“Testing for Your Own Good”: HIV Testing as an Intervention Among Men Who Have Sex With Men (MSM) in Northwestern China

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Thesis submitted in partial fulfillment of the requirements for the degree of Master of Science in the Duke Global Health Institute in the Graduate School of Duke University

2015
ABSTRACT

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Abstract

Since 2005, China Global Fund AIDS programs have considered men who have sex with men (MSM) an “at-risk population” with priority and significance to receiving HIV testing. Community-based organizations (CBOs) have been involved in implementing the intervention programs, including free HIV testing, to MSM. This thesis explores the consequences of HIV testing as an intervention on local MSM’s perceptions and relationships. Participant observation, in-depth interview and textual analysis were conducted during fieldwork research at a local CBO. It is argued that the complexities of everyday practices of public health programs at the community-level need to be emphasized in supervision. The success of China’s HIV/AIDS intervention strategies is at stake: free HIV testing needs to be implemented as a benefit to testing receivers’ health instead of as an obligation or commodity. In everyday practice, HIV testing is full of complexities and via HIV testing, interrelations among CDC system, local CBOs, and local MSM are reproduced and images and perceptions of free HIV testing are reconstructed. Moreover, receiving HIV testing was integrated into a new moral discourse of how to be a “good” MSM. It is recommended for local CBOs to cultivate their professionalization, and be aware of new stigmatization produced by free HIV testing. Meanwhile, a transition of local governmentality and supervision technologies is needed.
# Contents

Abstract.................................................................................................................................iv

List of Photos ..........................................................................................................................vii

List of Figures ...........................................................................................................................viii

Acknowledgements ..................................................................................................................ix

1. Introduction ..............................................................................................................................1
   1.1 Background ..........................................................................................................................1
   1.2 Previous studies ..................................................................................................................3
   1.3 Formulating research questions .........................................................................................4

2. Entering the Field ....................................................................................................................6
   2.1 Ethnography as a method ..................................................................................................6
   2.2 Locating fieldwork site in time-space ..............................................................................8
   2.3 Participants .......................................................................................................................10
   2.4 Method of sampling .........................................................................................................12
   2.5 Data collection process ...................................................................................................13

   3.1 T City’s move into AIDS program ..................................................................................15
   3.2 HIV testing at the gay bar ...............................................................................................16
   3.3 Sidestepping standard procedures ................................................................................20
   3.4 Romantic relationship and HIV testing ..........................................................................23

4. Supervision of the Quality of HIV Testing ..........................................................................26
4.1 “Purchase of service” in AIDS intervention .......................................................... 27
4.2 Economies of HIV testing: from bonus to commodity ........................................... 29
4.3 Qualities of quality-control methods .................................................................... 32
5. Initiating, Rationalizing and Moralizing HIV Testing as an Intervention .............. 36
  5.1 Scaling up testing ................................................................................................. 36
  5.2 Coming up from underground ............................................................................. 39
  5.3 Perceptions of accepting HIV testing as morally correct .................................... 43
6. Conclusion .............................................................................................................. 46
Appendix A- Glossary ................................................................................................. 50
Appendix B- List of Interviews .................................................................................. 51
References .................................................................................................................. 53
List of Photos

Photo 1: The Inner Space of TYHSCC ................................................................. 10

Photo 2: Beer Bottles and HIV Testing Materials .............................................. 19
List of Figures

Figure 1: Partner status of Fieldwork Research Participants (n=21)................................. 11

Figure 2: Occupations of Fieldwork Research Participants (n=21)...................................... 12
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1. Introduction

1.1 Background

In a recent report published by China’s health officials, there were 104,000 new HIV/AIDS infection cases in China in 2014, 14.8% higher than in the previous year (Burkitt, 2015). To prevent the transmission of the disease, “at-risk populations” in China have been categorized and targeted for HIV/AIDS prevention work for at least eight years. In 2003, an AIDS initiative named CARES project (Comprehensive AIDS Response) was launched by the government as a start for dealing with China’s AIDS crisis (Kaufman, 2010). The China Center of Disease Prevention and Control (CDC) started to expand its HIV/AIDS intervention by becoming a principal recipient of the third-round program of the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) in 2004. For the first round of the AIDS program, China CDC’s target population was the HIV-positive population of seven middle provinces who had been infected in 1990s because of illegal blood selling (Global-Fund, 2004). One year after, for the fourth round, the target populations shifted to four categories of “at-risk populations”: hidden sex workers, intravenous drug users (IDU), men who have sex with men (MSM), and migrant populations. From then on, MSM has always been considered one of the “at-risk populations” by China Global Fund AIDS programs (Global-Fund, 2005).
The rationality of including MSM as an “at-risk population” has been given from a scientific perspective. According to China National Health and Family Planning Commission (NHFPC), sexual transmission was the main form of transmission in 2014 (NHFPC, 2014b). A review and analysis of HIV prevalence among MSM was conducted in 2011, indicating that HIV prevalence among MSM experienced a rapid rise from 1.4% in 2001 to 5.3% in 2009 (Chow, Wilson, Zhang, Jing, & Zhang, 2011). In a China AIDS Response Progress Report submitted to the Joint United Nations Program on HIV/AIDS, a comparison of “HIV positive rates” among different groups also shows that from 2003 to 2013, the “HIV positive rate” (percentage of HIV-antibody-positive cases among all testing receivers) among MSM grew faster (from 0.7% to 7.3%) than any other group, such as “drug user,” “pregnant,” and “truck driver” (NHFPC, 2014a). Beside epidemiological measurements, social and cultural studies also indicate the crucial need to control HIV transmission among MSM. These studies show that because of moral and social pressures regarding filial piety and maintaining patriarchal family structure, Chinese MSM tend to enter heterosexual marriage and engage in sexual intercourse with women (Chow, Wilson, & Zhang, 2011). Consequently, intervention programs among MSM are perceived as of great importance, aiming at preventing not only transmission among this “at-risk” population itself, but also preventing the transmission from MSM to the “general population” (Choi, Gibson, Han, & Guo, 2004; Chow, Wilson, Zhang, et al., 2011; Chow, Wilson, & Zhang, 2011). While in this thesis, I’ll present and discuss
how evidences of categorization of the “at-risk” population was produced at local communities, and how scaling up of HIV testing biased people’s perception of HIV epidemic among MSM.

HIV testing has been confirmed by many empirical studies as an effective apparatus for preventing HIV transmission within high-risk populations in various settings including the United States (Cohen et al., 2011; Das et al., 2010). On the other hand, as mentioned, in China, the MSM population is perceived as a “bridge” population that involves transmission of HIV from MSM to their heterosexual partners (Chow, Wilson, & Zhang, 2011) Therefore scaling-up the testing has also been recommended as an apparatus for preventing HIV transmission from MSM to the “general population” (Fan, 2014). In this circumstance, it is necessary to discover and analyze issues related to the implementation of HIV testing among this particular “at-risk population” so as to maximize its functions and minimalize its ramifications.

1.2 Previous studies

Previous studies on the effects of HIV/AIDS testing in China among men who have sex with men (MSM) mainly use quantitative methods to draw epidemiological conclusions from large population scales (Gao, Zhang, & Jin, 2009; Guo, Li, & Stanton, 2011). Quantitative research, which involves testing hypotheses constructed according to certain models involving limited numbers of variables, lacks the capacity to describe and analyze the complex social and cultural backgrounds of disease transmission and
control. Ethnographic research is considered as a suitable instrument for filling this gap. Being seen as "‘soft science’ in service to the ‘hard,’” ethnographic research serves as a bridge of understanding between scientific perspectives and specific sociocultural contexts (Adams, 2010). Particularly, as Arthur Kleinman defines it, medical ethnography is “a description of a society through a medical lens, a systematic focus on the health-relevant aspects of social life” (Kleinman, 1980).

