

**Community Action on Harm Reduction (CAHR)**

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**End of Project Study Report - China**

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## **Injecting drug user: an invisible community in China**

By the end of May 2013, China had a drug using population of 2,220,000. This number is based on the number of drug users registered in the government system, which means the actual population is much larger<sup>1</sup>. At least 50% of the drug users are people who use injecting drugs (PWID). In China, 28.4% transmission of HIV is through injecting drugs<sup>2</sup>. HIV prevalence among PWID is, reportedly, 6.4%<sup>3</sup>, while HCV prevalence is 67%<sup>4</sup>.

Although numerous programmes, projects, services and other activities and facilities have been established to support improve the health of PWID, due to overwhelming conflicts between the agendas of public health and public security (*war against drugs*), PWID is a largely hidden population. They are facing unprecedented challenges, even for living a normal life. In addition, most of the public health policies and practices towards PWID see them as merely negative 'receivers', instead of active 'actors', it keeps the population even more invisible.

## **History of Community Action on Harm Reduction project (CAHR)in China**

CAHR has been implemented in China since 2011. This project was originally administered by the International HIV/AIDS Alliance China Office, prior to May 2013 under financial support from the Dutch Ministry of Foreign Affairs and overall management by International HIV/AIDS Alliance Secretariat. Project management and implementation was then handed over to the Alliance's linking organisation in China, AIDS Care China (ACC) in May 2013, due to a decision of closing the Alliance office in China.

At the time of hand-over, there were only three project sites (Chenghua, Xindu and Jiuniu Districts in Chengdu City), all in Sichuan Province. Between May 2013 and now, there have been 12 project sites, 6 in Yunnan Province and 6 in Sichuan Province. At the time of writing the present paper, there are 5 sites with on-going project activities, 4 in Yunnan and 1 in Sichuan.

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<sup>1</sup> <http://news.sohu.com/20130703/n380518992.shtml> Original article in Chinese, translated by the author.

<sup>2</sup> 2012 China AIDS Response Progress Report, *Ministry of Health of the People's Republic of China*, 31 March 2012

<sup>3</sup> Ibid

<sup>4</sup> Lancet, 28 July, 2011

Project Sites	Date	PDI*	Needle Exchange	Naloxone*	Methadone maintenance therapy (MMT) <sup>5</sup>		Community-Based Rehabilitation*
					Dose Increase*	Take-Away*	
Yunnan							
<i>Gejiu</i>	09/13 – 12/13						
<i>Ruili Jiegao</i>	05/13 - present						
<i>Ruili Needle Exchange Spot</i>	07/13 - present						
<i>Ruili MMT Clinic</i>	10/13 – present						
<i>Dali</i>	09/13 – present						
<i>Yuxi</i>	03/14 – present						
Sichuan							
<i>Xindu</i>	07/13 – 04/14						
<i>Chenghua</i>	05/13 – present		+ low death space syringe				
<i>Jinniu</i>	02/14 – 04/14						
<i>Jinjiang</i>	02/14 – present						
<i>Dujiangyan</i>	02/14 – 04/14						
<i>Qingyang</i>	02/14 – 04/14						

\*New activities initiated under CAHR

## Project Coverage

Started with one project city (Chengdu, Sichuan Province), CAHR project covered 11 project sites (cities and/or counties) in the south-western provinces of Sichuan and Yunnan in China, as of May 2014.

The following are the total number for each category of services provided by the project, wherever data collection was possible and feasible.

- 127,952 clean needles/syringes were distributed.
- 4,361 naloxone injections were distributed to 1990 PWID, with 119 saved from overdose.
- 820 PWID had their methadone dose increased (Yunnan: 547; Sichuan: 271).

<sup>5</sup> The registration and initiation of MMT is not included in this table of data, as this has been an on-going activity before and after the start of CAHR in these sites.

- 29 PWID were granted with methadone take-away.
- 593 PWID were having their MMT costs fully or partially compensated by insurance.
- 14 PWID were under community-based rehabilitation scheme, diverted from compulsory drug detention system.
- 3,200 low death space syringes were distributed.

Given the very short history of the project, a significant number of PWID was reached, through different grassroots organisations and institutions, mainly peer support groups, MMT clinics and grassroots NGOs.

Number of PWID Covered	Needle Exchange	Naloxone	Methadone			CBR <sup>6</sup>	LDSS <sup>7</sup>
			Dose Increase	Take-Away	Insurance Compensation		
<i>Gejiu</i>	262	379					
<i>Ruili Jiegao</i>	747	217			593		
<i>Ruili Needle Exchange Spot</i>							
<i>Ruili MMT Clinic</i>							
<i>Dali</i>		559					
<i>Yuxi</i>				29		14	
<i>Sichuan</i>							
<i>Xindu</i>	575 <sup>8</sup>	745 <sup>9</sup>	271 <sup>10</sup>				72
<i>Chenghua</i>							
<i>Jinniu</i>							
<i>Jinjiang</i>							
<i>Dujiangyan</i>							
<i>Qingyang</i>							
<i>17 MMT clinics in Yunnan</i>			549				
<b>Sub Totals</b>	<b>1584</b>	<b>1900</b>	<b>820</b>	<b>29</b>	<b>593</b>	<b>14</b>	<b>72</b>

It is important to note that all sites had peer-driven interventions (PDI)<sup>11</sup>, for which the total coverage were not able to capture. Various activities had been initiated under PDI and the following are a few examples:

- Free breakfast
- Temporary accommodation/shelter
- Training PWID with local authorities

## Methodology and Process

<sup>6</sup> Community-Based Rehabilitation

<sup>7</sup> Low Death Space Syringe

<sup>8</sup> Combined number for sites where activity exists.

