

**XINJIANG UYGUR AUTONOMOUS REGION  
PEOPLES REPUBLIC OF CHINA**

**HIV/AIDS**

**PREVENTION AND CARE PROJECT**

**GOVERNMENT OF AUSTRALIA  
AND THE  
GOVERNMENT OF THE PEOPLES REPUBLIC OF CHINA**

**PROJECT DESIGN DOCUMENT**

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## ***Acronyms and Abbreviations***

AIDS	Acquired Immune Deficiency Syndrome
AMC	Australian Managing Contractor
AFS	Activity Support Facility
AT	AusAID Assessment Team
AusAID	Australian Agency for International Development
BoH	Bureau of Health, Xinjiang
CMS	Cooperative Medical System
EPS	Epidemic Prevention Stations
GoA	Government of Australia
GoPRC	Government of the Peoples Republic of China
HIV	Human Immuno-deficiency Virus
IDU	Injecting Drug User
IEC	Information, Education, Communication
LTHBC	Long Term Home Based Care
MCH	Mother and Child Health
MoH	National Ministry of Health in Beijing
MoFTEC	National Ministry of Foreign Trade and Economic Cooperation in Beijing
PCC	Project Coordinating Committee
PDD	Project Design Document
PRC	Peoples Republic of China
STI	Sexually Transmitted Infection
UNAIDS	United Nations Joint Programme on AIDS
TAG	Technical Advisory Group
WB	World Bank
WB9	World Bank Loan Health Nine Project: HIV/AIDS Prevention and Control Sub-project
WHO	World Health Organisation
XHAPCP	Xinjiang HIV/AIDS Prevention and Care Project
Xinjiang	Xinjiang Uygur Autonomous Region

## ***Executive Summary***

### **Project Origin**

In 1999 the Government of the Peoples Republic of China (GoPRC) in Xinjiang-Uygur Autonomous Region (Xinjiang) submitted a project proposal, *Project Proposal on HIV/AIDS Prevention and Control in Xinjiang Uygur Autonomous Region*, to the Australian Government (GoA) through the GoPRC Ministry of Foreign Trade and Economic Cooperation (MoFTEC) for funding through the Australian Agency for International Development (AusAID). The proposal was in response to Xinjiang having the second highest number of people with HIV/AIDS in PRC and the highest rate of increase.

The aim of the project was to improve the capacity in Xinjiang to prevent HIV/AIDS and control the epidemic more effectively, through social mobilisation, HIV/AIDS intervention, and HIV/AIDS surveillance.

Prior to submitting the project proposal for AusAID support, the GoPRC had applied for loan funds under the World Bank Loan Health IX Project's sub-project on HIV/AIDS (WB9), planned for July 1999 to 2004 in four provinces in PRC. The WB9 budget for Xinjiang is about RMB 60.8 million, with USD 4.4 million (about RMB 36.5 million) provided as loan funds.

### **Design Preparation**

In April 1999, an AusAID Health Sector Strategy Mission recommended project revisions to give a clear understanding of the components for which Australian expertise and assistance was requested, the preferred prefectures/counties, and complementarity with WB9.

The revised proposal, received in July 1999, included more than 300 pages of tables detailing proposed activities and costing for an AusAID project, with comparison item by item with possible activities of WB9. In general, the Xinjiang Bureau of Health (BoH) sought AusAID assistance in areas, or with activities, not covered by WB9. AusAID's assessment was that the revised proposal was sufficiently strong to commence a feasibility and design study and that it reflected capacity and commitment of the Xinjiang Bureau of Health to work effectively with a design team to further develop the proposal.

AusAID specified that a possible project should be in accordance with GoA policies for health aid and with AusAID's China Health Sector Strategy; that it should meet priority health needs of the GoPRC; that the focus should be on sustainable management of health, particularly in vulnerable rural areas; and that elements of the project should have

the potential for replication in other provinces.

An AusAID design/feasibility mission visited Xinjiang in late 1999. In November 2000, an Appraisal Team (AT) visited Xinjiang to determine the proposed project's viability in terms of scale, scope and complexity; other donor-assisted activity in Xinjiang; and local absorptive capacity and commitment. The AT concluded that the project concept was viable. Accordingly, as agreed with AusAID, the output of the field appraisal mission is a PDD not an appraisal note. The strategies in the PDD are consistent with the national HIV/AIDS Prevention and Control Plan (1998-2010), and respond to changes in Xinjiang since the design/feasibility mission in 1999.

### **Problem Analysis and Strategies Chosen**

Xinjiang-Uygur Autonomous Region was established in 1955. It has the longest border in China, about 5,000 kilometres, making up one-fourth of the national borders. On the eastern side are Gansu and Qinghai Provinces. Tibet Autonomous Region is on the southern border. From the northeast to the southwest Xinjiang borders eight countries, Mongolia, Russia, Kazakhstan, Kirghizstan, Tajikistan, Afghanistan, Pakistan and India.

There is rapid population and economic growth and social change. These add to the existing development challenges posed by Xinjiang's remote location, size, arid climate, diverse ethnic population mix, and international transport routes that facilitate both trade, and the illegal trafficking of drugs. Poverty remains high in comparison with other areas in PRC and there are increasing gaps between the rich and the poor.

There are divisions between the poorer south and the wealthier and more industrialised north. The variety of languages, religions and customs in Xinjiang also contribute to social division and increase the challenge of developing appropriate strategies to reduce the prevalence rate of HIV/AIDS and develop care strategies for people with HIV/AIDS.

The first diagnosis of HIV/AIDS in Xinjiang was in 1995. In December 1998, the number of people registered with HIV/AIDS was 2,483. In December 1999 there were 3,656 reported diagnoses. In 2000, by September, the number had increased to 4,436, the 2<sup>nd</sup> highest reported number in PRC, after Yunnan. The prevalence rate in Xinjiang is the highest in PRC. However, data and surveillance is unreliable and Xinjiang surveillance experts estimate the number of people with HIV/AIDS could be as high as 15,000 to 25,000. In 1999 55 people were diagnosed with AIDS and there were 21 reported deaths from AIDS. The epidemic is presently concentrated in the Uygur population.

The main mode of transmission in Xinjiang is through injecting drug users (IDUs) sharing needles, reflecting the general overall local culture of sharing. The second risk group is commercial sex workers (CSWs). The third mode of transmission is through vertical transmission (mother to baby) as evidence grows of HIV/AIDS spreading to the

general population. Sexually transmitted infections (STIs) are also increasing, posing a further risk to HIV/AIDS increase.

Reported HIV/AIDS is mainly along drug trafficking routes (e.g. Yining) and in cities with rapid economic development (e.g. Urumqi). People with HIV/AIDS are mainly younger males from minority populations and people from the 'floating population' (internal migrants often seeking work, including from other provinces/regions; and people migrating from rural to urban areas). The majority of detained CSWs are reported as being from the floating population. Women and children are also vulnerable to contracting HIV/AIDS and STIs because of economic, religious, cultural and social factors in Xinjiang.

Xinjiang commenced a strategically focused response to the HIV/AIDS epidemic in 1997 with the establishment of a multi-sectoral, 33 member, HIV/AIDS Leading Group under the chairmanship of the Vice-Governor. This Leading Group is replicated at prefecture and city levels. The BoH and its Epidemic Prevention Stations (EPS) have primary responsibility for management of HIV/AIDS prevention and care. A Mid-Long Term Plan for HIV/AIDS Prevention and Control is currently before the Xinjiang Government. The BoH advises that this plan reflects the intent of the Mid-Long Term Plan for HIV/AIDS Prevention and Control in China (1998-2010), issued and distributed by the State Council on November 12, 1998.

However, there is continued low capacity in Xinjiang for an effective response to reduce the transmission rate of the HIV virus.

As well, some internationally accepted best practice strategies for HIV/AIDS prevention are hindered by the fact that drug use and prostitution are illegal activities in the Peoples Republic of China (PRC); by PRC social mores that IDUs and CSWs are morally reprehensible, resulting in denial or non-acceptance of the causative factors of the HIV/AIDS epidemic; and by the voluntary and involuntary incarceration of IDUs and CSWs. However, key stakeholders in PRC, including in Xinjiang, recognise the gravity of the situation and the success of strategies in other countries in containing HIV/AIDS prevalence rates and AIDS-related complications, and wish to increase capacity in Xinjiang to successfully reduce HIV transmission and contain the current epidemic.

The strategies in this PDD are consistent with the national HIV/AIDS Prevention and Control Plan (1998-2010), and respond to changes in Xinjiang since the design/feasibility mission in 1999. These changes include:

- The Xinjiang Regional Mid-Long Term Plan for HIV/AIDS Prevention and Control has been completed and is currently before government. It is possible the Xinjiang government's view will be known in early 2001.

- WB9 has commenced and its implications for this Project's activities are clearer: WB9 in Xinjiang is focused on small, specific geographic areas in 15 out of 95 counties and the uptake of WB9 funds is slow in Xinjiang, because of perceptions of expense (repayment of loan) and complexity of administrative arrangements. Monitoring of WB9 progress will be required by the Project to take any opportunities for synergy that present.
- Health system reform is proceeding, but downsizing of the BoH is being phased over the next three to four years, and there will be no or minimum reductions in service delivery capacity, reducing the previously perceived high risk to the Project of rapid health system downsizing.
- Long-term home-based care (LTHBC) is now strongly endorsed as a key strategy for cost-effective care for people with HIV/AIDS by the Regional BoH.
- Other donors have commenced activities in Xinjiang or are planning to.

The overall strategy of this Project is to strengthen multi-sectoral capacity for current and anticipated activities in Xinjiang in HIV/AIDS prevention and care, avoid duplication, and ensure synergy and complementarity with government and other donor activity.

The specific strategies in the PDD are multi-sectoral capacity building in policy, planning, collaboration and evaluation; in health promotion to achieve behaviour change in vulnerable groups and the general community; in strengthening the indirect care environment (diagnosis, testing, infection control) to provide a better enabling environment for direct care in hospitals and homes for people with HIV/AIDS and in outpatient settings for STD management; and effective Project management. Strengthening of surveillance and blood safety is being addressed through other donor activity and WB9.

The strategies address the root causes of the HIV/AIDS epidemic and take into account poverty factors, socio-cultural factors, gender issues, behavioural change, and institutional arrangements.

## **Project Description**

- The Project will support capacity building and trial interventions as an integral part of the current and anticipated BoH and multi-sectoral approaches to HIV/AIDS, to address current and emerging problems. The project will be of five years duration.
- There will be a series of designed capacity building outputs that:
  - support the development of HIV/ADS response planning, including monitoring, evaluation and feedback into a dynamic planning process;
  - build capacity for health promotion under a broad definition that includes some formative research, health education development and

implementation and the creation of enabling environments;

- support the development of capacity for direct and indirect care.
- These designed outputs will initially focus on BoH and EPS at regional level in recognition of the pivotal leadership role to be played, but will respond to needs from sub-regional health agencies and non-health sector agencies at all levels;
- The outputs will be supported by the input of a core team of long and short term advisors and other resources funded by Australia and managed on behalf of GoA by an Australian Managing Contractor (AMC);
- The total funding for the Project is A\$14.7m from the GoA and \$6m from the GoPRC, much of the latter 'in kind';
- A flexible funding facility will be designed, and its principles and procedures documented and disseminated. This facility will be able to provide technical assistance, training, minor plant and equipment and some operating funds for the implementation of well designed intervention trials that conform with the strategic frameworks developed and agreed at overall regional government and agency level;
- The funding facility will operate as far as possible within current structures and systems in Xinjiang, based around the Regional Multi-Sectoral Leading Group on HIV/AIDS Prevention and Control. It is suggested that a Working Group from within the leading group agencies is convened to provide guidance and oversight for the flexible funding facility that will be administered by the AMC;
- The funding facility will be substantial – amounting to around 40% of the total GoA budget for the Project. It is proposed that a significant proportion of this facility is quarantined for use by non-health sector agencies to provide a significant incentive for the development of a multi sectoral response to the epidemic;
- Activities are limited to trials at this point as there is no legal standing for other approaches.

### *Strategic Context*

Should the Xinjiang Government endorse the draft Xinjiang Mid-Long Term Plan for HIV/AIDS Prevention and Control, the Plan will provide the strategic context for the Project. If not endorsed, the national PRC 1998-2010 plan provides the strategic context. It is understood that the Regional Plan will include policies, strategies, and multi-sectoral role definitions and will provide an enabling and flexible framework. Current traditional top-down, as well as community-based innovative, approaches in Yining, Kashgar and Urumqi will be supported by the Project.

### *Length of Project*

The Project timeline is five years. A 2<sup>nd</sup> phase of the Project may be considered through a recommended Project review at Year 4, focused on opportunities for policy change and expanding trial interventions to the wider sector (for example, health promotion, long-term home-based care and condom use). A 2<sup>nd</sup> phase may be beneficial to consider given that long term approaches are required to sustainably contain HIV/AIDS.

### *Location of Project*

The Project is in the Xinjiang Uygur Autonomous Region in north-western PRC and will focus on Urumqi, Kashgar and Yining, while retaining flexibility to address capacity development in other areas (e.g. through broader attendance for training, and, possibly, inclusion of additional or replacement trial sites should need be identified and inclusion be within the capacity of the Project). The Project team will be based in Urumqi, with experts in the Project components visiting Kashgar and Yining as required, for short, mid and long-term periods, for capacity building and development, and supervision, monitoring and evaluation of pilot interventions.

### *Goal of Project*

To reduce the rapid transmission of HIV infection and reduce the impact of the epidemic on the social and economic development of the Xinjiang Uygur Autonomous Region.

### *Purpose of Project*

To increase the capacity of the Xinjiang Uygur Autonomous Region to respond to the HIV/AIDS epidemic with effective, multi-sectoral prevention and care programs.

### *Component Objectives of Project*

Component 1 is 'Planning and Coordination'. The objective is to improve institutional capacity at the regional, prefecture and county levels to plan and co-ordinate multi-sectoral responses to the HIV/AIDS epidemic.

Component 2 is 'Health Promotion'. The objective is to enable the general population and vulnerable groups to adopt healthy behaviours and accepting attitudes relating to the transmission and management of HIV/AIDS.

Component 3 is 'Indirect and Direct Care'. The objective is to enable health workers and family carers to adopt best practice standards in indirect and direct care environments or at-risk of HIV infection.

Component 4 is 'Project Management'. The objective is to effectively and efficiently manage the Project to achieve design goals and objectives within budget and planned timeframe.

## **Implementation**

Implementation should proceed quickly as the HIV/AIDS epidemic continues to grow, creating a climate of change and uncertainty.

### *Year 1*

In Year 1 there will be support for partner multi-sectoral agencies to develop their own HIV/AIDS Prevention and Care Plans within the strategic context of the Regional Plan (or the National Plan if not yet approved). To further support the development of these multi-sectoral plans, there will be further analysis of the epidemiological and behavioural aspects of the HIV/AIDS epidemic; further clarification of needs and gaps; identification of trial intervention sites and their capacity building needs; and development of a monitoring and evaluation methodology.

The Project is designed to be an integral support to Xinjiang multi-sectoral activities to address the current HIV/AIDS epidemic. It is not something additional to core activities or in parallel but is designed to strategically strengthen system effort, supporting core government activities.

The Project will be a partnership between GoA and GoPRC with the former providing A\$14.7m and the latter providing GoPRC A\$6m.

### *Later in Year 1 and Beyond*

From later in Year 1 and ongoing, the implementing partner agencies will be eligible to submit proposals for funding elements of their agreed plans. The activities and resources required will therefore depend on the content of their HIV/AIDS Prevention and Care Plans.

Proposals from other agencies may be considered if they are within partner agency plans, address identified need, its implementation is more robust through another agency, and agreement is reached with the partner agency. This will promote multi-sectoral collaboration.

Implementation of Project components will also be proceeding. Several of the Project components deal with highly sensitive collaborative issues, including sexual behaviour and illegal drug use. It is anticipated that the proposals for funding may also contain sensitivities. Because of this, the Project requires a sensitive and highly professional

approach.

### *Project Management*

The Project will be implemented in partnership between Australia and China and will be based on international best project management practice in accordance with AusAID's documented standards. The Project team will be physically located in the Epidemic Prevention Station (EPS) of the Xinjiang Regional Bureau of Health (BoH) in Urumqi, while the Chinese Team Leader will be the Vice Director (Public Health) of the BoH. It is recommended that there also be office space available for the Australian Team Leader (ATL) and administrative support person within the Bureau of Health to facilitate the appropriate level of interaction and communication. It is anticipated that a regional multi-sectoral HIV/AIDS Working Group will be formed, which will provide planning and co-ordination oversight to guide project implementation. This group, and the ATL, should meet monthly. A Project Coordinating Committee (PCC), based on the multi-sectoral Working Group membership, but with additional members from AusAID, MOFTEC and the AMC will be established and will meet every six months in Year 1 and annually thereafter.

The input of short-term advisers below is indicative only and will depend on the implementation strategy of the AMC and Project requirements during the course of the Project. Indicative Australian advisers may include:

<b>Long Term Advisors</b>		<b>Input (months)</b>
	Australian Team Leader / Planning & Management Advisor	60
	Health Promotion Advisor	48
	Funding Facility Administrator	52
<b>Total Long Term Input</b>		<b>160</b>
<b>Short Term Advisors – Specialists</b>		
	HIV/AIDS Policy & Planning Specialist	11.0
	Health Promotion Specialist	10.5
	Monitoring & Evaluation Specialist	11.5
	Training & Curriculum Development Specialist	1.75
	Infection Control Specialist	22.5

	Acute AIDS Care Specialist (Doctor)	7.75
	Acute AIDS Care Specialist (Nurse)	7.75
	Community Care Specialist	20
	STI Policy and Planning Specialist/Venereologist	13
	Technical Director	8
	<b>Total Short Term Input</b>	<b>113.75</b>

The competencies needed in the team are those technical competencies conveyed in the table above:

- leadership, planning and management;
- modern health promotion including IEC skills, social marketing and advanced formative research experience;
- administrative and financial capacity;
- HIV/AIDS policy and planning;
- medical and nursing HIV/AIDS acute and long-term home based care;
- advanced monitoring and evaluation;
- training and curriculum development;
- infection control;
- STI policy and planning/venereologist;
- and a technical director with competencies in HIV/AIDS policy, planning and direct and indirect care.

Within this technical framework other competencies required in the Project team include:

- sound and sensitive communication skills;
- strategic thinking and planning capacity;
- ability to maintain and strengthen a team approach;
- financial management capacity;
- integrity;
- ability to assume personal accountability for standard of work;
- experience in a resource constrained environment;
- international health experience or significant experience in health promotion in their own country;
- excellent interpersonal skills;

- clear understanding of the advisory role in a development co-operation project and should be able to act in the role of mentor/trainer rather than implementer;
- ability to work within the context of Chinese approaches to community mobilisation and development;
- project management, monitoring and evaluation;
- experience in achieving best practice approaches;
- formal qualifications as appropriate to each position.

## **Benefits, risks and justification**

### *Benefits*

The Project's focus is on cost-effective ways to increase capacity to reduce the social and economic impact of the HIV/AIDS epidemic. While the HIV prevalence rate is high and increasing, the epidemic is still at a relatively early stage in Xinjiang. Effective prevention and care strategies *now* have the potential to slow the epidemic and limit its potentially devastating impact. The five years of proposed Australian support will make a significant contribution to increasing capacity and achieving a slowing of the epidemic in the short term, and to sustain and improve effective responses in the mid to long term.

### *Risks*

There are five identified major risks. A more comprehensive risk analysis is provided at Annex 10. The first and highest risk is political. Political risks relate to the extreme sensitivity of some best practice HIV/AIDS responses, given social, ethnic, cultural, religious, security and legal factors in Xinjiang. The second highest risk is economic. Xinjiang's economy limits capacity for comprehensive responses to the epidemic.

A previously perceived high risk resulting from nation-wide civil service reforms and downsizing of the BoH is now reduced. BoH downsizing will be implemented gradually in Xinjiang over the next three to four years. As well, the EPS is not being downsized and will provide considerable support to the Project. However this requires ongoing monitoring.

The 3<sup>rd</sup> risk is the reported difficulty of finding competent translators proficient in the three essential languages for this project: Mandarin, Uygur and English.

The 4<sup>th</sup> risk is the potential for gaps and duplication between this Project and other donor activity in Xinjiang, including WB9, including ensuring that funding for this Project is spent only on this Project.

The 5th risk, similar to all complex projects in relatively remote areas, is ensuring appropriate Australian and Chinese staff are attracted and retained.

### *Justification*

Justification for the Project is evidentiary. The first evidence is the extremely high prevalence rate of HIV/AIDS in Xinjiang, which, if not contained, may have devastating social and economic costs, similar to those being experienced in Africa, particularly in sub-Saharan Africa. The second evidence is the strong concern of the Government of Xinjiang to limit the spread of HIV/AIDS, its determination to strengthen its effective response, and its recognition that external assistance is required to increase capacity. The third evidence is that Xinjiang is one of the poorest regions in China and a priority region for support within the AusAID China Health Sector Strategy. The fourth evidence is the ATs findings that the Project is feasible and manageable. The fifth evidence is the large body of international knowledge developed on how best to respond to HIV/AIDS, and the increasing body of knowledge developing within China, on both of which this Project is based.

The overriding justification is that without an effective response, the impact of HIV/AIDS, (e.g. in sub-Saharan Africa) can devastate whole communities by wiping out a generation and more including babies being born HIV positive; by creating large numbers of babies and children as 'AIDS orphans'; by reducing household's to abject poverty through direct health costs and reduced labour participation; and by the fundamental cumulative social, demographic and economic impact which impacts greatly on the poorest of the population.

### **Conclusion**

Xinjiang is facing a real crisis because of the HIV/AIDS epidemic. Government officials recognise this and are striving to achieve an effective response to the epidemic. They have asked for and need external assistance to build the required capacity for a sustainable response. There is a high level of political and administrative commitment to contain the epidemic, including ensuring adequate regular budget provision to achieve sustainable results. By the end of this 5-year Project, there will be strengthened capacity for effective HIV/AIDS prevention and care, including planning, resourcing, implementing, monitoring and evaluating. Project outcomes will enable replication of appropriate responses beyond the Project areas, and has the potential to inform regional and national policies and guidelines.

# 1 Introduction and Background

## 1.1 Introduction and Project Origin

In 1999 the Government of the Peoples Republic of China (GoPRC) in Xinjiang-Uygur Autonomous Region (Xinjiang) submitted a project proposal, *Project Proposal on HIV/AIDS Prevention and Control in Xinjiang Uygur Autonomous Region*, to the Australian Government (GoA) through the GoPRCs Ministry of Foreign Trade and Economic Cooperation (MoFTEC) for funding through the Australian Agency for International Development (AusAID). The proposal was in response to Xinjiang having the second highest number of people with HIV/AIDS in PRC and the highest rate of increase, since the first confirmed diagnosis of HIV in Xinjiang in 1995.

The aim of the project proposal was to improve capacity in Xinjiang to prevent HIV/AIDS and control the epidemic more effectively, through social mobilisation, HIV/AIDS intervention, and HIV/AIDS surveillance.

Prior to submitting the project proposal for AusAID support, the GoPRC had applied for loan funds under the HIV/AIDS/STI component of the World Bank Health IX Project on HIV/AIDS (WB9), planned for July 1999 to 2004 in four provinces, including Xinjiang. The WB9 budget for Xinjiang is about RMB 60.8 million, with USD 4.4 million (about RMB 36.5 million) provided as loan funds.

## 1.2 Design and Appraisal Process to Date

In April 1999, an AusAID Health Sector Strategy Mission recommended project revisions to give a clear understanding of the components for which Australian expertise and assistance was requested; of the preferred project prefectures/counties; and of complementarity with WB9.

The revised proposal, received in July 1999, included more than 300 pages of tables detailing proposed activities and costing for an AusAID project, with comparison item by item with possible activities of WB9. In general, the Xinjiang Bureau of Health (BoH) sought AusAID assistance in areas, or with activities, not covered by WB9. AusAID assessment was that the revised proposal was sufficiently strong to commence a feasibility and design study and that it reflected capacity and commitment of the BoH to work effectively with a design team to further develop the proposal.

AusAID specified that a possible project should be in accordance with GoA policies for health aid and with AusAID's China Health Sector Strategy; that it should meet priority health needs of the GoPRC; that the focus should be on sustainable management of

health, particularly in vulnerable rural areas; and that elements of the project should have the potential for replication in other provinces.

An AusAID design/feasibility mission visited Xinjiang in late 1999. In November 2000, an Appraisal Team (AT) visited Xinjiang to determine the proposed project's viability in terms of scale, scope and complexity; other donor-assisted activity in Xinjiang; local absorptive capacity and commitment; and viability in the light of any changes since the 1999 design/feasibility mission.

### **1.3 Logistics and Methodology for Field Appraisal**

In brief, the methodology of the AT, approved by AusAID, was a desk analysis of all relevant documents prior to travelling to China and further document analysis in-country (documents are listed at Annex 11); briefings, discussions and debriefings with key government and donor multi-sectoral stakeholders in Beijing and Xinjiang; direct observation of current multi-sectoral activities in HIV/AIDS in Xinjiang; and a multi-sectoral workshop prior to departure from Xinjiang with key prospective Project partner agencies, to describe the revised Project and receive final input. This PDD draws extensively on analysis by the Xinjiang partners, and AusAID and other donor analyses, as well as direct data obtained during the AT's mission. A list of organizations and people consulted is at Annex 2.

In Xinjiang, the AT visited Urumqi, Kashgar and Yining, the three areas on which this Project will focus. These field visits focused on observation of multi-sectoral activities and multi-sectoral consultations. Direct consultation with target populations was limited due to both time availability and the sensitive nature of HIV/AIDS in Xinjiang.

New information obtained included:

- The Xinjiang Regional Mid to Long Term Plan for HIV/AIDS Prevention and Control has been completed and is currently before government. It is possible the Xinjiang government's view on this will be known in early 2001.
- WB9 has commenced and its implications for this Project's activities are clearer: WB9 in Xinjiang is focused on small, specific geographic areas and the uptake of WB9 funds is slow in Xinjiang, because of perceptions of expense (repayment of loan) and complexity of administrative arrangements. Monitoring of WB9 progress will be required during the life of the Project to take any opportunities for synergy that present.
- Health system reform is proceeding, but downsizing of the BoH is being phased over the next three to four years, and there will be no or minimum reductions in service delivery capacity, reducing the previously perceived high risk to the Project of rapid health system downsizing. This will require ongoing monitoring as policy is

developed.

- Long-term home-based care (LTHBC) is now strongly endorsed as a key strategy for cost-effective care for people with HIV/AIDS.
- Other donors have commenced activities in Xinjiang or are planning to (see Section 2.6).

The AT concluded that the Project concept remained critically important to assist in reducing the spread of HIV/AIDS in Xinjiang. As agreed with AusAID, the output of the field appraisal mission is this PDD. The strategies in this PDD are consistent with the national HIV/AIDS Prevention and Control Plan (1998-2010), and respond to changes in Xinjiang since the design/feasibility mission in 1999.

## **2 Situation and Problem Analysis**

### **2.1 Development Context**

#### *Geographical*

Xinjiang covers a very large area in far north-western China and has the longest boundary in China, about 5,000 kilometres or one-fourth of the national boundary. Xinjiang borders Gansu and Qinghai Provinces on the eastern side, and Tibet Autonomous Region on the south. From the northeast to the southwest it borders eight countries, Mongolia, Russia, Kazakhstan, Kirghizstan, Tajikistan, Afghanistan, Pakistan and India.

The climate is arid, very cold in winter and hot in summer. In the north in January the mean temperature is about 16 degrees centigrade below zero in the Basin areas. In Tulufan Basin in the south, the July mean temperature is about 32.7 degrees centigrade, and temperature extremes can reach to 47 degrees centigrade. Rainfall is low and the annual frost-free period is 50 – 175 days in the northern plains and 90 – 200 days in the southern plains.

#### *Administrative*

The Xinjiang Uygur Autonomous Region was established in 1955. It has 8 prefectures, 5 autonomous prefectures, 3 provincially administered municipalities, and 95 counties and county level cities (15 cities administered by prefectures, 63 by counties, 6 by autonomous counties and 11 by districts). The capital city is Urumqi, with a population of close to 1.5 million.

In 1998, Xinjiang's population was about 17.47 million. About 8.75 million lived in urban areas or towns and 8.72 million in rural areas. In 1991, Xinjiang's population density was 9.7 persons per square km. In 1996, this had increased to 10.5 persons per square km.

### *Economic*

Economic development in Xinjiang has been rapid with average incomes increasing over recent years. However, the economy is still relatively underdeveloped compared with other provinces in China. There are also major economic imbalances between the north and south of Xinjiang, with the north more developed than the south.

Agriculture and animal husbandry are the foundations of Xinjiang's economy, augmented by significant industrial development in recent years. About 11.31 million people (65% of the population) are engaged in agriculture-animal husbandry and 6.16 million (35%) in other sectors. There are over 60,000 enterprises in Xinjiang producing over 2,000 different products. Urumqi, the capital city, is rich in natural resources, including coal, and has encouraged agricultural, industrial and new technology development. By December 1997, 339 joint ventures had been registered in Urumqi, with foreign investors from more than 20 countries and regions in Asia, Europe and North America. The other major cities, Kashgar, Turpan, Korla, Yining, Bortala and Shihezi, are also economic, cultural and transportation centres.

**Table 1: Economic indicators for the Xinjiang Uygur Autonomous Region 1993 to 1996**

Year	Gross Domestic Product #	Gross Industrial Product #	Gross Agricultural Product #	Net average income per head (yuan) *	
				Urban	Rural
1993	506.12	448.11	187.53	2215.32	778.00
1994	673.68	590.52	306.47	2869.00	935.50
1995	834.57	804.26	405.73	3828.40	1136.50
1996	912.15	682.24	430.96	4295.80	1290.10

Source: Xinjiang Government Reports

# In 100 million yuan

\* Some local authorities count non-cash components, however these figures do not include that, but are refined to remove costs, that is investment inputs such as fertiliser to earn an income. They are best treated as a guide.