There is a limited number of medical ethnographic works centered on HIV/AIDS epidemics in China, in which the authors investigate communities of female sex workers and injected drug users (Hyde, 2007; Liu, 2011; Zheng, 2009). The HIV/AIDS interventions among MSM in Northwestern China have seldom been studied previously, particularly focusing on HIV testing. In terms of this specific topic of HIV testing as an intervention in China, Elsa Fan’s study focuses on dynamics and relationships between governmental departments and CBOs. In this study, I sought to analyze interpersonal relationships and the consequences at the community level of HIV testing as an intervention and its scaling up. I utilize an ethnographic strategy to explore HIV testing as an intervention at this specific setting.

1.3 Formulating research questions

There are some ethnographic studies that have focused on the mechanisms and impacts of HIV testing as an intervention. In her research on a national intervention program of HIV/AIDS prevention in Southwest China, Shaohua Liu notes that in terms
of HIV testing and statistics of HIV-positive people, there exist “information blockages” among different state agencies, which produce barriers to data collection and effective program design for interventions (Liu, 2011). In another context of Brazilian HIV/AIDS intervention, João Biehl discusses the meanings of HIV testing among individuals receiving testing. He discovers that the actions of taking a test and obtaining the testing results has a profound influence on individuals’ perceptions and attitudes toward HIV/AIDS, themselves, and their romantic and sexual relationships (Biehl, 2007). Other than these studies that restrict their analysis to particularly institutional or individual perspectives, my project sought to delve into community-based HIV testing from a more interrelated angle, discussing how local MSM, CBOs, and the CDC system were linked together by HIV testing as an intervention, and how dynamics and complexities were generated by these links. Many studies mention complexities and contingencies in implementation of HIV/AIDS intervention programs (Fassin, 2007; Hyde, 2007; Liu, 2011). It has also been noted that in post-socialist China, social administration in areas such as cultural, ethnic, and public health is nonetheless a “singular structure” of socialist governance. It is imbued with and fragmented by complexities of personal desires and regional economies (Anagnost, 1985; Hyde, 2007; Litzinger, 1998).

This research project therefore sought to explore several questions of HIV testing’s complex and interpersonal production and consequences among MSM at the community level: Why and how has HIV testing been constructed and normalized as an
intervention to prevent HIV transmission? What emotional, social, economic and physical consequences were produced on local MSM by promoting and implementing free HIV testing? How did governing agencies supervise the effectiveness of HIV testing implementation? How was receiving HIV testing integrated into local discourse? Through exploration of these questions, I hope to shed light on people’s understanding of HIV testing as an intervention for preventing disease transmission--its mechanism, everyday practices, and consequences, thus stimulating a rethinking of technologies to implement and supervise the testing on a community level. It is anticipated that by this in-depth ethnographic study answering these questions, both critical analysis and practical suggestions can be inspired among HIV/AIDS prevention practitioners in China, in order to develop more effective and thoughtful AIDS programs for their target populations.

2. Entering the Field

2.1 Ethnography as a method

In Michael Agar’s view, empirical social science research focuses on testing preexisting hypotheses via data collection, while for ethnographic study, the researchers are in a learning position, aiming to explore an alien world, to understand its inhabitants, and “make sense of them” (Agar, 1986). Due to this reason, a standardized “scientific” method of hypothesis building, sampling, data collecting, and analyzing is
absent from my ethnographic research. Rather, the main process of my fieldwork was in an “improvisational style” (Agar, 1986). That is to say, my fieldwork involved a mixture of observations, discussions, interviews, and participation. Data collection and analysis were also conceived to involve a dynamic of trial and error, analogical to the process of archeological discovery: deepening and expanding inquiries into meanings, reconsidering objectives, and adjusting instruments of exploration correspondingly (Lévi-Strauss, 2012).

The sensitivity of my research topic also pushed me to utilize an ethnographic strategy. On the one hand, sexuality and HIV/AIDS are topics that people seldom talk about with strangers (Bernard, 2011); on the other hand, the MSM population is stigmatized and marginalized by Chinese social and cultural environment by and large (Burkitt, 2015; Chapman, Cai, Hillier, & Estcourt, 2009; Li, Holroyd, & Lau, 2010). Therefore, strong rapport was essential for me to get access to the population and collect data. My first step upon entering the field was to build rapport with key informants. With an introduction from China Family Planning Association and T City Family Planning Association, I was accepted by a local MSM and organization leader, and became familiar with him gradually. With his help, I was able to locate, select, and communicate with local MSM.

Despite of the advantages and necessities of applying an ethnographic strategy and work as an “insider” of the local MSM community, there is always a risk of over-
involvement which may bring hazardous ramifications to the researcher and research: this might involve losing a critical viewpoint, influencing research objects, and affecting research instruments (Adler & Adler, 1987). In address the concern of over-involvement, my gender identity as female helped me keep a distance from the MSM community and function as an outsider. However, this alienation might encourage research participants to keep secrets and realities from me. To deal with this limitation, multiple techniques of data collection were introduced to the fieldwork, and data concerning main themes were double-checked with various research participants with different perspectives.

Due to the fact that the MSM population stigmatized and discriminated against in China, the exposure of local MSM’s personal information could have a fatal impact on them. Therefore to protect local MSM’s confidentiality, names, phone numbers, and workplace information were not collected. Because of the same reason, I will use a pseudonym, “T City” to refer to the city where the research was conducted.

2.2 Locating fieldwork site in time-space

Throughout the fieldwork, I worked closely with my key informant, Lao Hu (a pseudonym), owner of the only gay bar of T City, as well as the director of T City Yangguang Health Service and Counseling Center (TYHSCC). The development of the gay bar and TYHSCC were tightly entangled with each other and with the trajectory of HIV/AIDS prevention work of T City CDC. TYHSCC did not even exist at the beginning of T City’s HIV/AIDS prevention work. Lao Hu had owned a hui suo (venues that
usually provide sexual services) for MSM recreation in T City since 2006. Self-defined as “ban gong kai (half-out)” “tongzhi (homosexual people in Chinese context)” (Interview P1), he initially participated in T City CDC’s interventions because he had access to local MSM and could help CDC recruit participants. In 2007, the hui suo was shut down and then Lao Hu opened a gay bar at a converted location, the dead-end of a small alley, chosen because of his perception that local MSM are reluctant to be exposed to public attention.

From then on, Lao Hu has been not only recruiting participants for HIV prevention activities, but also providing the activities with space by the gay bar. Before 2011, all the activities—HIV prevention education sessions, voluntary counseling and testing (VCT) for HIV, and condom dissemination were conducted by T City CDC officials; in 2011, Lao Hu got trained by Provincial CDC and China Family Planning Association (CFPA) and started to conduct education sessions and condom dissemination by himself and volunteering colleagues. Since then, T City CDC began to shift its role from director of the activities to technical and financial support. Lao Hu and his gradually built-up team of volunteers are shouldering an increasing amount of responsibilities: once people who “gave CDC a hand” (Interview P1; G2), they have become directors and hosts of the HIV-prevention work among local MSM and named their team Yangguang working team. In 2012, Yangguang working team members started to conduct HIV testing by themselves. In 2013, TYHSCC was initiated and
registered as a non-profit organization at T City Bureau of Civil Affairs by Lao Hu and his working team colleagues, and officially demonstrated its missions as “serving vulnerable populations and helping them to maintain their health and well-being.” The former Yangguang working team and now TYHSCC shared space with the gay bar.

