come to a university hospital emergency room for help with his substance abuse problems. He told the attending physician, "My sister works at the clinic by our house. I couldn't go

sues: preserving confidentiality, making difficult quality-of-life decisions, allocating scarce resources, and feeling a moral responsibility for bettering the life of the entire community. Examples of problem-solving strategies used by rural physicians described in this study included the keeping of second or "shadow" medical charts, inventing home health services so that patients would not have to travel to distant and alienating tertiary care settings for medical help, leading fund-raising efforts to pay for patient care costs, and attempting to separate professional and personal roles in the community.

In the fourth study, Luci Turner, Kathy Marquis, and Mary Burman conducted structured telephone interviews with seven women and two men who served as nurse practitioners in cities with fewer than 50,000 inhabitants in Wyoming and northern Colorado.⁴ The pilot study, published in 1996, sought to identify ethical dilemmas encountered by these rural nurse practitioners and to document decisionmaking "enhancers" and "constraints" they experienced. Patient noncompliance, abortion, immunization compliance, teen pregnancy, financial problems, confidentiality, legal conflicts (for example, suspected abuse, criminal involvement, teen contraception without parental consent), and colleague incompetence/impairment were the ethical dilemmas reported in this small sample. The strength of this modest study, however, relates to the factors influencing ethical decisionmaking in rural health care settings. Positive, ethically important "enhancers" in rural health care were identified as good rapport with patients, support from peers, mentors, referral system, intuition, emotional distance, patient involvement, and holistic understanding of the patient. Constraints included time limitations, conflicts with physicians and other providers, past experiences, emotional closeness to the patient, limited or inadequate patient information, isolation from peers and facilities, and interpersonal confrontation in decisionmaking. Interestingly, rules, regula-

tions, and past professional and personal experiences were reported as both constraints and enhancers. These elements influencing ethical decisions by rural nurse practitioners may offer some insights for guiding and further developing sound ethical practices in small communities.

Although these preliminary studies are valuable and helpful, much remains to be understood about health care ethics in small communities. For example, while two of these studies were relatively large (510 participants, 702 participants), they were both restricted to two states in the Southeastern region of the country. These studies did not include individuals from other rural and remote areas or participants from diverse ethnic groups. The other studies are best viewed as pilot work with considerably smaller sample sizes (125 participants, 9 participants), purposive sampling procedures, and other design features that raise questions of generalizability. In addition, the two written survey studies had relatively low response rates—55 percent and 30 percent—restricting their application and interpretation. Despite its limitations, this preliminary evidence nevertheless indicates the value of examining ethical issues and practices for their impact upon rural health care services.

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there because she would find out, and that would be bad for our whole family . . . and I know that she tells people things about other people, too."¹⁵ The patient was uninsured and received charity service at the distant university hospital, but the long drive became burdensome and was identified as a reason for noncompliance with subsequent treatment. In another case, a psychiatrist in a remote region was asked to conduct forensic

evaluations and appear before the court for charges against individuals with suspected or known mental illness. He felt conflicted about this request because the opinions offered by a psychiatrist directly influence the sentencing process, yet this psychiatrist is also likely to be involved in the patients' treatment as he is the only doctoral-level mental health professional in the area. While he preferred not to act as a "dual agent" in this

way, he also felt he had little choice if patients were to receive greatly needed help for their mental disorders.¹⁶

Such cases illustrate how overlapping relationships create complex choices and new sources of vulnerability for both clinicians and patients. The rural practitioner may feel very isolated and uncertain in such situations, especially because colleagues with clinical, legal, or ethics expertise—for example, those on hospital-

based ethics committees—are often not available to serve as “sounding boards” or sources of support for rural care providers.¹⁷ Patients too feel sensitive to the conflicts inherent to overlapping relationships, and this may be a disincentive to pursuing or accepting care.

As the “carriers” of highly sensitive knowledge, rural clinicians and their staff are at risk for social isolation and ostracism as they seek to protect their patients’ private information.

Constructive approaches to these problems include separating personal and professional roles to whatever extent is possible. For instance, some care providers may refer to their patients on a first-name basis in the grocery store or at a school board meeting, but address their patients more formally as “Mr. Jones” or “Ms. Smith” when they meet in the clinic. Setting up ways in which members of the clinical care team may excuse themselves—gracefully and without feeling like they have disappointed their teammates—from especially sensitive cases (for example, family members) may be important. Discussing the occasional awkwardness of overlapping relationships with patients is also helpful, both for clinicians and for patients. Seeking collaboration, supervision, and/or consultation when one’s personal feelings are very prominent in a clinical case is another key strategy for avoiding ethical problems in the context of overlapping relationships. When especially troublesome ethical dilemmas arise due to conflicting roles or conflicts of interest, it may be appropriate to refer patients for care in neighboring communities. Over time it may be possible to build collaborative networks of care across communities to help address these special situations. Rural

health care agencies can enhance this process by providing financial, technological, and programmatic support through education, Internet access, or agency-supported supervision.

Confidentiality. Respect for patient privacy is understood to be a fundamental element of the physi-

cian-patient relationship, but maintaining confidentiality is especially difficult in small communities. Ruth Purtilo and James Sorrell described a rural patient situation in which a pregnant woman was found by her obstetrician to have genital herpes derived from sexual contact outside of her marriage.¹⁸ The patient was most distressed and requested that the information not be entered in her medical record. The obstetrician explained that such documentation was necessary so that adequate precautions to protect the baby would be taken at the time of delivery. Fearful of repercussions for herself in the small community, the patient still begged the doctor not to reveal this information in any way. In this case, clinically competent care, fidelity to the patient and the child, confidentiality preferences, and the obligation to document and report communicable disease are in tension.

In such situations, losing the patient from a therapeutic alliance is a significant risk, and counseling or psychiatric services may not exist in rural areas to help patients cope with these stressful life experiences. On the other hand, great shame and perhaps direct harm may occur if patient information is disclosed in the context of a small, closed community. It is

often unclear which is the greater risk in a particular situation. Ironically, silence itself resulted in a form of disclosure of a patient’s personal information in a very small frontier community.¹⁹ A secretary in a rural mental health clinic in Alaska helped with the paperwork to transfer an adolescent boy to the state psychiatric hospital for commitment. The parents had told the townspeople that he had gone to an out-of-town relative’s house for the summer. Usually gregarious, the secretary was abnormally quiet at a social gathering where several of her friends were discussing the boy’s sudden departure from the community. Through the secretary’s silence it became apparent to the townspeople that the boy had left for psychiatric reasons. As similar cases are repeated over time, the foundation of professional and personal trust built within the community is potentially jeopardized. As the “carriers” of highly sensitive knowledge, rural clinicians and their staff are at risk for social isolation and ostracism as they seek to protect their patients’ private information.

Ethically sound measures used by rural clinicians to preserve confidentiality include remaining mindful of its importance to patients, speaking with colleagues and office staff about the role of confidentiality in effective patient care, and following up on any “leaks” that may occur from time to time. Routine office practices, such as keeping records out of public view, are important but may be overlooked on busy days in the clinic. Documenting sensitive patient data only when clinically or legally indicated is another approach used by rural clinicians. Maintaining separate “shadow” charts may also be a common practice, especially among mental health providers. Finally, it is ideal if collaborative clinics are set up such that medical and psychiatric or psychological services are both available; in this way, it is less obvious who specifically requires mental health care, thus minimizing the stigma associated with the need for mental health care.

Cultural issues. Cultural values and beliefs affect recognition of illness, care seeking, medical preferences, acceptance of caregivers and health care interventions, and patterns around reimbursement for health care services. Extensive evidence is mounting that individuals from different cultural backgrounds hold differing views of pain, disease concepts and etiologic explanations for sicknesses, patterns of use of folk healers, tolerance of illness, stoicism, mistrust of technology, and other factors. For instance, in a recent study by Leslie Blackhall and colleagues, 200 elderly Los Angeles residents were queried about their attitudes toward disclosure of the diagnosis and prognosis of a terminal illness and toward end-of-life decisionmaking.²⁰ Korean Americans and Mexican Americans were much less likely than Anglos and Blacks to believe that a patient should be told the diagnosis of metastatic cancer. Strong differences were also found among the ethnic minority groups regarding the role of families in making end-of-life decisions. A study by Clarann Weinert and Kathleen Long explored definitions of physical and psychological health among sixty-two men and women from thirteen rural counties in Montana.²¹ This study revealed that health was defined "as the ability to work or to be productive in one's role. Ranchers and farmers stated that pain would be tolerated for extended periods so long as it did not interfere (with work) . . . mental health problems were rarely mentioned . . . either because they do not define symptoms as a 'mental health' problem or they are reticent to admit to the symptoms" (p. 33). Such perceptions of health are likely to influence care-seeking behavior in this agricultural population.