<sup>9</sup> Combined number for sites where activity exists.

<sup>10</sup> Combined number for sites where activity exists.

<sup>11</sup> Developed in the 1990's by Robert S. Broadhead and Douglas D. Heckathorn as an alternative to the 'provider client' outreach model, PDI is a 'chain-referral' approach depends on active involvement of peers, who are incentivised for working with other peers, to reduce risky behaviours. (See: *Peer Driven Intervention* at Centre for Health, Intervention and Prevention of University of Connecticut)

Six CAHR cities/counties were included in the study, in which 321 PWID were randomly selected as samples. The consultant visited the programme sites where samples were based, in Yunnan and Sichuan provinces, to strengthen his understanding on the CAHR programme. During his visit, he talked to field staff as well as clients of the programme.

The provided questionnaire was translated and adapted, so that the questions could be understood by the interviewed PWID. Questions were also added, in order to capture extra interventions and activities carried out in China. The questionnaire was tested for revision. Upon finalisation, the questionnaire was uploaded to an internet-based system. Results and records from interviews were recorded collectively in this system, for data analysis.

During the course of writing the present report, the consultant has maintained regular communication with the management team, through face-to-face meetings, phone calls, emails and other social media.

Existing literatures were reviewed. These literatures included research papers, policy documents and service records – in Chinese or English.

## Samples

*Jike Shidu is a 23 year-old man from Liangshan Prefecture. He is now living in the Five Stones at the Northern Railway Station. It has been a few years since Jike went back to his hometown last time.*

*Jike needs 8 to 10 syringes a day. Sometimes, he shares needles with his friends and uses tap water for drugs.*

*Jike does not have stable accommodation. He is jobless so that he has to do 'illegal stuff' to make income and for heroin. Jike was diagnosed HCV positive back in Liangshan a few years ago but he does not have the money for treatment.*

*Jike said he wanted to have a job and an affordable room. He also hoped that he could cut off from drugs. Jike really want to join the MMT programme without having to present his identification card.*

***Living a 'healthy and normal life' without being discriminated is his biggest dream.***

There were 321 respondents interviewed for this study, 8 of them withdrew from the interview, filtered through one of the selective questions. All of the 321 respondents said they had injected drugs at least once within the 3 months prior to the interview.

Sampling size and coverage for the present study is significantly larger and more extensive than that of the baseline study<sup>12</sup>. Therefore, it is fair to say that the present study captures a more complete picture of the diversity and complexity of PWID and their life in China.

	Sample Size	# of Expatriate Samples	# of Cities/Counties	# of Provinces
<i>Baseline</i>	177	0	1	1
<i>End of Project</i>	321	73	6	2

## Demographic Background

321 PWID were sampled for the study, 204 from Sichuan Province (Chengdu, Leshan, Neijiang and Mianyang) and 117 from Yunnan Province (Dali and Ruili). Among them, there were 272 male, 40 female and 1 transgender. In terms of nationality, 248 respondents were Chinese and 73 were Burmese.

## Education

More than half (85%) of the respondents said they had the education level between primary school (6 years) and high school (12 years). About 11% did not have any education, while slightly less than 2% attended university/college but left without completing them.

Education		
No Education Background	34	10.86%
Primary School	96	30.67%
High School (Incomplete)	143	45.69%
High School (Complete)	31	9.90%
University/College (Incomplete)	6	1.92%

## Residential Registration, Actual Residential Status and Dependents

In terms of residential registration<sup>13</sup>, 77% of the respondents were registered as urban, while 250 respondents were studying/living/working in the location where the interviews were

<sup>12</sup> *Baseline Report for Community Action on Harm Reduction (CAHR) Project*, International HIV/AIDS Alliance, Regional Technical Hub for Eastern Europe and Central Asia, 02.08.2013, <http://www.cahrproject.org/resource/baseline-report-for-cahr-project/>, Last visited on June 24 2014

<sup>13</sup> Residential registration is called *Hukou* in Chinese. It is based on geographical locations and urban-rural categories. It is where an individual registered, instead of where s/he resides, that determines entitlements, access to education, levels of social welfare and safety nets.



held and 67 were there merely for accessing provided services. Slightly less than 40% of the respondents were born in the location where the interviews were conducted. Almost half of the respondents (47.60%) had one or more children.

<b>Residential Registration</b>		
Urban Resident	248	77.50%
Rural Resident	72	22.50%
<b>Residential Status</b>		
Born and Living Locally	123	39.30%
Resident > 10 Years	67	21.41%
Resident (5 - 10 Years)	27	8.63%
Resident (3 - 4 Years)	25	7.99%
Resident (1 - 2 Years)	38	12.14%
Resident (< 1 Year)	32	10.22%
<b>No. of Children</b>		
1 Child	117	37.38%
2 Children	19	6.07%
3 Children	5	1.60%
4 or more Children	4	1.28%
No Child	164	52.40%

## Service Access

33.33% of the respondents were new clients and nearly 67% were existing clients, at the time of the interviews. Among them, slightly more than 60% of them started accessing services from the project within 1 year prior to the interviews, while 23% were receiving services provided by organisations other than the ones covered by the project.