The former Yangguang working team and now TYHSCC shared space with the gay bar.

Photo 1: The Inner Space of TYHSCC

2.3 Participants

The majority of people that I observed in the field were males who lived in T City. My observation sites were two open spaces where local MSM socialized: a gay bar and a park, so the targets of my observation were both diverse and mobile. There were around 40 males who regularly visited the gay bar and participated in TYHSCC’s activities. People who I observed in the park tended to overlap with regulars of the gay

1 The working and counseling desk is on the left of this photo
bar. The youngest one that I observed was 17 years old and the oldest was 50. Most of the people who frequented the sites were in their 20s and 30s.

There were 21 local MSM who responded to my semi-structured in-depth interview, and their backgrounds were of great variety. Among these 21 people, three were married, three had long-term male partners, one had a long-term female partner, one was divorced, and the remaining 13 claimed to be single—they had never married, and did not have long-term partners. The age of these respondents ranged from 17 years old to 45. Four of the respondents were unemployed, two were students, and other 25 had jobs such as government officials, shop owners, assistants, teachers, etc. Four respondents claimed that they had undertaken commercial sex work occasionally. Among all of the 21 respondents, four disclosed their HIV positive status to me and the other 17 claimed to be HIV negative.

Figure 1: Partner status of Fieldwork Research Participants (n=21)
Nonprobability sampling was used for in-depth interview. As noted by Bernard, nonprobability sampling methods such as snowball sampling and convenience sampling are required for in-depth research on sensitive topics and vulnerable populations, and the sampling depends on rapport with the populations (Bernard, 2011). I applied this flexible sampling strategy of combining snowball sampling and convenience sampling based on mutual trust and friendship between me and local MSM. On the other hand, nonprobability strategy may render the sampling biased. To minimalize this bias, I was consistently working with Lao Hu, who was the most qualified person to grasp the
dynamics and relationships within the community since the gay bar served as a hub of local MSM’s social life. With his assistance in sampling, the reliability and comprehensiveness of samples were maximized.

2.5 Data collection process

The three main techniques of data collection—observation, in-depth interviews, and textual material collection—were undertaken simultaneously. Initial targets of observation were local MSM’s social life within the gay bar and HIV/AIDS prevention activities held by TYHSCC. I stayed in the gay bar every night from 8:00 p.m. to 1:00 a.m., to observe and socialize with customers. Additionally, I participated in three HIV/AIDS prevention educational sessions and took notes on them. After 10 days of fieldwork, I was offered a chance to observe TYHSCC’s intervention practices and local MSM’s interactions at a local park, which was also a dian er (point) for local MSM to socialize and seek for partners. I went to the park with TYHSCC members four times during my fieldwork.

I conducted 21 one-on-one in-depth, tape-recorded interviews with samples of local MSM. Respondents’ informed consent was acquired before the start of each interview. Interview questions focused on respondents’ experience and comments on TYHSCC’s interventions. Probing questions of their life history in relation to HIV/AIDS were also asked. Four semi-structured in-depth interviews were conducted with CDC officials in T City and Beijing. A description of China’s HIV/AIDS intervention programs
from an official perspective was obtained from these interviews, in order to present a
multifaceted perspective on the programs, and indicate complexities with the programs’
implementation. I also had many unstructured discussions with TYHSCC members.
Through these discussions, I was able to collect information about the everyday life and
history of team members and the organization. This information plays a key role in my
understanding of the local MSM community and its members’ personal experiences.
And with TYHSCC’s consent, I collected various categories of textual materials,
including educational flyers, training brochures, etc. I will always appreciate my key
informants’ selfless contribution and earnest friendship.

3. Uncertainties and Complexities of HIV Testing Practices

In T City’s implementation of AIDS programs, the dynamics of the relationship
between the local CDC and the CBO had consequences for both of these two subjects.
On the one hand, the CDC attempted to trust local communities and allow them to
participate in professional medical practices such as HIV testing; on the other hand, the
CBO’s participation was not only changing the politics of the local MSM community, but
also the professional medical practices of HIV testing itself.

TYHSCC’s method of undertaking HIV testing and counseling was called by its
members as ziyuan zixun jiance (voluntary and counseling testing), or “VCT”, a method
that is being standardized and promoted by UNAIDS (Interview P1; P2; P3). UNAIDS’s
principles of HIV VCT including voluntary testing, protecting the confidentiality, pre- and post-testing counseling, and treating VCT as an entry point for prevention and care (UNAIDS, 2000). While at TYHSCC, pre- and post-counseling, the parts that serve to inform testing receivers with knowledge about HIV/AIDS prevention and medical care, were undertaken with great flexibility and frequently were apt to be neglected when spontaneous incidents occurred or personal CBO members’ personal relationships were involved.

3.1 *T City’s move into AIDS program*

Free HIV testing has been perceived as an intervention intended to prevent HIV transmission among MSM since the China Global Fund AIDS program round 5 in 2006 when T City CDC followed the national trend by getting involved in the program. When Lao Hu initially got involved, his responsibility was to recruit participants among MSM for a package of CDC’s AIDS program interventions: educational sessions and free HIV testing. Several MSM community-based organizations (CBOs) at T City initially undertook this job at that time; Lao Hu’s team was the most well known. In 2011, Lao Hu and his working team colleagues founded T City Yangguang Health Service and Counseling center (TYHSCC) officially (registered at local Civil Affairs Bureau) and began to host and coordinate educational sessions by themselves with T City CDC’s help (Hu, 2014).
Also in 2011, T City CDC discovered that CBOs were a feasible way of delivering not only educational sessions, but also HIV testing, to the local MSM population. Members of TYHSCC and other CBOs were then trained by T City CDC to grasp substantial medical knowledge and learn the techniques of conducting the testing. Three TYHSCC members, Lao Hu, Bin (pseudonym), and Xin (pseudonym) participated in the training and were able to conduct testing independently at their counseling center from then on. In 2012, after that session of training, CBOs started to be fully in charge of their testing work. They received free test paper and toolkits from T City CDC and submitted the number of test recipients and their contact information to CDC monthly. A local routine of HIV testing and referral was deployed: MSM received free testing and acquired their test results at local CBOs. If the results were positive, they would be called by phone and asked to have another test at CDC for confirmation, and they received medical treatment from CDC. If they needed support and assistance, CBO members would go to CDC with them. 2012 was the first year that TYHSCC provided HIV testing, and 150 MSM were tested. In 2013, the number rose to 420.

### 3.2 HIV testing at the gay bar

TYHSCC was based at the gay bar operated by Lao Hu. It used a table on the gay bar’s first floor as its working and counseling desk, and whole lower level of the gay bar as its testing and counseling space. Hence, Lao Hu’s gay bar and TYHSCC converged in the same space and an environment of admixture was created. It could be difficult to
relate the gay bar’s casual and entertaining atmosphere with health testing that required professional medical knowledge and skill. But it can be seen from everyday life that a box of HIV test paper and a platter of disinfection toolkits on a shelf near the front window, right beside dozens of beer bottles. This was not a fixed point for these testing tools, which were sometimes taken downstairs to the lower level. Sometimes this was because clients wanted to have testing performed on the lower level, sometimes it was simply because that the gay bar’s customers needed the table by window and were reluctant to have the testing materials within their sight. A rigid distinction between professional medical procedures and entertainment activities was absent from the space and HIV testing took place in a context that appeared unofficial and improvisational.