**Table 2: Economic Status of Prefectures in Xinjiang  
(listed in descending order of GNP per capita)**

Prefecture		Gross Domestic Product	Gross National Product per capita*	Population
1	Kelamayi Metropolitan	943,709.70	37,218.40	253,560
2	Urumqi Prefecture	2,169,045.00	14,275.53	1,519,415
3	Bayinguolen Mongolia Autonomous Prefecture	1,037,744.58	10,585.96	980,303
4	Tulufan Prefecture	468,113.64	8,538.42	548,244
5	Changji Hui Autonomous Prefecture	1,054,321.50	7,333.05	1,437,767
6	Tacheng Prefecture	652,599.08	7,283.18	896,036
7	Hami Prefecture	267,652.00	5,743.36	466,020
8	Boertala Mongolia Autonomous Prefecture	196,771.24	5,099.99	385,827
9	Akeshu Prefecture	846,738.82	4,364.17	1,940,208
10	Arletai Prefecture	247,466.98	4,306.56	574,628
11	Yili Kazak Autonomous Prefecture	1,606,662.30	4,255.19	3,775,774
12	Shihezi Metropolitan	186,861.38	3,285.64	568,722
13	Yili Prefecture	614,230.24	3,002.60	2,045,664
14	Kashi Prefecture	714,292.00	2,225.92	3,208,974
15	Hetian Prefecture	283,195.58	1,822.71	1,553,708
16	Keerkezi Kezeleshu Autonomous Prefecture	59,546.67	1,419.13	419,600

Source: Xinjiang Government Reports

\* In units of 10 million yuan

### *Multi-ethnic*

Xinjiang is one of five autonomous regions in China constituted for major minority population areas. There are 47 ethnic groups in Xinjiang. The four principal ethnic groups are Uyghur, Han, Kazak and Hui. The nine other major ethnic groups are Mongol, Kirghiz, Xibe, Tajik, Uzbek, Manchu, Daur, Tatar and Russ.

**Table 3: Principal ethnic groups in Xinjiang as a proportion of the total population**

Uygur	46.58 %
Han	38.58 %
Kazak	7.30 %
Hui	4.48 %
Other ethnic minorities	3.10 %

Source: Xinjiang Official Statistical Yearbook

Most of the ethnic groups have their own spoken and written language with some languages commonly used by several ethnic groups. The major languages are Uygur, Mandarin, Kazak, Tuote Mongolian, Xibe and Kirghiz. The working languages of the People's Congress of Xinjiang are Uygur, Mandarin, Kazak, Mongolian, and Kirghiz. Xinjiang is also a region of many religions. Islam is followed by many of the major ethnic groups, including the Uygur, Kazak, Hui, Kirghiz, Tajik, Uzbek and Tatar.

#### *Population growth*

Xinjiang's population rate has increased significantly over the past few years, through a combination of natural population increases and internal migration from the eastern part of China. Xinjiang's birth rate and its natural population growth rate were 19.74 per 1,000 and 12.81 per 1,000 respectively in 1998. The mortality rate was 6.93 per 1,000.

**Table 4: Population Changes in the Xinjiang Uygur Autonomous Region 1992 to 1996**

Year	Population (10 thousands)	Birth rate (per 1,000)	Mortality rate (per 1,000)	Natural growth rate per 1,000
1992	1580.63	22.80	7.84	14.96
1993	1605.26	21.53	7.68	13.85
1994	1632.70	20.82	7.43	13.39
1995	1661.35	18.90	6.45	12.45
1996	1689.29	19.45	6.60	12.85

Source: Xinjiang Bureau of Health

Inward and outward migration began increasing in the late 1970s. The numbers of traders, business people, tourists, surplus labourers from other provinces and people travelling abroad have since increased steadily as a result of economic reforms and other policies to open up Xinjiang. Labourers seeking employment from other parts of China (part of the floating population) are concentrated in large and medium sized cities, roughly accounting for 20 per cent of the Xinjiang's urban population. In 1996 the number of visiting foreigners and overseas Chinese from Hong Kong and Macao totalled 176,900.

#### *Education*

In 1996, registered students for every 10,000 population in Xinjiang were: college or

university 26.7; technical secondary school 43.8; senior middle school 90.3; junior middle school 1,385.5. The enrolment rate for children age 7-11 years was 98.5%, and the junior school completion rate was 94.7%. Most areas of Xinjiang have eliminated illiteracy.

### *Health Infrastructure*

The number of hospital beds and specialised health workers per thousand population in Xinjiang is above the national average. At the end of 1997, Xinjiang had a total of 6,614 health service units and 71,558 ward beds, including 53,494 hospital ward beds. There were 122,265 health workers, of which 97,568 were professional medical and technical health workers (including 501 chief doctors or equivalent). For every 1,000 population, the number of ward beds was 4.31, the number of professional health workers was 5.87 and the number of medical doctors was 2.28.

### *Health Spending*

Health expenditure has increased in real terms since 1993, while spending on health prevention has decreased.

**Table 5: Public health expenditure in Xinjiang Uygur Autonomous Region 1993 to 1997**

Year	Total government expenditure*	Government health expenditure*		Health prevention expenditure*		AIDS/STI Funding*	
		Total	% total expenditure	Total	% health output	AIDS	STI
1993	647,111	56,850	8.8	1,185	2.1	3	20
1994	710,962	68,768	9.7	1,185	1.7	4	20
1995	964,021	91,949	9.5	1,185	1.3	5	20
1996	1,148,890	99,014	8.6	1,094	1.1	30	14
1997	..	102,929	..	1,114	1.1	50	14

Source: Xinjiang Government Reports

\* In units of 10 million yuan

### *Transport*

Except for a few townships and villages in mountainous areas, most of the counties and townships have roads open to traffic. The total length of the road network is 31,609 kilometres, with 20,641 kilometres of highways and sub-highways. The total length of commercial railways is 2,038 kilometres, with 1,803 kilometres inside the region's boundaries. The railway line between Urumqi and Kashgar was completed in 2000. The total length of airline routes is 122,089 kilometres, with 9,183 kilometres are local lines.

### *International border crossings*

There are 15 open border ports, road, railway and air. Open border ports create potential avenues for the spread of HIV/AIDS and are therefore important to consider when developing strategies. The open border ports include:

- Hongjerap (road port) on the Kashi (Kashgar) Prefecture - Pakistan-Kashmir border;
- Horgas (road and railway port) on the Yili Kazakh Autonomous Prefecture - Kazakhstan border;
- Turgart (road port) on the Keerkezi Kezeleshu Autonomous Prefecture - Kyrgyzstan border;
- Alashankou (road and railway port) on the Boertala Mongol Autonomous Prefecture - Kazakhstan border;
- Jeminay (road and railway port) and Ahetubieke (road port) on the Aletai Prefecture - Kazakhstan border;
- Dulata (road and railway port), and Baktu and Muzart (road ports) on the Yili Prefecture - Kazakhstan border;
- Takesken and Hongshanzui (road ports) on the Aletai Prefecture - Republic of Mongolia border;
- Laoyemiao (road port) on the Hami Prefecture - Republic of Mongolia border;
- Ulstay (road port) on the Changji Hui Autonomous Prefecture - Republic of Mongolia border;
- Urumqi (international airport); and
- Kashgar (airport).

## **2.2 The Problem**

### **2.2.1 Epidemiology**

#### *HIV/AIDS in PRC generally*

There have been three stages of HIV/AIDS in China to date. In Stage 1, 1985 to 1989, only sporadic infection was reported, principally amongst travellers returning from abroad. In Stage 2, 1990 to 1994, infection appeared to be limited primarily to injecting drug users (IDUs) in the southern areas of Yunnan Province bordering Burma. In Stage 3, 1995 to the present, HIV/AIDS has been more widely reported, with cases appearing in all provinces. Numbers in epidemic proportions are presently concentrated in Yunnan, Sichuan and Guangdong Provinces; and in the Xinjiang Uygur and Guangxi Zhuang Autonomous Regions.

#### *HIV/AIDS in Xinjiang*

The first reported case of HIV was in 1995 in Urumqi and was an injecting drug user. At

the beginning of 1996, an epidemic of HIV appeared amongst IDUs in Yining City and the trend since has been one of rapid increase. In 1997, cases of HIV infection were found from spot surveillance testing of pregnant women, and from routine examinations of military recruits and people working in recreation centres.

In December 1995, there were nine people reported as HIV positive in Xinjiang. By December 1998, there were 2,483. In December 1999 there were 3,656 reported HIV diagnoses, including 10 people with AIDS. In 2000, by September, reported HIV diagnoses had increased to 4,436, the 2<sup>nd</sup> highest reported number in PRC, after Yunnan. The prevalence rate in Xinjiang is the highest in PRC. However, data and surveillance is unreliable and Xinjiang surveillance experts estimate the number of people with HIV/AIDS could be as high as 15,000 to 25,000. Some cases have not been confirmed because, although testing positive on Elisa testing, funds have been unavailable for Western Blot testing. By the end of 1999, 55 people were diagnosed with AIDS and there were 21 reported deaths from AIDS. The epidemic is presently concentrated in the Uygur population.

#### *Characteristics of the HIV/AIDS epidemic in Xinjiang*

While one of the weaker points in Xinjiang is comprehensive reliable and valid data, based on known data the epidemic has the following characteristics:

- The majority of cases to date have been found among injecting drug users (97% of total), the majority (93%) of whom are urban residents.
- HIV infection through other means of transmission is now being identified, including transmission through blood transfusion and sexual contact and through mother-to-child transmission. In Yining City random screening among 400 antenatal women found one confirmed positive case in the second quarter of 1998 (0.2%) and two positive cases in the fourth quarter of 1998 (0.5%). Cases of transmission from IDUs to their spouses have been recorded. In 1998, 5 out of 13 sex workers tested were confirmed as positive. The low numbers tested makes conclusions impossible on the extent of a heterosexual epidemic.
- 90 % of reported HIV positive cases are aged 20-39; 77% are aged 20-29; about one-third are married.
- 93% of reported cases are male, but the rate of infection in females appears to be increasing.
- The ethnic distribution of reported cases is highly skewed to the Uygur nationality, which accounts for 85% of the total; Chinese (Han) account for 8% and Hui account for 6%.
- 48.5% of people reported with HIV/AIDS are unemployed; 33.5% are privately employed.

#### *Injecting drug users (IDUs)*

There are increasing IDUs in Xinjiang, especially along main routes for drug trafficking.

Some 15,035 drug users were recorded by Xinjiang Public Security in 1996, and 80% were IDUs. The number of drug users had increased to 17,000 in 1997. The real number, however, is estimated by Xinjiang experts as 80,000 to 100,000. The general Xinjiang culture of sharing also translates to sharing needles and syringes. This behaviour is a form of solidarity, binding people within an already marginalised group. Estimates are that 70% to 100% of IDUs share needles and syringes. The relapse rate following treatment in drug rehabilitation centres, voluntary or involuntary, is over 90%.

There is now a well-established HIV epidemic among IDUs in Xinjiang. The prevalence of HIV among IDUs in sentinel sites doubled over a six-month period and reached 17% by December 1996. During 1996, in Yili Prefecture HIV rates among tested IDUs increased from 9% in January to 76% in August. The Xinjiang reported HIV cases are 37% of the national total. The majority of HIV positive IDUs were Uygur (85%) and most lived in Urumqi City (48%) and Yining City (46%). In the 1998 HIV sentinel surveillance run, infection rates were above 85% among IDUs in Yining City but remained lower (above 40%) in Urumqi. ELISA mis-readings have left Kashgar cases unreported until very recently.

#### *Sexually transmitted infections (STIs)*

STIs have increased dramatically in most parts of China. Evidence from other countries is that STI is a risk factor in the spread of HIV/AIDS, due to behaviour patterns and broken skin enabling easy blood-to-blood contact. The rapid increase in syphilis in most coastal areas and in Xinjiang is particularly worrying given the potential for HIV spread in a country with the population size of China.

In 1986, gonorrhoea and syphilis cases were reported from Urumqi, Hetian and Kashi only, with the reported incident rate at 4.73 per 100,000. By 1996 a wide range of STIs was reported from all over the region, with the reported incident rate increasing to 29.9 per 100,000. There was a four-fold increase for Urumqi, from 41.64 per 100,000 in 1987 to 152.4 per 100,000 in 1996.

In 1998, reported STIs reached 632,512, an increase of 37% over the previous year. The number of reported syphilis cases was 60% higher than the previous year. Congenital syphilis showed an increase of 30%. Projections are that by December 2000 reported STIs could make up more than 50% of the total of all 35 legally notifiable infectious diseases in China. (Syphilis and gonorrhoea are notifiable diseases throughout China.) Chancroid, NGU, genital herpes, condiloma accuminata and lymphogranulomatosis are also reported in STI sentinel sites.

The majority of reported STIs are in major cities and along traffic routes, namely Urumqi, Hetian, Kashi, Aksu, Shihezi, Kuitun and Yining. Gonorrhoea has been mainly found in the north and syphilis mainly in the south. Nearly 90% of STI patients are in the

age group 20-39 years. Estimates are that reported STI cases are less than one fifth of the actual number in Xinjiang and that new STI cases could exceed 30,000.

## **2.2.2 Institutional and regulatory framework**

### *National*

The National AIDS Committee was established in October 1989 as the national coordinating body for HIV/AIDS. In October 1996 the National AIDS Coordinating Committee, an AIDS control coordinating mechanism hosted by the State Council, replaced it. The Coordinating Committee comprises 33 ministries and mass organisations. The Committee is required to meet on a regular basis, at least annually. The GoPRC Medium-Long Term Plan for HIV/AIDS Prevention and Control (1998-2010), approved by the State Council, is integrated into the Social Economic Development Plan. Every provincial government is expected to develop a provincial implementation plan for HIV/AIDS prevention and control, within the national strategic context.

The National Programme on HIV/AIDS Prevention and Control has been in the Ministry of Health (MoH) since June 1987. The National AIDS Programme's technical work is done through a number of national institutes, including the Chinese Academy of Preventive Medicine (CAPM), the Ministry of Health AIDS Prevention and Control Centre (under CAPM), the National Health Education Institute, the National Centre for STD Control, the Institute of Dermatology, and the Chinese Academy of Medical Sciences (Nanjing). Changes proposed for the management of HIV/AIDS may lead to national responsibilities coming under a Centre for Disease Control, developed from the current CAPM.

A comprehensive list of national and Xinjiang legislation, plans and guidelines on HIV/AIDS is at Annex 11.

### *Xinjiang*

The Xinjiang Regional Leading Group for HIV/AIDS Prevention and Control was established in January 1997, under the leadership of the Xinjiang's Vice-Governor with membership of 20 relevant sectors. In April 1998, the Autonomous Region Government further enlarged and strengthened the Leading Group to 33 agencies at Autonomous Region level. Meetings are held each six months to address problems and priorities in the response to HIV/AIDS/STI. The Regional Epidemic Prevention Station (EPS) provides the secretariat with three full-time staff.

The responsibility of the key agencies in the AIDS Regional Leading Group is set out below:

- **Regional Planning Commission:** integrating HIV/AIDS prevention into *9<sup>th</sup> Five Year Plan* and *Long Term Civil Social and Economic Development Plan*; plan funds allocation for HIV/AIDS prevention.
- **Regional Commission for Science and Technology:** support HIV/AIDS related research; participate in the development of the regional long and medium term plan for HIV/AIDS; publicise prevention knowledge.
- **Bureau of Finance:** Funds allocation and inspection.
- **Bureau of Health:** develop the regional long and medium term plan for HIV/AIDS and other plans; regularly make reports and provide suggestions to government; provide technical support (including materials) to partner sectors; capacity building for HIV/AIDS/STD prevention institutes; monitor trends in STD and HIV infection; guarantee safety of blood supply.
- **Bureau of Broadcasting and Film, Administration on News and Press Television:** regularly publicise user friendly, accurate knowledge.
- **Bureau of Culture:** disseminate prevention knowledge within entertainment settings.
- **Bureau of Public Security:** crackdown on prostitution, drug smuggling and illegal blood collection; health education within drug rehabilitation centres and detention centres for prostitutes and clients (also compulsory STD testing and treatment); management of the floating population.
- **Bureau of Justice:** HIV/AIDS/STD education within prisons and correctional institutions.
- **Education Commission:** Integrate HIV/AIDS/STD education into curriculum of middle schools and colleges; safer sex education among college students.
- **Family Planning Commission:** conduct safer sex education and HIV/AIDS/STD prevention knowledge and counselling among women of reproductive age; promote condom use with the emphasis on its dual function for contraception and disease prevention.
- **Bureau of Personnel Management:** allocate staff for STD/AIDS research, prevention and management institutions.
- **Government Office of Foreign Affairs, Bureau of Foreign Trade and Economic Co-operation and Administration of Tourism, Quarantine Office:** supervision and coordination of joint HIV/AIDS/STD projects between Xinjiang and international society; STD/AIDS health education to people who are going abroad; monitor STD/HIV among people crossing borders, according to relevant regulations.
- **Bureau of Transportation, Bureau of Railway Administration and Bureau of Civil Air Service:** health education among staff and passengers.

- **Bureau of Civil Affairs:** provide necessary support to families and people who are living in poverty due to AIDS; support STD/AIDS association and other relevant mass organisation work on AIDS prevention.
- **Bureau of Labour Management:** guarantee the basic rights of HIV infected persons and AIDS patients.
- **Regional Administration on Business and Trade:** collaborate with police section to crackdown on prostitution and on drug smuggling and drug use; support STD/AIDS education and advertising.
- **Regional Commission on Ethnic Affairs:** collaborate with other sectors to conduct STD/AIDS prevention among ethnic minorities.
- **Labour Union, Youth League and Women's Federation:** HIV/AIDS/STD education among workers, youth and women and protection of the basic rights of HIV infected persons.
- **Regional Red Cross Society:** mobilise its members and volunteers to conduct HIV/AIDS/STD prevention among women and young people; reinforce collaboration with international organisations in the area of AIDS prevention; promote blood donation according to law.
- **Military:** HIV/AIDS/STD education among staff within the system.

There are also Leading Groups at the city and prefecture levels of government. They are charged with integrating their work into the local situation and with actively implementing programs for AIDS/STD prevention and control.

The health system at all levels in Xinjiang is primarily responsible for local management and implementation of HIV/AIDS prevention and control.

Four Divisions within the Regional Health Bureau have responsibilities relevant to HIV/AIDS prevention and care. These are: Epidemic Prevention (surveillance/testing, health education, intervention, and inspection of the security of blood banks); Medical Administration (hospitals, blood bank and military recruit physical examination); Hygiene Inspection (staff physical examinations and hygiene inspection for hotels, restaurants, beauty salons, cosmetic salons), and Maternal & Child Health (maternal and child care, pre-marital counselling and examination).

The technical work for HIV/AIDS prevention and control is undertaken mainly by EPS at different levels. There are 112 EPS at all levels in Xinjiang: one at regional level, 16 at prefecture levels, and 95 at county levels. There is a regional STI prevention and testing centre. There is 5,927 staff currently involved in HIV/AIDS/STI prevention and control.

The Regional EPS is the central locus for HIV/AIDS prevention and control in Xinjiang, and, since 1986, has included the Regional AIDS Testing Centre. The Centre is responsible for HIV/AIDS surveillance and reporting, training of professional staff from

the basic levels, and education initiatives across Xinjiang. It has 12 professional staff, and is equipped with an auto ELISA reader, automatic washer, refrigerators and incubator. There are 10 HIV primary screening laboratories at EPS prefecture levels, with responsibility for primary screening for HIV antibodies and small vulnerable populations. There are additional primary screening laboratories in 23 blood collection stations and 5 regional level hospitals. HIV antibody screening is also done at prefecture and county levels by EPS, the Institute of Dermatology and STI centres.

### *Health Sector Reforms*

Access to quality health services by poorer people has been adversely influenced by the impact of economic reform, which began in China in the 1980's. Particular challenges have arisen because of the collapse of the former Cooperative Medical Scheme in most rural areas, structural over-supply of health services in China's tiered system, fixed price policies and self-financing requirements. The impact is greater on families reliant on incomes derived from agriculture that are vulnerable to natural disasters and marketing fluctuations, and on the floating population.

Competition is lowering prices for pharmaceuticals. However, there still appears to be a widening gap between those who can afford pharmaceuticals and those who cannot.

There is no replacement in sight for the collapse of the Cooperative Medical Scheme, formally an important source of financing, although national policy discussions have resulted in some piloting of new schemes. The Cooperative Medical Scheme is no longer subsidised by government. The Scheme's share of total national health expenditure has fallen from 28% in 1978 to 2% in 1993. Consequently rural communities, including in Xinjiang, are finding it increasingly difficult to cover the costs of health care.

### *Policy Issues*

There has been significant improvement in policy development, in particular over the last 5 years. However, there is a need to systematically review and revise general policy and guidelines, to guide appropriate policy action to encourage and support effective responses to HIV/AIDS. Priority policy areas include:

- Revision of some older regulations and policy guidelines where experience shows they are likely to hinder effective and sustainable HIV/AIDS prevention and care. These include quarantine regulations for notification of infectious diseases, including HIV/AIDS and STIs, and regulations relating to drug users and prostitutes.
- Development of additional regulations on how best to address sensitive issues and how to approach difficult-to-reach populations. In particular, clear policies are needed and instructions to authorities at all levels on effective approaches to demand reduction and harm minimisation practices among IDUs and prostitutes. These policies and instructions should not be restricted to rehabilitation centres and prisons. They should also especially focus on approaches within the community at large.

- Development of policies and regulations to achieve a modern, updated and comprehensive field system in public health management and care of people with HIV/AIDS/STI. Such a system should be inclusive of services provided by a wide range of health services, including STI clinics, general health clinics, private practitioners, family planning clinics and pharmacies.
- Development of policies and regulations to support greater availability of quality condoms, including condom marketing.

### *Institutional Constraints*

The Xinjiang Regional Government, the Regional Leading Group and the BoH are very supportive of the proposed AusAID Project. The Xinjiang BoH has improved collaboration with multi-sectoral partner agencies, developed preparatory analysis for the Project, identified a team leader, and provided assurance that there will be no shortage of staff to implement the Project, even with the proposed BoH downsizing, which will be contained to policy areas rather than operational areas, such as the EPS.

A broad institutional constraint, however, is likely to be the capacity of the system to work effectively across multi-sectoral bureaucratic boundaries. For this reason the Project will include capacity building in this area.

### **2.2.3 Resources**

National authorities are responsible for political issues and for providing technical guidelines (see Annex 11). They do not provide funds to the provincial, district/county level HIV/AIDS activities. At provincial, municipal, county and district levels respective local governments are responsible for financing multi-sectoral HIV/AIDS activities. There has been considerable strengthening of HIV/AIDS technical expertise in Xinjiang over the last few years, and this strengthening continues. However, it is largely limited to a few key personnel in the BoH and much capacity building is still required.

Funding constraints are understood to have severely limited the scale of current regional HIV/AIDS control and prevention activities. WB9 is planned to provide a substantial amount of equipment and other resources that will ease this situation somewhat. Only a limited number of prefectures and counties have committed to loan funds offered under this Project, however, and even within these there appears to be some reluctance to draw down funding. Funding constraints, particularly in the poorest areas of the region, can therefore be expected to continue. The Project will address funding constraints through the GoPRC making most contributions in kind.

### **2.2.4 Current Government and local NGO Responses to HIV/AIDS in Xinjiang**

The BoH has:

- Written and printed 150,000 picture posters and brochures and 40,000 copies of training materials on HIV/AIDS prevention and control in Uygur and Chinese languages; organised 'touring communication' at different levels with picture posters on boards; and developed video-cassettes in Uygur, Kazak and Chinese languages;
- Established four AIDS hotlines in Urumqi and Yili Prefectures;
- Provided support to the Regional HIV/AIDS Prevention and Control Leading Group for its successful organisation of a live broadcasting competition on HIV/AIDS prevention and control in December 1998;
- Published, through the Educational Committee, *Suggestions on The Dissemination of AIDS Prevention and Control in the Xinjiang Education System* in March 1998, and organised an informal discussion for staff;
- Developed an AIDS prevention training course for the leaders and medical doctors from the universities and professional colleges, in early 1998;
- Conducted training courses, since 1997, at the invitation of the Regional Justice Bureau, on HIV/AIDS prevention and control for prison administrative staff; and
- Approved training courses for more than 20 health staff provided by the World Health Organisation, World Health Organisation-Australia, the United Nations Development Programme, the United Nations Children's Fund and the European Union in recent years, and national training courses for 11 people;
- Organised five regional wide seminars (presented by national experts) and 21 training courses, involving more than 500 laboratory surveillance technicians from blood supply institutes, hospitals and epidemic prevention stations;
- Completed the first training cycle on HIV/AIDS prevention for clinical doctors;
- Begun regular surveillance of targeted vulnerable populations;
- Established 2 regional surveillance sentinels with cumulative surveys of 61,000 in vulnerable populations (in 1997, the surveillance program covered targeted vulnerable populations in 16 prefectures, sub-regions and cities, and involved the testing of 15,000 drug users, prostitutes, STI patients and long-distance truck drivers);
- Conducted pilot intervention activities in the region, including a trial HIV/AIDS neighbourhood intervention in Yining.

The Xinjiang Red Cross has:

- Commenced youth peer education programs in 1997, in Urumqi, Changji and Yili Prefectures, with technical and funding support from the Yunnan/Australian Red Cross Project, using the Yunnan/ Australian Red Cross Project youth peer education model;
- Commenced training additional facilitators and young people.

The Xinjiang Women's Federation has:

- Integrated HIV/AIDS/STI in its regular train-the-trainer programs through its Child Development Centre. Lack of skilled trainer and materials has limited integration at prefecture level and below. The Child Development Centre was

established by the All China Women's Federation cooperation program with the United Nations Children's Fund.

The private sector is not officially involved in Xinjiang's response to the HIV/AIDS epidemic. Regulations currently prohibit private clinics from diagnosing and treating STIs. However, estimates are that in many parts of China, including Xinjiang, more than half of those with STIs seek help from private practitioners (many of whom are unlicensed) or buy medicine from local pharmacies. They may do so for a combination of reasons, including fear of being identified and fear of possible unfriendly treatment in public hospitals. Experience elsewhere has demonstrated that providing STI training for private practitioners including in syndromic treatment, and ensuring standards of service and referral patterns of private practitioners, can significantly increase the accessibility and affordability of STI prevention and treatment services.

### **2.3 Beneficiary Population Groups**

The population groups that will benefit directly from this Project include:

- Commercial sex workers, predominantly young females, and their clients, predominantly male;
- Floating population, male and female workers from other parts of China, and from within Xinjiang, attracted to economic opportunities;
- Health workers, male and female;
- Hotel and bar attendants, and workers in other entertainment settings (in particular young females);
- Injecting drug users, reported as predominantly male, and their sexual partners, predominantly female;
- Long distance truck drivers, predominantly male;
- People living with HIV/AIDS, reported as predominantly male, and their families;
- Spouses of people practicing high risk behaviours, predominantly female;
- STI patients who are reported as predominantly male;
- Students at middle school, college and universities, male and female;
- Workers in beauty salons, predominantly female;
- Workers in institutional settings, male and female;
- The Xinjiang population in general, who will benefit from health promotion campaigns.

### **2.4 Technical Issues**

*Course of Epidemic and Flexibility*

Relevant technical issues will continue to emerge depending on the course of the epidemic. This is important as, based on reported epidemiological data, Xinjiang has the second highest number of HIV cases in China. However, data is not reliable, and surveillance experts in Xinjiang estimate that the true number of people with HIV may be between 15,000 to 25,000. The Project will, therefore, require flexibility to address issues that arise that cannot currently be confidently predicted.

#### *Mass Education and Communication*

Mass education and communication (information, education and communication or IEC) are key components of HIV/AIDS prevention programs. They are directed to the general public and aim to teach essential facts, promote healthy behaviour, quiet anxiety about casual transmission and prevent discrimination. Strategies may include peer education, counselling in various settings, outreach programs, development and distribution of IEC material, formation of AIDS committees and clubs, workshops and seminars, use of drama to convey messages, voluntary HIV testing and counselling, free clinics, and building community support for behaviour change.

There is strong support within the BoH for effective use of the media for HIV/AIDS IEC, while a comprehensive strategy is lacking. There is limited evidence of non-health sectors in general public education and of active involvement of targeted population groups and communities in their design and implementation. There are, however, some good examples of participative learning and peer education approaches including being conducted by mass organisations. Materials are, in general, developed separately by each organisation and there is a need to develop both a comprehensive approach and a repository of expertise, upon which all can draw.

*Behaviour Change* Vulnerability to HIV is aggravated by many factors including migration, economic disparities, inequality between men and women, and industrial development policies that attract workers to jobs far from their families. In Xinjiang, vulnerable groups, those that are more likely to engage in behaviour that puts them at risk of sexual and blood-borne infection, include commercial sex workers, workers in bars and entertainment centres, injecting drug users, workers in beauty salons, and long distance truck drivers. Many of these form part of the migratory or floating population, which is primarily adults of sexually active age, who often lack access to appropriate services, have disrupted social norms, and face discriminatory policies. Information on the prevalence of male-to-male sex or street children was not available to the assessment team.

Prostitution is illegal in China. They, and IDUs, face arrest or compulsory detention. Voluntary detention for rehabilitation, particularly for IDUs, also occurs. There is inadequate access to prevention and treatment services for STIs and there appears to be a low level of condom use in both groups. There is a limited amount of IEC in detention centres. Education, prevention and counselling is hindered by the current law

enforcement approach as distinct from harm minimisation, and by socio-cultural, religious and public morality attitudes.

Strategies for behaviour change need to target these vulnerable groups and women and children and ethnic groups. There should be emphasis on integrating HIV/AIDS education and counselling for women into existing programs, such as those conducted by the Women's Federation, maternal and child health services, and reproductive and primary health services.

Many young people can be easily reached through schools, and there is considerable experience in China in effective school-based life skills programs, in primary, middle, college and vocational sectors. For out-of-school youth, peer education is effective.

This Project will ensure that behaviour change approaches selected are best practice approaches adapted and developed for the socio-cultural and economic environment of Xinjiang, including their relevance to, and acceptance by, the various multi-sectoral groups and vulnerable groups.

#### *Condoms*

For effective behaviour change, quality condoms must be available to low-income groups and to those engaging in high risk sexual behaviour. This is a key strategy for HIV/AIDS prevention.

While hard data is lacking, there appears to be variation across prefectures and counties in Xinjiang on condom availability, related to marketing and distribution, and condom quality. The Project will address barriers to condom access and use, including cultural and religious barriers, to develop a better skill base for promoting condom use among ethnic minorities, as well as to the vulnerable groups discussed above.