<b>Length of Receiving Services from the Project</b>		
≤ 6 months	136	43.45%
6 - 11 months	56	17.89%
1 - 2 Years	72	23%
≥ 3 Years	49	15.65%
<b>Service Status</b>		
New Client	107	33.33%
Existing Client	214	66.67%

## Employment Status and Source of Income

A little more than 50% respondents were casual labours who were not under long-term employment; nearly 85% did not have secured income and were supported by social welfare, other family members/relatives.

<b>Employment Status</b>		
Employed	19	4.21%
Casual Labour	232	51.44%
Unemployed	180	39.91%
House Labour	13	2.88%
Disabled	1	0.22%
<b>Source of Income</b>		
Salary	51	12.23%
Income from Owned Business	1	0.23%
Income from Property	13	3.05%
Social Welfare	55	12.91%
Family Supported	95	22.30%
No Income	198	46.48%

65% of the respondents did not have any sex partners of any kind, while 28% were married and declared that their spouses were their sole sex partners. 121 respondents were living with other person/people, among whom 35% claimed that the people they lived with also injected drugs.

<b>Living Alone?</b>		
Yes	191	61.02%
No	122	38.98%
<b>Living with...</b>		
Husband/Wife or Permanent Partner	51	32.08%
Parent/Relative	45	28.30%
Child	24	15.09%
Roommate	39	24.53%
<b>Living with other PWID?</b>		
Yes	18	35.29%
No	31	60.78%

## **Results**

### **Knowledge about HIV/AIDS and Safe Injecting**

The following table shows that the respondents were at a good level for knowledge related to HIV/AIDS and safe injecting. Compared with the percentage of respondents who had given correct answers to the questions during the baseline study, the 313 respondents performed better in 7 out of 13 questions (see comparison table below). Most incorrect answers were given to questions related to needle sharing, opiate overdose symptom and mother-to-child transmission (MTCT) through pregnancy and delivery.

<b>Do you agree with the following statements about HIV/AIDS and injecting practices?</b>		
	<b>% Correct Answer</b>	<b>% Correct Answer (Baseline)</b>
<i>I can avoid HIV-infection having sex only with one faithful partner who is not infected.</i>	299(95.53%)	78.53%
<i>I can avoid HIV-infection using a condom correctly every time during the sexual intercourse</i>	304(97.12%)	94.42%
<i>A person looking healthy can be HIV-positive.</i>	294(93.93%)	93.22%
<i>A mosquito's bite can infect with HIV.</i>	293(93.61%)	68.93%
<i>A person can get HIV by drinking from a glass with an HIV-positive person.</i>	298(95.21%)	89.83%
<i>A person can get HIV by sharing a toilet, swimming pool, or sauna with an HIV-positive person.</i>	297(94.89%)	90.40%
<i>Using a shared needle even once can increase the risk of HIV transmission</i>	297(94.89%)	97.18%
<i>Not using another person's injecting equipment reduces the risk of HIV</i>	301(96.17%)	98.87%
<i>If someone is suffering overdose they should be put in a tub of cold water</i>	157(50.16%)	70.62%
<i>A person's lips turn blue when suffering from overdose</i>	259(82.75%)	90.96%
<i>HIV-infection can be transmitted from an HIV-positive mother to her child during pregnancy.</i>	287(91.69%)	93.79%
<i>HIV-infection can be transmitted from an HIV-positive mother to her child during delivery.</i>	283(90.42%)	90.96%
<i>HIV-infection can be transmitted from an HIV-positive mother to her child during breast-feeding.</i>	283(90.42%)	83.62%

## **Drug Injecting History and Pattern**

Among the 313 respondents, 55 (17.57%) said they started injecting drugs at or before the age of 18.

### **Frequency of Drug Injection**

Within 30 days prior to the interviews, nearly 60% of the respondents injected drugs more than once per day. 3.38% said they never injected during this period, compared with 0.6% from the baseline study. The ratio of respondents injected once a day decreased significantly from 53.7% to 15.54%. However, nearly 60% of the respondents said they injected more than 4 times a day during the last 30 days, while this data is not available for the baseline.

For an extended length of time (1 year prior to the interview), 25% injected drugs once a day, which demonstrates a decline from 37.3% of the baseline. However, higher percentage of respondents said they injected more than two times a day increased, compared to the baseline.