The process of HIV testing was conducted by TYHSCC in a similarly improvisational style. Typically, test recipients wanted to have their blood samples collected on the lower level, as it was a more private space out of sight of the bar’s other customers. So when a test recipient arrived, a TYHSCC member would lead him downstairs, have disinfection toolkits and test paper ready, and ask for the test recipient’s final consent. Explanations about HIV/AIDS and the testing process were offered occasionally, and were for the most part provided only when test recipients asked for it. Based on what I observed, pre-test counseling was largely absent for two main reasons: First, information about HIV testing and the disease had already been emphasized during each educational session, and since test recipients usually had
participated in the sessions, it was thought unnecessary to repeat the information; second, TYHSCC members’ attention was largely centered on the result of each test, instead of test recipients’ perceptions of HIV/AIDS (I’ll also discuss this argument in later parts). There was a consent form that stated test receivers were voluntary and consented to receive the testing. Once the test recipient signed official consent forms, the member would collect his blood samples to finish the testing. It took 30 minutes to have results processed and test recipients could choose to wait for the results upstairs (at the bar), or authorize the TYHSCC member to inform them of the results via phone call. Most of the test recipients stayed in the bar and hung out with other customers or TYHSCC members during this period.
The signed consent forms represented an official contract between test recipients and TYHSCC. Meanwhile, the test recipients and TYHSCC members were friends in the same community and potential sexual partners. In an analysis of Nicaraguan community health workers (CHW) who engaged in malaria prevention outreach, Alex M. Nading cites James Scott to articulate CHW’s dual commitment: to represent the state within communities, while also acting as “good neighbors.” Nading notes that there is a

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1 The beer bottles are in the left bottom corner and the two white boxes and a plastic bag beside the flowers contain HIV testing materials.
“moral economic contradiction” between the two commitments: collecting quantified data for the state vs. their efforts at health promotion within communities—a contradiction described as “disciplinary and bureaucratic” vs. “compassionate and flexible” (Nading, 2013). The CBOs that conducted HIV/AIDS interventions among MSM in T City were involved in a similar situation as the Nicaraguan CHWs. Since a majority of test recipients and CBO members shared the same social and sexual networks, the flexibility and casual nature of their everyday relations and interactions inevitably became entangled with the professional process of HIV testing and encouraged its improvisational style. In Improvising Medicine, Julie Livingston argues that not only medical practices but also the experience of suffering from diseases are highly contextualized and have to fit in specific situations; improvisation serves as an essential component of the fit-in process (Livingston, 2012). In the circumstance of HIV testing as an intervention among T City MSM, the improvisational style of conducting testing was more than a response to contextualized situations, it also had consequences for local MSM’s personal and interpersonal experience of HIV/AIDS.

### 3.3 Sidestepping standard procedures

Yang (pseudonym), a regular customer of the gay bar and a friend of Lao Hu, received his HIV testing and a positive result from TYHSCC in 2012. He told me that he had known nothing about HIV/AIDS before the testing, except that it was a horrible disease. Then he described what his testing was like:
“I came here and asked Lao Hu to give me a test. He did so, and when a positive result came out, he left. I went back home and felt days were passing as slowly as years. I was afraid that I had already transmitted the disease to my children and my wife.”

“Lao Hu did not tell me anything about the disease and just asked me to go to CDC. Then I went to T City CDC to have a clinical test again, and I took my medicine. I asked CDC’s people whether the disease would be transmitted to my children via kisses and having dinner together, they told me it wouldn’t. That was the first time I learnt that these intimate contacts would not transmit the disease.”(Interview P20)

What TYHSCC gave to Yang was merely a blood test; he received no counseling or information about HIV and he was left confused and horrified by the disease’s impact on himself and his family. In this case, TYHSCC had never delivered thorough (or any) counseling regarding HIV transmission and prevention to the test recipient. As a result, the test recipient experienced severe psychological pressures and a social crisis.

Lao Hu admitted that he made some mistakes and explained:

“There was an accident. Yang went to a local hospital for another disease, was tested and found to be HIV positive, which he could not believe. So he came here and asked me to test him. I actually was panicking and as a result I punctured my own skin. Then there was a matter of occupational exposure, you know. I was afraid of being infected and hurried to deal with my own wound, so I didn’t pay much attention to him.” (Interview P1)
Despite the official training that Lao Hu had received prior to conducting HIV testing independently, professional and standardized methods for dealing with suspected HIV-positive people and occupational exposure were not in place when emergencies occurred. When the test giver panicked, counseling and education about prevention were neglected in this HIV VCT case. Moreover, test givers perceived counseling and education as parts of the process that could be omitted, and that did not need to be “paid much attention” (see the piece of Interview P1 quoted above). While ramifications of the neglect and ignorance might have already been brought to test recipients from psychological, physical, and social aspects.

In her ethnographic monograph on HIV/AIDS interventions among female sex workers in Yunnan Province, Sandra Hyde emphasizes that China’s tendency toward nationalism in the political realm does not generate a monolithic entity on a practical level; instead, she found program design and implementation at the individual level “sidestepping the state” and reflecting the styles and desires of specific persons and their institutions (Hyde, 2007). As a branch of the health system’s intervention apparatus, AIDS programs conducted by CBOs like TYHSCC had similar characteristics as governmental institutions mentioned by Hyde. Though under close supervision by T City CDC, TYHSCC’s everyday HIV testing practices can be full of improvisation and transgressions of centralized control. Yang’s incident is an actual example of TYHSCC sidestepping official rubrics and requirements. Though TYHSCC members had been
trained by provincial and T City CDC with HIV VCT procedures and were required to implement accordingly, their everyday practice of carrying it out was still full of unpredictability and could have negative consequences for local individuals.

### 3.4 Romantic relationship and HIV testing

A story of a 23-year-old TYHSCC member, Bin, also illustrated how rules and standards were sidestepped by CBOs and how actual practices of VCT intertwined with factors other than disease intervention and scientific experiment: specific relations and interactions between TYHSCC members and the test recipients was an influential factor in the procedures. One day a young man came to the gay bar when Bin was there and told Bin that he wanted to have an HIV test, but refused to be tested at the gay bar. The next day, Bin came in the gay bar when Lao Hu and I were there and threw a pack of HIV testing tools on a table. Then he told Lao Hu that he had conducted the test on the young man at the man’s home. Bin refused to say more about the test or provide the young man’s consent form. He just said that the result was negative. Lao Hu saw the test had been conducted in a non-standard fashion and scolded Bin for being wu zuzhi, wu jilv (not organized and not disciplined). Lao Hu also expressed suspicion that Bin had used the test as a chance to gouda (flirt) with the young man. Bin said nothing in response to Lao Hu’s accusation, yet became very angry and ran away.

The implied romantic relationship between Bin and the young man had a significant influence on how the test was initiated and processed, thus Bin, as a CBO
member, allowed himself to combine his professional capacity with personal affection. The testing therefore shifted from a professional and public sphere under organizational scrutiny to a private sphere in which details of the test could be concealed on account of individual embarrassment. The interpersonal romantic relationship produced both opportunities of local MSM to be tested, and ambiguities of their testing process.

We will never know precisely the process Bin followed in the HIV test given to this young man since no evidence had been kept. Bin came back to the bar and apologized to Lao Hu the next day and both decided that they should not raise this topic again to avoid embarrassing each other. There were no records or reports that could help TYHSCC improve its work. All we knew was that the young man was negative, and just as in Yang’s case, the result of negative seemed to be the only thing that TYHSCC members cared about. This HIV-negative young man who had been tested disappeared from TYHSCC’s discourse of intervention quality control and internal management.