Studies of rural American Indians reveal the importance of culture in health care. For example, Spero Manson and colleagues found that among fifty-four Hopi Indians from Arizona "no conceptual equivalent" to the notion of clinical depression was appar-

ent to Hopi people and no analogous term was thought to exist within the Hopi language.²² Anthropologic study of the Zuni culture has shown that an understanding of native healers and knowledge of the role of community in causing and curing illness are critical to providing appropriate health care to individuals. As described by Scott Camazine, the role of the *ak'wa:mossi* (healer)

is to restore the [Zuni] patient's health and in the larger sense restore order to the society. The witch who is believed to have shot the illness into the patient is often felt to be one of society's deviants and the *ak'wa:mossi* can effect a cure. Thus, the illness may affect only the ailing patient, yet its etiology is of concern to the entire society, and it is the *ak'wa:mossi* who acts as the liaison between the society and the patient.²³

Suffering in these native cultures is conceptualized in a spiritual and community context, and the potential value of employing techniques of Western medicine might not arise in relation to specific symptoms.

Ethical mistakes thus may arise through insufficient respect for indigenous values (such as interfering with a healing ceremony), not working with the natural supports within families and communities, or appearing to question the life pattern of a patient (religious beliefs or long-standing self-reliant attitudes, for example, that prevented earlier medical intervention). This is poignantly illustrated in the example of a rural woman with advanced breast cancer described by Holly F. Matthews:

When I went to see the doctor, I just told him I didn't want the mastectomy—that I was going to put my faith in the Lord and trust God to cure me. And he said to me, "God can't do everything; you've got to do something for yourself." Well, that did it for me. I got up and walked right out that door because he was questioning

everything I have built my life on. So I went home and prayed without ceasing. I asked the people in my church to pray for me, too.²⁴

It is also apparent in the following story told by a New Mexican social worker:

Well, we sent one of my patients, a Navajo man, up to the hospital in town and they cut off his foot. He was diabetic, you see. They didn't keep the foot, you see. They didn't give it back to him. He's not complete now, you see, for when he dies. Now none of my patients will go up to that hospital any more.²⁵

Similarly, a physician new to an Alaskan community who, wishing not to be exploitive, refuses a gift offered by a native family may find that he or she has created a nearly irreparable breach of trust. Failing to recognize such important cultural influences on seeking, understanding, or complying with recommended treatment may result in inadequate care, causing key ethical problems. A second kind of ethical mistake may occur through over-identifying with or romanticizing indigenous values, for example, not confronting the patient who fails to get important laboratory tests performed or who is noncompliant with critical medications, which can lead to underdiagnosis or to inadvertent collusion with the health and coping problems of the patient.²⁶

Cultural issues such as these sometimes exert a greater influence on rural than on urban health care because local customs and practices may affect a great proportion of patients in a caregiver's practice. These cultural considerations fall within the purview of clinical ethics because of the heightened responsibility of health providers to be attuned to the psychological concerns of patients and to be self-observing of the therapeutic interaction. Consequently, the health care provider in a small community must work especially hard to



Waiting room, Coats Clinic, North Carolina, 1998

**Rural clinicians can see the results of their work—
in the children, adults, and elderly citizens they
encounter on a daily basis.**

communicate effectively and to build therapeutic alliances within the context of cultural differences. Without such efforts, cultural "errors" can prevent a new clinician from being trusted altogether, undermining his or her ability to help individuals and the community as a whole.

Valuable approaches to cultural dimensions of rural care relate primarily to clinicians' knowledge of a community's history and current concerns and their attunement to the cultural experience of individual patients. This level of understanding entails that clinicians new to a community engage in careful listening and observation, speak with community leaders, and be willing to do

things differently from their past practice settings. Clinicians who have grown up in or practiced for a long time in a particular community must repeatedly reexamine their assumptions about personal cultural expectations. In all instances, rural practitioners must be mindful of the cultural meaning they carry for their patients by virtue of their social role, ethnicity, gender, age, urban training, and other personal attributes. As many rural clinicians have discovered and discussed, it is not necessary to blend in or to share an identical background with all of one's patients in order to be an effective caregiver. It is, however, essential to have a sense of one's own cultural identity

and to be reflective about its influence on interactions with patients.

Limited access to care and related issues of clinical competence. In both ordinary and extraordinary cases, barriers to access and limited resources raise significant clinical ethical dilemmas for those who must provide care in rural systems. Rural areas experience considerable obstacles with respect to health care access, encompassing *continuum* of services, *relative effectiveness* of services, *willingness* and *ability* to use services, and *actual use* of services.²⁷ For instance, many areas do not have emergency, urgent care, or specialty care facilities. By one estimate, one out of every seventeen rural counties in the United States had no physician providing patient care.²⁸ Of the rural counties that have practicing physicians, as many as one-quarter have general and family practitioners exclusively and more than two-thirds of rural counties have no pediatricians or obstetricians. Many small communities do not have hospitals or hospital-based supports, including ethics committees and specialty consultants who can help provide enhanced clinical and ethical care to rural regions.²⁹

Relative effectiveness of care may also be limited by the lack of allied health services, leading to insufficient physical and psychological therapies and/or late detection of illness. Willingness to pursue and accept care and the actual use of services may be affected by a wide variety of factors, such as the ethnicity and cultural background of the care providers, perceived quality of past treatment, the time of year (harvest season, for example), the language(s) spoken in the clinic, and attitudinal factors, such as the clinician's acceptance of alternative healing practices. With respect to ability to use services, rural patients have been found to be twice as likely to have to travel for over thirty minutes to reach their usual source of health care than residents from other areas.³⁰ Rural clinics may also be less well equipped than urban centers to handle the special require-

ments of disabled patients. Rural clinicians may have to choose *which* patients receive resources and treatments, for instance. They may be reluctant to send patients far from home for serious medical conditions because of the absence of supports in these distant cities. Or, more simply, their patients may not have transportation or money for such outside care. These concerns about access to health care are now acute, given the pressures experienced by rural practitioners now functioning within constrained managed care systems.

For these reasons, greater attention to problems in health care access in rural areas is critical in terms of the fair distribution of medical services and awareness of the ethical impact of resource scarcity. To cope with these conditions of limited access to care, health care providers in rural communities may be forced to provide care outside of their usual areas of expertise. Nurses, nursing assistants, social workers and aides, and "deputized" local citizens often serve as the initial or principal caregivers in small towns and frontier communities. Evidence drawn from a study in Texas suggests that rural nurses may differ significantly from urban nurses in that the former are older, may have less advanced education, and have a far lower income than nurses in metropolitan settings.³¹ Rural nurses thus commonly perform their clinical work with expanded roles and responsibilities, with greater autonomy, and the need for extensive knowledge, but with less training and fewer resources than urban nurses. In native villages, a patient's entire treatment team may consist of family members recruited to do the work with little or no formal training. For these reasons, clinical competence, a fundamental prerequisite for sound ethical care, is a pressing moral consideration in many rural and remote health care settings.

To illustrate, an Indian Health Service physician once described a situation with which he struggles:

I have a family where the mom is seriously mentally ill and can't get to a psychiatrist. We have a circuit rider, a psychiatrist, but he can't come too often way out there. Anyway, the family doesn't get immunizations for the kids. Is this a kind of neglect that I should report? How much of this is our fault because we can't get a doctor out there?³²

Similarly, a social work aide and nurse described their annual home visit to a family with multiple problems.³³ On one such visit, they found that the wife had recently been beaten badly by her husband. No domestic shelters and no trained therapists were available in the neighboring counties. The extended family sided with the husband in the marital disputes. The visiting clinicians felt helpless and overwhelmed by the situation, and they did not feel that they had the resources to deal with its complexities and dangerousness. Limited health care resources and access thus may interfere with providers' ability to address patient safety and suffering. Taken together, these factors conspire so that small communities may have few health resources, lesser expertise, tremendous shortages of care providers, heightened ethical binds, and greater risk for errors.