Drug Injection in the Past 30 Days				Baseline
Once	13	4.39%		12.4%
2 - 3 times	20	6.76%		15.8%
Once a week	9	3.04%		3.4%
2 -3 times a week	13	4.39%		8.5%
4 - 6 times a week	10	3.38%		4.5%
Once a day	46	15.54%		53.7%
More than once a day	175	59.12%		N/A
Never	10	3.38%		0.6%
Drug Injection in the Past Year				
About once a week	1	0.35%		
2 - 3 times a week	1	0.35%		
More than 3 times a week	1	0.35%		
Once a day	71	25.00%		37.3%
2 -3 times a day	131	46.13%		45.2%
At least 4 times a day	63	22.18%		14.7%
Others	16	5.63%		

### **Types of Drugs Used**

Over 99% of the respondents used heroin/brown sugar, which was also the most preferred drug (72.25%). This is closely similar to the data from baseline. For all 313 respondents, more than 12 different types of drugs were used. While the drug used for respondents participating was dominantly heroin, a more diverse category of drugs were used by those in the End of Project (EoP) interviews. The main differences were that higher percentages of respondents in the EoP used 'liquid opium extract' (19.49% vs. 0%), 'amphetamine' (29.07% vs. 0%), 'methamphetamine powder' (9.58% vs. 0.6%) and 'diazepam' (28.75% vs. 0%). These variations may have occurred due to differences in locations for interviews therefore availability of drugs.

Drugs to Inject	Actual		Baseline	Preference (EoP)	
Heroin/Brown Sugar	311	99.36%	98.9%	227	72.52%
Liquid opium extract	61	19.49%	0%		
Morphine	2	0.64%	N/A		
Methadone	109	34.82%	0.6%	58	18.53%
Quidict	1	0.32%	0%		
Amphetamine	91	29.07%	0%		
Methamphetamine powder	30	9.58%	0.6%		
"Ecstasy"	5	1.60%	0%		

Midazolam	7	2.24%	N/A		
Ketamine	4	1.28%	0%		
Calmpose	5	1.60%	3.4%		
Diazepam	90	28.75%	0%		
Others	11	3.51%	N/A	28	8.95%

### ***Injection Practice***

Nearly 90% of respondents said they used clean and unused needle/syringe in their most recent injection, which declined slight from 92.7% of the baseline. 96.49% said they had never injected with a needle/syringe that was already used by someone else. Likely, 91% of the respondents never gave their peers the needles/syringes that had been already used.

For those who did use used needle and syringe, '*unavailability of clean syringe/needle at the time of injecting*' and '*trusting the person who used syringe/needle*' were the top two reasons, both in the baseline and EoP.

While using used needle/syringe, a third (27.27%) of the respondents said they never cleaned them, compared to a higher ratio of 31.8% from the baseline. To confirm this, more respondents (9.09%) said they '*always*' cleaned them before using, higher than the 4.6% from the baseline.

The ratio of respondents participating in 'blood-filling' was significantly lower than that from the baseline (52.4% vs. 76.8%).

<b>Using clean unused syringe in most recent injection</b>			<b>Baseline</b>
Yes	278	88.82%	92.7%
No	34	10.86%	
<b>Reasons of using needle/syringe used by others</b>			
Clean needle/syringe unavailable	5	45.45%	50%
I trusted the person.	5	45.45%	40.9%
Needle/syringe too expensive for me	2	18.18%	9.1%
<b>Using syringe used by others in the past 30 days</b>			
Yes	11	3.51%	
No	302	96.49%	
<b>Cleaning practice when using needle/syringe used by others in past 30 days</b>			
I always cleaned them.	1	9.09%	4.6%
Most of the time, I cleaned needle/syringe before using.	1	9.09%	4.6%
Half of the time, I cleaned needle/syringe before using.	1	9.09%	18.2%
I never cleaned needle/syringe before using.	3	27.27%	31.8%

<b>Giving used syringe to others to use in past 30 days</b>				
I did this most of the time.	1	0.32%		
I sometimes did this.	6	1.92%		
I rarely did this.	11	3.51%		
I never did this.	286	91.37%		
<b>Blood Filling</b>				
Yes	164	52.40%		76.8%
No	148	47.28%		

In terms of sharing other tools/appliances for injecting, around 90% of the respondents said they never shared cookers/cups/spoons (89.14%) or cotton/filter (92.33%) with others, compared to the 82.5% ratio from the baseline<sup>14</sup>.

A significantly big proportion of respondents said they had the experience of sharing water for injection (17 – 18%), by either drawing water from a container previously used by someone else, or from a container shared by more than two people at the same time. In relation to this, nearly half of the respondents (47.60%) received clean water provided by the project. 73.48% of the respondents said they never prepared drugs using a shared container.

A bigger proportion of respondents in the EoP said they had the experience of injecting from a pre-loaded syringe (27.16% vs. 9%). Similarly more respondents said they had ever been injected by someone else (59.74% vs. 35.6%).

<b>Sharing cookers/spoons in past 30 days</b>			<b>Baseline</b>
I always did this.	1	0.32%	5.1%
I did this most of the time.	2	0.64%	2.8%
I did this half of the time.	3	0.96%	0%
I sometimes did this.	4	1.28%	1.1%
I rarely did this.	22	7.03%	8.5%
I never did this.	279	89.14%	82.5%
<b>Sharing cotton/filter in past 30 days</b>			
I sometimes did this.	3	0.96%	
I rarely did this.	19	6.07%	
I never did this.	289	92.33%	
<b>Sharing water in past 30 days</b>			
I always did this.	1	0.32%	
I did this most of the time.	5	1.60%	
I did this half of the time.	2	0.64%	
I sometimes did this.	23	7.35%	
I rarely did this.	26	8.31%	
I never did this.	253	80.83%	

<sup>14</sup> In the baseline, all injecting equipment (water, spoon, filter, cotton and etc.) was asked in one question, while they were separate in the EoP study.