Yang and Bin’s cases reveal a fact of contingencies and flexibilities in practical implementation of the HIV testing provided to local MSM. It can be seen from official records that TYHSCC had been trained by T City CDC and reported statistical evidence to CDC monthly. Such a narrative represented TYHSCC’s testing work as abstract statistics and dehumanized standard procedures. It seems that the focus of TYHSCC’s testing and T City CDC’s supervising is only the negative/positive results of the testing.
In this situation, caring about and counseling offered to test recipients was perceived as omissible and as not needing to be standardized or scrutinized. Nevertheless, each testing case involved individualized perceptions, desires of specific individuals, and interpersonal relationships. These ambiguities and their ramifications for local HIV/AIDS prevention work had profound influences on individuals who received testing, as well as on the development of local CBOs, however they were largely overlooked by both CBOs themselves and CDC system.
4. Supervision of the Quality of HIV Testing

As noted by James Ferguson and Akhil Gupta, international organizations nowadays overlap with states (Ferguson & Gupta, 2002). The cooperation between China’s government and the Global Fund on AIDS programs can be seen as a typical instance of this overlap. In this particular instance of cooperation, the idea of collaborating on a community level was introduced as a part of a pattern of implementation. According to Wei Guo, a former China Global Fund officer, one of the priorities of the Global Fund’s AIDS programs is to enhance collaboration between the government’s public health departments and CBOs (Interview G3). The rationality of this principle is that on the one hand, CBOs are more familiar with the AIDS program’s target populations and therefore have more natural and easy access to the populations; on the other hand, CBOs can be motivated by various incentives to serve and regulate communities with a closer look than any governmental department. This principle, characterized by an explicit tendency to decentralize social and health management, was posited as a premise behind the provision of funding and technical support from Global Fund to China’s government. At the same time, China’s government also found it an effective approach to reach “groups that avoid government service programs (sex workers, drug users, gay men).” This approach coincidentally nourished the development of community-based organizations and non-governmental organizations (NGO), and loosened the government’s restrictions on civil society (Kaufman, 2010). The
tolerance of the development of civil society and CBO’s participation in HIV intervention show a move away from the centralized socialist governance that has long existed in China. Involving CBOs in program implementation is a practical attempt to decentralize responsibilities for healthcare provision, away from government and toward private sectors.

Plurality of medical authority has been brought about in some South American, Asian, and African countries as a result of marketization, weak state governance, and powerful international organizations (Biehl, 2004; Ferguson, 2006; Standing & Chowdhury, 2008). While in T City, although authority for training, supervising, and financing local HIV/AIDS interventions was still concentrated in government departments like T City CDC, the trend toward decentralization permeated practical and community levels.

4.1 “Purchase of service” in AIDS intervention

From my fieldwork, I saw indications that the trend toward decentralization would last in the future. Although according to Ms. Guo, the current Global Fund AIDS program would be the last round that China participated in, the pattern of CBO participation might be inherited by China’s government. In 2013, a State Council executive meeting proposed “purchase of service” from shehui liliang (non-governmental forces), emphasizing the introduction of market modes and social organizations into public services provision (Huang, 2013).
During my fieldwork, I also witnessed Lao Hu actively preparing to apply for “purchasing of service” programs. However, as noted by many scholars and politicians, this transition to market-oriented public service provision and decentralization requires a corresponding transition of governmental duties and supervision technologies. In T City’s HIV/AIDS prevention work, CBOs like TYHSCC increasingly were involved in and shouldering duties, while the transitioning of CDC system’s supervision technologies were yet to be completed. The implementation pattern of CBO participation and “purchase of service” had to work along with a socialist hierarchal configuration of supervision at the community level. This mismatch between implementation pattern and supervision technologies produced not only new economies of HIV testing among local MSM, but also invalid data and images.

Since T City CDC’s participation in Global Fund AIDS programs in 2005, its positions and duties in HIV/AIDS prevention among local MSM has continued transitioning. At the beginning, CBOs only complied with CDC’s order to recruit participants for T City CDC’s interventions, such as educational sessions and free HIV testing, and they received a small amount of subsidies; in ensuing years, T City CDC gradually entrusted CBOs such as TYHSCC with conducting HIV educational sessions and free testing, and they transferred program funding directly to them. The relationship between CBOs and T City CDC was transitioning from socialist bureaucratic subordination to marketized voluntary cooperation. As mentioned, I would
argue that in T City’s AIDS programs, the corresponding transition of supervision technologies was incomplete. Therefore the implementation of AIDS programs was currently built upon a marketized relationship and economic incentives, while technology of supervision was based on a socialist style of homogeneous standards and hierarchical commands. On the one hand, the economic incentives influenced and twisted the relationship between local MSM and CBOs, generating new economies of HIV testing. On the other hand, the standards and commands had limited effect on revealing and improving the CBO’s working capacity and efficiency with regard to HIV interventions since they overlooked the complexities of logics and practices to meet them.

4.2 Economies of HIV testing: from bonus to commodity

The numbers of test recipients and HIV-positive cases had to be reported to the CDC system monthly and they served as an essential item in a rubric for assessing the quality of the CBOs’ work and whether they were considered worthy of support in the next year. It was noted in the contract between T City CDC and the CBOs that each organization needed to provide a minimum number of tests to continue to receive their funding. Lao Hu showed me a form that recorded test recipients’ names, phone numbers, and signatures, and told me that he had to submit the form to T City CDC monthly. The form served as quantitative evidence that TYHSCC had genuinely done the work, and CDC officers might even randomly choose a phone number on the form
to call back and ask about the testing, to verify that the contact information and numbers of test recipients had not been made up.

Indeed they were not made up and they were *earned* by TYHSCC staff’s consistent efforts to persuade local MSM. In fact, persuasion and negotiations regarding testing were usually an anchor of TYHSCC staff’s chatting with local MSM who hung out at the gay bar. Lao Hu named this kind of chatting as *zuo ganyu* (conducting interventions). As mentioned in the previous section, the interpersonal relationships of TYHSCC members, who were also local MSM or friends of local MSM, were tightly entangled with HIV interventions: persuading friends to receive free HIV testing had become one essential topic of their interactions, so that their friendship and emotional devotions were utilized to realize the goal of testing more people, and the interactions served as an apparatus of interventions. As two of the gay bar’s regulars put it: “I am barely willing to come here and meet them now because I don’t want to be nagged about testing on and on” (Interview P8); and “some people don’t come anymore, because (they think) once they come their blood will be drawn for one time” (Interview P20). These opinions implied that local MSM’s incentives and decision-making processes were largely determined by interactions with TYHSCC’s members, rather than concerns about their own health. Additionally, it was also shown that the *zuo ganyu* stimulated resistance to interventions among local MSM. The free provision of testing but having to
endure constant efforts to persuade them to accept it made local MSM perceive the testing as an obligation rather than a service.

Besides utilizing friendship as an apparatus, local CBOs also gave little gifts to test recipients. Gifting had accompanied T City CDC’s HIV testing activities prior to the Global Fund programs and was inherited by the CBOs. The little gifts, such as umbrellas, thermoses, and towels gradually became incentives to encourage local MSM to undergo HIV testing. Sometimes, the incentives were the only reason they got tested. One night a bar customer asked Lao Hu what the most recent gift was for testing, and was told that it was umbrella. The man then said, “No, I won’t have test today because I don’t like the styles of the umbrellas and I want a thermo.” So more than an obligation, HIV testing also was perceived as a way to gain material rewards, and local MSM’s acceptance of HIV testing, or giving the permission to have tests conducted on them, became a currency that could be traded for material benefits.