#### *Counselling and Testing*

Voluntary HIV testing and counselling is a key component of effective HIV/AIDS prevention. Together they support improved health through earlier access to care, treatment and prevention of HIV-related illnesses, emotional support to better cope with HIV-related anxiety, awareness of safer options for reproduction and infant feeding, and assist motivation to initiate or maintain safer sexual and drug-related behaviours.

Essential features include good quality, voluntary and confidential HIV testing and counselling; and informed consent and confidentiality in clinical care, research, blood

donation, blood products receipt, and organ donation, where the individual's identity can be linked to his or her HIV test results. These features encourage community involvement in sentinel surveillance and epidemiological surveys and discourage mandatory testing.

### *Injecting Drug-Users*

The majority of rapid HIV transmission is likely to be between injecting drug users, with slower spread to their sexual partners, and from commercial workers to their clients. Stopping or dramatically reducing the spread of HIV between IDUs can dramatically reduce the prevalence rate. Effective strategies must significantly reduce needle sharing across the majority of population at risk. This is a major challenge in Xinjiang: to reach enough of the at-risk population with strategies that work particularly to overcome the culture of sharing needles.

Effective strategies require a balance between legal sanctions, education, drug treatment, a supportive public health context, and provision for behaviour change approaches. Separating public health responses to users and law enforcement responses to drug traffickers is essential. This will be a challenge in Xinjiang.

Detoxification is relatively inexpensive but, in Xinjiang, this needs to be complemented by community-based, vocational rehabilitation, including transition programs for those discharged from drug rehabilitation centres or from prisons, when currently there is none. Policy and management of matters associated with illicit drugs is largely the responsibility of Public Security. The multi-sectoral approach of this Project, is a key approach to ensuring integrated action across multi-sectoral agencies, with common understanding and goals. This is crucial to successful HIV prevention.

### *Mother- to- Child Transmission*

Mother-to-child transmission is the major source of HIV infection in babies. The virus can be transmitted during pregnancy, labour, delivery, or through breastfeeding. Effective strategies developed in other developing countries include:

- Policies that support effective prevention and promote human rights;
- Access to effective IEC strategies;
- Promotion of safe motherhood precautions including maternal and child health;
- Provision of antiretroviral drugs where budgets allow.

### *Treatment, Care and Positive Living*

People with HIV and AIDS have significant health care and support needs. HIV usually slowly progresses to ever-more serious complications leading to untimely death for most infected people in developing countries. The cost of treatment and pharmaceuticals is

prohibitive even in wealthy countries. In developing countries, this challenge is compounded by health systems that lack appropriate infrastructure to effectively care for people with HIV/AIDS.

In low resource environments, effective approaches include:

- Strengthening capacity for home and community-based care, using a continuum of care approach;
- Disseminating information and advice on low-cost nutrition, clinical, palliative care and counselling;
- Undertaking activities to foster compassion and support to people affected by HIV/AIDS, including their participation in program and service planning and delivery;
- Undertaking health worker training and capacity building for public health services for people with HIV/AIDS;
- Adapting successful low-resource experiences, linking the experience and learning across provinces and communities.

Medical therapy and nursing care are critically important, as are emotional support and social policies to alleviate the economic and other impacts of AIDS on families and households. Support groups can help kindle AIDS awareness in communities, reduce the rejection and shame associated with HIV/AIDS in Xinjiang, and influence public policy.

Local communities can assist in developing locally relevant standards of care for people living with HIV/AIDS, while ensuring that standards are technically sound and satisfactory to recipients of care. Such standards include palliative care (the alleviation of pain and distressing symptoms), and access to drugs for HIV-related opportunistic infections such as tuberculosis and fungal infections. Where resources permit, standards for sophisticated treatment such as antiretroviral therapy should be developed. Partnerships between public, private and community sectors can be helpful.

### *Infection Control*

There are standards for infection control in Xinjiang. The challenge in Xinjiang is to achieve adequate hygiene and sound sterilising practices. Disposal of single-use syringes and other medical supplies appears inadequate. Sterilising and disinfecting practices appear poor in some areas. The problems relate to limited budgets and inadequate training and assurance of standards. Beauty salons also do not always adhere to safe practices.

In Xinjiang, poor infection control practices probably pose a greater health threat to the

population through transmission of hepatitis B and C, than does HIV/AIDS. However, where hepatitis B and C are prevalent, the risk for increase in HIV/AIDS rises.

### *Tuberculosis*

People who are HIV-infected and who are carrying the tuberculosis germ are unusually prone to developing active tuberculosis, shortening life expectancy. The HIV epidemic spurs the spread of tuberculosis, increasing the tuberculosis risk for the population at large. Real progress in HIV/AIDS prevention in Xinjiang requires strategies targeting both diseases simultaneously through education and training of health workers in particular.

### *Blood Supply*

The human immunodeficiency virus (HIV) is efficiently transmitted through contaminated blood transfusions with a 90% probability of infection. Improvement of blood supply is a component of WB9. Risks arise in Xinjiang because of inadequate techniques and quality control of screening and transfusion, a relatively high level of unnecessary transfusion, and the continued use of paid donors because of limited progress in implementing the national policy for voluntary unpaid donors. Major medical centres do, however, appear to have safeguards in place for uncontaminated blood supply.

WB9 has a component addressing clean blood supply. In addition, there is a Swiss “Centralised System of Blood Service and Disease Control in Xinjiang Production and Construction Group, China” project which anticipates the establishment of 13 blood banks throughout Xinjiang based on the 13 existing branches of the Xinjiang Production and Construction Group. This project has no IEC or capacity building components and is restricted to staff and others directly associated with the Xinjiang Production and Construction Group.

### *Sexually Transmitted Infections*

Prevention and care of sexually transmitted infections reduces HIV transmission. Key strategies for STI management in limited resource settings include:

- Early diagnosis and treatment;
- Patient and population education;
- Education and treatment of sexual partners of people with STI;
- Targeting vulnerable groups including through tailoring services to meet their needs;
- Using the syndromic approach;
- Increasing women’s access to STI management, treatment and prevention, especially through reproductive and primary health services;

- Increasing access by unmarried youth through a range of non-discriminatory and user-friendly services.

In Xinjiang only government clinics are licensed to treat STI. However, private clinics appear to treat a large number of people with STIs, including sex workers, drug users and other workers within the floating population. WB9 contains policy and institutional reform measures in STI, including training and licensing of private practitioners treating STI patients, and maintaining anonymity of HIV/STI patients.

### *Surveillance and Reporting*

HIV/AIDS surveillance is a key tool for action against the epidemic. Surveillance is ongoing systematic collection, collation and analysis of data, and the dissemination of information to those who need to know, for action. Tracking the incidence and prevalence rate of HIV and AIDS can act as an early warning system, allowing appropriate strategies to be developed. Behavioural surveillance is also important, providing information on behaviour patterns that can then be targeted through IEC. Important additional factors are community attitudes, including stigmatisation and discrimination, and community participation.

Xinjiang has a well-established system of Epidemic Prevention Stations and an HIV/AIDS surveillance system. Some behavioural data has been collected in trial interventions but is of limited use for monitoring and policy development. The problems relate to lack of a strategic approach to forecasting, surveillance and reporting; the need for greater rational allocation and use of resources; policies on confirmatory testing; budget limitations for testing reagents; inadequate training and quality assurance.

WB9 has provision to develop and expand the surveillance system to enable monitoring of the epidemic and behavioural trends, influencing policy, informing project design, and measuring the impact of interventions.

### *Capacity Building*

In Xinjiang there is a need for a strategic approach to multi-sectoral capacity building, including strategic planning; knowledge, skills and experience for effective implementation; and rational allocation of financial and human resources. There is greater potential to learn from other HIV/AIDS activities elsewhere in China. International study tours have been available for a few, as have national workshops, and regional training, but the results fall short of capacity building. There is a need for a more comprehensive and strategic, multi-sectoral approach, to capacity building, which this Project addresses.

Capacity building is integral to Project effectiveness and sustainability. Needs and priorities for capacity building will be assessed early in the Project, and reviewed at key

points. Where possible, expertise already available in China should be utilised (e.g. the national level and Yunnan Province) such as in situation and response analysis, intervention methodologies, counselling, behavioural approaches including peer education, HIV/AIDS education to grass root level through the Women's Federation and Child Development Centre, and community-based HIV/AIDS trial neighbourhood interventions (e.g. at Du Lait Bak). Effective low-resource strategies should be given priority. Planning for capacity building will:

- Relate training and organisational development needs to project outcomes;
- Be directed to proven performance of individuals and teams on project activities;
- Ensure the individuals and team selected represent the diversity of the target populations for project activities;
- Ensure fair representation from all participating organizations, communities and groups.

#### **2.4 GoPRC Perspectives**

The GoPRC and the Xinjiang Regional Government, the Leading Group and the BoH are very supportive of, and committed to, the proposed AusAID Project to assist their fight to contain the HIV epidemic in Xinjiang. To enhance Project viability, the BoH continues to strengthen multi-sectoral collaboration. Proposed multi-sectoral Project partners demonstrated commitment to the Project. Government officials at all levels demonstrated commitment and interest and see the proposed Project as a key strategy to strengthen capacity to reduce the epidemic and minimise its social and economic impact. Partner team leader and BoH Project team members have been identified by the BoH to implement the proposed Project. Assurances were given by the Vice-Governor that Xinjiang budgetary provision for HIV/AIDS prevention and control will be increased to further strengthen the Project's impact. The draft Xinjiang HIV/AIDS Prevention Plan is currently before government and reflects the intent of the national plan.

#### **2.5 GoA Perspectives**

The proposed Project is in line with GoA's Aid Program Strategy 2000-2001 for China, with its objectives to reduce poverty and achieve sustainable development. Evidence from other parts of the world, e.g. sub-Saharan Africa, where HIV/AIDS has not been contained, is that social and economic devastation is a consequence of un-contained HIV transmission. The proposed Project is also in line with GoA's Health in Australia's Aid Program (1998) to prevent and control communicable diseases, with HIV/AIDS one of the specific communicable diseases to be targeted. Also in line with Health in Australia's AID Program (1998), the Project will provide support to inform effective planning, management and evaluation of strategies to reduce HIV transmission and contain Xinjiang's HIV epidemic. The proposed Project design draws on international and China experience in HIV/AIDS, including AusAID lessons learned in HIV/AIDS.

## **2.6 Other GoPRC and Donor-Supported Activities**

Other donor activities in Xinjiang impacting on HIV/AIDS responses in Xinjiang are summarised in the following matrix. The Project team will need to ensure complementarity with these projects and ensure duplication and overlap are avoided.

WB9, seen originally as a risk for potential duplication, is currently proceeding more slowly than planned in the 9 out of 15 prefectures and 15 out of 95 counties that have the capacity and will to repay the loan. Administrative procedures are cited as one constraint but it was also stated that prefectures and counties that made an earlier commitment to participate are in fact reluctant to draw down loan funds that have to be repaid. At the time of the Appraisal Mission it was reported that no procurement had taken place as the procedures were still not effectively in place. Acquittal procedures for funds applied to intervention trials were poorly understood and/or adhered to and reimbursements were delayed. Accordingly, if the interventions, a number of which had started prior to WB9 commencement, were proceeding at all they were doing so largely under local funding.

It must be emphasised that WB9 is operating in parts of Urumqi and in Yining, both of which are proposed as areas in which the AusAID project will operate. In addition, WB9 includes planning at regional level within its Policy Development component. Complementarity can, however, be achieved through close co-ordination. WB9 has relatively little provision for technical assistance whereas the AusAID project has a substantial element. WB9 is not focusing on care whereas the AusAID project does.

The Activity Support Facility funding mechanism will assist the process of co-ordination through the opportunity it presents to set each sub-project proposal in its current context before funding decisions are made. In this way, other activities, whether funded with WB9 assistance or not, can be taken account of. Every effort must be taken to establish strong working relationships with other donors to ensure strategic links and synergy. As well, robust and transparent financial accountability and reporting is built into the Project design, to ensure that all Project money is spent on Project activities.

**Matrix of Externally Funded Activities Impacting on HIV/AIDS Responses in Xinjiang Uygur Autonomous Region, as at December 2000**

DONOR /LENDING AGENCY	PROJECT TITLE	BRIEF DESCRIPTION OF PROJECT	COMPLEMENTARY COMPONENTS OR ACTIVITIES WITH XINJIANG HIV/AIDS PREVENTION AND CARE PROJECT (XHAPCP)	NEED FOR FORMAL COORDINATION
AusAID	Funding for UNICEF 40 Countries Project	Funding totalling A\$3.6m to this UNICEF project which focuses on MCH	Project operates in Hami, Tulufan, Tacheng, Byangle, Kashi and Hetian	
AusAID	Small Activities Scheme	Some water and education activities funded in Arletai Prefecture		
AusAID	Various	Funding through UNICEF and various NGOs for a range of health and HIV/AIDS activities	NGO funding has focused mainly on activities in Yunnan and Sichuan. In addition it is understood that some Australian expertise has been provided on a short term basis.	
World Bank with co-financing from AusAID	World Bank Health IX – HIV/AIDS/STD Prevention and Control Component	This Project component commenced in 1999 and is due for completion in 2005 – it is implemented in four provinces including Xinjiang – external funding (soft loan) for Xinjiang around A\$8.5million. Counterpart funding of around A\$5.8	<p>The Component has five sub-components, the first 3 of which have a considerable degree of complementarity with the proposed XHAPCP:</p> <ul style="list-style-type: none"> <li>• Policy Development and Institution Building</li> <li>• HIV/AIDS/STD Interventions</li> <li>• HIV/AIDS-STD Surveillance</li> <li>• Blood Management</li> <li>• Central Level Sub-component</li> </ul> <p>World Bank funding is provided as a loan and, within the Xinjiang Region, only 9 out of 16 prefectures and 15 out of 95 counties (or county level cities or districts) have elected to borrow to fund project activities. Less than A\$340,000 was originally allocated to TA across all the first 4 components for Xinjiang but this will be boosted by the AusAID co-funding – see below</p> <p>Kashi Prefecture is not participating in WB9 but active prefectures/counties include Yining City and three districts within Urumqi City. These two municipalities are also proposed areas to be included in XHAPCP because of the high number of confirmed cases. A number of on-going intervention trials are intended to be supported by WB9 funding. It is essential that careful co-ordination</p>	Close and frequent formal co-ordination required particularly when prioritising sub projects for funding under XHAPCP

DONOR /LENDING AGENCY	PROJECT TITLE	BRIEF DESCRIPTION OF PROJECT	COMPLEMENTARY COMPONENTS OR ACTIVITIES WITH XINJIANG HIV/AIDS PREVENTION AND CARE PROJECT (XHAPCP)	NEED FOR FORMAL COORDINATION
			<p>take place to maximise the potential for complementarity between the current trials and those proposed under XHAPCP. This needs to be an on-going process over the life of the Project rather than being set in the design at the outset.</p> <p>It is understood that a Xinjiang-specific project implementation document has been prepared and translated but this was not made available to the Appraisal Team.</p>	
World Bank	World Bank Health IX – MCH Component		This project is important because of its impact on the absorptive capacity of agencies within the health sector in Xinjiang. No documents were made available to the Appraisal Team.	
World Bank	World Bank Health X	Early in preparation negotiation stage – to be focussed on Tuberculosis		
EU	Training Project		The European Union is conducting a training program on STD and HIV/AIDS covering 21 provinces in China. They have carried out limited training in Xinjiang	Yes, as TB prevalence rate and HIV/SIDS can be linked.
DIFD		Being implemented in Yunnan and Sichuan	This is a major project from which useful lessons are being learned on strategies to address HIV/AIDS epidemics in China.	Yes, this Project has a number of similarities with XHAPCP – close collaboration and co-ordination will develop synergies
CIDA	Women's Micro-credit Scheme	Operating in Hetian Prefecture in Hetian City, Hetian County and Pichan County	The Project team has developed sound working arrangements with community groups and Xinjiang mass organisations, in particular the Women's Federation. The project has established a health centre in Hetian City and will begin operating as soon as the government provides medical staff. The full-time project coordinator, a Canadian national, is based in Urumqi. A Canadian national intern is currently working in Hetian (on a short term approval basis) as coordinator of the health centre.	Consideration should be given to the potential for information sharing and collaboration to avoid duplication and to increase the effectiveness of project activities.

<b>DONOR /LENDING AGENCY</b>	<b>PROJECT TITLE</b>	<b>BRIEF DESCRIPTION OF PROJECT</b>	<b>COMPLEMENTARY COMPONENTS OR ACTIVITIES WITH XINJIANG HIV/AIDS PREVENTION AND CARE PROJECT (XHAPCP)</b>	<b>NEED FOR FORMAL COORDINATION</b>
Luxembourg		Luxembourg embassy in PRC spending A\$200,000 on HIV/AIDS support and interventions	Visit by 9 regional staff to MacFarlane Burnet Centre in Melbourne in November/December 2000. Attendees include Dr Ni Mingjian – a key counterpart to World Bank Health IX at Regional EPS	
UNDP	Various		UNDP supports multisectoral approaches to HIV/AIDS, including political awareness, multisectoral training and community based demonstration projects targeting vulnerable populations. It has funded training in Australia for Chinese officials.	Yes
UNDCP	Sub-regional Development of Institutional Capacity for Demand Reduction Among Vulnerable Groups	1998-2001 in 6 countries including PRC	It is understood that Xinjiang Province will be included but no details are available. UNDCP may provide a useful entry point into Bureau of Public Security for collaborative activities.	Yes
UNDCP/ Xinjiang Red Cross	Youth Peer Education Training Project for the Prevention of Drug Use and HIV/AIDS	A one-year peer education training project to start in January 2001. Project sites in Urumqi and Yining	Currently at proposal stage.	Yes
UNAIDS		Regional level strategic Planning workshop in Xinjiang in 2001	Yet to be undertaken at time of drafting PDD	Yes
UNICEF			Surveillance	
UNICEF	Regional Mekong HIV/AIDS Project	This project has been completed. It operated in Yunnan, Hainan, Guizhou and Guangxi. It is understood that an ex-post evaluation has been carried out and documented.	Areas of focus include advocacy, promotion of multisectoral cooperation, community based IEC interventions, youth peer education, mass media, school-based health education and integration of HIV health education into MCH services.	Consideration should be given to the potential for learning from the experience of this project and for the adoption and modification of relevant materials and activities.
UNFPA	Reproductive Health Program		UNFPA has a small HIV/AIDS component as part of its new reproductive health program in China, and intends to conduct activities in Kuerla City.	Consideration should be given to the potential for information sharing and

DONOR /LENDING AGENCY	PROJECT TITLE	BRIEF DESCRIPTION OF PROJECT	COMPLEMENTARY COMPONENTS OR ACTIVITIES WITH XINJIANG HIV/AIDS PREVENTION AND CARE PROJECT (XHAPCP)	NEED FOR FORMAL COORDINATION
				collaboration to avoid duplication and to increase the effectiveness of project activities.
SCF (UK)	Workshop in Xinjiang	HIV/AIDS Awareness Raising	Completed – attended by representatives of 8 prefectures of the province from Women’s Federation, Education Commission and Health Bureau.	
SCF (UK)	Study Tour for Xinjiang officials	Officials from different Government agencies visited Yunnan to see a range of HIV/AIDS prevention work	Completed in January 2000.	– care should be taken in selecting participants for XHAPCP awareness raising activities.
SCF (UK)	School-Based Participatory HIV/AIDS Prevention Education in Xinjiang and Anhui	A proposal focussing on 15 middle schools in Urumqi and Kashgar to be undertaken over 18 months in partnership with the Xinjiang Regional Education Commission, Urumqi City Education Commission and the Xinjiang Children’s Development Centre (Women’s Federation) Proposed funding SCF - A\$75,000	Status of this proposal needs to be taken into account when considering intervention proposals that may be submitted by the Education Commission and/or NGOs.	Status of this proposal needs to be taken into account when considering intervention proposals that may be submitted by the Education Commission and/or NGOs.
Ford Foundation	Various	Ford Foundation has supported a number of innovative projects in China, mostly implemented by Chinese non-government organisations.	These projects address some of the more sensitive areas for HIV/AIDS prevention and care, such as prostitution and injecting drug use, and have included a harm reduction workshop for HIV/AIDS prevention among injecting drug users.	
Oxfam Hong Kong		Oxfam Hong Kong has set up HIV/AIDS Training, Hotline and Counselling Centres in Yunnan, Guizhou and Guangxi Provinces.		Consideration should be given to the potential for learning from the

DONOR /LENDING AGENCY	PROJECT TITLE	BRIEF DESCRIPTION OF PROJECT	COMPLEMENTARY COMPONENTS OR ACTIVITIES WITH XINJIANG HIV/AIDS PREVENTION AND CARE PROJECT (XHAPCP)	NEED FOR FORMAL COORDINATION
				experience of this project and for the adoption and modification of relevant IEC materials.
DKT International	Condom Social Marketing		DKT International, based in Shanghai, is involved in condom social marketing in a number of Chinese provinces. PSI, another social marketing organisation, plans to launch a condom promotion program in Guandong Province in collaboration with the Chinese Association of STD/AIDS prevention and Control.	Liase
MSF	Rural Water Supply & Hygiene Promotion Project	To improve the public health of poor villages in Kashgar Prefecture, by providing the population with safe drinking water sources, and by carrying out hygiene promotion	There may be useful knowledge and experience about working in rural Kashgar that would provide useful lessons for XHAPCP.	Liase

## **2.7 Australia's Capacity to Assist**

Australia has had a successful response to HIV/AIDS since the possibility of an epidemic in Australia was recognised in the mid-1980's. Its success and expertise is internationally recognised in designing and implementing innovative and effective strategies and targeted interventions. Australian expertise has significantly contributed to responses to HIV/AIDS in developing countries, in particular in Asia and the Pacific. Australian contributions to date in China, across policy, strategy, program and project areas, form a sound basis for building on learning and experience to support this proposed Project.

Australia's expertise includes:

- Assisting governments with policy development and review, strategic planning, program design and management.
- Assisting governments with the integration of HIV/STD/AIDS programming into government programs, and into non-governmental and community efforts in cooperation with local government.
- Communication information and education, including peer education and mass education campaigns.
- Condom and needle and syringe marketing.
- Curriculum development for primary and secondary schools.
- Epidemiological forecasting and monitoring.
- Harm reduction programs and community focused education and development, especially with marginalised populations.
- HIV testing and counselling, including laboratory quality control.
- HIV/AIDS treatment and care, including community based care.
- Monitoring and evaluation.
- Partnership approaches, collaboration with those most affected and institutional capacity building.
- Rational planning for resource allocation and use.
- Socio-cultural and behavioural research with vulnerable populations, focusing on sexual behaviour and drug use to inform prevention and care programs.
- STI prevention and treatment, including with marginalised and/or vulnerable populations.

Australian contractors are currently implementing major HIV/AIDS projects in Indonesia and Papua New Guinea. An HIV/AIDS project in India is currently at the feasibility/design stage.

New Zealand also has expertise across many of these areas and may also be a Project recruitment source.

## **2.8 LESSONS LEARNED**

There are now many lessons learned in successfully reducing the spread of HIV/AIDS and to ensuring, in general, a project has the best chance of success. These lessons learned include:

### *Impact of not containing HIV/AIDS epidemic*

Experience in Africa, particularly sub-Saharan Africa, demonstrates that failure to reduce the spread of the HIV virus results in economic and social devastation.

### *Multisectoral collaboration*

Multisectoral collaboration is essential to successfully target the core reasons for the spread of HIV/AIDS. Limiting project design to the health sector results in failure to contain HIV/AIDS. However, the health sector's role in providing leadership, expertise and coordination is pivotal, particularly in the early stages of response.

### *Support for long-term planning*

Support for partner government's capacity for long term planning, including multisectoral planning, is essential to limit the impact of the pandemic and facilitate sustainability.

### *Project design reflects local needs*

The project design should be sensitive to local needs including cultural, religious and ethnic values and mores; gender issues; geographic and climatic influences; epidemiological trends, and the political and economic context. It is not appropriate to use a pre-fixed project format where diversity exists among project sites. A situation and response analysis should be done as a preparation for the design of a relevant, effective and sustainable response.

### *Political advocacy and government commitment*

Political advocacy and high-level local government commitment is essential for the success of a project. Training of technical people alone will not have any impact on the overall response towards HIV/AIDS. As well as training, there needs to be multisectoral capacity building achieved through innovative multisectoral strategies, including study tours and training courses for leaders of different government ministries. For example, the UNDP multisectoral HIV/AIDS project in China led to national AIDS policy research in 1993, under the leadership of the State Council Research Group. The Yunnan Vice

Governor made the high level Yunnan AIDS Office available to ensure a better coordinated provincial response (with help from the UNICEF Mekong HIV/STD/AIDS project). In Lancang County, Yunnan Province, the Vice Governor initiated an intensive media campaign on AIDS prevention (with support from UNICEF).

#### *Project flexibility*

Flexibility should be built into the project design phase, in particular to be able to respond to changes in the HIV/AIDS epidemic and the policy environment. An example is WB9 requirement for participating provinces to develop and review their action plans on an annual basis.

#### *Geographic focus and action*

Projects are more effective when they are designed in a focused manner, targeting action on specific geographic areas. This helps the project provide a comprehensive response for a particular location, and helps the local people replicate successful activities on a larger scale. Too broad a coverage makes it difficult to manage and monitor a project, and often means that activities are spread too thinly and have less impact.

#### *Partnership with local government and non-government organizations*

Partnership with local government and non-government organizations improves the capacity of local partners and leads to more sustainable action. Successful examples in China include the Yunnan Red Cross/Australian Red Cross Youth Peer HIV/AIDS Education Project in Yunnan; and the Yunnan Education Commission/ Save the Children Fund (UK) collaboration on school HIV/AIDS education.

#### *Project technical advisory group and monitoring*

A good project technical advisory group (involving both international and domestic experts) and efficient monitoring has been shown to be essential elements for successful HIV/AIDS projects in China.

#### *Cooperative international technical assistance*

International cooperation projects can help in providing excellent technical expertise in sensitive areas such as HIV/AIDS. They can work together to share this technical expertise across a number of projects. Examples include the use of AusAID grant funds to support the WB9 intervention workshop on HIV/AIDS prevention among prostitutes; and the Ford Foundation sponsored harm reduction workshop on HIV prevention amongst drug users.

### *Capacity building for young professionals*

Capacity building for young professionals is a cost effective mid and long-term investment. An example is the European Union fellowship program that provided young professionals with five months of well designed training in European countries. Groups of these trained professionals are active in many technical areas of HIV/AIDS prevention and care in China.

### *Effective prevention*

There is good evidence that HIV infection rates are stabilising or decreasing in places where focused and sustained prevention programs have brought about significantly safer behaviour. HIV prevention approaches that have proven to be effective and affordable for developing countries include: information, life skills education, and peer support approaches among youth; voluntary counselling and testing programs; AZT treatment to reduce mother-to-child transmission; targeted interventions to promote condom use and to prevent and treat sexually transmitted infections among sex workers; and harm reduction programs among injecting drug users.

### *Strategies when prevalence rate is high*

Evidence from Thailand suggests prevention can work even if the epidemic is in a phase of rapid growth. In Thailand this was achieved by adopting a 100% condom use policy in brothels, mass media campaigns encouraging respect for women and discouraging men from commercial sex, and offering better educational and vocational opportunities to young women to keep them out of the sex industry.

### *Integrated approach to prevention and care*

Success in responding to the HIV/AIDS epidemic has shown the importance of a strategic approach that includes both prevention and care, even when the epidemic is at an early stage.

### *Counselling and HIV/AIDS*

Competent counselling assists in many ways. Competent counselling assists people to make informed decisions, such as whether to have an HIV test; helps people living with HIV/AIDS and their families to cope better and lead more positive lives; and helps prevent HIV transmission by HIV-positive people reducing or eliminating high-risk behaviour.

### *Non-formal home based care*

Long term home based care growing from supportive, informal networks is a key factor in providing supportive and appropriate care for people living in the community with illnesses associated with HIV/AIDS.

### *Spread of HIV/AIDS along transport routes*

In Nepal a vigorous campaign to inform truck drivers and sex workers of the risk of unprotected sex, plus the provision of condoms at convenient points along truck routes, successfully reduced the risk behaviour of sex workers and the transport workers who made up the bulk of their clientele.

### *Injecting drug users*

A recent comparison of cities with high and low HIV prevalence in drug injectors showed that those with success in averting a drug-user epidemic had a number of features in common. These included using community outreach or peer education to reach and educate drug users, and ensuring that drug users had cheap and easy access to sterile needles and syringes.

### *People's priorities*

Many years of experience in health promotion, including for HIV/AIDS, shows that health promotion that works and is sustained begins by asking people about their own priorities for living. People are then supported to meet those goals through community and group mobilisation.

### *Entry point for IEC (information, education and communication)*

Integrating HIV prevention and care with other health services (primary health care, reproductive health/maternal and child health, STD management) offers an efficient entry point for HIV/AIDS information, education and communication and for training and sensitising health staff.

### *Social research*

Participatory social research linked to program action has proven to greatly enhance prevention and care programs. Explaining the specific problem to those directly affected by it, then seeking their solutions, has proven highly effective.

### *Vulnerability*

Women, poor people and marginalised groups are generally more vulnerable to HIV infection and are often less able to protect themselves from infection or cope with illness resulting from being HIV-positive.

### *Community environment*

The development of an environment that is open, accepting and non-discriminatory has been shown to be essential to enable the community to provide support and ensure that

those at risk of HIV infection are able to access prevention and care programs. Stigmatisation and discrimination against people living with HIV/AIDS has a critical impact, not only on their self-esteem but also on their physical well-being and longevity.

#### *Contextual factors*

Addressing the contextual factors is the hardest part in reducing risk behaviour and vulnerability. It can involve a range of interventions including seeking to change legislation, policies, cultural and social norms, official and public attitudes, and other fundamentals of society.

#### *Appropriateness*

IEC messages and HIV/AIDS project activities have to be culturally and socially appropriate.

#### *Targeting*

The task is to identify the needs and concerns of the target group and work with them, or organisations representing them, to tailor the most effective means of communication.

#### *Traditional performers*

Traditional performers can be good disseminators of information, particularly in more isolated communities.

#### *Counterproductive strategies*

Identifying risk behaviour only in socially marginalised groups, such as sex workers and injecting drug users, can increase prejudice. Stigmatisation and discrimination undermines public health efforts to control the spread of HIV by discouraging those engaging in risk behaviour from seeking counselling and medical care.