Constructive approaches to these resource issues exist on the level of health care systems and on the level of direct patient care. Advocacy for rural health care funds is essential, and the active involvement of consumer groups, professional organizations, community leaders, and agency representatives may help to bring state and national funds to rural areas. Participation in epidemiologic, clinical services, social science, and biomedical research may also help to inform and devise responses to systemic resource problems. Ideally, decisions about community resources that influence direct patient care practices should be explored and supported by the community. Finally, when clinicians find themselves in

situations in which resource limitations appear to create ethically untenable patient care decisions, it is critical to speak with colleagues and with others in the community. While optimal solutions may not be readily at hand, through active problem-solving unknown or unexpected resources may become available to help resolve or improve the situation.

Unique stresses on caregivers. The clinical and ethical burdens experienced by rural providers create unique and immense stresses. Problems related to both professional and personal roles may create very painful situations for rural caregivers. This was described movingly by Linda M. Sigsby:

Near the conclusion of the city council's night meeting, [a man] begins firing his gun at council members. . . . [A]s the ambulances bring each of the victims into the community hospital emergency department, every physician in the town also begins to arrive. . . . We try not to look at Don's head. The trauma is severe . . . blood is everywhere. We sat side by side at our school desks in fourth grade as we had in first, second, and third grades because of alphabetical order. He was handsome in the high school football jersey. His sister, Jennifer, married my cousin, Tim, and they live just down the road from us. . . . My inside voice begs, "Please, please, someone help us, help Don, help! I've done everything I know how to do and he's still dying. Help me."³⁴

Other stresses relate to personal and professional isolation. The "carriers" of every town secret, rural clinicians must constantly be wary of talking in a way that reveals confidential information. Rural clinicians may become less socially involved and increasingly withdrawn as their tenure lengthens, until eventually they may feel themselves, ironically, to be outcasts. This stress is greatest in enmeshed communities, where clinicians are often in the bind of being a

caregiver and yet needing goods or services from their patients. Finally, David Hilfiker describes the immense suffering he experienced in relation to a clinical mistake he made, partly due to insufficient health resources in his small community:

Barb seems to be in good health with all the signs and symptoms of pregnancy, but her pregnancy test is negative . . . But the next urine test is negative, too, which leaves me troubled . . . Has she had a missed abortion? I could make sure right now, of course, by ordering an ultrasound, but the new examination is available only in Duluth, 100 miles away . . . and it is expensive . . . (Later) the pathology report confirms my worst fears: I have aborted a living fetus at about 13 weeks of age. No explanation can be found for the negative pregnancy tests . . . Some of my mistakes are obvious: I relied too heavily on one particular test . . . I should have ordered the ultrasound: . . . [T]here is simply no way I can justify what I have done.²⁶

Rural health caregivers thus often function alone, with few resources and little support. They experience significant barriers in their work as they care for patients whose illnesses may be beyond their training and expertise and whose suffering is severe. Emotional exhaustion, depersonalization of the patient, and loss of feelings of accomplishment may be experienced by the rural caregiver as a result. In the absence of special "hardiness" in health care providers, cynicism, isolation, and impairment are potential consequences of rural and frontier practice.

Self-care practices of rural clinicians are therefore especially important to ethically sound health care. Pacing one's work so as not to become exhausted, finding colleagues to talk with so as not to be completely alone with difficult and painful clinical de-

cisions, learning stress-management techniques, and finding a balance between professional and personal roles in the community all will help the rural clinician to remain healthy and to be able to sustain a career in a relatively isolated professional setting.

Ethical Strengths of Health Care in Small Communities

Positive and pragmatic approaches to ethical dilemmas are employed by wise, experienced rural health practitioners each day. Many of these individuals value their work in small towns and distant areas immensely and, despite limited resources, stresses, and ethical binds, far prefer it to the work of their "city slicker" counterparts. Rural clinicians know their patients with a familiarity seldom reached in urban health care settings. These clinicians frequently have contact with patients outside of the clinic and so gain a solid appreciation of their patients' functioning separate from what they hear during the office visit. This allows for more than just increased knowledge about the patient—it promotes a more comprehensive understanding of all of their patients' lives. Rural clinicians are thus poised to provide healing that is attuned to all aspects of the individual patient's suffering. Rural clinicians also commonly feel a special sense of commitment and emotional ownership in their work with their communities and with their patients specifically. Rural clinicians can see the results of their work—in the children, adults, and elderly citizens they encounter on a daily basis. When the town plumber has a heart attack, the entire community may be influenced by his recovery. This phenomenon can be stressful for rural practitioners, especially when patients have severe and chronic illnesses or poor treatment outcomes. On the other hand, rural practitioners may feel a special sense of pride and accomplishment when their work gives rise to the health and recovery seen throughout

their communities. Their role as healer is felt with a depth and fullness unusual in urban health care providers.

Constructive strategies for dealing with ethical dilemmas in rural, remote, and analogous small community or closed system settings are wide ranging. They include maintaining connections with colleagues locally and nationally to lessen isolation and to allow for consultation or referral on difficult cases; educating colleagues and patients regarding potential problems arising in small community ethics; advocating for health care resources; identifying and minimizing professional stresses and learning to find balance in one's personal and professional spheres; developing additional measures for protecting patient confidentiality; and putting thought and effort into ways of reducing conflicting roles and potential conflicts of interest.

Beyond the level of the individual practitioner, greater sensitivity nationally to the ethical dimensions of health care in rural and remote areas will do much to help address the frontier dilemmas experienced by our colleagues in nonmetropolitan settings. Increasing awareness of these issues will help small community practitioners to explain the dissonance and isolation they may feel when they encounter ethical complexities inherent to their settings. It will help health care leaders who are located in large metropolitan areas to appreciate more fully the ethical binds of the rural health culture. In this process, ethics guidelines for professionals and for small community clinical facilities may be revised in a manner that is attuned to the circumstances of rural areas, for example, by constructively addressing issues surrounding overlapping relationships, confidentiality, cultural issues, limited health care access and resources, and stress. Finally, growing attention to these ethical issues will help to foster reflection and formal empirical inquiry in this neglected but critical aspect of rural health care services.

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Attention: Dr. Peter Hartsock
NIDA / DLR

Approved Through 2/28/01
OMB No. 0925-0001

AA

Department of Health and Human Services

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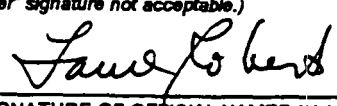
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MAY

NAME: ROBERTS, LAURA W
APPL NO:1 R01 DA13139-01
DUAL:MH RCVD:05-03-99
IRG: ZRG1-AARR-8(1S)

COUNCIL: 10/99

Follow instructions carefully.

Do not exceed character length restrictions indicate.