The third apparatus applied by TYHSCC members as persuasion is the discourse of window period. Since HIV testing measures antibodies to determine whether a person is infected by the virus and it takes time for antibodies to generate, there remains a “window” during which the test result will be negative even if the person is infected (US-CDC, 2015). João Biehl discusses how the meanings of this window period are constructed by Brazilian testing institutions, and how the meanings affect Brazilians’ perception of the testing. He points out that the length of the window period, in the
Brazilian institutions’ description, 3-6 months, is a quasi-scientific fact utilized by the institutions to make previous testing results invalid (Biehl, 2007). The window period was described as 1-3 months long in TYHSCC’s explanation to local MSM\(^1\), test recipients therefore were persuaded by THYSCC members to have another test a month or so later. Two tests on the same person would be recorded on the forms thus enlarging the numbers of test recipients for TYHSCC.

4.3 Qualities of quality-control methods

For quality control of the performance of testing, CDC officers occasionally visited the gay bar and required TYHSCC members to conduct testing on a male customer under their observation. I ran into one of the visiting tours of provincial CDC and T City CDC officers when I was in the field. They arrived around 9:00 p.m., while Lao Hu had grown nervous and started to prepare the gay bar and testing set during the afternoon. He also made several phone calls persuading people to come to the gay bar and get tested HIV; he complained about some of them refusing the request.

At that night, approximately 20 males sat in the gay bar, most of whom were regulars and Lao Hu’s friends, yet few of them had drinks at hand. When the officers came, they looked around at people and expressed their satisfaction at seeing that the gay bar could attract so many people, which was helpful for undertaking interventions.

\(^1\) TYHSCC members had learnt the definitions and length of window period from educational sessions given by China Family Planning Association from 2008 to 2011.

32
Then they were immediately led to the basement by Lao Hu, and had a 30-minute chat with TYHSCC staff about recent work. I sat with the people in the gay bar and asked Doudou (pseudonym), a respondent of my interview (Interview P7) about why he came here. He said,

“Lao Hu asked me to do so. He asked all of us (looked around the space).”

“So this seems like a performance for lingdao (officers of governments)?”

“I think you can say that.”

CDC officers saw the crowded room as an adequate sign of TYHSCC’s competency at implementing HIV interventions among local MSM, despite not spending any time observing the clientele or communicating with them. Because of this, they failed to hear the backstage stories as I did and thus had no chance of knowing that this was a well-prepared performance for them and it was far from the everyday realities of TYHSCC and the gay bar.

After a while, I was asked to go downstairs, along with a man who was sitting with me. When I was chatting with the officers, the man was invited to get a test “for lingdao to have a look” (quoted from Lao Hu). The man agreed, and sat down to be tested by Lao Hu under the officers’ eyes and TYHSCC staff’s camera. The officers expressed their appreciation for Lao Hu’s skill in conducting the test, and after a while asked about the test result. The man’s test was another performance presented to CDC officers to satisfy their need for quality control of CBO’s testing work. Yet the principle
of protecting testing receivers’ privacy was compromised by both TYHSCC and CDC officers. The quality control nevertheless damaged the quality of this specific test and infringed upon the test recipient’s rights.

The performance-like participation and testing were treated as images that the CDC system collected to acquire a qualitative assessment of TYSHCC’s everyday HIV testing practices, and that TYHSCC collected to represent their achievements in their HIV interventions. Nevertheless, the complexities and contingencies of each HIV testing case, including the underlying reasons for participation, and the way that cases could involve with personal and interpersonal factors were overlooked by this method of assessment. Additionally, achieving quality control via directly observing a test, even though the test was a performance, resulted in ethical violations of the test recipient’s privacy and rights.

All data that local CDC obtained, including the record of numbers and the observation results, was an outcome of intentional endeavors and rehearsals enacted by CBOs and local MSM to meet requirements. These statistics and images were not objective records of everyday HIV-testing practices, rather, they took CBOs’ extra effort to produce, and interfered with the intervention processes and outcomes. The alienation of statistics and images distorted the purpose of interventions designed to prevent HIV/AIDS and improve the health of local MSM while conforming to certain stiff standards and commands set by CDC. Free HIV VCT was hence converted from a bonus
of service to a set of involuntary obligations, or even business that had to be accomplished by the “cooperation” of CBOs and local MSM. On the other hand, this artificial data give no support to presenting the complexities and contingencies involved backstage and in everyday life. In his research on the public discourse of a cholera epidemic in Venezuela, Charles Briggs notes that the loss and death of marginalized people are turned into “categories and numbers,” while the inequalities, struggles, and sorrows that they experience daily are ignored by state officials (Briggs, 2004). In T City, the numbers and images obtained of HIV testing among MSM had a similar effect and buried deeper this hidden population’s everyday experience of HIV testing.
5. Initiating, Rationalizing and Moralizing HIV Testing as an Intervention

In China’s AIDS programs, HIV testing of MSM was perceived as important for different reasons by governments and MSM. From a governmental perspective, HIV testing among MSM was not only a technology to maximize control over HIV-positive people, but also to gain a resource of epidemiological data concerning HIV; while stories from the local community showed that acceptance of HIV testing had become a crucial component of the MSM community’s moral discourse, even a requirement of membership and citizenship.

5.1 Scaling up testing

According to Li and Yin, officers of T City CDC and China’s national CDC, the logic behind setting and elevating HIV-testing numbers is that they believe there are still enormous numbers of HIV-positive MSM who have not been tested and therefore remain hidden from government surveillance and control1 (Interview G2; G4). But does the making visible of these “hidden” ones hold such great significance for preventing HIV transmission? Elsa L. Fan’s research on HIV testing among MSM in China reveals the rationality of scaling-up the testing from the government side. Disease control officers are motivated to dig out the hidden HIV-positive MSM because they believe they are a bridge for the transmission of HIV to the “general population” via

1 Confirmed by a conversation with a National CDC director, Yin (Interview G4).
heterosexual marriage\(^2\) (Fan, 2014). After digging them out, they could be further controlled and scrutinized, preventing them from transmitting the virus to others. Therefore, both the CDC and the CBOs attempted to scale up testing and had a tendency of anticipating more positive results. This belief was also revealed by Lao Hu’s feeling about conducting HIV testing in everyday life, as a community health worker among MSM:

*I sometimes feel very contradictory, you know? Since if we have a lot of positive test results, then it means that our educational activities and condom dissemination campaigns are useless; while if we have no one testing positive, that means we are not doing the testing work well enough. We have not tested enough people.* (Interview P1)

Lao Hu’s opinion that if “there are few MSM testing positive, it means that [he] has not tested enough people” is a direct interpretation of the number requirements set by the local CDC. The CDC not only required local CBOs to give tests to a certain number of people, but would also give CBOs an additional financial reward if they found an HIV-positive case. Through the setting up of requirements for test numbers and prizes for detecting positive cases, a clear message of “the more the better” (both total numbers and positive cases numbers) was delivered to local CBOs (Interview P9).

In this way, not only the CDC system, but also local CBOs believed there were still large

\(^2\) In intervention brochures that were disseminated at T City, it was also noted that one of AIDS’ dangers was that “if one of fuqi (heterosexual couple) has AIDS, the marriage relationship will be damaged and family members will be infected.”
numbers of HIV-positive MSM hidden in local communities and their mission was to find as many of them as they could.