#### *Success of partnership model*

The relative success of the response to the HIV/AIDS epidemic in Australia and elsewhere would not have been achieved without a negotiated partnership commitment between organisations representing vulnerable groups, government, medical and scientific bodies, the media and the broader community.

#### *Collaboration with those most affected*

HIV/AIDS activities are most effective and sustainable when those most affected by the pandemic are involved in project design, implementation, review and evaluation. It is

thus important to work with people living with HIV/AIDS, their families and carers, commercial sex workers, injecting drug users and communities with a high incidence of infection.

#### *Dissipation of impact*

Attempting too many activities in too many geographical areas can dissipate project impact.

#### *Integrated prevention strategies*

Programs to prevent the spread of HIV work best as a package, with each initiative reinforcing the others.

#### *Youth*

The Yunnan-Australian Red Cross Youth Peer Education for HIV/AIDS Project is one example demonstrating that widespread awareness and improved knowledge of HIV/AIDS can be achieved through outreach work using young people to disseminate information to their peers.

#### *Training*

Too much training has been done as a one off event in the name of capacity building. A 'training of trainers' model without continued support that allows for an ongoing process of planning, training and evaluation is likely to have limited long term effects. Monitoring and feedback on training outputs is essential as is an organisational development approach.

## **3 Design Issues**

### **3.1 Design and Implementation Principles**

A number of fundamental Project principles have been negotiated and agreed with BoH and endorsed by MOFTEC, at least informally. These principles have guided the Project design and should be borne clearly in mind during final appraisal and implementation. They are based on the needs of sustainable capacity building and on AusAID best practice guidelines for the design and implementation of development projects focusing on HIV/AIDS prevention and care. These principles are:

- The Project must be multi sectoral in approach, recognising that HIV/AIDS is a social and economic challenge and not just a health problem. At the same time, the pivotal role to be played by the health sector in providing leadership and expertise at least in these early stages of the response is also recognised.

- Under the national Mid-Long Term Plan for HIV/AIDS Prevention and Control 1998-2010, the Project will both facilitate the further development of regional response frameworks and will operate within them.
- The Project will be structured and managed so as to maximise opportunities for collaboration with other initiatives and to avoid wasteful duplication.
- By working within a regional strategy framework, rather than creating its own, the Project will support people within the system to undertake their allocated roles and responsibilities.
- Thus the Project as designed represents a collaborative effort to be undertaken by the BoH/EPS and other multi-sectoral stakeholders, together with external technical assistance and other resources provide by AusAID.
- Because the characteristics of the epidemic are evolving and it is developing quite rapidly, the Project is designed to be flexible and responsive so that it can adapt to changing needs over its proposed life.
- The Project is based on an approach to the epidemic that integrates prevention and care initiatives to achieve system response.
- The Project design reflects GoA requirements for the design and implementation of development assistance.

The Project will seek to develop best practice in the particular context of Xinjiang, adapting practices developed and tested elsewhere where replication is inappropriate.

A hybrid design for this project offers flexibility and responsiveness in terms of both a developing and changing epidemic and an evolving set of strategies for responding to it. Developing issues can be overcome by appropriate resourcing and by ensuring that there is a well designed and clearly understood procedure for the management and administration of the funding facility.

Key characteristics of the Project as designed along these lines are as follows, with a more detailed description of components and outputs and expected activities following in Section 4.

#### *Key Characteristics*

- The project will be of five years duration – this is generally regarded as a minimum requirement when substantial capacity building and institutional change is an objective of the intervention. Accordingly, there will be provision in the design for a review process in Year 4 to consider the case for on-going support after 5 years.
- There will be a series of designed capacity building outputs that:

- support the development of HIV/AIDS response planning, including monitoring, evaluation and feedback into a dynamic planning process;
  - build capacity for health promotion under a broad definition that includes some formative research, health education development and implementation and the creation of enabling environments;
  - support the development of capacity for direct and indirect care.
- 
- These designed outputs will initially focus on BoH and EPS at regional level in recognition of the pivotal leadership role to be played, but will respond to needs from sub-regional health agencies and non-health sector agencies at all levels;
  - The outputs will be supported by the input of a core team of long and short term advisors and other resources funded by Australia and managed on behalf of GoA by an Australian Managing Contractor;
  - A flexible funding facility will be designed, and its principles and procedures documented and disseminated. This facility will be able to provide technical assistance, training, minor plant and equipment and some operating funds for the implementation of well designed intervention trials that conform with the strategic frameworks developed and agreed at overall regional government and agency level;
  - The funding facility will operate as far as possible within a current structure and system, probably based around the Regional Multi-Sectoral Leading Group on HIV/AIDS Prevention and Control. It is suggested at this stage that a Working Group from within the leading group agencies is convened to provide guidance and oversight for the facility that will be administered by the Australian Managing Contractor;
  - The funding facility will be substantial – amounting to around 40% of the total GoA budget for the Project. It is proposed that a significant proportion of this facility is quarantined for use by non-health sector agencies to provide a significant incentive for the development of a multi sectoral response to the epidemic;
  - This project partnership concept is unfamiliar in the Chinese context and there exists a certain inertia among some of the key stakeholders. It is important therefore that Project implementation works towards this ideal in a collaborative and consultative fashion. Accordingly, the conventional arrangement of a set number of counterpart staff appointed to work extensively with expatriate advisors, will be adopted at least until the project is well established and constructive relationships have been built. The Project will, however, work towards these staff being re-absorbed into the existing structure as soon as feasible.

### 3.2 **Strategies for Sustainability**

A project with a goal that relates strongly to capacity building - and that is designed according to the principle of supporting and working within locally grown strategies and regulatory frameworks - is inherently focusing strongly on sustainability. Additional design features that reinforce this focus on sustainability include the following:

- The recommended technical assistance inputs will be specified with sustainability as a key objective. Rather than an extended range of short-term specialists undertaking a large number of brief visits, the pattern of inputs should ensure that each advisor has time to assist with the implementation and institutionalisation of recommended change;
- Technical assistance advisors and specialists will have multiple partnership responsibilities with local staff both horizontally and vertically within the relevant agency structure. This will reduce the vulnerability to loss of one or more local at an advanced stage in the Project;
- Three key elements have been introduced to ensure, as far as possible, that the counterpart-advisor interaction generates sustainable benefits:
  - ***advisors will be selected for their skills in training and one-on-one mentoring capacity as well as for their technical ability;***
  - project partnership workshops will be held to engender full understanding by both local staff and external advisors of how the relationship should function;
  - skill transfer programs will be developed and mutually agreed in respect of each advisor-local staff member partnership setting clear objectives for formal and on-the-job skill and knowledge transfer. The achievement of these objectives will be evaluated.

Other aspects of the project partnership concept that could significantly assist with sustainability are discussed above. The extent to which they do in fact contribute will depend on the success in reintegrating Chinese employed “project staff” back into the fabric of the relevant agency. Activities will include the preparation of user-friendly procedure manuals whenever possible, so as to leave a reference document for new staff and as an *aide memoire* for existing staff.

Computer hardware/software and other equipment items procured under the Project will be selected with on-going support as a priority. Standard, off-the-shelf products which are relatively simple, robust and which are supported in Xinjiang will be identified wherever possible. Compatibility with current equipment and systems will also be a key consideration.

### **3.3 Cross Cutting Issues**

#### *Reduction of Poverty*

Poverty reduction is a central aim of the Australian Aid Program. International experience where HIV epidemics have not been contained (e.g. sub-Saharan Africa) is that economic effects on households include the financial burden of health care costs, poor health and death resulting in lost household productivity and decrease food security and income, and increasing poverty. Socially, HIV/AIDS causes dislocation, stigmatisation, exclusion, single headed households and orphans, which burden traditional communal caring mechanisms. As a result, the demographic profile is severely skewed, which in turn negatively affects social and economic indicators.

The Project has been designed to involve target groups, including individuals and households particularly susceptible to HIV, as partners for behaviour change rather than as simply recipients of aid. This will be expressed in terms of the target vulnerable groups that will be supported for the adoption of healthy behaviours, and also those individuals and organizations involved in the delivery of preventative and care activities and services.

HIV/AIDS is a sensitive issue, and therefore requires care with the identification of vulnerable groups, such as intravenous drug users, commercial sex workers and their clients. The Project will work through Chinese partners for all activities in an effort to reduce any negative impact on these groups that may come about through the process of identification and targeting for intervention trials.

Poverty reduction strategies are a feature of the project design by focusing attention on groups most vulnerable to HIV/AIDS, with the view to reducing transmission, and thereby improving health status – an identified variable of poverty. These at-risk groups have been identified at three levels. Those individuals and families in the general community in contact with higher-risk individuals, high-risk communities with high prevalence of HIV/AIDS risk behaviours and of transmission, and institutions, such as rehabilitation and re-education centres with large numbers of intravenous drug users and commercial sex workers. The latter two target groups are often member of the poorest sections of the population.

This Project aims to contribute to the reduction of poverty by reducing HIV transmission through investing in the human resources available to participate in HIV/AIDS prevention and care via a multi-sectoral approach; contributing to the investment in the human capital of the poor by mitigating the profound loss of productive workforce from AIDS; and through working towards the removal of barriers to quality prevention and care services for HIV/AIDS prevention and care. Finally, the Project aims to reduce the discrimination by supporting activities that will change attitudes towards people living

with HIV/AIDS.

Proposals for interventions from partner organizations, as well as from this Project, must include criteria that ensure the poorer and more vulnerable members of the community are included; and that their needs are met. However, as HIV/AIDS is a problem that affects the entire community, and requires a community-wide response, some strategies such as mass media campaigns and assisting families to care for relatives with HIV/AIDS, require broadly targeted approaches.

### *Gender*

The Australian Aid Program aims to promote equal opportunities for women and men as participants and beneficiaries of development assistance. To achieve this aim, the project will focus attention on improving women's and men's access to information about HIV/AIDS by ensuring appropriate communication channels are adopted to meet the needs of both men and women separately where required; developing IEC messages and materials to meet the different information needs of women and men; and providing an enabling environment for woman and men to adopt healthy behaviours. Care will be required to ensure that attempts to empower women to request their partners to adopt healthy behaviours are delivered in a way that does not disrupt the social norms and values of the target communities.

China has made substantial progress over the past 30 years in the development of the role and status of women. The Project will support these efforts by encouraging women to participate equally in training and educational opportunities and decision-making where this may be appropriate. The Woman's Federation will play an important role in guiding project activities in a way that supports Chinese approaches to gender equity. Their presence, and expressed support of this project will position them well as key informants for further activity design. As members of the HIV Leading Group and Working Group, the Women's Federation will also be provided with a range of capacity-building opportunities.

Monitoring, evaluation and operations research activities should include the examination of the role of men and women, and their responsibilities with respect to reproductive health, the prevention of HIV transmission and the adoption of healthy behaviours, and the care of individuals living with HIV/AIDS. Where possible, data from community surveys will be disaggregated by sex to assess the impact of project activities on men and women separately.

### *Governance*

According to *AusAID's Guiding Principles on Good Governance*, good governance

refers to the competent management of a country's resources and affairs in a manner that is open, transparent, accountable equitable and responsive to people's needs. This project aims to enhance governance by focusing on improving the financial management and planning processes relating to HIV/AIDS strategies and intervention trials. It aims to increase public and NGO effectiveness. Much of this Project is concerned with institutional strengthening of partner agencies, and improving the delivery of basic services with respect to HIV/AIDS prevention and care.

Local leadership will be an essential ingredient for the success of the Project. The Project aims to develop leadership for effective HIV/AIDS responses by the provision of support and the facilitation of realistic, but steady change. The approach taken will be not only to provide technical training, but also to ensure quality, on-going support throughout the life of the Project with technical advisers working closely, and continuously with partners. Participation of a wide range of partner organizations has been planned to support a multi-sectoral response within the region. Appropriate levels of expertise will be required for the long and short terms adviser positions.

#### *Environment*

It is anticipated that the Project will have a limited impact on the environment. However, there will be issues relating to the safe disposal of HIV infected materials at a number of points. These include at the point of diagnosis of HIV/AIDS during screening, in outpatient facilities where HIV infected patients may have undergone procedures that create a risk for cross-infection, and in-patient and home care where the caring process produces a range of infected materials, and safe disposal of syringes and needles by IDUs to reduce the harm to those who come into contact with used needles.

It will be essential to ensure that with the development and trialing of interventions, adequate precautions are taken to ensure appropriate and safe management of infectious waste even where a trial is not directly addressing waste management.

## **4. Project Design**

### **4.1 Project location and target**

#### *Location*

The Project is located in the Xinjiang Uygur Autonomous Region in northern PRC. The Project will focus, but not necessarily limit, its activities in Urumqi, Kashgar and Yining Prefectures. The Project will be based in Urumqi, from where team members will make frequent visits to other areas for capacity development, supervision, and monitoring and evaluation visits, as required.

### *Target Groups*

The target groups include the following:

- At-risk groups, such as IDUs and their partners; sex workers and their clients; truck drivers
- Communities with at-risk populations, or with a high incidence of HIV
- Rehabilitation or re-education institutions
- Employees of the Provincial, prefecture, municipal and county BoHs
- Health care workers at all levels, including private practitioners
- Health training institutes

## **4.2 Goal, Purpose and Component Structure**

*The goal* of the Project, and the national development goal that it supports, is to reduce the transmission of HIV infection, and contribute to the reduction of the impact of the epidemic on the social and economic development of the region.

*The purpose*, or immediate outcome of the Project, is to increase the capacity of the Xinjiang Uygur Autonomous Region to respond to the HIV/AIDS epidemic with effective multi-sectoral prevention and care programs.

The component objectives, outputs and indicative activities are responsive to *The Mid-Long Term Plan of HIV/AIDS Prevention and Control in China (1998-2010)*, and the *Mid-Long Term Plan of HIV/AIDS Prevention and Control in Xinjiang*. The reader can therefore assume that all objectives and outputs have been requested or are supported by the GoPRC.

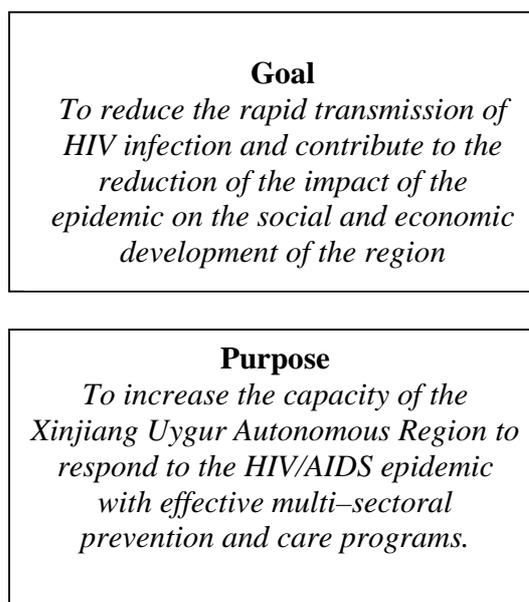
The Project has been designed to support current initiatives of the GOPRC, and develop the knowledge and skills of those individuals and organizations that are currently responsible for the implementation of the Regional HIV/AIDS Plan. The Project should not be considered as a separate entity with its own staff and activities, rather, it is embedded within current structures and utilizes current systems. This important aspect of the design is described in more detail in the first component, and in Section 5: Project Management and Monitoring.

This Project can be conceptualised as having two distinct approaches. First, the Project will build capacity to respond to the epidemic through assisting multisectoral partners develop their own HIV/AIDS strategic plans within the context of the Regional and/or National Plans, formal training, on-going support and facilitation, provision of essential equipment, and the development of an environment where new skills can be practiced across a number of agencies participating in the implementation of the Regional HIV/AIDS plan. The second approach is the design and conduct of a range of trial

interventions where new knowledge and skills can be applied in a practical implementation setting, and, where best-practice international and Chinese approaches to HIV/AIDS prevention and care can be adapted and rigorously tested in the Xinjiang context.

Project components and their objectives are shown in Figure 4.1.

**Figure 4.1: Component Structure**



<b>Component 1: Planning and Coordination</b>	To improve institutional capacity at the regional, prefecture and county levels to plan and coordinate multi-sectoral responses to the HIV/AIDS epidemic
<b>Component 2: Health Promotion</b>	To enable the general population and vulnerable groups to adopt healthy behaviours and accepting attitudes related to the transmission and management of HIV/AIDS
<b>Component 3: Direct and Indirect Care</b>	To enable health workers and family carers to adopt best practice standards in direct and indirect care environments or at risk of HIV infection.
<b>Component 4: Project Management</b>	To effectively and efficiently manage the project to achieve desired goals and objectives within budget and planned timeframe

## **4.2 Component and Output Description**

This section will provide a description of the Project, and is organised according to the component objectives and outputs of the logical framework. For each component, this section will provide a general overview, and then a more detailed treatment of each output showing indicative activities and inputs where appropriate. Component Two (Health Promotion) and Three (Direct and Indirect Care) involve a number of trial interventions that will be identified and implemented by partner agencies to support the Xinjiang Region HIV/AIDS plan. Therefore, activities related to these trials are not described in this design document. To enable sustained management of preventative and care interventions it is considered important that partner organisations identify their priorities through planning, design appropriate trials to test proposed interventions, conduct their own assessment of the worth of the trial intervention, and feed results back into the planning process. For this reason it is considered inappropriate to define interventions and possible outputs for trials before regional planning has begun.

### **COMPONENT 1: PLANNING AND COORDINATION**

#### Objective

To improve institutional capacity at the regional, prefecture and county levels to plan and co-ordinate multi-sectoral responses to the HIV/AIDS epidemic

#### *Outputs*

- Provision of education to senior policy makers and planners of the need for, and elements of, a planned and resourced response to HIV/AIDS.
- HIV/AIDS response plans by selected Project partner agencies within the Regional Multi-Sectoral Leading Group.
- Multi-sectoral HIV/AIDS response plans at prefecture and county level in participating locations.
- Well-designed proposals for intervention trials that support agency HIV/AIDS plans.
- Comprehensive M&E reports of intervention trials.
- Inter-agency coordination and communication mechanisms in place.

#### Overview

This component is central to the concept of sustainable capacity building for an effective multi-sectoral response to the rapidly developing HIV/AIDS epidemic. The key underlying principle is that of developing and supporting regional and sub-regional commitment to, and planning for, prevention and care activities, rather than creating a program of interventions that is specific only to the Project and that has little on-going support or ownership.

The key policy framework at national level is the *Mid-Long Term Plan of HIV/AIDS Prevention and Control (1998 – 2010)* that was issued by the State Council in November 1998. As noted above, a regional Mid-Long Term Plan, setting out broad strategies in line with the national framework, has been drafted by the Regional BoH/EPS with contributions from other agencies, and is now awaiting Regional Government endorsement. While it is understood that the roles and responsibilities of agencies, particularly those that make up the Multi-Sectoral Leading Group on HIV/AIDS Prevention and Control, have been identified, it is also understood that the plan is broad and needs considerable additional work to make it operational.

This component of the Project will contribute to the advocacy process by undertaking additional awareness raising for senior government representatives and planners, where clear gaps can be identified in what has already been done or planned for under WB9 and other initiatives. A responsive package of technical assistance will be provided to extend HIV/AIDS planning to individual agencies at regional level and to participating prefectures and counties.

Given that a significant proportion of the total Australian funded resources will be expended through a responsive Activity Support Facility, the technical assistance in this component will also be available to assist agencies at various levels to understand the facility procedures and to plan and design activities that can be supported by the facility.

*Output 1.1 Provision of education to senior policy makers and planners of the need for, and elements of, a planned and resourced response to HIV/AIDS*

Although there is already significant awareness of HIV/AIDS as a potentially serious health issue, it is clear that not all policy makers and planners understand the need for a planned, resourced and urgent response to reduce the rate of HIV infection and to plan for the care of those already infected.

In working to achieve this output, an assessment of needs will initially be undertaken, noting the awareness raising initiatives sponsored by the Joint United Nations Programme on HIV/AIDS (UNAIDS), the WB9 component, and other agencies. As appropriate, and avoiding duplication, one overseas study tour and two domestic study tours will be supported for representatives of the Regional Multi-sectoral Leading Group, key members of prefecture multi sectoral leading groups and senior planners of individual agencies. Study tours to be funded will be rigorously designed and planned with ample preparation for the participants, ensuring a program that is tailored to achieve the tour objectives and some program of follow-up and reinforcement.

Indicative activities will include:

- A needs assessment in the light of other awareness raising initiatives;
- Design of overseas and/or domestic study tours (when planning study tours, care needs to be undertaken not to exceed the capacity of the organisations and individuals being visited); selection of participants (this process should be made transparent and should be agreed beforehand with clear criteria established in advance);
- Conduct of tours and follow-up programs.

*Output 1.2 HIV/AIDS response plans by selected Project partner agencies within the Regional Multi-Sectoral Leading Group*

In this Output, technical assistance to support improved planning and management will be provided as a fixed input to the Project, and will be made available to agencies that wish to participate as partner implementing agencies. Planning in this context is understood to mean a cyclical and dynamic process including situational analysis, plan development, evaluation and revision. Assistance will be given to assess planning and management capacity. A series of workshops in the development and design of HIV/AIDS response plans will be conducted in Urumqi. These will assist agencies to translate their roles and responsibilities, established by the regional Mid-Long Term Plan for HIV/AIDS Prevention and Control, into programs and activities at agency level, with adequate resourcing. Where requested, formal training courses in planning may be offered.

The Contractor will provide a number of agencies within the multi sectoral group technical assistance to facilitate the development of clearly documented plans through to approval and funding. These plans will have clear indicators against which to assess progress and which are consistent with the regional strategy framework. The output will have been achieved when the plans are jointly reviewed (and revised as necessary) two years after initial implementation.

In working towards the achievement of this Output, planners and the technical assistance personnel will pay close attention to the policy and regulatory framework within which the respective agency works. Some opportunities may exist to positively influence this environment, particularly if Output 1.1 has been successfully achieved.

Indicative activities include:

- Capacity assessment, on an agency basis, in respect of planning and management of HIV/AIDS responses;
- Training workshops for agency managers in HIV/AIDS response planning;

- Selected formal training courses in planning and management;
- Technical assistance for on-the-job training and facilitation of planning activity
- With counterparts, review the plans 2 years after initial implementation

*Output 1.3 Multi-sectoral HIV/AIDS response plans at prefecture and county level in participating locations*

This Output is similar to Output 1.2, but focuses at prefecture and county level, initially in the three prefectures that have been identified as early target areas (Urumqi, Yining, and Kashgar). This coverage may be extended at a later stage.

Again the objective is to support the development of indigenous long-term plans, consistent with those at regional and national level, so that other Project sponsored capacity building and intervention support is reinforcing internal and sustainable programs and not external and temporary Project generated initiatives. Similarly, the output will have been achieved when the plans are jointly reviewed (and revised as necessary) two years after initial implementation.

While some activities can be undertaken centrally for participants from a range of prefectures and counties, this output may require that technical assistance personnel spend significant amounts of time with individual prefectures and counties to facilitate planning processes and further develop skills.

Indicative activities include:

- Assessment of current capacity and status;
- Awareness raising/ sensitisation through domestic study tours;
- Training workshops, work attachments and/or formal training courses;
- Technical assistance for on-the-job training, support and facilitation
- With counterparts, review the plans 2 years after initial implementation

*Output 1.4 Well designed proposals for intervention trials that support agency HIV/AIDS plans*

The Project has a facility to support trial interventions that are carefully designed and planned and which are consistent with the framework of regional, prefecture and agency strategies. Once agencies at the various levels have developed HIV/AIDS response strategies, it will be possible to identify specific activities for inclusion in their respective

plans, which can be supported by this facility.

Output 4.4 is an operating mechanism for this funding facility, which will be developed and put in place early in the Project. While detailed guidelines, selection criteria and procedures are not certain at this stage, it is clear that agencies will need to prepare activity and intervention proposals (including replication potential) for consideration. Such proposals will need to show evidence of careful planning and design. The criteria for funding approval will include these aspects.

Output 1.4 is therefore a series of well-planned and documented proposals spread over a range of agencies, both inside and outside the health sector, covering parts of more than one prefecture and spanning the lifetime of the Project.

Indicative activities will include:

- Raising awareness of the Project funded support facility for selected intervention activities (this will be undertaken concurrently with activities in Output 1.2 & 1.3 so that the Project support facility can be included in resource planning at agency and prefecture level);
- Promulgation of funding guidelines and procedures, including selection criteria, developed as part of Output 4.4;
- Training in proposal preparation;
- Technical assistance to support the planning and design of the activities to be funded (this will be provided out of the fixed TA input and will be responsive to requests by agencies for such support);
- Technical assistance to facilitate the preparation of funding submissions for agency activities (the Project will have no control over the number of funding submissions it is asked to assist with).

#### *Output 1.5 Comprehensive Monitoring and Evaluation reports of intervention trials*

Given the centrality of intervention trials in developing policy and refining plans, monitoring and evaluation is a critical aspect of the regional and prefecture HIV/AIDS program management. To enable the utilisation of trial results, it will be important not only to ensure the rigour of evaluation activities, but to assist in building local capacity to continue to evaluate new interventions after the Project is completed, and to evaluate the effectiveness of the HIV/AIDS plan ion reaching its stated goals. Evaluation skills will also assist participating organisations to improve the quality of planning, HIV/AIDS activities and for other services delivered.

Capacity building is needed at three levels:

- Implementing agencies require an awareness of the need for rigorous design and evaluation of trials. They then need adequate support to participate in the selection of priority evaluation questions, the criteria by which performance will be judged, facilitation of evaluation activities, and dissemination of findings to appropriate stakeholders.
- Second, the Regional EPS require adequate skills to oversee the design and conduct of evaluation of trial interventions and other aspects of the HIV/AIDS plan, and to provide basic technical assistance to participating organizations. This will include the design of baselines where appropriate. It is recommended that several options be trialed to determine the best option for each target group. Trials should be developed with rigorous monitoring and evaluation and established behaviour change indicators. Each option will require a cost-effectiveness analysis to establish the most appropriate approach for replication to a wider area. Trials should include the provision for a re-design stage for any adjustments required. Policy options for sustainable funding should be addressed.
- Monitoring and evaluation will also encompass baseline surveys for possible later comparisons and as guides to the possible course of the epidemic in some areas (especially with regard to sexual behaviour). The project may support further work derived from the World Bank funded sexual behaviour studies. It will also conduct a Needs Analysis Survey/s that targets effective communication across cultures and within cultures. This will be an essential base for strengthening activities directed to changing attitudes and behaviours (in order to lower rates of HIV transmission). The contribution of this survey/s to the understanding of all peoples involved will assist in strengthening the foundation for further training, IEC, care activities, counselling, community-based intervention, harm minimisation, drug rehabilitation, monitoring and other project activities.

In summary, specialist evaluation expertise is required for several reasons: to ensure quality skills transfer in evaluation methodologies; for the development of a comprehensive monitoring and evaluation framework that can respond to the on-going needs of the EPS in terms of trial development and refinement; for the identification of important contextual factors contributing to outcomes in specific locations; to define lessons learned for replication; and for accountability to relevant stakeholders. The study of contextual factors is particularly important where replication is desired to locations that may not share the same cultural and social characteristics as the original pilot site.

Indicative activities include:

- Evaluation capacity assessment for all relevant organisations;
- Needs Analysis Survey/s
- Introductory workshops to raise awareness of the contribution valuation can make

to policy and planning, project development, and assessment of worth;

- Basic level short courses in evaluation design, conduct, report writing and dissemination of findings to EPS staff (proposal preparation may also perhaps be included here);
- Advanced level short courses for academic institutions in evaluation methodology with a balance between quantitative and qualitative methods;
- On-going technical support and facilitation of trial design and evaluation.

*Output 1.6 Inter-agency coordination and communication mechanisms in place*

This Output is designed to ensure, as far as possible, multi-sectoral collaboration. Component 1 reflects the need for substantial system change starting at regional government level and radiating outwards to cover individual government and non-government agencies at various levels in the system. The system change strategies enable the evolution of an enabling policy, planning and resourcing environment for prevention and care activities to develop. This requirement is generally recognised and some institutional and policy capacity building is included in each of the current external agency support interventions. Considerable potential for co-operation and collaboration exists on the one hand, and for overlap and duplication on the other. In addition, if the response is to be truly multi-sectoral then considerable system change is required in the way in which agencies work together and share information to acknowledge and achieve common goals.

The Multi-Sectoral Leading Group is a high level committee with a membership of 33 agencies. Delegates to the committee tend to be drawn from policy level rather than the operational level. There is a need for a smaller, sub-ordinate Working Group to facilitate multi-sectoral activities, information sharing and co-ordination among the key agencies. This concept was discussed positively during the Appraisal Mission.

The Project will support the creation and operation of this Working Group. Key members might comprise representatives from the following agencies in Xinjiang:

- Bureau of Health
- Epidemic Prevention Centre
- Bureau of Public Security
- Bureau of Justice
- Education Commission
- Family Planning Association
- Women's Federation

- Xinjiang Red Cross
- Tourism Commission
- Xinjiang Medical University

The GoPRC will nominate membership and the chairmanship of the Group. It is important that this Group be established early in the Project if it is not already in existence when the Project commences.

As part of the support offered by the Project, it is expected that the Working Group will have a significant role in the management of the Project's intervention support facility (see Output 4.4) and that with the addition of some external members (including AusAID and MOFTEC) it can also form the basis of the Project Co-ordinating Committee (see Section 5.1 Institutional and Management Arrangements).

The process of communication and co-ordination can be significantly boosted by a program of well organised activities to inform key individuals and to provide opportunities for discussion and information sharing within Xinjiang and with others in China and overseas.

The Project will seek to facilitate a proposal from an agency or series of agencies for a program of activities that might include: an annual regional conference on HIV/AIDS Prevention and Care, a series of seminars, guest speakers, workshops and the production and distribution of a regular newsletter. This program could be funded under the intervention support facility

Indicative activities include:

- Facilitate the establishment of a regional multi-sectoral working group, comprising operational level representatives of key leading group agencies and reporting to the leading group;
- Develop and document operating and reporting protocols;
- Assist where appropriate with the development of operational capacity in line with these protocols;
- Provide secretariat support;
- Identify and implement appropriate mechanisms (eg newsletter, seminars, workshops, resource centre, annual regional conference) among the Working Group and/or Regional Leading Group members to share information, ideas, lessons learned (this may possibly be achieved through a sub-project with the Chinese Association for STI and AIDS Prevention and Control).

## COMPONENT 2: HEALTH PROMOTION

### Objective

To enable the general population and vulnerable groups to adopt healthy behaviours and accepting attitudes related to the transmission and management of HIV/AIDS.