1. TITLE OF PROJECT (Do not exceed 56 characters, including spaces and punctuation.) Stigma & Ruralty: Drug Abuse, HIV/STD & Mental Illness					
2. RESPONSE TO SPECIFIC REQUEST FOR APPLICATIONS OR PROGRAM ANNOUNCEMENT ☐ NO ☐ YES (If "Yes," state number and title) Number: PA-95-060 Title: Drug and Alcohol Use and Abuse in Rural America					
3. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR					
3a. NAME (Last, first, middle) Laura Weiss Roberts		3b. DEGREE(S) MD		3c. SOCIAL SECURITY NO. <i>Provide on Form Page KK</i>	
3d. POSITION TITLE Assistant Professor		3e. MAILING ADDRESS (Street, city, state, zip code) Department of Psychiatry 2400 Tucker NE Albuquerque, NM 87131			
3f. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT Psychiatry					
3g. MAJOR SUBDIVISION School of Medicine					
3h. TELEPHONE AND FAX (Area code, number and extension) TEL: 505-272-2223 FAX: 505-272-4639		E-MAIL ADDRESS: lroberts.@salud.unm.edu			
4. HUMAN SUBJECTS ☐ No ☒ Yes		4a. If "Yes," Exemption no. or IRB approval date { ☒ Full IRB or ☐ Expedited Review Pending		4b. Assurance of compliance no. M 1450	
5. VERTEBRATE ANIMALS ☒ No ☐ Yes		5a. If "Yes," IACUC approval date		5b. Animal welfare assurance no. A 3350-01	
6. DATES OF PROPOSED PERIOD OF SUPPORT (month, day, year—MM/DD/YY) From 12/01/99 Through 11/30/04		7. COSTS REQUESTED FOR INITIAL BUDGET PERIOD 7a. Direct Costs (\$) 347,054		8. COSTS REQUESTED FOR PROPOSED PERIOD OF SUPPORT 8a. Direct Costs (\$) 1,926,712 8b. Total Costs (\$) 2,635,702	
9. APPLICANT ORGANIZATION Name University of New Mexico Health Sciences Ctr Address 915 Camino de Salud NE Albuquerque, NM 87131-5041		10. TYPE OF ORGANIZATION Public: → ☐ Federal ☒ State ☐ Local Private: → ☐ Private Nonprofit Forprofit: → ☐ General ☐ Small Business			
		11. ORGANIZATIONAL COMPONENT CODE			
		12. ENTITY IDENTIFICATION NUMBER 85-6000-642		Congressional District 1	
13. ADMINISTRATIVE OFFICIAL TO BE NOTIFIED IF AWARD IS MADE Name Lee A. Gulbransen Title Manager Restricted Funds Address Univ. of New Mexico Health Sciences Center Controller's Office Basic Medical Sciences Building, B61 Albuquerque, NM 87131-5041 Telephone (505) 272-6264 FAX (505) 272-5037 E-Mail lgulbran@salud.unm.edu		14. OFFICIAL SIGNING FOR APPLICATION ORGANIZATION Name Robert A. Earnest Title Interim Assoc. VP for Finance & Admin. Address Univ. of New Mexico Health Sciences Center Controller's Office Basic Medical Sciences Building, B61 Albuquerque, NM 87131-5041 Telephone (505) 272-6264 FAX (505) 272-5037 E-Mail beamest@salud.unm.edu			
15. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR ASSURANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. I agree to accept responsibility for the scientific conduct of the project and to provide the required progress reports if a grant is awarded as a result of this application.		SIGNATURE OF P/PI/D NAMED IN 3a. (In ink. Per signature not acceptable.) 		DATE 4/27/99	
16. APPLICATION ORGANIZATION CERTIFICATION AND ACCEPTANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge, and accept the obligation to comply with Public Health Services terms and conditions if a grant is awarded as a result of this application. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties.		SIGNATURE OF OFFICIAL NAMED IN 14. (In ink. Per signature not acceptable.) 		DATE 4.28.99	

DESCRIPTION: State the application's broad, long-term objectives and specific aims, making reference to the health relatedness of the project. Describe concisely the research design and methods for achieving these goals. Avoid summaries of past accomplishments and the use of the first person. This abstract is meant to serve as a succinct and accurate description of the proposed work when separated from the application. If the application is funded, this description, as is, will become public information. Therefore, do not include proprietary/confidential information. **DO NOT EXCEED THE SPACE PROVIDED.**

Roughly 15 million rural residents struggle with drug and alcohol abuse, HIV, Hepatitis B and C, other sexually transmitted/infectious diseases, and mental disorders, and rural life has been characterized as having distinct features that create significant barriers to care for these stigmatizing illnesses. We will study clinical practice domains that are the cornerstone for ethically sound treatment—the therapeutic alliance, confidentiality, informed consent, and treatment compliance. Three specific aims are offered: (1) to use multi-source qualitative data to develop a new health care instrument and conceptual model that will identify barriers adversely affecting clinicians' efforts to care for people with stigmatizing illnesses in various settings; (2) to use that quantitative instrument to survey multidisciplinary clinicians and thus to test 3 hypotheses and to test the fit of the initial model; and (3) to identify educational and informational resources that may improve care for stigmatizing illnesses. Our hypotheses are: (1) Clinicians will identify ethical and psychosocial issues that are barriers to optimal care that are greater when caring for more highly stigmatizing illnesses, particularly for those in rural areas; (2) Clinicians will report distinct clinical care problem-seeking behaviors that are different when caring for more highly stigmatizing illnesses, particularly in rural areas; and (3) Clinicians' community, practice, professional, and personal characteristics will moderate the effects. Our 5 year project has 2 phases: (1) a qualitative phase with experts, panels, interviews, and focus groups to identify assessment constructs and indicators; and (2) a quantitative phase to survey multidisciplinary licensed clinicians about their views, experiences, behaviors, problems, and needs in caring for people with stigmatizing illnesses in rural and non-rural areas of Alaska and New Mexico. Thus, the project will produce a new survey instrument, extensive qualitative and quantitative data, and a needs assessment, all concerning clinicians' care of people with stigmatizing illnesses. This is the initial step of a program that will later study patients and non-licensed caregivers to characterize barriers to optimal clinical care for often neglected disorders that represent immense human suffering and resource utilization in our country. Ultimately, our aim is to improve health care for people suffering from stigmatizing illnesses such as substance abuse, HIV and other sexually transmitted diseases, and mental disorders.

PERFORMANCE SITE(S) (organization, city, state)

Health Sciences Center, University of New Mexico, Albuquerque, NM

Alaska Psychiatric Institute, State of Alaska, Anchorage, AK

KEY PERSONNEL. See instructions on Page 11. Use continuation pages as needed to provide the required information in the format shown below.

Name

Organization

Role on Project

See attached continuation pages.

ROUTINE

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WHITE HOUSE SITUATION ROOM

PAGE 01 OF 05

PRT: FUERTH aidspolicythurman

SIT: Bernard NSC HUSO KEITH LIEBERTHAL MCADEN OSIUS PRITCHARD ROBERTS
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RUEHZN/ENVIRONMENT SCIENCE AND TECHNOLOGY COLLECTIVE
RUEHUM/AMEMBASSY ULAANBAATAR 1522
RUEHVK/AMCONSUL VLADIVOSTOK 0166
RUEHGO/AMEMBASSY RANGOON 3230
RUEHVN/AMEMBASSY VIENTIANE 2863
RUEHSB/AMEMBASSY HARARE 0032
RUEHPH/CDC ATLANTA GA
RUEHRC/DEPT OF AGRICULTURE WASHDC
RHEHAAA/WHITE HOUSE WASHDC
RUEIFBS/FBIS RESTON VA
RUCPDO/USDOC WASHDC
RUCPCIM/CIMS NTDB WASHDC
RUEKDIA/DIA WASHDC
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WHITE HOUSE FOR OSTP AND OVP
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NIAIDS/JOHNSTON
HHS FOR HOHMAN, NOVOTNY, PHS AGENCIES
OES FOR EMERGING DISEASES/NANCY CARTER-FOSTER
BANGKOK FOR CDC/TIMOTHY MASTRO

E.O. 12958: N/A

TAGS: TBIO, KHIV, SOCI, UNFPA, NTDB, CH

SUBJECT: PRC AIDS: ADVICE FOR U.S. COLLABORATORS

REFS: (A) BEIJING

1. SUMMARY. CHINA'S MODERN HIGH VOLUME VACCINE
PRODUCTION CAPACITY AND NATIONWIDE EPIDEMIOLOGICAL
NETWORK COULD MAKE A MEANINGFUL CONTRIBUTION TOWARDS
DEVELOPING AN AIDS VACCINE. YET WEAK MANAGEMENT AND POOR
COORDINATION AMONG RESEARCH ORGANIZATIONS MAKE IT HARD
TO REALIZE THIS POTENTIAL. U.S. COLLABORATORS SHOULD TRY
TO MEET A WIDE RANGE OF CHINESE RESEARCHERS, ESPECIALLY
IN THE PROVINCES, SINCE CHINA'S BEST RESEARCH WORKERS
ARE OFTEN NOT IN CLOSE CONTACT WITH ONE ANOTHER. END

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PAGE 02 OF 05

SUMMARY.