Meanwhile, in my discussion with a T City CDC officer, I discovered that the CDC relied heavily on local CBOs to determine the number of HIV-positive people at the local level (Interview G2):

“Yangguang working team started to conduct HIV blood testing in 2012. Nowadays, in my estimation, 90% of HIV-positive cases are discovered by the working team. Because of ignorance and fear, few people come to the CDC to get tested. But the working team is different; it can find those people (who would like to receive testing) via the gay bar.”

Thus the rationality of scaling-up HIV testing to the MSM population is not only that this will elevate the visibility of presumed HIV-positive cases among this population, but also to maintain and expand a source of HIV/AIDS epidemiological data. However, the reason why the CBOs’ HIV testing was a main source of HIV positive cases is that the CBOs were given incentives to scale-up testing within communities. Moreover, the CBOs’ means of persuasion and negotiation regarding testing were richer enhanced by their clos interpersonal relationships with local MSM and the emotional power embedded in these relationships. As discussed before, these interpersonal relationships were imbued with individuals’ emotions, perceptions, and desires, and encouraged an improvisational style in the CBOs’ HIV testing. Therefore, fundamental evidence that serves for HIV/AIDS intervention policymaking and
implementation was actually collected in this skewed economy and with this improvisational style of HIV testing that was provided by the CBOs.

In a discussion of the role of science in China’s policymaking, Susan Greenhalgh points out a growing tendency to perceive “science as a panacea” in the post Mao years, along with the development of social science (Greenhalgh, 2008). As Foucault notes, modern power engendered social sciences that take bodies as objects to be calculated and manipulated for their own development, and masks this purpose by producing certain discourses (Dreyfus & Rabinow, 2014). In this specific circumstance, the need to “make progress” in detecting HIV-positive people among local MSM was constructed and normalized by moral discourse on sexuality and by a bureaucratic desire for numbers, i.e., scientific data. Yet as has been discussed, complexities and contingences that nevertheless have significant influences on the production of the data were largely out of scrutiny and discussion.

**5.2 Coming up from underground**

João Biehl found that in Brazil many originally marginalized people gain their citizenship by becoming AIDS patients (“AIDS citizens”): once they are infected, they can legitimately benefit from AIDS policies that involve rights and welfare such as free condoms, food baskets, and therapies (Biehl, 2007). In T city, members of local CBOs

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3 The examples of discourses espoused by modern power are “traditional theories of sovereignty, natural law, and social contract” (p. 113).
became AIDS citizens in a different way: through intervention programs, they were constructed and regulated as role models of “good” MSM that successfully stay away from AIDS.

Sexual behaviors between males used to be completely yinbi (“hidden” or “covered”) in this city. There’s a moral and legitimate contradiction: despite the fact that homosexual contacts are considered to be buhao (not good) and buxing (not allowed) by local social and cultural norms, there were no formal rules and laws that forbid or regulated homosexual behaviors in China. Moreover, due to the fact that homosexual relationships are stigmatized in mainstream moral discourse on sexuality, thus maintaining an underground status, homosexuality correspondingly escapes from the norms and laws that regulate heterosexual relationships, such as the obligation of monogamous marriage with long-term partners. Lao Hu emphasized several times to me that it was extremely hard for MSM to bu luangao (not have multiple short-term sexual partners), since there were no constraints. Nuonuo (pseudonym), a 19-year-old regular of the gay bar, also noticed that for heterosexual couples, their relationships not only could be guaranteed by the Marriage Law, but also were monitored by their families and friends. Whereas for underground homosexual relationships, neither legitimacy nor social acknowledgement existed. In this way, because of the absence of moral restrictions, MSM experienced more freedom and less moral pressures in homosexual relationships than in heterosexual ones, in terms of the opportunity for
multiple short-term sexual partners and involvement in commercial sexual relationships.

State-oriented HIV interventions dragged local MSM up from underground and integrated them into mainstream moral discourse on sexuality. This process began with MSM members of local CBOs who participated in the implementation of intervention programs. Lao Hu used to own a tongzhi huisuo (venue that provide MSM with commercial sexual services) for over a year before he set up the gay bar and TYHSCC. The huisuo was located in an apartment building and was not registered at the local government’s administration department. He said he did not run into much difficulty that year although commercial sexual services were considered immoral and in a grey area of legislation in China. The reason why it had been shut down was that neighbors complained about the noise.4 I asked him why he did not run a huisuo at the bar, thinking a huisuo that provided sexual services was more profitable than a simple gay bar. He said (Interview P1),

“That’s not possible. Now I am a figure here, you know. Because of this organization and the interventions, people know me, and the government knows me. It would have a bad influence on the interventions and myself if I did that.”

Since being a subject in the intervention programs, Lao Hu’s life became exposed in the MSM public sphere overseen by local authorities, it therefore needed to be

4 This statement needs to be confirmed by other local people.
regulated and self-regulated according to mainstream moral discourse on sexuality. Because of this, he had to behave decently and suspend his business managing sexual services, which was deemed by mainstream norms as *bu hao* (not good) and *bu zhengjing* (not decent). Similar transitions also appeared with local CBO members in terms of their individual sexualities and sexual lives. Wood (pseudonym), who was a colleague and close friend of Lao Hu, told me that he would not *yuepao* (go looking for short-term sexual partners) as frequently as before and explained the reason (Interview P3):

“Now I am in this working team (referring to TYHSCC) it is not good to let other people see that I always go to *yuepao*. Because people watch you, and they will say that you are not decent. And since we promote people reducing the number of their sexual partners to prevent HIV and other sexual transmitted diseases, if they see us having a lot of sexual partners, they will no longer listen to us.”

Social and cultural norms originally applied to heterosexual people⁵ thus were transferred to local MSM who were CBO members because of their gaining visibility in the eyes of both local MSM and the government by participating in intervention programs. Moreover, these norms were incorporated as techniques to prevent transmission of HIV and presented by CBO members. The members became “AIDS citizens”—in this circumstance, “becoming AIDS citizens” meant their lives started to be

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⁵ Many scholars discuss the aims and meanings of social and sexual norms applied to heterosexual relationships and point out that the norms serve to maintain patriarchal family structure and patrilineal descent or “bloodlines” (Fu, 2012; Li et al., 2010).
absorbed and scrutinized by mainstream moral discourse on sexuality as a result of participating in state-oriented intervention programs intended to prevent and control HIV/AIDS.

**5.3 Perceptions of accepting HIV testing as morally correct**

Due to the entanglement of the AIDS program with mainstream moral discourse, the intervention apparatus permeated the MSM community and produced a new moral discourse, one in which receiving HIV testing was integrated into social and cultural norms. In education sessions held at TYHSCC, “receiving HIV testing regularly” was emphasized as a way to prevent HIV/AIDS and be responsible for one’s own health, along with “reducing numbers of sexual partners” and “using condoms.” These three actions were viewed as an inseparable entity—the new moral discourse, for local MSM to embrace. Lao Hu and I discussed the process of he zuo ganyu (conducting intervention) with local MSM individually. He told me there were several tips that he always offered local MSM (Interview P1):

“First, do not luangao (maintain chaotic sexual relationships), luangao is not good; then if you are making love with strangers, use condoms to prevent transmission; also, come to get HIV tests regularly to make sure you are not positive—this is also to show you are responsible for yourself.”

These three tips were a simplified representation of the new moral discourse and what “good” MSM were required to do. If an MSM achieved the requirements, he
would be considered a person that was rational, responsible, and someone who avoided HIV. In AIDS programs’ advocacy and in the new moral discourse these programs produced, receiving HIV testing thus shared the same importance with maintaining long-term monogamous sexual relationships and using condoms properly.