### *Outputs*

- Appropriate HIV/AIDS IEC materials available for general use and Project supported trials in participating locations at regional and prefecture level.
- Revised HIV/AIDS curricula for basic and continuing education of health workforce at regional and participating prefecture levels.
- Models of general community health behaviour change interventions adopting the settings approach.
- Models of vulnerable community behaviour change interventions.
- Models of institution-based behaviour change interventions.
- Models of condom marketing.

### Overview

Health promotion should encompass health communication activities for raising awareness of policy makers and target groups, developing positive attitudes and building knowledge about HIV/AIDS prevention and care; and marketing strategies that aim to bring about the adoption of a specific behaviour, and/or the provision of products to support that desired behaviour change, such as condom use.

Raising awareness of those responsible for developing a supportive policy environment, and allocating adequate resources is addressed in component 1.

This component has two broad elements. The first is directed at building critical capacities amongst partner organisations, and the second, at supporting the actual delivery of effective interventions to target groups to enable behaviour change during the life of the project.

Organisational capacities required include: the ability to design, produce and disseminate effective IEC materials throughout the region – focussing on the EPS; the ability to design, manage and evaluate effective trial health promotive interventions – focussing on participating member organizations of the leading group; and the development of high quality training curricula for improved performance of the health workforce in health communication strategies – focussing on regional medical colleges and universities.

To complement the capacity building activities, it is important to ensure that capacities

lead to effective interventions that have an impact on the adoption of healthy behaviours, and ultimately a reduction in HIV prevalence. To ensure these objectives are achieved the second element will directly support the implementation of effective intervention trials.

Intervention trials will be carried out by EPS at regional and prefecture level, as well as by a number of participating partner organizations. The mechanism for generating, selecting and funding trial proposals is outlined in Component 1. Following discussions with potential partner organizations in Xinjiang, trials are expected to fall into one of four main categories: trials targeting the general community; trials targeting vulnerable communities; trials targeting residents of institutions; and the marketing of condoms.

It is recommended that several options be trialed to determine the best option for each target group. Options may require a cost-effectiveness analysis to establish the most appropriate approach for replication to a wider area. Trials should include the provision for a re-design stage for any adjustments required. Policy options for sustainable funding should be addressed.

Specific target groups for health promotive activities are: the general community; Injecting drug users; commercial sex workers and their clients; entertainment setting workers; STI patients; hotel and bar attendants; long distance truck and bus drivers; partners and spouses of individuals practicing high risk behaviours; and the floating population

*Output 2.1 Appropriate HIV/AIDS IEC materials available for general use and for Project supported trials in participating locations at regional and prefecture level*

Currently IEC materials are largely adapted from national IEC materials, or from HIV/AIDS activities in other regions such as Yunnan. However, generic messages may not address the specific health beliefs and practices of the Xinjiang community given Xinjiang's socio-cultural diversity. Capacity development is required to assess local health beliefs and practices to recognise and incorporate them into IEC messages issues concerning social or physical barriers to the adoption of healthy behaviours, and for the development, production and distribution of materials that will meet the specific needs of this population. Skills are required at Regional and Prefecture level.

There are limited resources available in Xinjiang for developing and producing IEC materials, and these activities require a critical mass of somewhat complex skills and considerable resources. This is especially true of the development of IEC materials that requires skills in formative research to identify health beliefs and behaviours in the location. It is considered essential to develop a critical mass of skills and resources within the EPS to begin with so that after the project has completed there will be at least one regional organisation that has the capacity to design and produce materials to meet the needs of Xinjiang. This will allow partner organisations to focus their limited resources on their own specialist areas of expertise. Capacity development could well

address the transfer of more advanced skills from EPS to other organisations when the resource environment improves. This output therefore focuses on the concentration of more advanced skills within the EPS, and encourages partner organisations (through developing an awareness of the resources required to develop suitable materials) to work with the EPS to reduce duplication of effort, wastage of limited resources and increase the potential for effective strategies.

Training and education activities should focus on the development of awareness, knowledge and skills relating to marketing of activities to change behaviours and health promotion. Equipment procurement should not overlap with WB9. Training will be needed for equipment use and its maintenance and maintenance plans should be developed.

Indicative activities are:

- An appraisal of current mass media for HIV/AIDS including a description of materials currently available, current and potential channels of communication, and the audiences to which they are targeted;
- Provision of adequate equipment for IEC development and production;
- Formal short courses in health promotion and formative research;
- Technical assistance for on-going technical support;
- Study tours to other areas in Xinjiang, China or overseas.

*Output 2.2 Revised HIV/AIDS curricula for basic and continuing education of health workforce at regional and participating prefecture levels*

Currently HIV/AIDS only accounts for a small fragment of basic and continuing education for the health workforce at all levels. Capacity to develop and implement updated curricula that addresses HIV/AIDS is required so that the health workforce can: contribute to the health communication channels for the general population and vulnerable groups; deliver quality counselling; diagnose and refer patients for testing; and deliver treatment and palliative care in appropriate facilities, including hospitals and homes.

Indicative activities include:

- Review of existing curricula
- Development of HIV/AIDS curricula suitable for all levels of health workers;
- Provision of technical support to assist in the implementation and evaluation of the curricula.

*Output 2.3 Models of general community behaviour change interventions adopting the settings approach.*

EPS is the organisation with lead responsibility for mass media health promotion campaigns in Xinjiang. The EPS wishes to conduct a range of mass media campaigns targeting the general population with a range of messages designed to reduce discrimination towards people with HIV/AIDS, and to encourage the adoption of healthy behaviours. Where partner organisations can complement these efforts, additional support will be provided through trial interventions selected by these groups.

Particularly for mass media campaigns, formative research will be required to identify local health beliefs and behaviours to ensure the development of appropriate health messages and other health promotive interventions.

A settings approach to health promotion is proposed. ‘Settings’ refer to “the place or social context in which people engage in daily activities in which environmental, organisational and personal factors interact to affect health and well being” (WHO, 1998). Settings will be used in this project to reach certain vulnerable populations such as places where people work, are entertained, attend school, or seek services such as health care. It is likely to cover a range of activities that may include peer education in middle school, high school and colleges through the Bureau of Health and/or Red Cross; peer education and provision of condoms in entertainment and tourism settings through the Bureau of Tourism and Bureau of Industry; peer education, IEC materials provision and improved access to condoms for truck drivers; and general health education for young men and women out of school through the Regional EPS or partner organizations, or community-based peer education through the Women’s Federation. Funding proposals would include adequate resources for rigorous evaluation and dissemination of findings.

Messages would focus on reducing discrimination and stigma towards people with HIV/AIDS and the adoption of healthy behaviours related to HIV transmission. Funding proposals would include adequate resources for rigorous evaluation and dissemination of findings.

For the EPS to attract funds to implement trial interventions, they will have to submit proposals to the Leading Group for approval and compete with other member organizations.

Indicative activities are:

- Development of organisational capacity in health promotion trial design, implementation and evaluation through training workshops or seminars for operational staff in participating organisations;

- Direct technical support to EPS (and participating academic institutions supporting the EPS) for the conduct of formative research activities to inform the design of health communication messages;
- On-the-job technical support and facilitation to participating member organisations to develop, pilot and implement trial models;

*Output 2.4 Models of vulnerable communities behaviour change interventions.*

Throughout the region there are a number of communities that could be considered at higher risk to HIV/AIDS than other communities. Yining, for example, is known to have geographical locations where injecting drug use and/or commercial sex work is more prevalent. It is within these communities that specially targeted trials will be developed. The purpose is to reduce the discrimination towards people living with HIV/AIDS including in areas where larger numbers of people with AIDS will require home-based care; and secondly to target vulnerable individuals, their families, and social network members to adopt healthy behaviours. Although no specific activities have yet been identified, an exploration of the appropriateness of community-based peer educators of vulnerable groups and their social networks would be beneficial.

- Indicative activities are: Development of organisational capacity in trial design, conduct and evaluation through training workshops or seminars; On-the-job technical support and facilitation to participating member organisations during the conduct of trials;

*Output 2.5 Models of institution-based behaviour change interventions.*

There are a number of opportunities for health education and counselling with individuals in rehabilitation and re-education centres through the Bureaux of Public Security and Justice in all Project locations. Due to the typically high recidivism, there may be an opportunity to track changes in an individual's health behaviour as a result of trial interventions, while there are sensitivities around behavioural surveillance of specific individuals.

Indicative activities are:

- Development of organisational capacity in trial design, conduct and evaluation through training workshops or seminars;
- On-the-job technical support and facilitation to participating member organisations to develop, pilot and implement trial models;

*Output 2.6 Models of condom marketing.*

Correct condom use is central to desired healthy behaviours. There are risks involved in promoting the adoption of behaviours that individuals are not able to carry through. For example, if there are effective messages about the use of condoms, and condoms are not available at the time the individual decides to adopt the new behaviour, even future behaviour change efforts may be compromised as individuals may consider that the behaviours promoted are not feasible.

A more detailed analysis of awareness of, and access to, condoms is required to determine the most appropriate contribution the Project can make to enable behaviour change through condom availability, quality and use in participating locations. Issues that require clarification through a marketing survey include the most appropriate channels for condom distribution, and appropriate approaches that the project could take to support immediate condom availability without compromising sustainability. The survey should address not only the public sector, but also private clinics and distributions channels. The survey should be designed and carried out with due regard to counterpart resourcing issues balanced with the need to collect verifiable, quality data. The team should consult with other groups undertaking social marketing surveys in China to ensure the design of the survey for Xinjiang is appropriate to local conditions.

DFID's Condom Social marketing specialist will organize condom social marketing procedures for the DFID project, and is tasked to produce a Social Marketing 'How to' guide for China. This work should complement the marketing survey. UNFPA, UNAIDS and others are seeking to use the family planning network to broaden condom promotion messages from family planning to STIs/HIV/AIDS. These activities should be incorporated into more detailed Project planning and processes established to ensure ongoing sharing of information.

Condom availability and use are affected by a very general national policy and provincial and local regulations. According to UNAIDS local availability and regulations are the responsibility of the Public Security Bureau who should be consulted during project development.

Indicative activities are:

- A literature review of experiences in condom distribution and sale in similar types of locations – this review would utilise the findings of other organization's reviews, but would need to meet the specific needs of this project;
- A marketing survey into the availability and quality of condoms in participating locations (it is not feasible to quantify the regional procurement of condoms from all sources, however, it is possible to conduct a probability sample survey of retail outlets and service delivery points (SDP) to determine the availability and quality of condoms). This would also include a Public Awareness Survey to determine

the awareness within the community of condom availability, quality and use (the results of these studies would determine the extent of the problem, and identify the resources required to respond effectively);

- Ensuring adequate access to testing activities of the State Technology and Supervision Bureau;
- Development of appropriate trials addressing behaviour change, condom availability and affordability, in close consultation and collaboration with other groups in China already doing this work;
- Condom marketing trials targeting the general community and vulnerable groups in conjunction with outputs 2.3, 2.4, and 2.5 above, involving support and publicity.

A special fund will be quarantined for use in the marketing of condoms. Until the market survey is completed, it is not clear what level of resources will be required to ensure the availability of quality condoms in participating locations. The project should adopt an approach to provision or supplementation that will not compromise future supply sustainability.

### **Component 3: Indirect And Direct Care**

#### Objective

To enable health workers and family carers to adopt best practice standards in direct and indirect care environments or at risk of HIV infection

#### *Outputs*

- Models of effective testing and reporting systems.
- Models of infection control in health facilities.
- Models of best-practice care in the treatment and palliative care of patients infected with HIV in selected facilities.
- Models of best-practice long-term home-based care in selected communities.
- Models of best-practice clinical management of STIs in selected health facilities.

#### Overview

Component 3 addresses capacity building and implementation of care trials in a low resource environment with the potential for replication across the health system as a public health response to the HIV/AIDS epidemic. *Indirect care* refers to strengthening the capacity of the enabling environment for prevention of, and care of people with, HIV/AIDS and STIs (diagnosis, testing, infection control), within which the capacity for

*direct care* and support, in outpatient settings, hospitals and in the home (especially for family carers), can be strengthened.

The success of Component 3 is directly linked with that of Component 2, the objective of which is to support healthy behaviours related to HIV/AIDS, including strengthening community knowledge, tolerance, acceptance and support for people with HIV/AIDS. Without this shift in community knowledge, attitudes and behaviour, there is a risk that some outputs in Component 2 will not be fully achieved.

The implementation of Component 2 is based on using current PRC national guidelines on diagnosis, testing, infection control and hospital care and adapted international best practice standards where appropriate and applicable.

Long-term home-based care is a new concept to China. It is a strategy within the GoPRC National Mid to Long-Term Plan for HIV/AIDS but has yet to be satisfactorily implemented in China. The long-term home-based care (LTHBC) output will draw on current World Health Organisation (WHO) development of policies and frameworks in LTHBC, relevant other international experience (including, it is suggested, some of the *principles* in Australia's reforms in LTHBC for veterans and Australia's experience in providing LTHBC support to people with HIV/AIDS and their carers, including through quasi-formal networks), and current new MoH initiatives to introduce community nursing to PRC. Because of China's unique social and cultural factors, and Xinjiang's low-resource environment, an appropriate LTHBC model will require careful design, building on current initiatives e.g. in Yining.

For each output, or as an integrated approach, domestic and international study tours and inward visits of experts, are recommended. Similar to Components 1 and 2 they should be carefully planned to ensure capacity building results. This component will be planned and delivered as part of the core business of the BoH. Intervention trials may also be supported through the mechanism in Component 1.

### *Output 3.1 Models of effective testing and reporting systems.*

The intent of this output is to achieve quicker and cheaper confirmatory HIV/AIDS tests, more efficient feedback of confirmed tests to the originating organization, and confidential pre and post-test counselling. There are three foci of this output for indicative activities.

The first focus is assessing and possibly strengthening the cost-effectiveness of HIV/AIDS tests. Currently the HIV/AIDS testing kits used for initial testing of blood

samples are thought to be 'too sensitive' and blood samples are sent to the Regional EPS in Urumqi for confirmatory testing, using the Western Blot technique. Procurement of testing equipment is carried out by the Regional EPS. Specification of testing kits and equipment is done nationally. Confirmation tests at least halve the original rate of HIV positive results. Findings on cost-effectiveness would therefore need to be submitted to both the regional and national levels. The consumer cost of HIV/AIDS confirmatory testing as a barrier to satisfactory surveillance should also be assessed. Outside of Urumqi there appears to be a problem in developing and maintaining the required EPS skills for HIV testing and in maintaining supplies for reagents. This capacity needs to be assessed as part of addressing improved cost-effectiveness.

The second focus is increasing the efficiency of the current regional system of submitting the samples, and the request, for confirmatory testing, and the confirmed results being sent back to the requester. Anecdotal evidence is that this feedback time period varies greatly and can take up to six months.

The third focus is pre and post-test counselling capacity building. Currently in Xinjiang people are not usually informed that they are HIV positive. This is because general community fear and lack of accurate knowledge of HIV/AIDS in Xinjiang, and lack of counselling skills, have previously resulted in adverse and sometimes violent reactions in the person who is HIV positive and in their community. Currently medical doctors and epidemiologists provide some counselling, including via a telephone hot line. However, pre and post test counselling needs significant development.

In Beijing, people found to be HIV positive, and their families, are informed of the positive HIV results and are given pre and post-test counselling. New model STI clinics elsewhere in PRC (Guandong, Fujian and Hainan) have introduced anonymous testing and treatment for STIs and HIV/AIDS. Precedents therefore exist in PRC as a basis for change to the current system in Xinjiang. As part of the overall strategy for behaviour change, this output is linked strongly to Component 2.

Indicative activities are:

- Work with counterparts to select trial sites in Kashgar, Yining and Urumqi;
- Conducting cost-effective analysis of HIV/AIDS testing kits being generally used versus those used for confirmatory tests and developing strategies for improved cost effectiveness;
- Conducting analysis of current modes of submission of requests and samples for confirmatory tests, analysing reasons for time delays and developing options for improvement;
- Training key staff in confidential pre and post-test counselling;
- Facilitating regional policy/strategic thinking capacity for potential system-wide

change against lessons learned.

*Output 3.2 Models of infection control in health facilities.*

The intent of this output is to increase the safety of patients and staff from current high levels of iatrogenic infections in hospitals, including hepatitis A, B and C, thereby establishing an enabling environment for the safe care of future AIDS patients and reducing the risk of HIV/AIDS to those patients iatrogenically infected with hepatitis. It is anticipated that significant cohorts of HIV/AIDS patient in Urumqi and Yining will require hospital care for tertiary AIDS within the next two to three years. In Yining, deaths from AIDS are already reported.

There are two foci of this output. The first is the capacity of health workers and support staff to understand and implement universal precautions for infection control in those hospitals designated as pilot sites. The second is strengthening the capacity of the trial sites to improve sterility of supplies and equipment.

Over the last ten years China has implemented a strategy for improving nursing clinical and holistic care in trial wards, known as Holistic Care Model Wards, including in Xinjiang. In some places, e.g. Beijing, this improved model of care has extended hospital-wide. It is suggested that these wards be chosen as trial sites (as well as theatres and central supply [sterilising] departments in the selected hospitals) for both foci, given the significant advances in standards of care resulting from the holistic care model wards strategy.

Urumqi and Yining are suggested as the initial trial sites, as their HIV prevalence rate is continuing to increase, while the incidence of HIV in Kashgar is reported to be low. However, as reporting accuracy increases, the incidence of HIV in Kashgar needs to be carefully monitored.

Indicative activities are:

- Selection of trial sites of at least one holistic care model ward, theatres, and central supply (sterilising) departments in one hospital each in Urumqi and Yining;
- Conducting base-lines analyses of current infection control methods, including waste management of infected materials and needles;
- Assessing current HIV/AIDS knowledge, skills and attitudes among key staff, including hospital infection control committees/leading groups.
- Developing plans, models/protocols and standards for strengthening the capacity for infection control;
- Training of key staff including hospital infection control committees, doctors, nurses and cleaning staff; supporting supervision and monitoring of infection control standards;

- Strengthening capacity for procuring essential supplies and equipment (gloves, masks, sterilisers, cleaning materials);
- Evaluating results including to distil lessons learned;
- Facilitating Regional policy/strategic thinking capacity for potential system-wide change against lessons learned.

*Output 3.3 Models of best practice care in treatment and palliative care of patients infected with HIV in selected health facilities*

The intent of this output is to improve the capacity of hospital doctors, nurses and support staff to provide best practice direct care to AIDS patients in hospitals, given the anticipated influx of patients with tertiary AIDS in the next two to three years who will require hospitalisation. Direct care of patients with tertiary AIDS is a public health response, focused on individuals in the context of their family and other carer support.

Indicative activities are:

- Selection of the same trial sites as for Output 3.2 above;
- Analysis of existing treatment and care, including palliative care, protocols and practices;
- Increasing capacity through facilitating the development of model protocols and standards of clinical medical and nursing care (clinical to be holistic and to include education and counselling as well as direct physical care) and training key staff in best practice direct care;
- Developing capacity for procuring essential equipment (linen, skin care products, mouth care products and integrated with universal precautions procurement in Output 3.2);
- Evaluating results including to distil lessons learned;
- Facilitating Regional policy/strategic thinking capacity for potential system-wide change against lessons learned.

*Output 3.4 Models of best practice long-term home based care in selected communities*

The intent of this output is to develop capacity for long-term home-based care by supporting pilot sites for models of long-term home-based care for people with HIV/AIDS, enabling them to be accepted, live and be cared for, within their family or community environment as long as possible. This approach reflects the intent of the GoPRCs health system reforms over the last three years to shift the current emphasis away from expensive hospital care to care in the community wherever possible.

As LTHBC is a public health response focused on individuals within the context of their carers and their community, it is highly dependent on changes in community knowledge and attitudes resulting from Component 2 and other current initiatives in Xinjiang, to reduce the current stigma of HIV/AIDS, so that people with HIV/AIDS and their carers are willing to be identified and to accept support. Reluctance to be identified is reported as a significant factor in Shanghai's difficulties with implementing long-term home-based care.

The challenge is compounded in Xinjiang where, although there are registers of those with HIV/AIDS, the person who is HIV positive has not usually been informed. Great care and sensitivity is therefore needed with this component.

The model will focus primarily on supporting the capacity of the existing family or community carers to provide better care for the person with HIV/AIDS. Direct care by doctors and nurses should be regarded as supplementary when the care needs of the person with HIV/AIDS become more complex. Even in these circumstances, every effort should be made to continue to transfer skills and knowledge to the family/community carers to avoid or delay the patient becoming the full time responsibility of the health system.

The World Health Organization has developed expert advice on long-term home-based care in the last two years and is conducting research in low-resource countries and this should be drawn upon (contact [hirschfeldm@who.ch](mailto:hirschfeldm@who.ch)) as well as relevant other international experience.

As well, the MoH has, for the last three years, been developing capacity for community nursing in PRC. Community nursing has not previously existed in PRC. A continuing education curriculum for community nursing has been developed nationally through the MoH and is being implemented in some areas (e.g. Shanghai, Beijing). The MoH anticipates possible initiatives in Xinjiang in 2001/2002. This output should ensure synergy with these community nursing initiatives, developing the capacity amongst the proposed community nurses, as well as community based medical doctors, to support LTHBC.

Indicative activities are:

- Analysing the current system of identifying, registering and informing HIV positive people;
- Identifying at least one pilot geographical area in Yining for possible long-term home-based care based on numbers of HIV positive people in a convenient geographical area, building on Yining's current community and home-based care

efforts.

- Linking with and supporting the proposed MoH-led community nursing capacity building in Xinjiang;
- Developing model protocols and standards and education/training modules for long-term home-based care for people with HIV/AIDS (these might include counselling, infection control, clinical care);
- Training health workers in the pilot area on home-based care for people with HIV/AIDS, and how to support and train ‘lay’ carers;
- Supporting supervision and monitoring of home-based care;
- Developing capacity for procuring essential supplies and equipment (gloves, linen, bedpans, skin and mouth care supplies, cleaning materials);
- Evaluating results including to distil lessons learned;
- Facilitating Regional policy/strategic thinking capacity for potential system-wide change against lessons learned.

*Output 3.5: Models of best-practice prevention and clinical management of STIs in selected health facilities*

The intent of this output is to improve the capacity of the health system for prevention and care of people with STIs based on the evidence that people with STIs are more susceptible to HIV/AIDS because of open skin lesions facilitating blood-to-blood transfer of the HIV virus and the need to prevent further risk behaviour. An additional risk group are pregnant women because of the vertical transfer of gonorrhoea and syphilis, and HIV/AIDS if contracted.

It will be important to select pilot sites that have sufficient numbers of STI patients to undertake a trial by analysing patient attendance volumes. In one directly observed STI outpatient clinic in Yining, for example, the patient volume is 2 per day. It may be necessary to negotiate inclusion of private sector STI clinics as pilot sites (see description below). Barriers to STI treatment are its cost (currently around Y200, equivalent to the average monthly salary of an unskilled worker) and confidentiality issues (STI is a reportable disease). These policy matters need also to be addressed during the Project.

There are private and illegal STI clinics that apparently have higher patient volumes than official clinics. Their cost varies and standards are unknown but anecdotal evidence is that more people with STIs attend private or illegal clinics than public STI clinics. This may be related to costs and confidentiality or anonymity.

Public STI clinics are the responsibility of EPS and are vertical services in Xinjiang. There may be scope during the life of the Project to develop policy thinking to integrate STI diagnosis and treatment into a primary health care model.

There are lessons learned from STI projects elsewhere in China for new models of STI clinics. The components of the new models (in Guangdong, Fujian and Hainan) include anonymous testing and treatment for STIs and HIV/AIDS; counselling to all clients including education material; sale of condoms to clients; and syndromic management of STIs.

In addition, consideration needs to be given to the extent to which systemic policies and practices mitigate against use of the use of syndromic approaches, and, barriers to access including institutional policies linked to maximising income from STI services.

Indicative activities are:

- Identifying one pilot site each in Kashgar, Yining and Urumqi based on high volumes of STI patients (these could be EPS clinics, family planning clinics, rehabilitation centres for CSWs, or others, including private clinics if agreed by the BoH);
- Analysing barriers to access including privacy, confidentiality and costs.
- Developing policy and operational capacity to reduce these barriers;
- Facilitating the development of standards and protocols for care of STIs.
- Developing and implementing training modules on best practice syndromic STI management, provision of condoms, appropriate medications and counselling to achieve behaviour change;
- Linking with Component 2 for developing capacity for procuring *effective* condoms (and here the Yunnan HIV/AIDS project may be useful for lessons learned) and developing strategies for appropriate medications;
- Evaluating results including to distil lessons learned;
- Facilitating Regional policy/strategic thinking capacity for potential system-wide change against lessons learned.

#### **Component 4: Project Management**

##### Objective

To effectively and efficiently manage the project to achieve design goals and objectives within budget and planned timeframe.

### *Outputs*

- Effective management of Project inputs and activities.
- Project monitoring, evaluation and reporting system.
- Procedures and systems for skills transfer from technical advisors to partner staff and organisations.
- An appropriate mechanism to provide funds to for sub-projects or trials to project implementing partner agencies.

### Overview

This component is concerned with the effective management of this Xinjiang HIV/AIDS Prevention and Care Project, and should not be confused with generic project management per se. The component is separated out in acknowledgment of the need to focus attention on the management (including the cyclical process of planning, implementation and evaluation) of the considerable resources that will be mobilised, in order to gain most benefit from them. In addition, the component has been structured to focus attention on the management of effective Project partner relationships between the staff of various agencies in Xinjiang and specialists employed by the Project so as to optimise the skill transfer process. Thirdly, the component includes an output that is designed to facilitate and manage the provision of funding for a range of, as yet unspecified, activities. These activities will be designed and carried out by agencies including not only BoH/EPS but also other member agencies of the Multi-sectoral Leading Group on HIV/AIDS Prevention and Control.

#### *Output 4.1 Effective management of Project inputs and activities.*

One important aspect of this output is the need to ensure that staff within the relevant sections of BoH/EPS at regional, prefecture and county levels, together with those of other stakeholder agencies, are aware of the Project, its role, and progress. Workshops will be held to facilitate an understanding of the Project goal, its component structure and its objectives, the designed activities and inputs and, most importantly, how it will interface with and support the Regional Mid to Long-Term Plan for HIV/AIDS Prevention and Control, when endorsed, and stakeholder agency plans. These workshops will be just one part of an on-going communications program for the Project

Overall, the Project will be jointly managed on a day-to-day basis by the Australian Team Leader (this may be a combined role with that of the Planning and Management Advisor specified in Component 1) and the Deputy Director responsible for Public Health in the Xinjiang Regional Bureau of Health (or his delegate). Financial management systems and planning activities will need to conform not only with AusAID requirements but also, as far as possible, with those of the GoPRC.

Indicative activities are:

- Establishment and maintenance of Project office (the main office in Xinjiang should enable regular access to the Deputy Director or his delegate by the ATL and the Senior Administrator and possibly be in the Regional BoH; the BoH currently has indicated office space will be provided in the Regional EPS for the full Project Team);
- Preparation of a brief Inception Report within the first 3 months after mobilisation;
- Design and implementation of a Project communication strategy to include familiarisation workshops for BoH/EPS staff and other stakeholders. There will also be some on-going mechanism (seminars or newsletters for example) to communicate progress, forthcoming work schedule etc;
- Further development and utilisation of the Risk Management Matrix;
- On-going co-ordination, through BoH, with other agencies and activities relating HIV/AIDS in the region. This will require a significant allocation of time by the ATL for regular discussions with parties involved;
- Preparation of Annual Plans for each year of the Project;
- Procurement of all planned items according to agreed guidelines (in addition to the procurement specified in the PDD, it is expected that the proposals for funding support for interventions by other partner agencies may include items of equipment and, possibly, consumables);
- Establishment and maintenance of appropriate accounts and financial reporting systems;
- Orderly hand-over to BoH and demobilisation on Project completion.

#### *Output 4.2 Project monitoring, evaluation and reporting system.*

This output covers routine monitoring and reporting through quarterly and six monthly reports, support for the activities of the Project Co-ordinating Committee (PCC), input in response to the Technical Advisory Group (TAG) and the design and implementation of an evaluation framework focussing on Project impact.

Routine reporting requirements are specified by AusAID, consistent with AusGuide. The emphasis needs to be on reporting that is useful to the target audience. Wherever possible, such reporting should be in a format that is also consistent with GoPRC requirements so as to reduce the resources expended on reporting.

In Component 1, the Project aims to develop local capacity in the monitoring and evaluation of intervention trials, but it should not be expected that Regional EPS or local academic institutions will have adequate capacity to meet all the needs of Project evaluation, especially in the early phases of implementation. In addition, for certain evaluation needs related to accountability to AusAID, it may not be appropriate to place an added burden on the EPS evaluation systems to meet these needs. Where possible, Chinese information and associated systems will be employed, and it is expected that only a small number of special activities would be required to meet AusAID needs. This output addresses the monitoring and evaluation needs of the Project directly.

A monitoring and evaluation framework for the Project is required and should include the needs of all stakeholders, but should clearly indicate responsibility for evaluation activities. Project monitoring and evaluation should encompass a broad interpretation of evaluation that includes formative research that informs activity design (for example the development of suitable health messages and communication channels for health promotion); developmental evaluation to refine and improve trial implementation; an examination of contextual factors that explain Project outcomes; and outcome and impact assessments where appropriate.

Given the sensitive nature of the Project and the limited resource envelope, quasi-experimental, or population-based designs may not be appropriate or possible to assess all Project outcomes or impact. Adequate emphasis should be given to process evaluations, and evaluation activities should employ a mix of qualitative and quantitative methods. Most of the activities for this output could be supervised by a Monitoring and Evaluation short term advisor (STA) described in Output 1.5.

A Technical Advisory Group will be separately appointed and funded by AusAID. The Project will provide input to the TAG by way of monitoring and evaluation data and reports to enable that Group to function effectively and, if possible, in a collegiate manner with all Project partners.

Indicative activities are:

- Develop a monitoring and evaluation framework that would include:
  - Project evaluability assessment (i.e. review of the Project logic and design as they relate to monitoring and evaluation, identification of selected issues of importance to stakeholders, review of actual data sources available and baseline data from other sources, and identification of resources available for monitoring and evaluation)
  - Principles and standards for project monitoring and evaluation
  - Overarching strategy for monitoring and evaluation
  - Baseline and follow-up data requirements
  - Special studies
  - Monitoring and evaluation matrix including indicators at outcome and output level, data sources, data collection methods, frequency of collection, reporting tools, parties responsible, and decisions that information will inform.