<b>Ways of sharing water</b>				
Drew injecting water into a syringe from a container used by someone else	41	71.93%		
Drew water for rinsing from a common container	15	26.32%		
<b>Injecting oneself using a preloaded syringe in last 30 days</b>				
Yes	85	27.16%	9.0%	
No	219	69.97%	90.4%	
<b>Being injected by someone else – ever</b>				
Yes	187	59.74%	35.6%	
No	124	39.62%	64.4%	
<b>Accessing clean water</b>				
Yes	149	47.60%		
No	164	52.40%		
<b>Injecting with water from one vial</b>				
I always only use it for once.	103	69.13%		
I used it for once most of the time and occasionally for two or more times.	27	18.12%		
I used it for 2 or more times most of the time.	19	12.75%		
<b>Sharing water from same vial</b>				
I did this all the time.	1	0.67%		
I did this most of the time.	7	4.70%		
I did this half of the time.	2	1.34%		
I sometimes did this.	15	10.07%		
I rarely did this.	100	67.11%		
<b>Preparing drugs in the same container with others?</b>				
Yes	83	26.52%		
No	230	73.48%		

Less respondents (60.06%) said they injected alone at home, compared with that (83.6%) of the baseline. Significantly more respondents said they injected at home or friend's with others (51.76% vs. 15.3%) and/or in public venues (38.66% vs. 14.7%).

In terms of who they injected with, nearly 40% of them said they had injected in a public venue. Related to this, most respondents said they always injected alone (15.65%) or did so most of the time (46.33%). For their first injecting experience, 45.37% said they were injected by a sex partner or friend. This group of questions were not included in the baseline.

In terms of first time injecting experience, 45.37% of the EoP respondents said they were injected by someone else, while the majority (38.4%) of baseline respondents said they injected by themselves.

Where to inject			Baseline
Alone at home	188	60.06%	83.6%
At home or friend's with others	162	51.76%	15.3%
In street, parks or other public venues	121	38.66%	14.7%
Inject with others?			
I did this all the time.	19	6.07%	
I did this most of the time.	45	14.38%	
I did this half of the time.	55	17.57%	
I sometimes did this.	145	46.33%	
I never did this.	49	15.65%	
First injecting experience			
By oneself	80	25.56%	38.4%
Helped by sex partner or friend	90	28.75%	31.1%
Injected by sex partner or friend	142	45.37%	30.5%

### Choices of Injecting Aids

For the 313 respondents, the top three options for syringe were 'syringe with detachable needle' (3.6.1%), 2 ml syringe (50.80%) and syringe with rubber plunger (28.43%). In contrast, they never chose to use syringe bigger than 5 ml (82.43%), 27 (81.47%) and 29 (82.11%) gauge needles.

Syringe preference	The best option	Good option	Ok to use	Try to avoid	Never use
Syringe with detachable needle	113(36.1%)	6(1.92%)	5(1.60%)	49(15.65%)	143(45.69%)
Single unit syringe	6(1.92%)	5(1.6%)	4(1.28%)	49(15.65%)	249(79.55%)
0.5 ml syringe	2(0.64%)	2(0.64%)	1(0.32%)	57(18.21%)	251(80.19%)
1 ml syringe	70(22.36%)	35(11.18%)	13(4.15%)	95(30.35%)	103(32.91%)
2 ml syringe	159(50.8%)	84(26.84%)	13(4.15%)	16(5.11%)	41(13.1%)
3 ml syringe	16(5.11%)	62(19.81%)	4(1.28%)	52(16.61%)	179(57.19%)
5 ml syringe	10(3.19%)	11(3.51%)	4(1.28%)	58(18.53%)	230(73.48%)
Syringe bigger than 5 ml	0(0%)	1(0.32%)	1(0.32%)	53(16.93%)	258(82.43%)
Syringe with plastic (transparent/white) plunger	3(0.96%)	7(2.24%)	9(2.88%)	55(17.57%)	239(76.36%)
Syringe with rubber (black) plunger	89(28.43%)	18(5.75%)	7(2.2.4%)	47(15.02%)	152(48.56%)
23 gauge needle	31(9.9%)	73(23.32%)	2(0.64%)	48(15.34%)	159(50.8%)
25 gauge needle	6(1.92%)	52(16.61%)	3(0.96%)	54(17.25%)	198(63.26%)
27 gauge needle	0(0%)	1(0.32%)	2(0.64%)	55(17.57%)	255(81.47%)
29 gauge needle	0(0%)	1(0.32%)	3(0.96%)	52(16.61%)	257(82.11%)



Reasons of preferences on different types of syringes varied. Most (82.43%) respondents said that they preferred certain types of syringes for the following reasons.

- Easy to use
- Comfortable
- Saving drug
- Familiarity

13.42% of respondents said they had to use certain types of syringes as they were the only ones available, either in the local 'market' (pharmacies) or provided by various organisations.

Reasons of syringe preferences		
Access	42	13.42%
Easiness/efficiency	258	82.43%

About one fifth (18.21%) of the respondents said they had received low death space syringes<sup>15</sup> provided by the project, all but one respondents (17.89%) said they had used this type of syringe. For the benefits of using low death space syringe, the respondents who had experience said they could 'save drug' (91.07%), and 'reduce disease transmission' (62.50%).