MAJOR AIDS COLLABORATORS WITH CHINA

2. MAJOR FOREIGN DONORS FOR AIDS PREVENTION AND EDUCATION WORK IN CHINA INCLUDE THE WORLD BANK, UNAIDS, WHO, THE EUROPEAN UNION, THE UNITED KINGDOM, AND AUSTRALIA AS WELL AS NGOS SUCH AS THE FORD FOUNDATION. A LIST OF INTERNATIONAL COLLABORATORS AND OF KEY CHINESE AIDS RESEARCH AND GOVERNMENT CONTACTS APPEARS ON THE UNAIDS-BEIJING WEBSITE AT [HTTP://WWW.UNCHINA.ORG/UNAIDS/](http://www.unchina.org/unaids/)

CHINESE RESEARCHERS CAPABLE BUT UNDERFUNDED

3. CHINA HAS MANY BRILLIANT YET POORLY FUNDED, HUNGRY SCIENTISTS. SOME OF CHINA'S BEST TALENT IS LOCATED IN RESEARCH BUREAUCRACIES MODELED ON THE SOVIET ACADEMY OF SCIENCES. MUCH OF CHINA'S GOVERNMENT-TO-GOVERNMENT COOPERATION IS FUNNELED THROUGH THE CENTRAL GOVERNMENT MINISTRIES IN BEIJING. WHILE GOVERNMENT-TO-GOVERNMENT PROJECTS SEEM TO REQUIRE A HEAVY INVOLVEMENT BY GOVERNMENT BUREAUCRACIES, THIS IS NOT NECESSARILY TRUE FOR PRIVATELY FUNDED PROJECTS. MOREOVER LOCAL GOVERNMENTS SOMETIMES SEE BENEFITS TO THEIR OWN PEOPLE AND SO ARE EVEN MORE ENTHUSIASTIC ABOUT PROJECTS THAT OFFICIALS AT THE CENTER. NGOS FROM THE UNITED STATES AND OTHER COUNTRIES DO IMPORTANT WORK ON AIDS IN THE PROVINCES, PARTICULARLY IN YUNNAN PROVINCE.

4. RESOURCES ARE SPREAD THINLY AMONG CHINA'S MANY RESEARCH ORGANIZATIONS, SOME OF WHICH HAVE BEEN PUSHED INTO THE PRIVATE SECTOR TO SINK OR SWIM OVER THE PAST HALF-DOZEN YEARS. GOVERNMENT GRANTS TO RESEARCHERS TEND TO BE VERY SMALL, ON THE ORDER OF A FEW THOUSAND U.S. DOLLARS AND DO NOT INCLUDE OVERHEAD FOR INSTITUTIONS. BASIC RESEARCH IS SUPPORTED BY ORGANIZATIONS SUCH AS THE NATIONAL NATURAL SCIENCE FOUNDATION OF CHINA AND THE MINISTRY OF SCIENCE AND TECHNOLOGY AS WELL AS ON A SMALLER SCALE BY PROVINCIAL GOVERNMENTS. ONE RESEARCHER COMMENTED RECENTLY, "WHEN YOU GET YOUR GRANT, YOU HAVE TO SHARE IT WITH YOUR TEACHER, WITH YOUR DEAN, AND WITH ANYONE ELSE WHO COULD HURT YOU." SO GRANTS OFTEN DON'T GO VERY FAR. ONE HOPEFUL SIGN: THE PEER REVIEW GRANT SYSTEM PROMOTED BY THE NATIONAL NATURAL SCIENCE FOUNDATION OF CHINA AND OTHER ORGANIZATION IS MAKING IT INCREASINGLY LIKELY THAT SUPPORT WILL BE BASED ON MORE ON MERIT THAN JUST ON POLITICAL CONNECTIONS.

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BARRIERS BETWEEN ORGANIZATIONS REDUCE EFFECTIVENESS

5. WHILE RIVALRIES BETWEEN AND AMONG ORGANIZATIONS AND BETWEEN THOSE LOCATED IN THE CAPITAL AND THOSE IN THE PROVINCES OCCUR IN MANY COUNTRIES, THEY SEEM TO BE PARTICULARLY ACUTE IN CHINA. AS ONE LONGTIME AMERICAN UNCLAS SECTION 02 OF 03 BEIJING 006037

WHITE HOUSE FOR OSTP AND OVP
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TAGS: TBIO, KHIV, SOCI, UNFPA, NTDB, CH
SUBJECT: PRC AIDS: ADVICE FOR U.S. COLLABORATORS

STUDENT OF CHINA COMMENTED, "CHINESE LIKE TO BUILD WALLS". CHINESE POLITICAL SCIENTISTS AND SOCIOLOGISTS TALK ABOUT THE HIGH BARRIERS TO EXCHANGE AND COMMUNICATION BETWEEN ORGANIZATIONS AT THE SAME HIERARCHICAL LEVEL AND BETWEEN ORGANIZATIONS AT DIFFERENT LEVELS (TIAO AND KUAI).

6. THE WORK UNIT SYSTEM ESTABLISHED DURING THE EARLY 1950'S GAVE WORK UNIT LEADERS CONSIDERABLE CONTROL AND THE SOMETIMES UNQUESTIONED POWER OVER THE HOUSING, WORK, AND ECONOMIC OPPORTUNITIES OF WORK UNIT MEMBERS. ALL THIS IN ORDER, AS A CHINESE SOCIAL SCIENTIST COMMENTED IN THE 1998 BOOK "CHINA'S WORK UNIT SYSTEM" [ZHONGGUO DANWEI ZHIDU], TO MAXIMIZE BOTH THE STATE'S POLITICAL CONTROL AND ITS EXTRACTION OF ECONOMIC RESOURCES FROM SOCIETY. ALTHOUGH THIS WORK UNIT SYSTEM IS ALREADY FADING, IT STILL TENDS TO KEEP BARRIERS BETWEEN ORGANIZATIONS HIGH.

DON'T LET FERTILE WATERS FLOW INTO OTHER PEOPLE'S FIELDS

7. IN THIS CONTEXT, FOREIGN COLLABORATORS WITH CHINESE SCIENTISTS SHOULD BEAR IN MIND THE CHINESE SAYING, "DON'T LET YOUR FERTILE WATERS FLOW ON OTHER PEOPLE'S FIELDS" [FEISHUI BU LIU WAITIAN]. CHINESE SCIENTISTS WILL SOMETIMES NOT BE INTERESTED IN INTRODUCING U.S. COLLABORATORS TO OTHER DISTINGUISHED CHINESE SCIENTISTS (READ RIVALS). RESEARCH OPPORTUNITIES WILL VARY CONSIDERABLY WITH THE ATTITUDE OF LOCAL GOVERNMENTS AND

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PAGE 04 OF 05

THE EXPERIENCE OF LOCAL COLLABORATORS.

ISOLATION OF CHINESE SCIENTISTS PARTLY DUE TO SYSTEM

8. YET OFTENTIMES, THE PLOT IS NOT SO THICK -- THE CHINESE SCIENTISTS SIMPLY DON'T KNOW EACH OTHER. CHINESE SCIENTISTS SOMETIMES COMPLAIN ABOUT BEING ISOLATED. SOME OF THIS TO BE SURE IS DUE TO WORKING IN A DEVELOPED COUNTRY THAT IS STILL IN SOME RESPECTS ON THE PERIPHERY OF WORLD SCIENCE. YET MUCH OF THIS ISOLATION CAN ALSO BE ATTRIBUTED TO THE CHINESE RESEARCH SYSTEM AND THE FREQUENT RELUCTANCE OF CHINESE SCIENTISTS TO SPEAK THEIR MINDS FOR A VARIETY OF POLITICAL, SOCIAL AND CULTURAL REASONS. ACADEMICIAN ZENG YI'S RECENT VERY FRANK TALK ON CHINA'S AIDS CRISIS (SEE SEPTTEL) IS A REMARKABLE EXCEPTION.

U.S. COLLABORATORS SHOULD SPREAD THEIR NET WIDELY

9. WHAT DOES THIS MEAN FOR U.S. SCIENTISTS WHO COLLABORATE WITH U.S. AIDS COLLABORATORS? FIRST, U.S. COLLABORATORS SHOULD NOT ASSUME THAT THE PEOPLE IN BEIJING THEY MEET KNOW ALL THE BEST PEOPLE IN THE PROVINCES. THEY SHOULD TRY TO CAST THEIR NET AS WIDELY AS POSSIBLE. SECOND, THE VERY MANY CHINESE SCIENTISTS SETTLED IN THE UNITED STATES WHO HAVE ALREADY BUILT A DENSE NETWORK OF CONTACTS ACROSS THE PACIFIC WITH THEIR CLASSMATES CAN HELP AVOID TOO NARROW AN EXPERIENCE OF COLLABORATION WITH CHINESE COLLEAGUES. THIRD, YUNNAN, FUJIAN AND THE MORE DEVELOPED PROVINCES OF THE CHINESE COAST MAY BE RELATIVELY GOOD PLACES TO WORK. SOME OF THE INTERIOR PROVINCES SUCH AS HENAN CAN BE DIFFICULT PLACES TO DO AIDS RESEARCH.