- Further analysis of risks and risk management
- Design, conduct and reporting of advanced, special studies for the purposes of Project development and accountability (rather than building local capacity, see Component 1);
- Submit annual monitoring and evaluation reports;
- Prepare and submit regular monitoring reports as specified (a list of the required reports is included in sub-section 5.2);
- Liaise regularly with AusAID, Beijing. It is expected that Quarterly Reports and Six-Monthly Reports will be produced by the AMC, and following liaison with the Deputy Director, BoH;
- Provide secretariat services for the PCC and contribute to meetings;
- Provide required input to TAG review process. While the primary role of the TAG is to provide independent technical advice to AusAID and GoPRC, it is hoped that the professionalism of the AMC, the TAG members and BoH/EPS will allow the development of a somewhat collegiate relationship which will contribute positively to Project implementation;
- Prepare and submit Project Completion Report.

*Output 4.3 Procedures and systems for skills transfer from technical advisors to partner staff and organisations*

This output is included to focus attention on the development of effective relationships and understanding between the staff of BoH/EPS and other implementing partner agencies, and the specialist advisors provided by the AMC with AusAID funding. While the long term advisors and principal short term advisors may well be selected partly on the basis of their development project experience in China or elsewhere, it is likely that a number of the Australian funded advisory team will be selected primarily for their technical expertise.

The specialist advisory role is probably some combination of mentor, role model, trainer and professional friend. Those advisors that have not had formal training as trainers should be given such a course before being mobilised and all advisors that have not worked extensively in China in the preceding 12 months must be given appropriate orientation on culture and custom, economic and social development, politics etc.

For long-term advisors, consideration will be given to language training during the assignment so that at least some basic Mandarin and/or Uygur can be spoken. This will not remove the need for competent translators/interpreters throughout the life of the Project. Competent translators, proficient in three languages, Mandarin, Uygur and English, are critical to the success of the Project. There are differing views on the degree of difficulty of finding this linguistic competence, with the BoH stating that it would be relatively easy. Donor experience in Tibet has been that competence in three languages is

not so easy to find and is expensive.

BoH/EPS and other partner agencies are expected to allocate responsibilities for Project activities among appropriate staff. These staff members will be supported by the technical assistance advisors in a counterpart relationship that strengthens individual capacity in the context of current roles and responsibilities. This approach is in sharp contrast to the more traditional concept where staff of the host agencies was often drawn away from their existing roles to take on new, “counterpart” responsibilities that focused more on the needs of the Advisor. Thus, for example, in this Project, the Planning and Co-ordination Advisor will have support responsibility to multiple BoH/EPS staff and staff in other partner agencies that are responsible for developing and monitoring HIV/AIDS response plans.

Core advisor inputs must be jointly planned between the AMC and BoH/EPS so that they coincide as far as possible with the availability of local staff. All advisor visits must be preceded by the submission and agreement of a work-plan for the input, stating the objectives of the input, its intended duration and the work program that will be undertaken. These must be endorsed by the Deputy Director, BoH or his delegate prior to the visit taking place.

There will be an arrangement whereby skill transfer “contracts” will be negotiated and agreed between advisors and individual partner agency staff members which specify, among other things, time inputs and commitments on both sides, training methods, competencies/skills to be acquired etc. These will be monitored as part of the Project management role in this component.

Indicative Activities are:

- Mobilisation and management of appropriate technical assistance inputs including the provision of appropriate orientation, cultural awareness and language training;
- Conduct of advisor/partner staff relationship workshops;
- Preparation of training objectives for each advisor assignment;
- Evaluation and reporting of achievement of advisor/partner staff training. The ATL, in discussion with appropriate partner agency management staff for short term advisors will undertake this analysis and report progress in Six-Monthly Reports. For long term advisors, the evaluation will form part of TAG responsibilities to be undertaken in consultation with Project managers.

*Output 4.4 An appropriate mechanism to provide funds for sub-projects or trials to project implementing partner agencies.*

As noted in Section 3.2 above, a major proportion of the total Australian-funded

resources for the Project are reserved for activities and intervention trials that are as yet unspecified. Component 1 will support the development of individual agency HIV/AIDS response plans and the identification and design of discrete activities that can be resourced with assistance from the Project and that are consistent with overall strategies and plans.

This Output comprises a fully operational mechanism by which such activities can be assessed, prioritised, approved or otherwise and the successful ones can be supported with Project resources. The mechanism will also ensure that the supported activities are monitored and properly evaluated, so that successful trials can be replicated and less successful ones can be terminated or appropriately modified in a timely manner.

The principles of the funding mechanism will include:

- Agencies eligible to apply for support will include BoH/EPS at various levels (regional, prefecture and county), and other government agencies and mass organisations that are represented in the leading groups on HIV/AIDS Prevention and Control that have been established, again at regional prefecture and county level;
- The Activity Support Facility (ASF) will be as simple as possible taking account of the practicalities of operating through the Australian Managing Contractor but within the Chinese legal system and the need for accountability to both Governments;
- The ASF will be fully documented so as to be transparent in all aspects. The documentation will include eligibility, scope, funding limits, application requirements and procedures, assessment procedure and criteria, monitoring, evaluation and reporting requirements, acquittal procedures.

A part of the fund will be quarantined for activities sponsored by agencies other than BoH/EPS. At this stage it is suggested that the appropriate proportion to quarantine should be around 60%. Most of the funding (90%) will be allocated to interventions under Component 2 – Health Promotion Interventions and a small proportion will be reserved for Component 3 – Direct and Indirect Care (7%). A small proportion should, however, be available to support activities related to co-ordination and communication mechanisms facilitated in Output 1.6, if such proposals are forthcoming, possibly from the Chinese Association for AIDS and STD Prevention and Control or similar NGO.

Furthermore, it is important that uncommitted funding is available past Year 1 and extends through Years 3 & 4 so the Project, through this funding mechanism, is able to adapt to changing response needs as the epidemic progresses and is better understood. No activities should be funded beyond the life of the Project, however.

While there is not expected to be a specified minimum size of activity that can be given support, it will be important that the selection of proposals for funding does not simply divide up the available funds between the proposals received. This could dilute the impact so that few worthwhile trials are carried out. Activities to be funded should be substantial and rigorous enough to facilitate meaningful evaluation so that successful interventions can be recommended for replication with some degree of confidence.

Assuming that there are more proposals than can be resourced, prioritisation of proposals will be based on clearly articulated criteria that might include:

- Whether the activity fits within a clearly articulated HIV/AIDS response plan for the respective agency and conforms with any guidelines provided by the Regional Mid-Long Term Plan for HIV/AIDS Prevention and Control;
- The extent of “counterpart” funding to be contributed by the agency concerned;
- The availability, if any, of alternative sources of funding, via WB9 or international NGOs, for example;
- The number of other activities funded by the Project in the particular agency;
- An assessment of the agency’s capacity to implement, monitor and evaluate the activity;
- Performance of the agency with prior activities, if any, funded under the scheme;
- Assessment of the scope and design of the intervention trial or other activity proposed in terms of its prospects of providing new and relevant information or experience suitable for replication or that provides new directions;
- Likely impact on specific genders, minority groups, and its impact on poverty reduction and the environment.

Indicative activities are:

- A review of current schemes to identify strengths and weaknesses and to benefit from prior experience. Current schemes for review and comparison could, for example, include the UNICEF Mekong Regional Grant Facility;
- In consultation with a wide group of stakeholders, the development and documentation of draft funding guidelines and their finalisation subject to GoPRC and AusAID endorsement;
- Familiarisation workshops with prospective partner agency staff to ensure that they understand and can work within the approved guidelines;
- Assessment and prioritisation of proposals received – in this regard the Project would work as a secretariat to the multi sectoral working group that will make the final selection;
- Administrative assistance and management oversight of approved and funded activities, including the mobilisation of additional short term TA, procurement of equipment, and assistance with the arrangement of appropriate training;
- Review of implementation, expenditure and ASF, and the preparation of regular, aggregate reporting to GoPRC and to AusAID.

There is additional description of the ASF and AMC responsibilities at section 5.3.

### **4.3 Inputs and Costs**

As noted in Section 3 on Design Options and Issues, this design structure has two major

elements:

- A conventionally designed and specified element in which outputs, and indicative activities are specified. This means that inputs also are quite readily specified and the costs estimated. In this design, this element is mostly focused on capacity building, particularly within regional BoH/EPS; and
- A funding facility element, to be managed by the Project, that can be utilised by various agencies to support activities (mostly intervention trials) within a set of guidelines, but which are as yet unspecified. This facility may be used to fund procurement, training, operating expenses and some technical assistance.

#### 4.3.1 GoA Funding

For the first element, much of the input to be funded through AusAID will comprise technical assistance personnel and their support requirements. It must be emphasised that the design ensures that advisor-partner agency staff skill transfer will take place – much of the “personnel” expenditure is thus in effect “training” leading to capacity building.

Examples of a possible range of positions are:

<b>Long Term Advisors</b>		<b>Input (months)</b>
	Australian Team Leader / Planning & Management Advisor	60
	Health Promotion Advisor	48
	Funding Facility Administrator	52
<b>Total Long Term Input</b>		<b>160</b>
<b>Short Term Advisors – Specialists</b>		
	HIV/AIDS Policy & Planning Specialist	11.0
	Health Promotion Specialist	10.5
	Monitoring & Evaluation Specialist	11.5
	Training & Curriculum Development Specialist	1.75
	Infection Control Specialist	22.5
	Acute AIDS Care Specialist (Doctor)	7.75
	Acute AIDS Care Specialist (Nurse)	7.75
	Community Care Specialist	20
	STI Policy and Planning Specialist/Venereologist	13

	Technical Director	8
	<b>Total Short Term Input</b>	<b>113.75</b>

The competencies needed in the team are those technical competencies conveyed in the table above:

- leadership, planning and management;
- modern health promotion including IEC skills, social marketing and advanced formative research experience;
- administrative and financial capacity;
- HIV/AIDS policy and planning;
- medical and nursing HIV/AIDS acute and long-term home based care;
- advanced monitoring and evaluation;
- training and curriculum development;
- infection control;
- STI policy and planning/venereologist;
- and a technical director with competencies in HIV/AIDS policy, planning and direct and indirect care.

Within this technical framework other competencies required in the Project team include:

- sound and sensitive communication skills;
- strategic thinking and planning capacity;
- ability to maintain and strengthen a team approach;
- financial management capacity;
- integrity;
- ability to assume personal accountability for standard of work;
- experience in a resource constrained environment;
- international health experience or significant experience in health promotion in their own country;
- excellent interpersonal skills;
- clear understanding of the advisory role in a development co-operation project and should be able to act in the role of mentor/trainer rather than implementer;
- ability to work within the context of Chinese approaches to community mobilisation and development;

- project management, monitoring and evaluation;
- experience in achieving best practice approaches;
- formal qualifications as appropriate to each position.

In association with the considerable expenditure on TA personnel, there will be a cost component that is allocated to Project office equipment and computer systems, Project vehicle purchase and operation, and general advisory team and office operating costs, including international and local travel and accommodation.

Australian funding will cover the cost of the majority of translation / interpretation requirements and of the provision of drivers. In terms of translation / interpretation, the prime requirement will be for good language skills with medical / health knowledge a secondary concern, as this can be learned fairly quickly, while linguistic skills cannot.

Other procurement will include some consumables for Component 3 including:

- Trial HIV testing kits
- Sterilisers
- Gloves gowns masks, linen
- Cleaning materials
- Skin and mouth care products
- Basic medicines for pain relief

A total of A\$185,000 has been budgeted for these items, to supplement expenditure by partner agencies.

Finally, in terms of specified inputs there will be considerable funding of training workshops, seminars and study tours covering all three core components of the Project. A total of A\$675,000 has been budgeted over the life of the Project.

The second element, the Activity Support Facility (ASF) provides a fund of A\$5.2 million that will be managed by the AMC through a trust fund mechanism utilising carefully designed procedures that are transparent and realistic. A possible model for this is the AusAID Small Activities Scheme, which is operated through the post in Beijing.

The total funding for the ASF is made up of the following elements:

- Support for communications and co-ordination activities associated with Component 1 – A\$200,000;

- Support for Health Promotion trial interventions – A\$3,040,000;
- Support for condom marketing survey trials – A\$1,600,000
- Support for intervention trials relating to direct and indirect care models – A\$320,000

If the initial activities undertaken in relation to Output 2.6 indicate that condom marketing is not required or is inappropriate, the funding support for this element will not be utilised. Otherwise, the sub-divisions between elements are **notional** – the funding mechanism will however provide for the quarantining of a certain proportion of the total funds for the support of agencies other than BoH/EPS so as to ensure, as far as possible, that this is a truly multi sectoral project.

### 4.3.2 GoPRC Funding

GoPRC funding for the Project will cover:

Staff salaries and allowances for direct involvement in specified project outputs. Much of this input will be within the budget of the agency concerned, since most staff will continue to operate within their current roles to undertake activities included in the Project. However at least 2 staff will be allocated to the Project full time to assist in establishment and the development of effective relationships. These staff may assist with occasional translation/interpretation but the majority of translation resources are to be funded by Australia;

- The cost of providing office accommodation in Urumqi, Yining and Kashgar as required;
- Reagents and other consumables for condom marketing, for sterilisation in hospitals and other health and multisectoral facilities, and for HIV testing;
- The provision of places for counselling;
- Communication costs other than those now subsumed by GoA in recent changes to the MOU between both governments;
- Upgrading of AIDS wards and other related facilities.

Overall, the Regional Government of Xinjiang has committed itself to increased funding for HIV/AIDS prevention and care programs, and BoH/EPS has undertaken to provide the equivalent of over A\$6m over the life of the Project in partner funding for specified activities, which may be ‘in kind’. This latter commitment includes funds made available at regional and prefecture levels through health sector agencies alone. The Xinjiang government will establish special accounts for the project, at regional and prefecture levels. Each project area receiving funding under the project will maintain separate accounts. The Regional Audit Administration will be responsible for the annual auditing of accounts and submitting a report to the ATL six months after the end of the government fiscal year.

The ASF selection criteria for funding support of agencies in sectors other than health

will include some assessment of the proposed counterpart funding arrangements by the agency seeking support. Final details of this mechanism will be determined collaboratively once the Project is mobilised.

Further to the contribution described above, the Xinjiang Bureau of Health (and the Epidemic Prevention Station) will provide:

- Chinese Team Leader
- Chinese Team Leader's report's
- Two full time staff to assist the project
- Members and secretariat support for all leading and working groups to include continuity of representation at appropriate levels
- Translation of meeting documentation
- Support for the baseline studies
- Additional staff as appropriate
- Assistance in locating cost-effective accommodation
- Obtaining the World Bank Health 9 baseline sexual behaviour study Results for joint analysis by Australian and Chinese team members
- Meeting venues
- All relevant World Bank Health 9 documentation and cost schedules
- Minutes and notes of the meetings, activity and cost schedules for the Xinjiang Regional HIV/AIDS Prevention Leading Group and sub groups
- In-house specialist support in the development of health campaign materials
- Heating, electrification and local telephone calls for the project office
- Some interpreters and translators
- Salary for multi-sectoral agency staff implementing their HIV/AIDS response
- Regional level project preparation costs
- Regional level daily expenses
- Regional level costs for local and long distance telephone calls, and telephone installation
- Maintenance, insurance and running costs (fuel and subsidy for drivers) for the component vehicle
- Registration and licence identification for all component vehicles

The multi-sectoral agencies will provide:

- Agency representatives to the multi-sectoral project leading groups to include continuity of representation at appropriate levels
- Monitoring and evaluation reports

#### **4.4 Elements of a Memorandum of Understanding**

It is expected that an MOU will be negotiated with GoPRC that seeks, among other things, commitment:

- Not to reduce resource allocation to the health sector because of this Project and

- to continue to support other agencies in respect to HIV/AIDS responses;
- To ensure joint management of the project with the AMC so that it is implemented as a collaborative initiative. In this regard, part time input by the Vice Director (Public Health) Xinjiang Regional Bureau of Health as Chinese Team Leader and part time input by the Chief of the Epidemic Disease Control Division of the Bureau as the day by day “project partner” of the ATL, will be a requirement
  - To appoint two suitably qualified full time staff members to work within the project office, at least until the Project becomes fully established. The re integration of these individuals into the Xinjiang government structure will require the endorsement of the PCC.
  - To ensure a timely process for the endorsement of recommended policies, procedures and the like which are developed through the Project and which are required for further planned progress to be made;
  - To ensure as far as possible that appropriate staff are appointed to the approved structure so that the advisors to be provided have suitable partner staff to transfer skills to;
  - To make available reasonable office space at the regional BoH headquarters in Urumqi and at prefecture level for the ATL and other long term advisors on the understanding that AusAID will fund the furnishing and equipping of this office space and will provide a major portion of the associated operating costs;
  - To provide other inputs as already orally agreed between the Appraisal Team and the Vice-Director (Public Health) of the Regional BoH. These inputs are summarised in the cost schedules prepared as part of this design process.

## **5 Project Management and Monitoring**

### **5.1 Institutional and Management Arrangements**

It is recommended that AusAID, through its normal tendering procedures, appoint an Australian Managing Contractor (AMC) to implement the Project in collaboration with the Xinjiang Bureau of Health, and to manage the Australian funded inputs on behalf of the Government of Australia. The contract should be for the five-year time span of the Project.

The AMC should in turn nominate a principal of the organisation, or someone who is duly authorised to make decisions on the AMC’s behalf, to act as Project Manager/Administrator. The Project Manager will be based in Australia but may make occasional visits to China. This will be the prime point of contact regarding contractual matters between the AMC and AusAID.

In addition, the AMC will appoint a Technical Director with wide experience at senior level in HIV/AIDS prevention and care. This individual will oversee the mobilisation and implementation of Australian funded inputs to ensure technical standards and methodologies are appropriate and consistently applied. It is envisaged that the Technical Director will have only part-time involvement in the Project, amounting to around one month a year over its planned 5-year life.

In Xinjiang, the implementing agency will be BoH, with the Vice Director for Public Health responsible for the key health sector inputs. The Project will be jointly managed by the Vice Director and a full-time Australian Team Leader/Planning & Management Advisor, based in regional BoH in Urumqi for the duration of the Project. It is acknowledged that the Vice Director cannot spend a major proportion of his time on Project issues and will delegate at least some day by day responsibility to a subordinate, the Chief of the Epidemic Disease Control Division.

The Australian Team Leader (ATL) will be responsible for all Australian-funded inputs in China and will liaise with AusAID staff at the Australian Embassy in Beijing, the Project and Technical Directors, as well as drafting reports listed in Section 5.2 below.

The AMC will maintain appropriate financial records and appropriately detailed invoices will be provided to AusAID on an agreed basis.

The Project will report to a Project Coordinating Committee (PCC) to be convened under the instruction of AusAID. Two meetings should be held in the first year and annually thereafter. The first meeting will be held in month 6 of Year 1 - to consider the Inception Report - and the second in month 10. Thereafter, meetings will be scheduled so as to consider 6 monthly reports.

The PCC will include senior regional BoH representatives and representatives from key stakeholder agencies – this local representation could be the proposed multi sectoral Working Group or alternatively higher level representatives who are themselves members of the Multi Sectoral Leading Group. Representatives from MOFTEC, DOFTEC and AusAID, the Project Technical Director and the Australian Team Leader, will join local representatives to make up the standing PCC. In addition, other relevant people, including representatives of other donors, may be invited to contribute on an *ad hoc* basis. Records of Project progress, in the form of the 6 monthly Project reports (see 5.2 below), will be tabled at PCC meetings along with other monitoring reports on progress towards the achievement of outputs. These will all be identified in formally recorded minutes of meetings and forwarded to AusAID and GoPRC. The AMC will ensure that secretariat services are provided to the PCC – a PCC support budget for meetings and secretariat activities will be included in Component 4 – Project Management.

## **5.2 Project Reporting**

The reporting requirements to be met by the Project will be:

- Inception Report
- Six-Monthly Reports
- Monthly exception reports
- Annual Plans
- Project Completion Report
- Quarterly Activity Support Facility Reports (see 5.3 below)

In general, the responsibility for the above reporting will fall on the AMC, but it is expected that the reports will be developed collaboratively and that if they can satisfy internal Chinese reporting requirements then they should be available for this purpose. Where there is collaboration, the input of each party should be acknowledged.

On initial mobilisation, a brief Inception Report will be prepared and submitted detailing any Project Design changes recommended, with a justification for the change proposed, to both Governments within 4.5 months of mobilisation. Both governments must approve any design changes recommended in this report before they are implemented, but the implementation of the unaffected elements of the Project should not be delayed while the Inception Report is completed and approved. Changes are not expected to be major. This Inception Reporting process, however, recognises the elapsed time between the finalisation of the PDD and the commencement of the Project. This may be significant in the face of rapid changes in understanding of the epidemic in Xinjiang and other donor activity.

Every 6 months, the AMC will submit a Six-Monthly Report. These reports will report progress against the Annual Plan. They will form the basis of reporting to the PCC and may propose minor changes to the Project design to reflect changed circumstances, but any such proposals must be fully justified. As with all other reports drafted by the AMC, the Six-Monthly Reports will be translated and forwarded to both governments.

The AMC will also provide short Monthly Exception Reports that will be submitted via the AusAID office in Beijing. Monthly exception reports should be brief and to the point – they will generally be exception reports dealing with specific problems that may have arisen but they should also highlight particular achievements in order to present a positive perspective. They will not contain redundant material that is not useful for Project management purposes, but they will identify short-term advisory inputs for the period.

The Completion Report, in accordance with AusAID's guidelines for form and content, will be drafted and submitted by the AMC no less than 12 weeks prior to the end of year 5.

Project Evaluation reports may also be required in addition to the reporting outlined above. This will depend on the development of the monitoring and evaluation framework as discussed in 5.3 below.

### **5.3 Activity Support Facility**

The Activity Support Facility is a funding mechanism to be established to manage the transfer of funds from the project to the agencies that will implement the activities. As noted in Section 4.4, a proportion of total project resources will be allocated to an Activity Support Facility (ASF). The facility will be available to support well designed activities proposed by regional and sub regional agencies in health and other sectors provided the proposals are in line with endorsed regional and agency HIV/AIDS response plans. The principles of the ASF will be developed and negotiated as an early activity in Output 4.4 but at this stage it is expected to possibly include:

- Agencies eligible to apply for support will include BoH/EPS at various levels (regional, prefecture and county), and other government agencies and mass organisations that are represented in the leading groups on HIV/AIDS Prevention and Control that have been established, again at regional, prefecture and county level;
- The Activity Support Facility (ASF) procedures will be as simple as possible taking account of the practicalities of operating through the Australian Managing Contractor but within the Chinese legal system and the need for accountability to both Governments;
- The ASF will be fully documented so as to be transparent in all aspects. The documentation will include eligibility, scope, funding limits, application requirements and procedures, assessment procedure and criteria, monitoring, evaluation and reporting requirements, and acquittal procedures.
- Funding support should be available through the Facility for technical assistance (where this cannot be provided by the core AMC team or by BoH/EPS), procurement of minor plant, equipment or specific consumables, training and some operating costs. The procedures may set limits such as the proportion of a proposed budget that can be spend on procurement, or restrictions on the type of training that can be supported – but in general, the “rules” should be flexible, leaving the assessment process to consider the merits of individual cases.
- The ASF comprises a fund of A\$5.2 million that will be managed by the AMC through a trust fund mechanism utilising carefully designed procedures that are transparent and realistic.
- The total funding for the ASF is made up of the following elements:
  - Support for communications and co-ordination activities associated with Component 1 – A\$200,000;
  - Support for Health Promotion trial interventions – A\$3,040,000;

- Support for condom marketing surveys – A\$1,600,000
- Support for intervention trials relating to direct and indirect care models – A\$320,000
- If the initial activities undertaken in relation to Output 2.6 indicate that condom marketing is not required or is inappropriate the funding support for this element will not be utilised. Otherwise, the sub-divisions between elements are notional – the funding mechanism will however provide for the quarantining of a certain proportion of the total funds for the support of agencies other than BoH/EPS so as to ensure, as far as possible, that this is a truly multi sectoral project.
- Furthermore, it is important that uncommitted funding is available past Year 1 and extends through Years 3 & 4 so the Project, through this funding mechanism, is able to adapt to changing response needs as the epidemic progresses and is better understood. No activities should be funded beyond the life of the Project, however.

While there is not expected to be a specified minimum size of activity that can be given support, it will be important that the selection of proposals for funding does not simply divide up the available funds between the proposals received. This could dilute the impact so that few worthwhile trials are carried out. Activities to be funded should be substantial and rigorous enough to facilitate meaningful evaluation so that successful interventions can be recommended for replication with some degree of confidence.

Assuming that there are more proposals than can be resourced, prioritisation of proposals will be based on clearly articulated criteria that should include:

- Whether the activity fits within a clearly articulated HIV/AIDS response plan for the respective agency and conforms with any guidelines provided by the Regional Mid to Long Term Plan for HIV/AIDS Prevention and Control;
- The extent of “counterpart” funding to be contributed by the agency concerned;
- The availability, if any, of alternative sources of funding, via WB9 or international NGOs, for example;
- The number of other activities funded by the Project in the particular agency;
- An assessment of the agency’s capacity to implement, monitor and evaluate the activity;
- Performance of the agency with prior activities, if any, funded under the scheme;
- Likelihood of transfer to other areas if successful;
- Assessment of the scope and design of the intervention trial or other activity proposed in terms of its prospects of providing new and relevant information or experience;
- Likely impact on specific genders, minority groups, and its impact on poverty reduction and the environment.

As noted above, the AMC will control the disbursement of funds under the ASF. A Funding Facility Administrator will be appointed and will serve full time with the Project for the first four years and part time thereafter. This position would perhaps be suitable for a qualified spouse, young professional or other qualified administrator, possibly a Chinese national, able to work closely and competently with the ATL.

Funding may be disbursed for TA, training, procurement and for operating budgets. The funds may be disbursed on a quarterly basis to the agency concerned, with subsequent quarterly tranches dependent on adequate acquittal and reporting. In these instances, successful agencies will set out an implementation plan or 'funding agreement'. This will define the mutual obligations of the project and the implementing agency according to the strategic and activity implementation plans and budgets established in the initial stages of the project. Prior to activities being agreed, the successful partner agency will need to demonstrate their capacity to meet their obligations under an agreed work plan. Decisions to fund a work plan will be taken after an "agreement" between the AMC and the partner agency is reached and documented. The agreement will ensure that:

- partner agency plans are consistent with project objectives, principles and outputs
- that activity implementation plans are achievable and include enough detail so that the AMC can assess progress
- the proposed budget is broken down into line items and identifies tranches payable by quarter, subject to subsequent tranches being reduced by the amount unspent by the partner in a previous quarter
- inputs from the project in support of the partner agency activity are clearly identified
- the proposed schedule is realistic
- reporting, monitoring and evaluation arrangements are adequate.

A pro-forma grant agreement will be provided to AusAID for approval prior to the funding of any ASF activities.

The project team will be responsible for:

- establishing the system including preparation of a detailed guide to its operation and eligibility criteria for partner agencies
- provision of capacity building support, including training as required
- advising AusAID in Annual Plans of annual deposits into the project Trust Account for funding of the ASF
- assessing and ensuring that proposed activities are consistent with project objectives, outputs and principles
- managing "agreements" and subsequent disbursement of funds
- monitoring the financial operation and activity implementation of implementation plan

- reporting to AusAID as required.

During the inception phase the AMC will ensure that capacity of partner agencies to manage and implement activities is described and demonstrated in proposals and capacity building assistance provided as required.

Additional criteria for the financial operation of the ASF include that:

- the maximum for procurement in any one implementation plan should be 35% in year one and declining thereafter
- the partner agency will establish a separate bank account and set of accounts
- the partner agency will use appropriate expenditure request procedures, systems of invoicing, vouchers and receipts
- the partner agencies will submit monthly financial statements and quarterly financial and narrative reports

The AMC will provide technical assistance to ensure that the implementing partner agency financial systems are able to manage such arrangements and to establish coordination between the financial system requirements of the GoPRC and GoA.

If a stakeholder is unable to meet the financial monitoring and evaluation requirements, then the AMC will submit a report to AusAID commenting on why the partner agency has not met requirements. The funds for that stakeholder's activities will not be released for implementation until adequate documentation is produced.

The ASF processes will most likely have an annual or bi-annual round of receiving proposals within specified periods and deadlines. The arrangements with specific agencies will be encapsulated in a form of agreement – an MOU for example – that is realistic and effective in the Xinjiang context, again the experience of AusAID's Small Activities Scheme may provide some useful guidance.

The AMC will prepare and submit quarterly financial reports on the ASF including reconciliation of the trust account, and an annual progress and evaluation report on the funded activities.

#### **5.4 Monitoring and Evaluation**

Monitoring and evaluation will play a central role in this project. This is both in terms of capacity building activities to improve regional evaluation capacity to evaluate their plans and trial interventions in the future, and also in terms of ensuring that the project trial interventions are rigorously evaluated. This will ensure that the information generated to inform policy and planning is utilised with confidence, and will provide information for accountability purposes to stakeholders including AusAID. This situation requires more advanced skills in monitoring and evaluation than is typical for the development of local capacity and for the design and management of the monitoring and evaluation framework.

As outlined in Section 4, the monitoring and evaluation framework should reflect a broad

interpretation of evaluation and should include the following sections:

- Project evaluability assessment (i.e. review of the project logic and design as they relate to monitoring and evaluation, identification of selected issues of importance to stakeholders, review of actual data sources available and baseline data from other sources, and identification of resources available for monitoring and evaluation);
- Principles and standards for project monitoring and evaluation;
- Overarching strategy for monitoring and evaluation;
- Baseline and follow-up data requirements;
- Special studies;
- Monitoring and evaluation matrix including indicators at outcome and output level, data sources, data collection methods, frequency of collection, reporting tools, parties responsible, and decisions that information will inform;
- Risk monitoring matrix.

Current practice in project evaluation encourages an utilisation-focus with monitoring and evaluation activities. This refers to the imperative to design evaluation activities so that they are likely to be acted upon. For this to occur it is essential that major stakeholders are involved in the determination of: monitoring and evaluation questions, the negotiated and agreed criteria that will be used to judge the worth of the project, the responsibility for the conduct of evaluation activities, the analysis of findings, and the decisions that the monitoring and evaluation activities will inform.