<b>Have you received low-death space syringe?</b>		
Yes	57	18.21%
No	255	81.47%
<b>Have you used a low-death space syringe?</b>		
Yes	56	17.89%
No	241	77%
Never heard of it	16	5.11%
<b>What are the benefits of using a low death space syringe?</b>		
Reducing disease transmission	35	62.50%
Saving drug	51	91.07%

14.70%, 10.86% and 39.94% of the respondents said they always, regularly, or sometimes used alcohol swabs during injection, respectively, while 34.50% said they never used it. For those who did use it, 75% said the use alcohol swabs to wipe the injecting site, both before and after injecting. When asked about the main reasons of using alcohol swabs, most of the respondents (71.22%) said they used it to 'avoid infections entering the body through the skin puncture'.

Use of alcohol swabs		
Always	46	14.70%
Most of the time	34	10.86%
Sometimes	125	39.94%

<sup>15</sup> This is a new group of questions added for China.

Never	108	34.50%
<b>When to use alcohol swabs</b>		
Wipe the injecting site before and after injection	154	75.12%
Using it before injecting	23	11.22%
Using it after injecting	28	13.66%
<b>Main reason to use alcohol swabs</b>		
To remove visible traces of blood from the skin after injection	37	18.05%
To avoid infections entering the body through the skin puncture	146	71.22%
To soften the skin so that it is easier to puncture with a needle	15	7.32%

## Methadone Maintenance Treatment (MMT)

*Ms. X is a 46 year-old lady. She started accessing services on January 27 2014.*

*She was already on MMT before coming to the project for help. At that time, she said, she always had 'goose bumps' and was constantly 'panicking'. The organization helped get her MMT dose raised, after investigation and diagnosis. She said, "I now feel much better. My father, who lives with me, also feels a lot more eased. My sisters and brothers come to see us more often – now no one is frightened".*

*Ms. X said that she wanted to get even healthier so that she could take care of her grandchild – her daughter was about to get married.*

*On direct feelings on the increased dose, she said, "I now can sleep and eat better. I gained 5 kilos of weights since my dose was increased". But she is also a bit worried because she heard higher dose meant more toxic.*

113 respondents (36%) were on methadone maintenance treatment (MMT) at the time of interview. According to the baseline report, as little as 20 to 30% PWID were registered in MMT in China. Supported by the project, 81 (71.68%) had their dose increased. For them, being provided a higher dose had various benefits, among which almost 60% said the side-effects caused by low dose were reduced. Almost 35% of them also said that there had been decreased occasions for injecting drugs. Having the dose lower than actual needs caused various problems. The most prominent ones were increased drug injection (64.60%) and regular discomfort (62.83%). 13 of the 22 respondents who said they did not have the need to increase methadone dose thought by increasing the dose it would be more difficult for them to cut off from drugs (100%) and/or their health would be damaged (85.71%).

Another featured service provided by the project was to help those who were on MMT applying for take-away methadone. After numerous attempts and efforts, the project achieved this major breakthrough in one site. Among all respondents of this study, 2 granted with such entitlement. For them, the main benefits were '*improved compliance to designated time to take MMT*' and '*normalised life and work*'. 72% of the respondents who were not granted with take-away methadone said they would also like to apply for it. For them, the overwhelming barrier to this was the unavailability of policy and practice locally.

### Methadone Take-Away

Mr. T, a 37 year-old man from Yuxi. He joined the group in February 2014.

Mr. T is now allowed to take methadone (dose for two days) home. Previously, he had to go to the MMT clinic once or even twice a day. It was 'very inconvenient'. He said, "I had to check if the place I was traveling to had an MMT clinic whenever I needed to travel. If not, I won't be able to go". Now Mr. T is entitled to take the dose for two days, plus any holiday/s. When asked about the benefits of take-away methadone, he said, "Life is so much more convenient than before. I can arrange my vacations at weekends or public holidays, without having to worry about not taking the treatment. It saves quite some time and money". Mr. T hopes that the take-away service can continue.

<b>Are you currently on MMT?</b>		
Yes	113	36.10%
No	200	63.90%
<b>Was your MMT dose increased supported by the organisation?</b>		
Yes	81	71.68%
No	31	27.43%
<b>Benefits of increasing dose</b>		
Less side-effects due to low dose	49	60.49%
Reduced injecting	48	59.26%
Normalising life/work	28	34.57%
Stabilising emotions	30	37.04%
Others	2	2.47%
<b>Problems of lower-than-need dose</b>		
Regular discomfort	71	62.83%
More prone to injecting	73	64.60%
Difficult to maintain normal life/work	39	34.51%
Unstable emotions - easy to get angry	42	37.17%
<b>Do you feel a need to increase MMT dose?</b>		
Yes	7	22.58%
No	22	70.97%
I don't know.	2	6.45%
<b>Barriers to increasing dose</b>		
Don't know to do it.	2	28.57%
Afraid of damages to my health.	6	85.71%
Worries of increased difficulty to cut off.	7	100%
<b>Are you granted methadone take-away?</b>		
Yes	2	1.77%
No	109	96.46%