10. PREVIOUS U.S. EMBASSY BEIJING REPORTS ON HIV IN CHINA AND SOME CHINA HIV WEB LINKS AND SUMMARY
UNCLAS SECTION 03 OF 03 BEIJING 006037

WHITE HOUSE FOR OSTP AND OVP
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SUBJECT: PRC AIDS: ADVICE FOR U.S. COLLABORATORS

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PRT: FUERTH aidspolicythurman

SIT: Bernard NSC ROBERTS SAUNDERS

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BANGKOK FOR CDC/TIMOTHY MASTRO

E.O. 12958: N/A

TAGS: TBIO, KHIV, SOCI, UNFPA, NTDB, CH
SUBJECT: PRC AIDS: MID 2000 OVERVIEW

REFS: (A) 99 CHENGDU 84 (B) BEIJING 3043

1. SUMMARY: THE HUMAN COMPLEXION OF CHINA'S AIDS
EPIDEMIC VARIES BY REGION: HOMOSEXUALS AND DRUG USERS IN
BEIJING; HETEROSEXUALS ALONG CHINA'S SOUTHEASTERN COAST;
AND DRUG USERS AND HETEROSEXUALS IN XINJIANG AND YUNNAN.
CHINA'S SENIOR AIDS RESEARCHER, ZENG YI, WORRIES THAT
THE CHINESE CENTRAL AND LOCAL GOVERNMENTS HAVE NOT MADE
AIDS PREVENTION, EDUCATION AND RESEARCH A SUFFICIENTLY
HIGH PRIORITY. HE CRITICIZES LOCAL GOVERNMENTS FOR
HIDING THE TRUE SITUATION IN THEIR REGIONS AND SAYS SOME
LOCAL AUTHORITIES HARASS AND HINDER AIDS RESEARCHERS.

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END SUMMARY.

CHINA AIDS OVERVIEW

2. CHINA'S AIDS EPIDEMIC PROFILE VARIES GREATLY BY REGION AND SOCIAL STRATA. INTRAVENOUS DRUG USE AND HETEROSEXUAL SEX ARE THE MOST IMPORTANT CHANNELS OF HIV TRANSMISSION IN THE WESTERN PROVINCES OF YUNNAN, XINJIANG AND GUANGXI. THE TWO AREAS WITH THE MOST NUMBERS OF NEW CASES ARE XINJIANG, FOLLOWED BY YUNNAN. IN THE RELATIVELY PROSPEROUS PROVINCES ALONG CHINA'S SOUTHEASTERN COAST SUCH AS GUANGDONG, HETEROSEXUAL TRANSMISSION IS THE MOST IMPORTANT SOURCE OF HIV TRANSMISSION. THIRTY PERCENT ANNUAL INCREASES IN SEXUALLY TRANSMITTED DISEASES RATES MAKE HIV SPREAD FASTER AND MORE WIDELY HETEROSEXUALLY. IN SOME AREAS OF YUNNAN AND XINJIANG VERY HIGH LEVELS OF HIV INFECTION AMONG INTRAVENOUS DRUG USERS HAVE BEEN REPORTED. IN BEIJING, HIV HAS APPEARED AMONG MALE HOMOSEXUALS AND INTRAVENOUS DRUG USERS. CHINESE EPIDEMIOLOGISTS, SOME COLLABORATING WITH NIH-FUNDED U.S. SCIENTISTS, STRIVE TO UNDERSTAND THE BEHAVIORS OF THESE GROUPS SO AS TO LEARN HOW HIGH-RISK BEHAVIORS CAN BE MODIFIED. LIMITED SUPPLIES OF SOME FOREIGN HIV DRUGS (SUCH AS AZT PROVIDED BY FOREIGN COMPANIES FOR PRC DRUG CERTIFICATION TRIALS) ARE PROVIDED FREE TO SOME HIV PATIENTS. MOST CHINESE CANNOT AFFORD TO PURCHASE THESE DRUGS THEMSELVES.

LACK OF COHORT STUDIES COMPLICATES UNDERSTANDING PRC AIDS

3. CHINESE AND FOREIGN AIDS RESEARCHERS HAVE REMARKED THAT CHINA LACKS LONGITUDINAL COHORT STUDIES ESSENTIAL FOR UNDERSTANDING THE DEVELOPMENT OF AIDS IN CHINA. THIS MAY BE AT LEAST PARTLY DUE TO THE DETERMINATION OF SOME LOCAL GOVERNMENT TO EXCLUDE OUT AIDS RESEARCHERS FROM THEIR AREAS IN ORDER TO HIDE THE TRUE SITUATION.

[COMMENT: SEE THE TRANSLATION OF A JUNE 2000 NEWS REPORT ON ZENG'S CRITICISM OF LOCAL OFFICIALS WHO BLOCK AIDS RESEARCH. THE LOCAL OFFICIALS ARE CONCEALING THE TRUE SITUATION NOT ONLY FROM THEIR OWN COMMUNITY BUT FROM THE CENTRAL GOVERNMENT AS WELL. END COMMENT] THE ATTITUDE OF LOCAL GOVERNMENT TOWARD THEIR HIV PROBLEM VARIES WIDELY. YUNNAN PROVINCE, WHICH HAS THE LONGEST EXPERIENCE WITH AIDS OF ANY CHINESE PROVINCE, IS AMONG THE MOST OPEN. MANY RESEARCHERS, SOME SUPPORTED BY INTERNATIONAL ORGANIZATIONS AND NGOS, OPERATE IN YUNNAN PROVINCE WITH THE APPROVAL AND COOPERATION OF LOCAL GOVERNMENT AND POLICE.

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HOW MANY PEOPLE HAVE HIV IN CHINA?

4. NOBODY HAS A VERY GOOD IDEA OF HOW MANY PEOPLE HAVE
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HIV IN CHINA. THE OFFICIAL NUMBER IS OVER 500,000. DATA
ON HIV CASES IN VARIOUS RISK GROUPS IS OFTEN FRAGMENTARY
AND OF UNCERTAIN QUALITY SO ADJUSTMENTS AND PROJECTIONS
MUST BE MADE TO ARRIVE AT AN ESTIMATE OF THE TOTAL
NUMBER OF CASES. [COMMENT: AS PEOPLE CORRECT FUZZY DATA,
THEY MAY FIND IT HARD NOT TO ADJUST IT TO MEET THEIR
EXPECTATIONS. END NOTE.] SOME CHINESE AGENCIES USE THE
NUMBER FOUR MILLION INTERNALLY, BUT OTHER RESEARCHERS
WITH EXTENSIVE FIELDWORK EXPERIENCE SAY THIS NUMBER IS
TOO HIGH AND THE REAL NUMBER IS SOMEWHERE IN BETWEEN.
THE EPIDEMIOLOGICAL MONITORING NETWORK APPEARS TO BE
STRONGER IN THE CITIES THAN IN THE COUNTRYSIDE WHERE 70
PERCENT OF CHINA'S PEOPLE LIVE.

LITTLE IS KNOWN ABOUT HIV IN RURAL CHINA

5. THE EXTENT OF AIDS IN THE COUNTRYSIDE IS NOT WELL
UNDERSTOOD. TENS OF MILLIONS OF MIGRANT WORKERS MOVE
REGULARLY BETWEEN THEIR COUNTRY HOMES AND THE BIG
CITIES. ALTHOUGH THE LEVEL OF PHYSICIAN'S TRAINING
CONTINUES TO IMPROVE IN THE CHINESE COUNTRYSIDE, MOST
PRIMARY CARE PHYSICIANS ONLY ENJOY THREE YEARS MEDICAL
VOCATIONAL SCHOOL TRAINING AFTER GRADUATION FROM JUNIOR
HIGH SCHOOL. THUS MANY RURAL PHYSICIANS HAVE DIFFICULTY
DIAGNOSING AIDS -- ESPECIALLY WHERE LOCAL GOVERNMENTS
ARE NOT WILLING TO ACKNOWLEDGE THAT HIV IS PRESENT IN
THEIR COMMUNITY.