Acceptance of the need for involvement of stakeholders requires that the monitoring and evaluation framework is developed through a highly consultative process, and only once plans have been developed and finalised. It is recommended that this framework is developed within the first quarter of project implementation, but not before implementation has begun. This allows project stakeholders the opportunity to articulate more clearly on monitoring and evaluation needs, once more familiarity with the project has been developed, and stakeholders have been provided with the technical support to participate meaningfully in these consultations.

Some aspects related to the evaluation of project outcomes and impact for the purposes of accountability may require additional activities not necessarily requiring the involvement of all stakeholders. These should be clearly indicated in the monitoring and evaluation framework.

Finally, it is not appropriate to fix project indicators, or determine when evaluation activities should be conducted until a professional evaluability assessment has been carried out. This assessment is important as it informs the selection of project indicators

and evaluation activities. This assessment focuses on the evaluability of the logical framework, it identifies the key issues of major stakeholders, assesses the evaluation capacity available, it allows adequate time to determine whether or not the information sources identified as means of verification either exist, or provide an adequate level of quality, and identifies the financial resources available for monitoring and evaluation.

#### *Indicative Key Performance Indicators*

Key performance indicators cannot be finalised until the completion of the monitoring and evaluation framework. However indicative indicators related to the four project components are likely to include:

- Level of institutional capacity to plan and coordinate multi-sectoral responses to the HIV/AIDS epidemic;
- The level of adoption of healthy behaviours and accepting attitudes by the general community and vulnerable groups related to the transmission and management of HIV/AIDS;
- The level of adoption of best-practice standards in direct and in-direct care by health workers and family carers;
- The level of effectiveness and efficiency of project management.

These key performance indicators require more specificity for the purposes of measurement. These are clearly stated on the logical framework at the outcome (or objective) level of the framework. It is not anticipated that these more specific outcome indicators will be changed substantially in the monitoring and evaluation framework and should be considered a reasonable guide to expected performance indicators.

More detailed performance indicators should include a good mix of process, output, outcome and impact measures. Particular attention should be given to the development of indicators of the *quality of capacity building and skill transfer* activities and should employ both qualitative and quantitative measures.

### **5.5 Technical Advisory Group**

In view of the dynamic environment in which this Project will operate and the likely pressure on the Project to adapt itself accordingly, AusAID will contract a Technical Advisory Group (TAG) to perform a project monitoring and advisory role for AusAID and GoPRC. The TAG will play no direct role in the implementation or management of the Project, nor will it issue any directions to the AMC or agencies of the GoPRC. The TAG's contribution to the successful implementation of the Project will be through the provision of objective, expert advice identifying problems and emerging issues and assisting in formulating strategies for problem solving. It is intended that the TAG will

utilise the information, monitoring and evaluation systems established by the AMC.

The TAG will visit the Project periodically and will have specific TORs identified by AusAID and/or the GoPRC and each is likely to incorporate both pre and post mission briefings in Canberra. It may be necessary to support one or more of these TAG visits with some additional specialist expertise. In addition to field visits, the TAG may be instructed by AusAID to carry out other tasks including the examination and assessment of periodic reporting by the AMC.

### **5.6 Co-ordination with Other Activities**

The Donor-Assisted Activity Matrix in Section 2 clearly illustrates the need for systematic co-ordination between donor-assisted activities in the STD/HIV/AIDS and drug abuse areas. There is also a considerable number of activities planned or underway, undertaken by BoH/EPS and other agencies, without additional external support. Co-ordination is required to avoid over stepping the absorptive capacity of the regional and sub-regional agencies concerned, to maximise opportunities for collaboration and to avoid wasteful duplication or the promulgation of mutually inconsistent messages.

During the design process it became quite clear that there is no easy response to this challenge. There is no rational way to identify a clear delineation between XHAPCP and other activities prior to the commencement of what is to be a five year project. Not only is the form and progress of the epidemic uncertain, but the Xinjiang Regional Mid to Long Term HIV/AIDS Prevention and Control response strategy is not yet endorsed and it is far from clear how and when a number of the planned activities will be implemented.

Co-ordination must, therefore, be a management process that will require attention by all parties throughout the Project.

In terms of capacity building, no awareness raising study tours will be implemented without careful analysis of what has already been undertaken or is planned in the near future. Care must be taken to establish clear and transparent selection criteria for participation in any such activity. One of the criteria is likely to be that the individual has not previously been on a study tour with similar objectives. Training should be offered following a systematic training needs analysis, so that only individual position holders that need specific skills and competencies, but do not yet have them, are selected for training. It will be important for the ATL and other long term Project advisors to keep up to date, as far as practicable, with plans for training by other donors, projects and the GoPRC.

It is also expected that the funding facility mechanism will provide continuing opportunity for co-ordination with other initiatives, including intervention trials. The

application process for funding support must include the identification and analysis of other activities underway or planned, so that issues of absorptive capacity, duplication and or opportunities for synergy can be taken into account in the assessment of the application.

It is hoped that the Working Group to be established, as appropriate, under Output 1.6, and its overarching Leading Group, will be able to play a major role in co-ordination. Indeed, Output 1.6 has been included in the design to facilitate this.

Finally, it will be a specified requirement of the ATL that an appropriate amount of management time is spent in active liaison with the key individuals responsible for other activities, and with the working group, to ensure that there is good co-ordination. It will not be sufficient to have short formal meetings once a month. A key role of the ATL will be to develop good communication with his or her peers so that workable co-ordination is achieved on a daily or weekly basis.

## **6 Risks and Risk Management**

### *Project Components*

There is a risk that successful interventions will not be replicated due to lack of funding commitment by the GoPRC. To minimise this risk the development of clear transfer strategies are needed. Other risks include lack of commitment by multisectoral agencies to develop their own HIV/AIDS plans, and the interdependency of Component 3 on the success of Component 2 in assisting change in community attitudes. These risks can be minimised by sound Project management (see below).

### *Project Management*

Given the sensitive issues surrounding HIV/AIDS prevention, control and care in Xinjiang, and the complex political and social environment, the Australian Managing Contractor (AMC) and the Project team will need to have a consistent and very high level of expertise and professional management capacity. The AMC will be key. In-country, the Australian team leader (ATL) will be key, and appropriate incentives and support will be needed to ensure s/he leads and manages the Project for its duration. The AMC should ensure adequate leadership, communication and advice is available to support the ATL. ATL incentives should include adequate financing to select their own accommodation, private use of a Project vehicle, and regular work/R&R visits to Beijing.

### *Security*

The security risk relates to reported political unrest in the South, which could have the effect of restricting Project staff movement and reduce the effectiveness of Project activities in the Kashgar region from time to time. This risk can be countered by building

a close relationship with relevant government agencies at the local level, observing government advice on personal safety, and having an appropriate level of caution in moving around any affected urban and rural areas.

### *Health Reforms*

An impact of health reforms across China is downsizing. In Xinjiang, downsizing will apparently be phased in over 3 to 4 years, and affect the BoH only. Service delivery, such as EPS, is stated to be unaffected. However, the impact of the reforms needs to be monitored and managed to ensure ongoing availability of appropriate Xinjiang counterpart staff and minimise local Project staff turnover. The Xinjiang team leader, in collaboration with the Australian team leader, should ensure this risk is addressed during selection and assignment, and that provision is made for overlap of local Project staff where possible, when turnover is inevitable.

### *Legislative*

IDU and prostitution in China are illegal. There is a risk, therefore, that limitations may be placed on broadly based harm minimisation strategies, for example, general community messages such as “DO NOT SHARE NEEDLES OR SYRINGES” albeit targeted at IDUs, or “INSIST ON A CONDOM” primarily targeted at prostitutes. The Project will, therefore, initially target staff of drug rehabilitation centres and pilot interventions among drug users and within communities. It will also focus on strengthening existing education and counselling. The successes of harm reduction activities in the Department of International Development Yunnan and Sichuan project will be monitored. Similar risk management applies to activities targeting commercial sex workers.

### *Socio-cultural*

Frank and public discussions on sexual behaviour are not generally culturally or religiously acceptable in Xinjiang, including among major ethnic minority groups. There is, therefore, some sensitivity around strategies targeting sexual behaviour change. Pilot peer education is acceptable and is built into the Project design. To manage the risk, the Project team will need guidance from their China partner agencies in developing activities on how best to ensure behaviour change strategies are sensitive to local social mores while ensuring effectiveness.

### *Translation*

There will be three languages in which the Project team will be working: Mandarin, Uygur and English. While assurances were given that translators would be easily found, this view is not universally shared. AusAID experience in other parts of China, e.g. Tibet, is that people skilled in all three languages are difficult to find and that translation expenses are high. The risk will be reduced by: the AMC having the responsibility and

funding to ensure translator skills are competent; and by translators being sought first for their language skills and second for their subject knowledge of HIV/AIDS. Experience has shown that the latter can be learned quickly for the purposes of competent translation while the former, clearly, cannot.

### *Monitoring and Evaluation*

Monitoring of progress towards, and the evaluation of, the achievements of goals is essential and a risk exists if this is not done well. The Project design incorporates a transparent and robust approach to monitoring and evaluation.

### *Financial*

The first risk is ensuring Project funds are used for this Project only and not for counterpart contributions to, for example, WB9. This risk will be minimised by Component 4, which provides for clear and transparent Project management.

The second risk is that Project activities aimed at developing institutional, family and individual HIV/AIDS care and coping capacities will be restricted by the inability of institutions, poorer families and individuals to meet basic costs of supplies and pharmaceuticals for treatment and care. This risk is heightened by the lack of health system resources to subsidise treatment and care for those who cannot afford to pay. The Project design includes support for supplies and simple pharmaceuticals (e.g. for skin and mouth care) and will provide data on sustainable health financing policy implications for broader implementation.

### *Technical*

There are three major risks. The first is availability of base-line data to ensure targeted Project activities. The risk will be minimised by development of the evaluation and monitoring framework and the inception report in the first three months of the Project.

The second risk is technical capacity of partner agencies. However, as capacity building is the central tenet of the Project, this risk is known and addressed in the Project design, starting with strategic thinking and planning capacity within partner agencies to develop multi-sectoral plans to address HIV/AIDS, within which the Project will work, and which will be a guide for sub-project funding approvals.

The third risk is technical capacity of the AMC Project team and retention of long term advisors. This risk will be managed through the usual rigorous AusAID tendering and selection processes, resulting in an AMC with appropriate technical capacity and excellent management skills to assist retention of in-country team members.

### *Multi-sectoral Collaboration*

Multi-sectoral collaboration is a relatively new phenomenon and needs to be supported and facilitated, within the reality of a certain bureaucratic rigidity in Xinjiang, and current central planning and top down implementation, albeit in a climate of reform. Since the original feasibility/design team visited Xinjiang in 1999, there appears to have been a shift in the previous view that HIV/AIDS was primarily a health problem, to a greater understanding of its multi-sectoral dimensions if the epidemic is to be contained. Nonetheless, multi-sectoral liaison and collaboration needs to be carefully supported and facilitated including to ensure commitment and sustainability. The calibre of the AMC, ATL and Project team will be key, as will wide dissemination of information about the Project and access to funds for interventions.

#### *Community*

Unless and until community attitudes towards, and tolerance for, people with HIV/AIDS increase, long-term home-based care activities will be challenging to develop. Shanghai's efforts have been problematic as people with HIV/AIDS and their families wish to remain anonymous within their communities. However, Yining is developing some home-based activities, using community volunteers, and this should be more fertile ground to develop pilot activities in LTHBC. As well, effective implementation of Component 2 will assist in managing the risk.

#### *Other Donor Activity*

There is a general risk of lack of coordination between this Project and other donor projects in Xinjiang, including WB9. The risk will be reduced by incorporation of all HIV/AIDS activities in multi-sectoral partners' strategic plans, enabling transparency of who is doing what and when, and by the ATL establishing sound work relationships with other project teams and open dialogue. In addition, for WB9, technical input is low, geographical areas are small and specific, and thus complementarity should be relatively easy to ensure.

#### *Road transport*

To reduce road accident risk the ATL should control all Project vehicle use; select all drivers; ensure driver skills training on 4-wheel drive vehicles and an adequate maintenance schedule for all vehicles; and have the authority to change drivers for poor driver performance.

#### *Other*

There is a range of other risks common to HIV/AIDS projects that are addressed in the Project design and can be further addressed in the inception report. Further detail on risks and their management is provided in the assumptions column of the logical framework matrix against each indicative activity. A full risk management matrix is provided at Annex 10.

## **7 Feasibility and Sustainability**

The Project is designed to have an impact on the ability of the Xinjiang Uygur Autonomous Region's ability to respond effectively to the HIV/AIDS epidemic in the Region. Capacities to develop policy and plans in a multi-sectoral setting, and deliver prevention and care programs should be enhanced within a range of participating partner agencies. In participating trial locations, where aspects of the Regional HIV/AIDS plan have been implemented, the Project should have an impact on the adoption of healthy behaviours in the general and at-risk populations, and improve the standards of direct and indirect care of people living with HIV or AIDS.

### **7.1 Manageability of the Project**

Australia has demonstrated expertise in the prevention and care of HIV/AIDS. There is likely to be an adequate pool of technical expertise on which to draw, however, Australian long-term advisers would require adequate compensation and support to work in this challenging environment. Providing the AMC is sensitive to the breadth of technical and personal support that these advisers would require, and have the networks required to identify long-term advisers with the special skills and flexibility to work in this environment. Project manageability from this respect should not be compromised.

The Xinjiang BoH is the lead agency in this Project, with participation from a number of partner agencies that make up the Leading Group for HIV/AIDS in the Region. Resources are constrained, and to date limited resources have been dedicated to the Regional HIV/AIDS plan. The Project aims to improve the resources that are available for activities by carrying out awareness raising activities amongst major decision-makers, and those responsible for committing resources. The Project will require some flexibility in responding to the limited resources available, especially in its early phases.

Risks and opportunities will be clearly identified through the comprehensive monitoring and evaluation activities, including risk monitoring. Evaluation of interventions and trials will be carried out in a broad fashion, identifying important contextual factors before and during implementation. This should reduce the risk of poorly designed trials that cannot respond well to environmental or contextual factors, and increase the capacity of partner organizations to monitor and evaluate interventions.

The Project structure has been carefully designed to ensure that it is not a separate entity to GoPRC systems and structures, and supports only those activities identified as priorities in the Regional HIV/AIDS plan. For this reason issues of absorptive capacity should be reduced. However, this is only likely to succeed if technical advisers and partners are aware of their respective roles with this approach.

Urumqi, where the project office will be based, is a modern city with a high standard of infrastructure. Project locations are all connected by airline services. There is easy access

to Urumqi from Beijing and other major cities in China.

Partner organisations have demonstrated a high level of commitment to the Project, however, counterpart-funding capacity will require close attention.

## **7.2 Technical Feasibility**

Technical aspects of the design have been chosen with careful consideration of Xinjiang's resource limitations. New equipment for the development of and production of health education materials, operations research and evaluation, screening for HIV/AIDS, and direct care will be selected based on the capacity of the partner organisation to maintain and operate. Trial interventions will be selected and designed by partner organisations, rather than by technical experts working in isolation. However, where partner organisations propose technically unsustainable activities, technical advisers will work with partners to identify more suitable choices. Project awareness raising activities and training in proposal preparation will be given to partner agencies to increase the number and quality of intervention proposals. Cost-effectiveness of trial interventions will be assessed where appropriate using simple techniques.

## **7.3 Financial and Economic Feasibility**

Should the Project succeed in building the capacity of the Region to design and deliver effective HIV prevention programs, the social and economic benefits are clear and have been described earlier. As well, enabling the community to manage AIDS cases within the home reduces the financial burden on the formal health sector, and the families who would be required to find adequate resources to meet the user fees charged diagnostic, treatment and palliative care services.

The Project is also designed to assist the Regional Leading Group to make more rational resource allocation decisions within the currently limited resource envelope available for HIV/AIDS.

## **7.4 Impact on Poverty**

There is sufficient evidence that HIV/AIDS has a profound impact on the lives of people living in poverty and increases poverty. Reduction in the family work force through illness and death, and the high costs of diagnosis, treatment and palliative care have a major impact on the financial and human resources available to poor households throughout Africa and Asia, and indeed, the rest of the world. A reduction in the transmission of HIV and the improved home-based care of those living with AIDS will have a positive impact on the poor by increasing access to care, decreasing stigmatisation, achieving cost savings and leading to improved health status. Poverty is multi-faceted. The social impact of HIV includes social dislocation, stigma and community exclusion. The Project aims to change attitudes to accepting people with HIV and AIDS through health promotion and direct care activities.

The Project has been designed to target at-risk or vulnerable groups. Injecting drug users and commercial sex workers are priority target groups. These groups are usually amongst the poorest and most vulnerable members of the community.

Project locations have also been chosen according to the numbers of vulnerable groups living within the area. Kashgar, although not recording a high HIV prevalence, is one of the poorer locations within the Region, is currently receiving very limited assistance with HIV/AIDS prevention and care, and is on a major trading route.

### **7.5 Social and Cultural Impact and Gender Implications**

Given the sensitive nature of this project, it will be a continuous challenge to ensure that all Project activities and interventions are carefully designed to ensure that local social and cultural sensitivities are respected. As stated previously, the Project is designed to be planned and carried out by appropriate local partners, with technical advisers taking a mentoring or supportive role. This should reduce the possibility that the Project could overlook these needs within all target communities, however where partners are not from the same ethnic groups as target beneficiaries, these aspects will be continually addressed during planning activities.

The Region is also made up a number of diverse ethnic groups. Project design reflects the need to explore local health beliefs and practices, using local research staff, so that health promotive activities, as well as direct and indirect care will respond to the divergent needs of these groups.

The comprehensive approach to evaluation will provide further opportunities to assess the success of the Project-supported trials and interventions to meet the needs of the different ethnic groups, or the sub-cultures within them.

The present social and cultural environment in which the Project will operate does face certain strains and division. It will be important for the Project advisers and partners to work amongst the various groups and contribute to the breakdown of various stereotyping between the different communities.

With regard to gender, the Project's likely impact on women, men and children as separate groups should be positive. HIV/AIDS presents particularly insidious dangers to women and children who may be placed in particularly vulnerable circumstances over which they may have little or no control (such as in the case of wives of men engaging in high-risk sexual or drug-use behaviour, and children born HIV positive). HIV-related illness and AIDS in the family increases the care and financial burden for women, in particular those in poor households. The Project will directly involve women professionally in the various participating partner government agencies and through the

Xinjiang Uygur Women's Federation. Children and youth (both female and male) will be addressed through the education system, Red Cross youth peer training, and Women's Federation education activities, and possibly also through Youth League activities. Men will be specifically addressed through interventions with injecting drug users, the majority of whom appear to be male. Community trials will involve entire communities.

There is expected to be a positive social impact on people living with HIV/AIDS as a result of a reduction in stigma attached to them. The Xinjiang Region, with support from the project, may also achieve shifts in community social behaviours as a result of new information and marketing of desired behaviours.

## **7.6 Institutional and Governance Feasibility**

The Project is designed to work *only* through existing institutional arrangements and programs. A more detailed discussion of the institutional and management arrangements of the project can be found in Section 5. The Xinjiang Regional Government, the Bureau of Health and the members of the proposed Regional Working Group are highly supportive of the proposed Project. Leading groups and organisations consulted at prefecture and county levels also expressed strong interest in participating in Project activities. There are a number of successful initiatives already underway (although largely supported by donors) that demonstrate the increasing awareness of the importance of addressing the HIV/AIDS epidemic.

Earlier concerns about the impact of civil service reforms have been mitigated to a large degree. Staff reductions in the BoH will be borne at the policy and administrative level, rather than at the service delivery level, or at the interface between the health service and the community. However, civil service reform and its impact should be monitored during the life of the Project, particularly as these proceed to prefecture and county level in 2001.

The Project will have a positive impact on governance. Participating leading groups and implementing institutions will gain familiarity with more collaborative, transparent and effective mechanisms for planning including rational resource allocation, utilisation and management, implementation of HIV/AIDS intervention trials, and evaluation of both plans and interventions.

## **7.7 Environmental Impact**

The environmental impact of the Project is limited, however issues around waste management of contaminated products is a primary concern. Safe disposal of such items will be addressed by the project in Component 3. A study of the present collection systems of used syringes is also an indicative activity that should yield further information to encourage the safe disposal of sharps. Access to clean water and safe disposal of contaminated products will need to be considered in the context of caring for

family members with HIV-related illness. Harm reduction aspects of needle and syringe disposal after use by IDUs will be considered.

### **7.8 Factors in the Design to Promote Sustainability**

A critical Project design factor to promote sustainability is Project management arrangements. The Project will not operate as an independent unit, that draws local counterparts into the Project office and involves them in Project activities, rather the Project will provide mentoring, support, and resources to facilitate the implementation of Regional HIV/AIDS plans, and to improve their capacity to do so. .

To support this approach, technical advisers, partner organisations and individuals will need to spend time early in the project, clarifying their respective roles, developing a shared vision and team relationship, and adequate inclusive communication strategies for maximal flow of information.

The Project has a strong focus on building local capacity for strategic and annual planning for the Regional and Prefecture level HIV/AIDS response, and the capacity to design, implement and evaluate innovative models for prevention and care. Regular assessments will be made, by participating advisers and partner organisations and individuals, of the quality and outcomes of capacity-building activities. Process indicators of the quality of capacity-building activities will be included in the monitoring and evaluation framework.

The project will provide financial support to the trial interventions through the funding facility, but will not be supporting the replication or expansion of trials throughout the Region for the life of this project. To support sustainability, proposals for trial interventions should include how the organisation proposes to support the adoption of successful trials in the future.

In Year 5, activities will focus on the phasing out of Project support. This will require specific planning in year 4, with a clear strategy required. The strategy would involve more limited contact between advisers and partner organisations, and a large reduction in resources provided by the project for capacity building and implementation activities. Trials that are still underway in Year 5 will continue to be resourced by the project but will not continue beyond the life of the Project.

**XINJIANG UYGUR AUTONOMOUS REGION  
PEOPLES REPUBLIC OF CHINA**

**HIV/AIDS  
PREVENTION AND CARE PROJECT**

**GOVERNMENT OF AUSTRALIA  
AND THE  
GOVERNMENT OF THE PEOPLES REPUBLIC OF CHINA**

**PROJECT DESIGN DOCUMENT  
ANNEXES**

## Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AMC	Australian Managing Contractor
AT	AusAID Assessment Team
AusAID	Australian Agency for International Development
EPS	Epidemic Prevention Stations
GoA	Government of Australia
GoPRC	Government of the Peoples Republic of China
HIV	Human Immuno-deficiency Virus
IDU	Injecting Drug User
IEC	Information, Education, Communication
LTHBC	Long Term Home Based Care
MCH	Mother and Child Health
MoH	National Ministry of Health in Beijing
MoFTEC	National Ministry of Foreign Trade and Economic Cooperation in Beijing
PCC	Project Coordinating Committee
PDD	Project Design Document
PRC	Peoples Republic of China
STI	Sexually Transmitted Infection
UNAIDS	United Nations Joint Programme on AIDS
TAG	Technical Advisory Group
WB	World Bank
WB9	World Bank Loan Health Nine Project: HIV/AIDS Prevention and Control Sub-project
WHO	World Health Organisation
Xinjiang	Xinjiang Uygur Autonomous Region

**Annex 2: List of People/Organisations Consulted**

***Australian Agency for International Development (AusAID)***

Stephanie Copus Campbell, Assistant Director, North Asia Section, Canberra  
 Andrew Dollimore, North Asia Section, Canberra  
 Romaine Kwesius, Beijing  
 Raha Roggero, Program Officer, Beijing  
 Liu Lili, Senior Project Officer (Development Co-operation), Beijing  
 Briefings on contract, gender and other issues, Canberra

***Previous Project Feasibility/Design Team (Australian Members)***

Stephen Ranck, HIV/AIDS Design Specialist  
 Judy Rudland, HIV/AIDS Institutional Specialist

***HIV/AIDS Consultant Input to Assessment Team***

Wu Fan, Shanghai

***Ministry of Foreign Trade and Economic Cooperation, Beijing (MOFTEC)***

Zhao Zhongyi, Deputy Division Director, Department of International Trade and Economic Affairs  
 Huang Jing, Department of International Trade and Economic Affairs  
 Economic Affairs

***Ministry of Health, Beijing***

Shen Jie, Director, Division 11 of Communicable Diseases Control, Department of Diseases Control  
 Xiao Dong Zhan, Programme Officer, Department of International Cooperation  
 Xia Gang, Programme Officer, Division 11 of Communicable Diseases Control, Department of Diseases Control  
 Mme Gong, Nursing Division, Department of Medical Administration

***Canadian Cooperative Association***

Sue Carey, Country Program Director  
 Xiaolong Hu, Country Program Manager

***UNAIDS***

Emile Fox, Country Programme Advisor, UNAIDS China Office  
 Sun Gang, National Programme Officer, UNAIDS China Office

***United Nations Children's Fund (UNICEF)***

George Ionita, International Consultant, Area Office for China and Mongolia

***United Nations International Drug Control Programme (UNDCP)***

Marc Morival, Project Manager, Subregional Development of Institutional Capacity for Demand Reduction Among High Risk Groups

*World Bank*

Wayne Shiyong, Health Specialist, Beijing

*Canadian Co-operative Association*

Xiaolung Hu, Country Program Manager

Sue Carey, Country Program Director

***China AIDS Network (CAN)***

Zhang Kong Lai (and Professor, Department of Epidemiology, Peking Union Medical College (PUMC); Member, National Expert Advisory Committee on AIDS Control; Vice-President, Chinese Association of Prevention and Control of STD/AIDS; Vice-President, Beijing Association of Prevention and Control of STD/AIDS)

***Department for International Development, UK (DFID)***

Jane Haycock, Health Sector Manager, First Secretary

*Medecins Sans Frontiers*

Ms Frederick, Project Director

*Xinjiang Region Government*

Maimaitiming Zhaker, Vice Chairman

*Xinjiang Region Department of Foreign Trade and Economic Cooperation (DOFTEC)*

Wang Kelin, Deputy Director General

Omerjan, Foreign Economic Cooperation Division

*Xinjiang Bureau of Health*

Maimaitiming Yasen, Director

Wang Shaohua, Deputy Director

*Xinjiang Region Bureau of Public Security*

Yang Sugun, Secretary

*Xinjiang Region Department of Justice, Labour Reform and Correction Centre*

Yuan Weipig, Party Secretary

Zhang Hua, Director

Mi Maher, Sports, Health and Education Committee

*Xinjiang Region Department of Jail*

Tu Sunjiang, Deputy Division Director

Feng Zengjun, Section Chief

*Xinjiang Region Bureau of Justice*

Sun Xichun, Deputy Division Director

*Xinjiang Region Red Cross*

Rehefu Abbas, President and Director of General Committee of China Red Cross  
Hai Li Man, Director

*Xinjiang Region Bureau of Tourism*  
Bai Er Ni Sha, Marketing and Promotion Department

*Xinjiang Region Women's Federation*  
Fan Yuzhi, Director, Department of Women's Rights and Interests  
Ha Si Ye Ti, Director, Children's Development Centre

*Xinjiang Region Committee of Family Planning*  
Yang Liping, Director

*Xinjiang Region Association of Blood Transfusion*  
Lian Wa

*Xinjiang Institute for Endemic Disease Research and Control STD Surveillance Centre*  
Ju Laiti, Director  
Hu Zong Yao, Physician

*Xinjiang Region EPS*  
Tulahong Yakupu, Director  
Luo Kaiji, Vice Director and Director of HIV/AIDS Surveillance Centre  
Zhang Wei, Vice Director, HIV AIDS Surveillance Centre  
Li Fan, Vice Chief, Intervention Station, HIV/AIDS Surveillance Centre  
Ni Mingjian, Vice Director, Executive Office, WB9 at Regional EPS  
Deng Hong, Staff Member, HIV/AIDS Surveillance Centre Laboratory  
Other staff members

*Urumqi Municipal Bureau of Health*  
Tian Xu Zhong, Chief, Disease Prevention Department  
Wu Osman, Vice Chief

*Urumqi Bureau of Education*  
Mr Ma, Sports, Health Education and Arts Department

*Urumqi Municipal EPS*  
Huang Sen, Director and Chief Physician  
Rui Bao Ling, Chief, HIV/AIDS Prevention Section  
Du Da Wei, Vice Chief, HIV/AIDS Prevention Section  
Zhang Man, Inspector, HIV/AIDS Laboratory  
Other staff members

*Urumqi Municipal Detoxification Centre*  
Jia Sen Min, Vice Director  
Staff members

*Ili Autonomous Prefecture*

Lu Tiaxin, Secretary General, Autonomous Prefecture Government  
 Fong Xiang Yan, Vice Director, Bureau of Justice  
 Ms. Shabahair, Vice Chairman, Women Federation  
 Chen Mingqing, Vice Department Chief, Public Security Bureau  
 Zhen Minixing, Vice Director, EPS  
 Duan Tian Min, Vice Director, EPS  
 Dr. Wong, Director of Autonomous Prefecture Hospital

*Ili Administrative Prefecture*

Zhong Chian, Vice Department Chief, Public Security Bureau  
 Shen Domjim, Secretary, Justice Bureau  
 Silamu, Vice Director, Health Bureau

*Yining City*

Tian Long, Director, Justice Bureau  
 Zhao Zhixin, Vice Director, Public Security Bureau  
 Mr. Salaiti, Vice Director, Public Security Bureau  
 Cao Yongtin, Director, Tourism Bureau  
 Shayiliati, Staff, Education Bureau  
 Xioa Kaiti, Staff, Education Bureau  
 Ms. Rexidan, Family Planning Commission  
 Wanh Ju Pin, Head, HIV Surveillance Intervention Centre  
 Staff and volunteers of Street Clinics, STD Clinics, Peer Education Programmes

*Kashgar Prefecture Bureau of Justice*

Mr. Lai, Director

*Kashgar Prefecture Bureau of Public Security*

Mr. Awarted

*Kashgar Prefecture Bureau of Health*

Dr. Zhong Peng, Director and Director, EPS  
 Dr. Yu, EPS  
 Other staff members

*Kashgar Prefecture Education Commission*

Mr. Awuti

*Kashgar Prefecture Bureau of Tourism*

Mr. Ren

*Kashgar Secondary School of Medicine*

Yin Jing Zhen, President  
 Dr. Muther, Vice President

Yang Shi Qing, Head, Administration  
Other staff members

*Kashgar Womens Federation*  
Ms. Anakertz, Administration

*Annex 8: Outline TOR for Key Advisors*

**AUSTRALIAN TEAM LEADER / PLANNING & MANAGEMENT  
ADVISOR**

**Overall Responsibility**

This “**core**” long-term position, will report to the Project Director and will be responsible, firstly, for the management of all Australian-funded inputs in Xinjiang and, secondly, for the provision of planning and management advice to the Director of the regional Bureau of Health, his senior executive team and the planners and managers of other stakeholder agencies.