<b>Benefits of methadone take-away</b>		
Improved compliance to MMT (time)	1	50%
Normalising life/work	1	50%
<b>Do you want to get methadone take-away?</b>		
Yes	80	72.07%
No	31	27.93%
<b>Why haven't you applied for it?</b>		
I haven't met the requirements.	10	12.50%
I don't know what standards are for it.	41	51.25%
I don't where to apply for this.	28	35%
I am afraid of being out of control and overdose.	1	1.25%
Policy unavailable	62	77.50%

## Overdose and Use of Naloxone

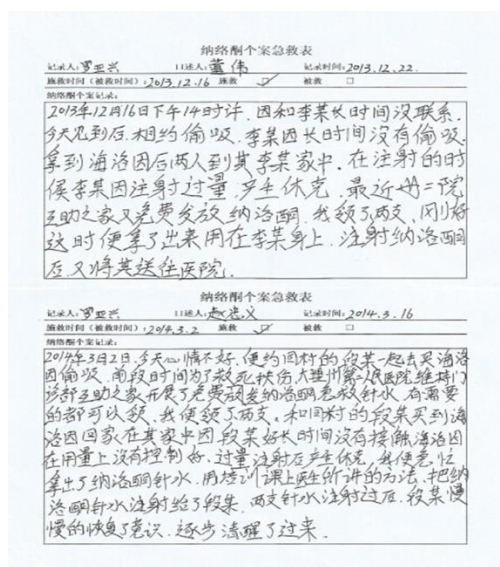
### Mr. Guan and Naloxone

*“I started to participate in the first aid training at your organization in May 2014. I also took some naloxone. Now I have the right knowledge and skills about saving others (who are overdosed). The previous methods, such slapping face, banging on the body or pouring cold water on the body, were all wrong. Now, if I see my friends overdosed, I know how to use naloxone. I have done this and saved three friends. It feels so happy to save life. I even feel that I am more respected by others. I will tell more friends about naloxone – its good function and how to use it so that they can also save more lives”.*

Among all respondents, 32 (10.22%) said they had opiates overdose during the past 12 months before the interview, slightly higher than that of the baseline (9.7%). 31 respondents shared their respective numbers of times for overdose. Around 45% of them had had at least two overdoses during the previous year, among which only 21.88% said they were injected once with naloxone to treat overdose by someone else. 26 respondents (8.31%) also said they had the experience of injecting others with naloxone for overdose.

<b>Opiates overdoses during the last 12 months</b>			Baseline
Yes	32	10.22%	17%
No	278	88.82%	
<b>Overdose: times</b>			
7 times	1	3.23%	
3 times	6	19.35%	
2 times	7	22.58%	
Once	17	54.84%	
<b>Being injected with naloxone by others to treat an opiate overdose</b>			
Yes	7	21.88%	
No	24	75%	
<b>Being injected with naloxone for overdose: times</b>			
Once	7		
<b>Having injected someone else with naloxone to treat an opiate overdose</b>			
Yes	26	8.31%	
No	284	90.73%	
<b>Having injected naloxone for others for overdose</b>			
4 times	1	3.85%	
3 times	1	3.85%	
2 times	10	38.46%	

Once	14	53.85%	
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**Picture:** naloxone use records – name, location, symptoms, critical times, dose and other important information.

## Experience in Conflicts with Laws

About half of the respondents (48.88%) had the experience of being arrested for drug-related crimes. This ratio was 61.6% for the baseline. For a defined period of 12 month, this ratio was 49.67% for the EoP study and surprisingly lower (14%) for the baseline. The same pattern occurred for their experience of being kept in a compulsory drug detention centre, in which 53.67% of the EoP respondents said they had been ever kept in a centre and 52.38% said they had such experience one year prior to the interview. These two ratios were 68.9% and 5.7% for the baseline.

Have you ever been arrested for drug-related crimes – such as using, possessing, buying or selling drugs?				Baseline
Yes	153	48.88%		61.6%
No	158	50.48%		
Have you been arrested for drug-related crimes – such as using, possessing, buying or selling drugs during the last year?				
Yes	76	49.67%		14%
No	75	49.02%		
Have you ever been kept in compulsory (not voluntary) drug detention centres?				
Yes	168	53.67%		68.9%
No	144	46.01%		

Have you been kept in compulsory (not voluntary) drug detention centres during the last year?			
Yes	88	52.38%	5.7%
No	80	47.62%	

## Sexual Behaviours

Less than 20% of the respondents (16.93%) said they had sexual intercourse with someone during the past 12 months before the interview. For those said yes, the majority of respondents (75.47% during past 12 months; 73.58% during past 30 days) chose 'permanent partner' as the person who they had sex with.

<b>Have you had sexual intercourse in the last 12 months?</b>		
Yes	53	16.93%
No	252	80.51%
<b>Have you had sexual intercourse in the last 12 months with</b>		
A permanent partner	40	75.47%
Casual sexual partner	11	20.75%
Commercial sexual partner	4	7.55%
<b>Have you had sexual intercourse in the last 30 days?</b>	<b>Yes</b>	<b>No</b>
A permanent partner	39(73.58%)	3(5.66%)
Casual sexual partner	9(16.98%)	13(24.53%)
Commercial sexual partner	3(5.66%)	10(18.87%)

59.75% of the respondents chose not to give an answer, when they were asked if they used condom during their most recent sexual intercourse. With this considered, higher proportion of respondents used condom in their most recent sexual intercourse with a permanent partner than that from baseline study (35.85% vs. 27.9%). This proportion was lower than the baseline, for the category of 'casual' and 'commercial' sexual partners (see below table).