HENAN BLOOD DONOR VILLAGE AIDS DISASTER STORY CONFIRMED

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6. A SICHUAN NEWSPAPER RECENTLY CLAIMED THAT MANY PEOPLE IN A BLOOD DONOR VILLAGE IN SHANGCAI COUNTY, HENAN WERE INFECTED WITH HIV AND HAD EXPERIENCED A RASH OF AIDS DEATHS. BUT WHEN ESTOFF VISITED THE COUNTY, THE LOCAL EPIDEMIOLOGICAL STATION TOLD HIM THAT "THERE IS NO AIDS HERE". THIS ASSERTION WAS DIRECTLY CONTRADICATED BY A CHINESE AIDS RESEARCHER WHO TOLD ESTOFF THAT THERE CERTAINLY IS AIDS THERE -- AND THAT HE HAD IN FACT TESTED THE BLOOD SAMPLES FROM THE VILLAGE MENTIONED IN THE PRESS REPORT. FIVE PERCENT OF THE BLOOD DONORS IN SOME AREAS OF RURAL HENAN PROVINCE HAVE HIV, SAID THE RESEARCHER. THE RESEARCHER SAID THAT THE PROPORTION OF PEOPLE WHO GOT HIV FROM BLOOD TRANSFUSIONS IS FAR HIGHER THAN THE 0.3 PERCENT OF REPORTED CASES (INCLUDING 50 CASES 1985 - 99 AND 15 CASES DURING 1999). [COMMENT: COMPARE THIS OFFICIAL FIGURE OF 50 REPORTED CASES OF HIV DUE TO BLOOD TRANSMISSION WITH THE 70 HIV CASES THE RESEARCHER CONFIRMED IN ONE HENAN BLOOD DONOR VILLAGE ALONE. END COMMENT]

FUNDING PROBLEMS REFLECT GOVERNMENT PRIORITIES

7. LACK OF FUNDING REFLECTS NOT JUST POVERTY BUT THE RANKING AIDS HAS IN THE PRIORITIES OF CHINA'S CENTRAL AND LOCAL GOVERNMENTS RELATIVE TO OTHER PRIORITIES INCLUDING HEPATITIS AND TUBERCULOSIS. HIV INFECTIONS CANNOT BE CONFIRMED UNTIL A WESTIN BLOT CONFIRMATORY TEST IS DONE. YET SOMETIMES GOVERNMENT AGENCIES CAN'T AFFORD TO DO THE SECOND TEST -- SUCH CASES ARE NOT COUNTED IN THE STATISTICS. THE NUMBER OF AIDS TESTS CONDUCTED IN NATIONAL SURVEILLANCE SURVEYS FELL FROM 3.4 MILLION IN 1997 TO 1.3 MILLION IN 1998. TESTS OF PEOPLE IN HIGH RISK GROUPS FELL FROM 170,000 IN 1997 TO 70,000 IN 1998. (SEE SUMMARY TRANSLATIONS "RECENT REPORTS ON HIV/AIDS AND STDS IN CHINA" AT [HTTP://WWW.USEMBASSY-UNCLAS](http://www.usembassy-unclas) SECTION 03 OF 05 BEIJING 006040

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CHINA.ORG.CN/SANDT/HIVARTIC.HTML FOR MORE DETAILS) THIS DROP WAS CONCURRENT WITH 40 PERCENT ACROSS THE BOARD BUDGET CUTS IN THE CENTRAL GOVERNMENT. THE DECEMBER AIDS DAY EDUCATION CAMPAIGNS OF 1998 AND 1999 ALSO SEEM TO HAVE BEEN LESS EXTENSIVE THAN THE ONE IN 1997.

COMBATING FLOOD OF SUBSTANDARD SYRINGES DIFFICULT

8. PREVENTING THE SPREAD OF BLOOD-BORNE DISEASES VIA UNHEALTHY (AND ILLEGAL) PAID BLOOD DONORS AND THE SALE OF SUBSTANDARD MEDICAL EQUIPMENT IS DIFFICULT. LARGE VOLUMES OF LOW QUALITY, SUBSTANDARD AND DANGEROUS "ILLEGAL" HYPODERMIC SYRINGES AND BLOOD TRANSFUSION EQUIPMENT ARE NOW FLOODING THE CHINESE MARKET. ONE MILLION SUBSTANDARD SYRINGES ARE SHIPPED DAILY FROM ONE REGION OF ZHEJIANG PROVINCE ALONE, ACCORDING TO AN ARTICLE IN THE APRIL 14, 2000 SOUTHERN WEEKEND [NANFANG ZHOUMO - AVAILABLE IN FULL CHINESE TEXT ON THE WEB THROUGH THE NANFANG RIBAO WEBSITE AT WWW.SOUTHCN.COM].

9. LOCAL AUTHORITIES TOLD JOURNALISTS THAT THE ADMINISTRATIVE MEASURES AT THEIR DISPOSAL ARE WEAK, AND PUBLIC SECURITY OFFICIALS ONLY WANT TO TAKE UP CASES THAT INVOLVES MORE MONEY. PRODUCTION IS DISPERSED -- ONE REGION HAD FIFTY SMALL FACTORIES, AND MORE IF SMALL HOUSEHOLD SYRINGES ARE COUNTED AND SO PRODUCTION IS HARD TO STOP. THE SOUTHERN WEEKEND ARTICLE RELATED HOW ILLEGAL SYRINGE MAKERS BEAT UP AN EPIDEMIOLOGICAL STATION WORKER WHO WAS TRYING TO CLOSE DOWN THEIR FACTORY.

BLOODBANKING: VOLUNTEERS PAID, LIABILITY CONCERNS GROW

10. AN AMERICAN BLOODBANKING EXPERT WHO ATTENDED A CHINESE BLOODBANKING CONFERENCE SAID THAT THE QUESTION MOST OFTEN RAISED WAS LEGAL LIABILITY FOR MEDICAL MISTAKES. [COMMENT: GROWING FEAR OF LAWSUITS MAY WELL RESULT IN GREATER ACCOUNTABILITY AND BETTER MANAGEMENT. END COMMENT] WHILE THE NUMBER OF NEW HIV CASES CAUSED BY BLOOD TRANSFUSIONS ARE PROBABLY MANY FEWER THAN BEFORE REFORMS IN 1996, SHORTAGES REQUIRE THE CHINESE TO CONTINUE TO RELY ON "ILLEGAL" PAID DONATIONS FOR A SIGNIFICANT PART OF THE BLOOD SUPPLY. THE AMERICAN VISITOR NOTED THAT THE VOLUNTEERS AT A BEIJING BLOOD BANK WERE BEING PAID A 200 RMB "NUTRITIONAL ALLOWANCE". [NOTE: THIS USD 25 PAYMENT IS A WEEK'S PAY FOR MANY URBAN WORKERS. END NOTE] THE AMERICAN VISITOR SAID THAT THE PERSISTENCE OF PAYMENTS IN WHATEVER FORM INCREASES

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THE LIKELIHOOD THAT UNHEALTHY DONORS WILL GIVE TAINTED BLOOD.

11. THE AMERICAN EXPERT SAID THAT THE VOLUNTEERS APPEARED TO BE HEALTHY PEOPLE IN THEIR TWENTIES, ADDING THAT CHINESE BLOOD BANKS ONLY TAKE HALF AS MUCH BLOOD (100 ML) FROM BLOOD DONORS AS DO AMERICAN BLOOD BANKS. DOUBLING THE AMOUNT OF BLOOD TAKEN FROM EACH DONOR WOULD SEEM TO BE AN EASY WAY OF BOOSTING THE SUPPLY OF BLOOD FROM VOLUNTARY DONORS AND HALVING THE NUMBER OF DONATIONS NEEDED, BUT LONGSTANDING CUSTOM MAKES THIS SEEMINGLY SIMPLE REFORM DIFFICULT.

LACK OF PRIVACY MAKE AIDS, STD DETECTION, CARE DIFFICULT

12. FOLLOWING THE PATTERN OF OTHER SEXUALLY-TRANSMITTED DISEASE EPIDEMICS, IN WHICH MANY INFECTED PEOPLE PATRONI UNCLAS SECTION 04 OF 05 BEIJING 006040

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"ILLEGAL" STD CLINICS RATHER THAN GOING TO AN OFFICIAL HOSPITAL FOR FEAR OF EMBARRASSMENT, IT APPEARS THAT MANY CHINESE ARE RELUCTANT TO HAVE AN HIV TEST FOR FEAR OF SOCIAL EMBARRASSMENT. THE CONCEPT OF MEDICAL PRIVACY IS NOT VERY STRONG IN CHINA FOR CULTURAL AND PRACTICAL REASONS. CHINESE PHYSICIANS MUST OFTEN WORK WITH LARGE NUMBERS OF PATIENTS IN A SMALL WORKING SPACE -- PRIVATE CONSULTATIONS ARE SOMETIMES NOT POSSIBLE.