**Duties**

As **Australian Team Leader**, provide direction and leadership throughout the Project, with responsibilities including:

- Management and co-ordination of all Australian-funded inputs into the Project, including all other technical assistance;
- Ensuring that the Project operates efficiently and effectively and within budgets and specified timeframes;
- Preparing the Inception Report, Annual Plans, Monthly Reports, Six-Monthly Reports, and other necessary Project documentation, in conjunction with the Project Manager and Technical Director as appropriate;
- Providing necessary reports and advice to the AusAID officers in Beijing and to the Project Co-ordinating Committee;
- With the support of the various specialist advisors, ensuring that the Project produces a coherent and integrated set of outputs which materially improve and strengthen the planning, management and delivery of interventions in HIV/AIDS prevention and care;
- Assess and report on the achievement of Advisor / partner staff skill transfer objectives for each short term specialist advisor assignment. These reports are to form annexes to the respective exit reports;

- Oversee the establishment, on-going management and reporting of the activity support facility which will provide funding for trial interventions to be undertaken by a range of stakeholder agencies;
- Ensure that adequate time and appropriate processes are devoted to co-ordination with other national and international agencies involving themselves in HIV/AIDS prevention and care activities;
- Manage the monitoring and evaluation of the Project.

As **Planning and Management Advisor**, the individual will be expected to provide wide-ranging advice, training and systems development that will strengthen local capability in the overall, strategic level planning, management and monitoring HIV/AIDS prevention and care responses in the region. Areas to be addressed will include:

- Managing the process of implementing one or more study tours to provide senior policy makers and planners with exposure to experience and lessons learned in other countries and other parts of China;
- Developing and implementing orientation and advocacy workshops to raise awareness of the need for systematic planning of HIV/AIDS responses;
- Providing assistance and advice as requested with the further development and implementation of the Regional Mid to Long Term Plan for HIV/AIDS Prevention and Control;
- Providing advice on the development and use of evidence based planning capacity in regional, prefecture and county level agencies;
- Providing guidance as required with the development, monitoring, evaluation and refinement of response plans in various agencies, including the development and use of useful performance indicators;
- Facilitating the design and documentation of proposals for agency activities that may be suitable for support under the Activity Support facility to be established under the Project;
- Overseeing the inputs of the Monitoring and Evaluation Specialist and continuing the initiatives between inputs by the specialist.

- Supporting the review of HIV testing and reporting procedures in Component 3 and providing advice and assistance in the strengthening of systems and procedures;
- Supporting the development of initiatives to strengthen co-ordination between agencies and promoting the sharing of information and lessons learned;

In all of the above, the Health Sector Management Advisor may be supported by other, specialist Advisors from time to time but will be required to provide strong guidance and reinforcement throughout the Project.

In carrying out these tasks the Advisor will:

- Seek to promote the concept and practice of a multi sectoral approach to the epidemic;
- Develop and implement a program of skill transfer objectives for the individuals that are identified as key partners, in close consultation with the those individuals;
- Provide day-to-day interaction with the Vice Director (Public Health) and other senior technical and management staff, where effective planning and management practices can be demonstrated and developed;
- Assist with the development of procedure manuals and other documentation in a user-friendly format and with appropriate content so as to provide a real aid to sustainability;
- Conduct regular workshops and facilitate other useful mechanisms for sharing of skills and information with partners;
- Travel with partner staff to project prefectures throughout Xinjiang to support and strengthen consultative and supervisory processes and capabilities;
- Provide advice and mentoring in report writing, submission preparation, personal organisation at work, time management, staff supervision and management, understanding, preparing and using program budgets, the development of financing strategies, approaches to decision-making, the conduct of meetings and workshops.

### ***Key Partner Staff***

The key partner will be the Vice Director Public Health, of the regional BoH, but the ATL/Planning and Management Advisor will also work closely with senior staff in other stakeholder agencies

### **Experience and Qualifications**

Extensive experience at a senior level in development, planning and management of public service within the health sector. Close familiarity with a range of best practice initiatives in HIV/AIDS prevention and care should also be evident. Project and/or management experience in China would be a distinct advantage as would working ability in Mandarin.

The individual must have excellent interpersonal skills, a clear understanding of the advisory role in a development co-operation project and should be used to acting in the role of mentor/trainer.

### **Location**

Based in regional BoH Headquarters, Urumqi, but regularly visiting other agencies and prefectures throughout Xinjiang region.

### **Duration**

The input is expected to be full time for the duration of the Project. This role is crucial because of its dual advisory and management responsibilities.

## **AUSTRALIAN SHORT TERM ADVISOR**

### **POLICY AND PLANNING**

#### **Overall Responsibility**

This position will report to the ATL / Planning and Management Advisor and will be responsible for the provision of advice, training, and systems and process development assistance in respect of HIV/AIDS policy response and planning, across a range of agencies in Xinjiang.

#### **Duties**

- Support the ATL / Planning and Management Advisor in providing advice and assistance with the further development of the regional Mid to Long Term Plan for HIV/AIDS Prevention and Control;
- Advise member agencies of the Regional Multi Sectoral Leading Group on HIV/AIDS Prevention and Control on the development of roles and responsibilities in relation to prevention and care;
- Conduct training workshops on planning with particular reference to HIV/AIDS responses and their resourcing;
- Assist with the identification and assessment of the policy and regulatory frameworks, within which agencies operate, that may serve to assist or hinder HIV/AIDS responses;
- Assist where requested in the development of coherent agency response plans in line with agreed roles and responsibilities and within regional and national policy guidelines;
- Assist with the development and documentation of proposals for funding support under the Activity Support Facility;
- Liaise with other national and international agencies involved in HIV/AIDS initiatives to assist with planning and co-ordination.
- Assist with the documentation of appropriate, user-friendly procedures manuals and guidelines which can be used in staff training and familiarisation and thereby contribute to sustainability;.

- Prior to each visit prepare a draft work program and submit to the ATL. Prior to leaving China on completion of each visit, prepare and submit a brief but salient exit report.

In carrying out these duties, the specialist HIV/AIDS Policy and Planning Advisor will consult closely and interact co-operatively with partner agency staff and with the long term advisors.

### **Partner Staff**

This advisor will consult with and assist planners in BoH/EPS and in a range of other agencies as they seek to become involved in the multi sectoral response.

### **Location**

Based in regional BoH Headquarters in Urumqi but with significant time spent with other agencies in the regional capital and in Yining and Kashgar.

### **Duration**

This is a short-term advisory role with a total expected input of 12 months over the five year life of the Project. These inputs will probably occur mostly in the first two years of the Project but there will be return visits for reinforcement of skills transfer.

### **Experience and Qualifications**

A degree in an appropriate discipline is required together with substantial and senior level experience in policy development and planning for HIV/AIDS responses. Health sector planning consultancy in Asia would be a major advantage.

The individual must have excellent interpersonal skills, a clear understanding of the advisory role in a development co-operation project and should be used to acting in the role of mentor/trainer.

## **AUSTRALIAN LONG TERM ADVISOR**

### **HEALTH PROMOTION**

#### **Overall Responsibility**

This “**core**” long-term position, will report to the team leader and will be responsible, for the provision of advice and technical support for all aspects of Component 2 (Health Promotion) and for inputs relating to improved counselling in HIV/AIDS in Component 3.

#### **Duties**

As **Long-term Adviser in Health Promotion**, provide technical advice and support from years one to four for:

- Planning health promotion capacity building activities in consultation with the Short-Term Adviser for Health Promotion (STA/HP), and the appropriate Chinese project partners
- Providing support to the STA/HP and appropriate Chinese project partners in the appraisal of current mass media for HIV/AIDS, and equipment needs for IEC development and production
- Designing and delivering formal training sessions in health promotion and social marketing to appropriate Chinese partners and trainers under the supervision of the STA-HP
- Providing on-going technical advise and support and facilitate the institutionalization of training content with participants
- Supporting health training institution to deliver and evaluate new HIV/AIDS curricula (under the guidance of the STA-Training and Curricula Development)
- Providing on-going technical advise and support to the partner agencies implementing trials focused on behavior change (component 2)
- Designing and deliver formal training sessions in counselling skills for HIV/AIDS (Component 3) to appropriate Chinese trainers
- Producing progress reports as requested by the Australian Team Leader
- Adopting a sustainable approach to skills transfer

#### **Counterparts or Project Partners**

The key project partners will be the Director of the Regional EPS and appropriate staff from the Health Education Unit. The LTA/HP will also work directly with the prefecture level counterparts, and suitable members of the partner agencies that will participate in

health promotion and social marketing.

### **Experience and Qualifications**

Post-graduate qualifications in health or social sciences including training in basic or operations research methods. A post-graduate qualification in health promotion is desirable, but not essential.

Experience in health promotion in resource-constrained environments would be highly advantageous. If the individual does not have international health experience, they must have developed significant experience in health promotion in their own country. This role will be strongly supported by the STA/HP.

The individual must have excellent interpersonal skills, a clear understanding of the advisory role in a development co-operation project and should be able to act in the role of mentor/trainer rather than implementer. In addition, the individual must be able to work within the context of Chinese approaches to community mobilisation and development.

### **Location**

Based in Urumqi, Xinjiang and situated within the BOH. Travelling within Xinjiang required particularly to Kashgar and Yining.

### **Duration**

The input is expected to be full time from years one to four. The fourth year is expected to focus on phasing out of support, and ensuring maximum sustainability is achieved.

## **AUSTRALIAN SHORT TERM ADVISER**

### **MONITORING AND EVALUATION**

#### **Overall Responsibility**

This short-term position, will report to the team leader and will be responsible, for the provision of advice and technical support for all aspects of Monitoring and Evaluation in the Project. This includes capacity building with Project partners as well as the development and management of the Project monitoring and evaluation framework.

#### **Duties**

As **Short-Term Adviser for Monitoring and Evaluation**, provide technical advice and support from years one to five for:

- Assess the evaluation capacity amongst Project partner organizations, the EPS, and academic institutions in Xinjiang;
- Building appropriate evaluation capacity amongst Project partners organizations, the EPS, and academic institutions in Xinjiang through the provision of formal short courses and on-the-job support and facilitation;
- Provide support to partners to facilitate an annual monitoring and evaluation seminar that will review the M&E activities and findings and generate lessons learnt;
- Adopt a sustainable approach to skills transfer;
- Review the design of selected intervention trials and make recommendations for improvement in design and management;
- Conduct an Evaluability assessment of the Project;
- Develop and manage the Monitoring and Evaluation Framework;
- Submit annual Monitoring and Evaluation Report;

#### **Counterparts or Project Partners**

The key Project partners will be the Director of the Regional EPS. The STA/M&E will also work directly with the prefecture level counterparts, and suitable members of the partner agencies and academic institutions that will be involved in the monitoring and evaluation of intervention trials, as well as work with other STAs for M&E of all components.

**Experience and Qualifications**

Post-graduate qualifications in health or social sciences including training in, at a minimum, basic or operations research methods. More advanced training in research or evaluation methods is highly desirable.

Experience in project management, and more specifically project monitoring and evaluation is essential. The incumbent should be able to demonstrate a good knowledge of current practice in project evaluation.

The individual must have excellent interpersonal skills, a clear understanding of the advisory role in a development co-operation project and should be able to act in the role of mentor/trainer rather than implementer. In addition, the individual must be able to work within the context of Chinese approaches to health care delivery, and social science research and practice.

**Location**

Urumqi, Kashgar and Yining in Xinjiang.

**Duration**

The input is expected to be 330 days over five years with 80 days in year one.

## **AUSTRALIAN SHORT TERM ADVISER**

### **CURRICULA DEVELOPMENT**

#### **Overall Responsibility**

This short-term position, will report to the team leader and will be responsible, for the provision of advice and technical support for the development of training curricula for basic and on-going training of health workers in HIV/AIDS.

#### **Duties**

As **Short-Term Adviser for Curricula Development**, provide technical advice and support from years one to five for:

- A training needs analysis for all levels of health workers with respect to HIV/AIDS;
- Curricula development for all levels of health workers:
- The design of monitoring and evaluation activities for the delivery of curricula;
- Work within a capacity building/skills transfer approach.

#### **Counterparts or Project Partners**

The key project partners will be the Director of relevant academic institutions, while working more directly with staff engaged in curricula development.

#### **Experience and Qualifications**

Qualifications in health or education. Experience in curricula development, education and/or training is essential, preferably gained in resource constrained environments.

The individual must have excellent interpersonal skills, a clear understanding of the advisory role in a development co-operation project and should be able to act in the role of mentor/trainer rather than implementer. In addition, the individual must be able to work within the context of Chinese approaches to health care delivery, and education.

#### **Location**

Urumqi, Kashgar and Yining in Xinjiang.

#### **Duration**

The input is expected to be 45 days over 2 years with 35 days in year one, and 10 days in year 2.

## **AUSTRALIAN SHORT TERM ADVISER**

### **HIV/AIDS TESTING AND HOSPITAL MEDICAL CARE**

#### **Overall Responsibility**

This short-term position, will report to the team leader and will be responsible, for the provision of advice and technical support for efficient and effective HIV/AIDS testing and best practice medical care in hospitals of people with HIV/AIDS.

#### **Duties**

As **Short-Term Adviser for HIV/AIDS Testing and Hospital Medical Care**, provide technical advice and support from years one to five for:

- Clarifying appropriateness of testing materials and their use;
- Training of doctors in hospital pilot site(s) in best practice care;
- The design of monitoring and evaluation activities for assessing progress;
- Work within a capacity building/skills transfer and multidisciplinary approach.

#### **Counterparts or Project Partners**

The key project partners will be the Director and medical staff of relevant hospital(s).

#### **Experience and Qualifications**

Qualifications in medicine. Experience in HIV/AIDS clinical care in hospitals.  
Experience in teaching and evaluation.

The individual must have excellent interpersonal skills, a clear understanding of the advisory role in a development co-operation project and should be able to act in the role of mentor/trainer rather than implementer. In addition, the individual must be able to work within the context of Chinese approaches to health care delivery, and education.

#### **Location**

Urumqi, Kashgar and Yining in Xinjiang.

#### **Duration**

The input is expected to be 204 days over 5 years with 30 days in year one, 72 days in year 2, 30 days in year 3, 42 days in year 4, and 30 days in year 5.

## **AUSTRALIAN SHORT TERM ADVISER**

### **HIV/AIDS HOSPITAL NURSING CARE**

#### **Overall Responsibility**

This short-term position, will report to the team leader and will be responsible, for the provision of advice and technical support for best practice nursing care in hospitals of people with HIV/AIDS.

#### **Duties**

As **Short-Term Adviser for HIV/AIDS Hospital Nursing Care**, provide technical advice and support from years one to five for:

- Training of nurses in hospital pilot site(s) in best practice care;
- The design of monitoring and evaluation activities for assessing progress;
- Work within a capacity building/skills transfer and multidisciplinary approach.

#### **Counterparts or Project Partners**

The key project partners will be the Hospital Director, Nursing Director and nursing staff of relevant hospital(s).

#### **Experience and Qualifications**

Qualifications in nursing. Experience in HIV/AIDS clinical care in hospitals. Experience in teaching and evaluation.

The individual must have excellent interpersonal skills, a clear understanding of the advisory role in a development co-operation project and should be able to act in the role of mentor/trainer rather than implementer. In addition, the individual must be able to work within the context of Chinese approaches to health care delivery, and education.

#### **Location**

Urumqi, Kashgar and Yining in Xinjiang.

#### **Duration**

The input is expected to be 204 days over 5 years with 30 days in year one, 72 days in year 2, 30 days in year 3, 42 days in year 4, and 30 days in year 5.

## **AUSTRALIAN SHORT TERM ADVISER**

### **STI POLICY AND PLANNING**

#### **Overall Responsibility**

This short-term position, will report to the team leader and will be responsible, for the provision of advice and technical support for best practice management of people with STIs.

#### **Duties**

As **Short-Term Adviser for STI Policy and Planning**, provide technical advice and support from years one to five for:

- Training of doctors in STI clinics in best practice care;
- The design of monitoring and evaluation activities for assessing progress;
- Work within a capacity building/skills transfer, primary health care approach.

#### **Counterparts or Project Partners**

The key project partners will be the Vice-Director of Public Health and key EPS staff.

#### **Experience and Qualifications**

Qualifications in medicine with specialist experience in STIs. Experience in developing and implementing best practice approaches to STIs, including policy and planning development to achieve system change. Experience in teaching and evaluation.

The individual must have excellent interpersonal skills, a clear understanding of the advisory role in a development co-operation project and should be able to act in the role of mentor/trainer rather than implementer. In addition, the individual must be able to work within the context of Chinese approaches to health care delivery, and education.

#### **Location**

Urumqi, Kashgar and Yining in Xinjiang.

#### **Duration**

The input is expected to be 264 days over 5 years with 42 days in year one, 60 each in years 2, 3 and 4, and 42 in year 5.

## **AUSTRALIAN SHORT TERM ADVISER**

### **LONG TERM HOME BASED CARE FOR PEOPLE WITH HIV/AIDS**

#### **Overall Responsibility**

This short-term position, will report to the team leader and will be responsible, for the provision of advice and technical support for developing best-practice long term home-based care.

#### **Duties**

As **Short-Term Adviser for Long-Term Home-Based Care**, provide technical advice and support from years one to five for:

- Developing policy and planning guidelines for Long Term Home Based Care;
- Training of nurses and doctors to give skills-transfer to home carers of people with HIV/AIDS;
- Training of key personnel in all relevant components in counselling;
- The design of monitoring and evaluation activities for assessing progress;
- Work within a capacity building/skills transfer, multidisciplinary, primary health care approach.

#### **Counterparts or Project Partners**

The key project partners will be the Vice-Director of Public Health and key staff at prefecture and county level of the pilot site(s).

#### **Experience and Qualifications**

Qualifications in nursing with specialist experience in home-based long-term care of people with HIV/AIDS (including counselling). Experience in developing and implementing best practice approaches to long-term home-based care, including policy and planning development to achieve system change. Experience in teaching and evaluation.

The individual must have excellent interpersonal skills, a clear understanding of the advisory role in a development co-operation project and should be able to act in the role of mentor/trainer rather than implementer. In addition, the individual must be able to work within the context of Chinese approaches to health care delivery, and education.

#### **Location**

Urumqi, Kashgar and Yining in Xinjiang.

**Duration**

The input is expected to be 582 days in-country and 42 days in Australia (for research): 60 days in-country in year 1 and 42 days in Australia, 180 in-country in years 2 and 3, 120 days in year 4, and 42 in year 5.

## **AUSTRALIAN SHORT TERM ADVISER**

### **INFECTION CONTROL**

#### **Overall Responsibility**

This short-term position, will report to the team leader and will be responsible, for the provision of advice and technical support for developing best-practice infection control in hospitals and the home.

#### **Duties**

As **Short-Term Adviser on Infection Control**, provide technical advice and support from years one to five for:

- Developing policy and planning guidelines for infection control;
- Training of nurses, doctors and other key staff in infection control;
- The design of monitoring and evaluation activities for assessing progress;
- Work within a capacity building/skills transfer, multidisciplinary approach.

#### **Counterparts or Project Partners**

The key project partners will be the Vice-Director of Public Health and key staff at prefecture and county level of the pilot site(s).

#### **Experience and Qualifications**

Qualifications in health with specialist experience in infection control, including relating to HIV/AIDS. Experience in developing and implementing best practice approaches to infection control in hospitals and in the home, including policy and planning development to achieve system change. Experience in teaching and evaluation.

The individual must have excellent interpersonal skills, a clear understanding of the advisory role in a development co-operation project and should be able to act in the role of mentor/trainer rather than implementer. In addition, the individual must be able to work within the context of Chinese approaches to health care delivery, and education.

#### **Location**

Urumqi, Kashgar and Yining in Xinjiang.

**Duration**

The input is expected to be 372 days over 5 years with 90 days each in years 1, 2 and 3, 60 in year 4, and 42 days in year 5.

**Annex 10: Risk Management Matrix**

**Key**

L Likelihood 5 = Almost certain ..... 1= Rare  
 C Consequence 5 = Severe..... 1= Negligible  
 R Risk level 4 = Extreme, 3 = High, 2 = Medium, 1 = Low

Risk Event	Source of risk	Impact on the project	L	C	R	Risk treatment	Responsibility	Timing
Difficulty to contract a suitable Australian Team Leader (ATL) and other Australian professional staff.	Availability of Australians with the required expertise and track record for Project length.	Inadequate technical and management expertise will compromise all Components and overall Project.	4	5	3	Careful selection of team leader and other professional staff. Provide adequate remuneration and accommodation and establish supportive mechanisms, especially for the team leader. Build in major overlap for team leader changes.	Australian Managing Contractor	Project preparation and ongoing
Retention of Project staff for the contracted period.	Remote locality of Project, institutional constraints and sensitive nature of key Project activities.	Loss of leadership if ATL leaves; loss of institutional knowledge at critical points; difficulty in maintaining relationships with PRC partners, which take a lengthy time to build in PRC; loss of Project momentum; increased cost to AMC.	4	5	3	Good management support from AMC; adequate remuneration; good accommodation; particular support for ATL.	Australian Managing Contractor	Project preparation and ongoing

<b>Risk Event</b>	<b>Source of risk</b>	<b>Impact on the project</b>	<b>L</b>	<b>C</b>	<b>R</b>	<b>Risk treatment</b>	<b>Responsibility</b>	<b>Timing</b>
Competent translators	Difficulty in finding competent translators knowledgeable in the three major working languages of Mandarin, Uygur and English	Slow progress; communication unclear leading to misunderstandings and frustrations; IEC incorrect; potential success of Project compromised.	4	5	3	AMC responsibility for, and funding of, competent translation; seek language skills first and technical knowledge of HIV/AIDS second. The latter can be quickly taught for competent translation. The former clearly cannot be. As Uygur is a Xinjiang-specific language, it is unlikely that an AMC could find such skills outside of Xinjiang.	Australian Managing Contractor	A priority immediately the Project AMC is known, in collaboration with BoH.
Overlap and duplication with other projects, including WB9	Other donors working in the field of HIV/AIDS.	Funding for this project utilised in other areas; resources wasted by several (or two) donors working on same issue in same geographical area; frustration of Project staff, multisectoral partners and target communities leading to loss of interest and reduction in sustainability potential.	4	5	3	HIV/AIDS strategic plans for all multisectoral partners developed in Year 1, containing within them all donor funded activities, enabling transparency; good working relationships established between ATL and other donor key people; good working relationships established between ATL and Project team and key people in multisectoral partner agencies.	Australian Managing Contractor	A priority in Year 1 and then ongoing to maintain and continuously strengthen relationships, ensure transparency and enable monitoring.

<b>Risk Event</b>	<b>Source of risk</b>	<b>Impact on the project</b>	<b>L</b>	<b>C</b>	<b>R</b>	<b>Risk treatment</b>	<b>Responsibility</b>	<b>Timing</b>
Interventions not replicated.	Lack of funding commitment by GoPRC.	Non-sustainability of reduction in transmission of HIV.	4	5	3	Development of transparent and agreed transfer strategies of Project interventions to GoPRC including for GoPRC budget provision.	Australian Managing Contractor and GoPRC	In Year 1 as initial discussions and firmed up and agreed as replication need becomes clear, including in Year 4 for transfer in Year 5 for all remaining issues.
Multisectoral agency HIV/AIDS Plans not developed and Component 2 not successful enough to fully enable Component 3.	Poor AMC management and lack of commitment by GoPRC.	Minimal impact in reducing transmission of HIV.	3	5	2	Carefully planned involvement of multi-sectoral partners; close working relationship established and maintained with BoH and multi-sectoral partners on Working Group; sound Project management by AMC.	Australian Managing Contractor and GoPRC	From Day 1 and ongoing.

Risk Event	Source of risk	Impact on the project	L	C	R	Risk treatment	Responsibility	Timing
Health risk for Australian Project staff.	Remote locality and some air pollution in Urumqi (although appears to be diminishing).	Illness resulting in staff absences.	3	4	2	Regular use of a Project vehicle for weekend travel beyond Urumqi; regular work/R & R visits to Beijing and elsewhere; mechanisms for adequate health care if illness arises.	AMC and support through AusAID guidelines and policy.	Project preparation and ongoing
Travel safety risk for Australian Project staff	Unsafe aircraft on southern Xinjiang routes during winter, although there are plans to overcome this in 2001. Long distance road travel has dangerous traffic conditions. Poor vehicle maintenance and lack of skilled and safety conscious drivers.	Project vehicle accidents. Possible loss of Australian project staff.	4	4	4	Ensure that the Australian team leader controls all project vehicle use; selects all drivers; ensures driver skills training on 4-wheel drive vehicles; ensures an adequate maintenance schedule for all vehicles; and can immediately dismiss drivers for poor driver performance. Use train travel Urumqi-Kashgar if unsafe aircraft operating.	AMC; ATL; Project staff; support through AusAID guidelines and policy	Project preparation and ongoing
Limited availability of baseline data for targeting project activities, especially to the Uygur and vulnerable groups	Current lack of formal Xinjiang socio-cultural data to inform project design.	Reduced appropriateness and effectiveness of project activities.	4	4	3	Project design incorporates assessments and surveys. Senior officials assure that information is available and conditions, attitudes and behaviours are known. Evaluation methodology in Project is rigorous.	AusAID. AMC. ATL and Project staff. Chinese Team Leader.	Project design and ongoing
Restriction of harm reduction approaches for activities targeting injecting drug users	Injecting drug use is illegal in China. Problem of acceptability to government agencies of harm reduction strategies for HIV prevention among injecting drug users	Limitation of project activities targeting injecting drug users, in particular harm reduction approaches relating to messages to IDUs not to share needles and syringes,	4	4	4	Initially target activities to staff of drug rehabilitation centres and to trial interventions amongst drug users and within communities. Strengthen existing education and counselling by Women's Federation and Red Cross. Monitor successes of harm reduction activities in the Department of	AMC. ATL and Project staff. Chinese Team Leader.	Project design and ongoing

Risk Event	Source of risk	Impact on the project	L	C	R	Risk treatment	Responsibility	Timing
		when appears to condone an illegal activity. Reduced Project effectiveness in reaching the core of the epidemic				International Development Yunnan and Sichuan project		
Restriction of harm reduction approaches for activities targeting CSWs	Environment in which sexuality is not a subject for frank and public discussion, in particular when ethnic minority populations are involved. Prostitution is illegal in China. Problem of acceptability to government agencies of harm reduction strategies for HIV prevention among sex workers	Limitation of project activities targeting CSWs. Reduced Project effectiveness.	4	4	4	Trial interventions targeting CSWs in rehabilitation and re-education centres. Monitor harm reduction activities in Yunnan and Sichuan projects for lessons learned. Develop multi-sectoral capacity to target entertainment industry.	AMC. ATL and Project staff. Chinese Team Leader.	Project design and ongoing
Most activities implemented by counterpart agencies with limited role of the Australian Managing Contractor project team in direct implementation of key activities	Project Design based on local ownership and capacity building.	Longer time frame for effective trial interventions.	4	3	2	The design of the Project for capacity building, support and monitoring and evaluation is robust.	AMC. ATL and Project staff. Chinese Team Leader.	Project design, inception phase and duration of project

Risk Event	Source of risk	Impact on the project	L	C	R	Risk treatment	Responsibility	Timing
Limited experience of implementing partner agencies for multi-sectoral collaboration and to design, manage, implement and monitor effective HIV/AIDS prevention and care programs and activities	Rigid bureaucratic boundaries. Tradition of government top down planning and implementation. Limited experience in collaborating with foreign donor projects. Limited technical skills in HIV/AIDS, multi-sectoral planning, managing and evaluation.	Reduced effectiveness of project activities.	3	4	3	Regional Multi-sectoral Leading Group on HIV/AIDS has provided some learning experiences. Smaller multisectoral Working Group planned for Project will be effective with Project support. Capacity building design robust. Regional HIV/AIDS Plan (when endorsed) will provide multi-sectoral framework, as does national plan. Civil service reform and delegation of responsibilities in progress.	AMC. ATL and Project Staff. Chinese Team Leader.	Project design, inception phase and ongoing
Xinjiang stakeholders use AusAID project funds for counterpart contributions to WB9	Xinjiang budget limitations to provide counterpart funds	Diversion of resources from Project.	3	5	3	Transparent accounting and accountability mechanisms built into Project design.	AMC. WB9 team leader. Independent AusAID scrutiny (TAG).	Project design and ongoing
Ineffective monitoring of progress toward achieving objectives; lack of transparency and shared commitment to assessing progress and achieving goals.	Confusion or misunderstanding amongst the various groups involved in implementation.	Inability to detail project impact; inability to fully utilise project monitoring as feedback for change or adjustment of activities.	3	4	3	Support for developing multi-sectoral partner agencies' own HIV/AIDS plans early in Project. Strong emphasis on rigorous selection of trials and their evaluation. Emphasis on broader capacity building in planning, effective project management and evaluation. Ongoing risk assessment built into Project design.	AMC. ATL and Project staff. Chinese Team Leader. Xinjiang Working Group. TAG.	

<b>Risk Event</b>	<b>Source of risk</b>	<b>Impact on the project</b>	<b>L</b>	<b>C</b>	<b>R</b>	<b>Risk treatment</b>	<b>Responsibility</b>	<b>Timing</b>
Inability of project staff to meet the geographical coverage planned by the project.	Logistical, political or other considerations that may prevent staff from adequately servicing the planned project activities across the planned geographical coverage of the project.	Reduced geographical impact of the project; potential for those who are (1) the poorest or (2) most isolated, to receive the least attention and resources.	3	5	4	Managed through monitoring and evaluation, inbuilt in Project design. Partnership approach emphasised in Project to develop strong relationships at all levels to ensure mutual cooperation. Project team following guidance of Xinjiang partners on precautions re travel.	AMC. ATL and project staff. Chinese Team Leader. TAG.	From commencement of monitoring and evaluation

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