In a discussion of awarding prizes to young people in health competitions held among the United States 4-H members in the 1920s, Gabriel N. Rosenberg notices that these “vigorou...
For Lao Liu, the purpose of receiving HIV testing was not related to his health, or physical benefits; rather, it was more about a social need to maintain morally good character. Liu and other CBO members accepted HIV testing that seemed unnecessary for their bodies because they anticipated that other local MSM would follow them as they would follow a role model. On the other hand, because of their personal charisma and influence within the local MSM community, HIV testing was also crucial for local MSM to get membership in the community. And due to the new moral discourse’s entanglement with official AIDS programs, to become a new “good” MSM furthermore meant to be admitted and accepted by local government powers and authorities.

HIV testing was characterized, normalized, and popularized by AIDS programs as an irreducible action that would be undertaken by a good, responsible, and healthy MSM regulated by the new moral discourse. Consequently, in this era of HIV/AIDS epidemic and prevention, MSM acquire their membership and citizenship within the community by accepting HIV testing.
6. Conclusion

In the conclusion to their book *Ten Thousand Things*, Judith Farquhar and Qicheng Zhang argue with a passion for “the fundamental multiplicity of life,” insisting that the body has a “composite” link with “myriad things” temporally and spatially and requires careful inquiries (Farquhar & Zhang, 2012). Methodologically, this idea corresponding to Clifford Geertz’s famous definition of *what doing ethnography is*: it is “an elaborate venture in ‘thick description.’ To achieve “thick description,” ethnographers or cultural interpreters ought to acknowledge the rich symbolic meanings of small things and actions, and articulate the sociocultural multiplicity of relations and consequences produced by them (Geertz, 1973).

In China, HIV testing is conceived and implemented by public health authorities as an effective technique to prevention transmission of the virus. However as underlined by Farquhar and Zhang, it is impossible to reduce “bodies, communities, and forms of life” to abstract concepts and entities. It is equally ridiculous if we imagine HIV testing without taking into consideration its uncertainties and complexities. This thesis provides an incomplete answer (as Geertz notes, “Cultural analysis is intrinsically incomplete” (Geertz, 1973)) to the question “what we talk about when we talk about HIV testing”: revealing things related to testing among MSM in T city which are covered over by an over-simplified notion that “testing can serve as an intervention facing the HIV epidemic” (Interview G2).
Right beneath this notion, it was nonetheless a fact that the local CBOs’ everyday practices of HIV testing were full of contingent intentions and activities that were interwoven with CBO members’ perceptions of the disease and their complex interpersonal relationships with other local MSM. These contingencies were obscured from local governmentality because of the simplified and superficial technologies of supervision that were applied. What’s more, these technologies had consequences for the implementation of testing. The numbers of testing recipients were indeed authentic; but from another perspective, they were also made up since local MSM’s reasons for receiving (or not receiving) testing could be much more complex than merely consideration of their own health. Rather, their considerations might include interpersonal emotions and tensions, “quasi-scientific” notions about the window period, and material incentives. Meanwhile, HIV testing had been incorporated into local MSM’s new moral discourse on sexuality and became a must-do for a “good” MSM. The construction and normalization of this notion was tied to the HIV intervention programs. These complexities in relationships, economies, knowledge, and discourse that I discuss in this paper are only preliminary explorations of HIV testing as an intervention in a specific setting. I would suggest that in the policymaking process, only through such focused, in-depth observation and analysis can public health practitioners maximize their grasp of local circumstances, thus designing and implementing the most suitable and effective programs.
Based on my observations and analysis, there are several other recommendations that I would like to make regarding the future design and implementation of HIV interventions among MSM in China. First, the internal management of local CBOs should be strengthened. It is essential for the local CDC and CBOs to realize that although HIV testing is entangled with interpersonal relationships, it is also a professional medical practice that requires restricted procedures and quality control with professional methods and techniques. Specifically, pre- and post-test counseling as well as sexual education in everyday life should be paid more attention and there should be efforts to guarantee that local MSM understand basic facts about HIV/AIDS and undergo testing truly out of concern for their own health. Additionally, it is necessary for CBOs and governmental departments to rethink the situation of HIV testing being incorporated into local MSM’s new moral discourse. Whether this new moral discourse will produce new stigma toward people who are reluctant to receive testing and how to eliminate this stigma need to be considered. Second, changes and innovation in supervision technologies are needed for HIV interventions. Susan Greenhalgh cites Foucault to argue that China has experienced “shifts in the locus of power over life” from the state to market since 1980s (Greenhalgh, 2008). Currently, “purchase of service” is an explicit example of a marketized governmentality pattern. With governmentality transitioning from an administrative pattern to a marketized pattern, the form of connection between governmental departments and local CBOs was
also shifting from one of hierarchal command to contracted cooperation. Governmental departments’ technologies of supervision over local CBOs had yet to be adjusted correspondingly. The biased, oversimplified emphasis on numbers—numbers of testing recipients and HIV-positive people, failed to realize responsibility of quality control and produced unexpected twists in local MSM’s interpersonal relationships and their perceptions of HIV/AIDS and testing. I would propose local governmental departments to design and implement more comprehensive and multivariate methods with which to conduct supervision.

As preliminary research on HIV testing among MSM at a specific location, this study has some obvious limitations. First, the fieldwork concentrated on one CBO of T City, therefore potential diversity among local organizations was not addressed. Further research is needed to grasp a more comprehensive overview of CBOs’ work among all MSM in T City, instead of simply generalizing from observations and experience obtained from TYHSCC. Second, associations between MSM’s demographic and social and economic status characteristics and their motivations for undergoing HIV testing have yet to be analyzed. More specific hypotheses regarding these associations can be developed on the basis of my observations and tested in future quantitative research. Third, more information from official and institutional perspectives should have been gathered in order to enrich the discussion of the consequences and implications of free HIV testing.
Appendix A- Glossary

Abbreviations

CDC: Centers of Disease Control and Prevention
CBO: Community-based organization
HIV/AIDS: Human immunodeficiency virus/ acquired immunodeficiency syndrome
MSM: Men who have sex with men
TYHSCC: T city Yangguang Health Service and Counseling Center

Translations

Ban gongkai: half-out of the closet
Bu hao: not good
Bu xing: not allowed
Bu zhengjing: not decent
Dian er: Point
Gouda: flirt with
Huisuo: venue that provide MSM with commercial sexual services
Lingdao: officers of governments
Luangao: maintain chaotic sexual relationships
Tongzhi: homosexual people in Chinese context
Wu zuzhi, wu jilv: not organized and not disciplined
Yuepao: looking for short-term sexual partners
Yinbi: hidden, covered
Zuo ganyu: conduct intervention
### Appendix B- List of Interviews

a) Fieldwork interview participants:

<table>
<thead>
<tr>
<th>Number</th>
<th>Name</th>
<th>Title</th>
<th>Date of interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>&quot;Lao Hu&quot;</td>
<td>director of TYHSC</td>
<td>2014-5-17</td>
</tr>
<tr>
<td>P2</td>
<td>Xin Wang</td>
<td>member of TYHSC working team</td>
<td>2014-5-21</td>
</tr>
<tr>
<td>P3</td>
<td>&quot;Wood&quot;</td>
<td>member of TYHSC working team</td>
<td>2014-5-24</td>
</tr>
<tr>
<td>P4</td>
<td>&quot;Zhang&quot;</td>
<td>member of TYHSC working team</td>
<td>2014-6-8</td>
</tr>
<tr>
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<td>Hao Tao</td>
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b) Interview with officers

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References