13. WHILE PRIVACY IS NOT AS LARGE A PERSONAL AND LEGAL ISSUE IN CHINA AS IT IS IN THE UNITED STATES, CHINESE AIDS OR STD PATIENTS, LIKE PEOPLE IN OTHER COUNTRIES, DO NOT WANT THEIR CONDITION TO BECOME WIDELY KNOWN. A YUNNAN PUBLIC HEALTH OFFICIAL TOLD ESTOFF IN NOVEMBER 1999 THAT LACK OF CONCERN FOR PROTECTING PATIENT PRIVACY AMONG MANY CHINESE PHYSICIANS IS A BIG OBSTACLE TO EFFECTIVE PREVENTION AND TREATMENT OF SEXUALLY TRANSMITTED DISEASES. THE OFFICIAL CONTRASTED

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UNFAVORABLY THE ATTITUDE OF MANY CHINESE PHYSICIANS WITH THAT OF FOREIGN PHYSICIANS WORKING IN YUNNAN PROVINCE WHOM HE SAID, "TREAT THEIR PATIENTS LIKE FAMILY". ONE REVEALING ANECDOTE: A GROUP OF U.S. VISITORS WATCHED A DEMONSTRATION OF AN AIDS DATABASE RECENTLY, THE NAMES AND HOMETOWNS OF PEOPLE INFECTED WITH HIV SCROLLED DOWN THE SCREEN.

14. PREVIOUS U.S. EMBASSY BEIJING REPORTS ON HIV IN CHINA AND SOME CHINA HIV WEB LINKS AND SUMMARY TRANSLATIONS ARE MAINTAINED ON THE U.S. EMBASSY BEIJING WEBSITE AT
[HTTP://WWW.USEMBASSY-CHINA.ORG.CN/ENGLISH/SANDT/INDEX.HTML](http://www.usembassy-china.org.cn/english/sandt/index.html)

APPENDIX

THE RAPID SPREAD OF AIDS WILL BRING DISASTER TO CHINA

CHINA NEWS AGENCY, JUNE 10, 2000. ARTICLE BY YANG
RUICHUN

IF CHINA DOES NOT TAKE EFFECTIVE MEASURES; CHINA WILL HAVE ONE OF THE HIGHEST NUMBER OF AIDS INFECTED PEOPLE IN THE ENTIRE WORLD. AIDS WILL BECOME A CHINESE NATIONAL DISASTER. CHINESE ACADEMY OF SCIENCES ACADEMICIAN AND AIDS RESEARCHER ZENG YI SAID THIS IN A RECENT SCHOLARLY REPORT.

THE RESULTING ECONOMIC LOSSES TO THE NATION WOULD AMOUNT TO BETWEEN 460 - 770 BILLION RMB. THIS ENORMOUS FIGURE MAKES CHINA'S LEADERS WORRY THAT AIDS THREATENS TO RUIN THE GAINS CHINA HAS MADE WITH GREAT DIFFICULTY SINCE REFORM AND OPENING TO THE OUTSIDE WORLD BEGAN.

ACADEMICIAN ZENG YI MADE THESE STATEMENTS IN A SCHOLARLY REPORT AT THE TENTH CONFERENCE OF THE ACADEMICIANS OF THE CHINESE ACADEMY OF SCIENCES. ACADEMICIAN ZENG YI'S REPORT WAS ENTITLED "TRENDS IN THE SPREAD OF AIDS, PROGRESS IN AIDS RESEARCH AND POLICIES FOR STOPPING THE SPREAD OF AIDS" THAT LEFT HIS AUDIENCE UNEASY AND SPEECHLESS.

ZENG YI SAID THAT THE INCREASE IN THE NUMBER OF PEOPLE INFECTED WITH HIV HAS CLIMBED RAPIDLY OVER THE LAST FEW YEARS. THIS MEANS THAT CHINA HAS ALREADY ENTERED THE STAGE OF THE RAPID SPREAD OF THE AIDS VIRUS. ACCORDING
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TO THE PATTERN IN WHICH THE AIDS VIRUS SPREADS IN A
COUNTRY, THE AIDS VIRUS STARTS WITH A PERIOD OF
INTRODUCTION, FOLLOWED BY A PERIOD OF SPREADING, AND
THEN REACHES A PERIOD OF RAPID GROWTH. ONCE IT BEGINS
THE PERIOD OF RAPID GROWTH, THE PACE OF GROWTH GRADUALLY
QUICKENS. IF PREVENTIVE MEASURES ARE NOT TAKEN AT THIS
STAGE, THEN THE AIDS VIRUS WILL QUICKLY REACH THE PERIOD
DURING WHICH IT ENGULFS THE COUNTRY IN AN UNCHECKED
RAPID SPREAD. THEREFORE THERE NOW REMAINS LITTLE TIME
AND JUST A FEW OPPORTUNITIES FOR CHINA TO CHECK THE
SPREAD OF THE AIDS VIRUS.

YET CHINA HAS BEEN VERY SLUGGISH IN ITS EFFORTS TO
CONTROL THE SPREAD OF THE AIDS VIRUS. THERE ARE THREE
MAJOR PROBLEMS IN CHINA EFFORTS TO PREVENT THE SPREAD OF
AIDS:

- THERE HASN'T BEEN ADEQUATE WORK DONE IN ESTIMATING
THE EXTENT OF THE SPREAD OF THE AIDS VIRUS IN CHINA.
- UNDERSTANDING OF THE SEVERE HARM CAUSED BY THE AIDS
VIRUS IS INADEQUATE.
- INVESTMENT IN AIDS PREVENTION WORK HAS BEEN
INSUFFICIENT.

THE RESULT OF THESE THREE INADEQUACIES HAS BEEN:
INSUFFICIENT WORK BEING DONE ON AIDS PREVENTION
EDUCATION; INADEQUATE POLICY SUPPORT TO AIDS PREVENTION
MEASURES; INADEQUATE AND INSUFFICIENTLY WIDE RANGING
ENOUGH INTERVENTIONS TO PREVENT THE SPREAD OF THE AIDS
VIRUS AND NOT BEEN ENOUGH INVESTMENT IN SCIENTIFIC
RESEARCH.

THE ATTITUDES OF SOME CHINESE OFFICIALS ALSO HARMS AIDS
PREVENTION WORK. IN SOME AREAS, LOCAL OFFICIALS LIE TO
CONCEAL THE AIDS SITUATION IN THEIR COMMUNITIES AND EVEN
GO SO FAR AS TO KEEP OUT OF THEIR AREA PEOPLE DOING
SURVEY OR RESEARCH WORK ON THE SPREAD OF HIV. ZENG YI

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MENTIONED THE CASE OF A RESEARCHER WHO WORKS WITH HIM WHO WAS FIRED BECAUSE OFFICIALS IN A CERTAIN LOCALITY BELIEVED THAT, BY REVEALING THE AIDS SITUATION IN THEIR REGION, THE RESEARCHER MADE THE OFFICIALS LOOK BAD AND HURT THE IMAGE OF THE LOCALITY.

ZENG YI SAID THAT THE AIDS VIRUS IS FRIGHTENING BUT IS PREVENTABLE. THE PREVENTION MEASURES ARE FAIRLY SIMPLE. ZENG SAID THAT HE HOPES THAT CHINA'S LEADERS WILL SUFFICIENTLY UNDERSTAND THE IMPORTANCE OF AIDS PREVENTION AND WILL COME OUT IN SUPPORT OF EFFECTIVE MEASURES TO PREVENT THE SPREAD OF AIDS.

ZENG EMPHASIZED THAT THE KEY TO STOPPING THE SPREAD OF AIDS IN CHINA IS THAT EVERY LEVEL OF GOVERNMENT AND ALL GOVERNMENT DEPARTMENTS SEE AIDS AS IMPORTANT AND TAKE EFFECTIVE MEASURES TO PREVENT ITS SPREAD. - -

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