Did you use a condom the last time you had sexual intercourse with:				
	Yes	No	No Answer	Yes (Baseline)
A permanent partner	19(35.85%)	22(41.51%)	12(22.64%)	27.9%
Casual sexual partner	9(16.98%)	7(13.21%)	37(69.81%)	33.3%
Commercial sexual partner	5(9.43%)	2(3.77%)	46(86.79%)	50%

Significantly more respondents said that they always used condom in sexual intercourse one month prior to the interviews than that of the baseline (43.14% vs. 24.6%), while more than 15% less said they never used a condom during the same period (see table below).



Within the last month (30 days), how often did you use a condom during sexual intercourse?						
	Always	In the majority of cases	In half of cases	Sometimes	Rarely	Never
EoP	43.14%	11.76%	1.96%	3.92%	5.88%	39.22%
Baseline	24.6%	3.5%	0(0%)	3.5%	12.3%	56.1%

## HIV Testing and Status

The majority of respondents (91.05%) said they knew where to access HIV testing, which shows a significant increase from the baseline (73%). 83.07% said that they could have the testing anonymously, nearly 10% higher than that (73%) of the baseline. Among the 313 respondents, 88.50% had been tested, by the time of the interview, 11% higher than the baseline (77.4%).

When discussing about reasons of not being tested, *'not knowing where to be tested'* was ranked the highest, followed by *'lack of money for testing'* and *'being afraid of status disclosed'*. In the baseline, the top reason for not taking HIV testing was the same as the EoP. However, it is important to note that among the 30 baseline respondents who said they had not done an HIV testing, at least 19 (63%) did not provide any reason, while all 35 (100%) EoP respondents who had not received tests provided their answers.

Among the EoP respondents, 77% of those who had not been tested said they would take up HIV testing if it was *'performed by NGO workers in the community setting'*. They shared that information about, access to and confidentiality of testing were the main barriers to HIV testing.

For the EoP respondents who had not done an HIV testing, 77.14% said they would take up the test if it was conducted by NGO workers.

Do you know where to get HIV testing?			Baseline
Yes	285	91.05%	72.9%
No	27	8.63%	
Can you get anonymous HIV testing?			
Yes	260	83.07%	73%
No	49	15.65%	
Were you tested?			
Yes	277	88.50%	77.4%
No	35	11.18%	
Why not tested?			
I don't know where to go	18	51.43%	26.7%

There is no HIV testing point/station/centre where such tests are available in my city/village	5	14.29%	0
I don't know where the HIV testing point /station/centre is located	9	25.71%	0
I have no money for an HIV test	6	17.14%	3.3%
Working schedule of such HIV testing point /station/centre does not match my needs	4	11.43%	6.7%
The location of the HIV testing point /station/centre does not match my needs	1	2.86%	0
The staff's attitudes are a problem for me	0	0%	0
I am afraid that my HIV status or my drug use will be made public	4	11.43%	0
I am afraid that my HIV status or my drug use will be known by the Government	6	17.14%	0
<b>Would you take a test if it was performed by NGO workers in the community setting (health camp)?</b>			
Yes	27	77.14%	N/A
No	7	20%	N/A

Among the 285 respondents who said that they had been tested, 218 (78%) received testing within the past 12 months before the interview, compared with 82.5% for the baseline. 178 (64%) EoP respondents said their most recent tests were conducted by using rapid test, and most of the tests (70%) were conducted in the community. 201 (72.56%) respondents had received results for their most recent testing, among whom 40 (19.90%) were tested positive. This ratio was higher for baseline, in which 91.2% said they had received results for the most recent tests. 33 positive respondents had been registered with the local ART centre. For those who had not done this, seeing ART was not needed at their respective stage was ranked the top reason. Baseline data for status of HIV and registration with ART was not provided.

<b>Did you get an HIV test during the last 12 months?</b>			<b>Baseline</b>
Yes, it was within the last 12 months	218	78.70%	82.5%
No, it was more than 12 months ago	54	19.49%	
<b>Was rapid test used in your most recent testing?</b>			
Yes	178	64.26%	
No	95	34.30%	
<b>Was your last HIV test performed in a clinic or in community setting</b>			
Clinic	48	17.33%	

Community	195	70.40%	
Others:	34	12.27%	
- Compulsory drug detention: 24	-		
- Needle exchange spot: 4			
- CDC: 3			
- Prison: 1			
- MMT clinic: 1			
Unknown: 1			
<b>Do you have the result from the most recent testing?</b>			
Yes	201	72.56%	91.2%
No	51	18.41%	
I am still waiting for the result	8	2.89%	
<b>Do you want to tell us about your HIV-status?</b>			
Yes (+)	40	19.90%	N/A
Yes (-)	139	69.15%	N/A
No	2	1%	
<b>Are you registered with ART provision centre?</b>			
Yes	33	82.50%	N/A
No	7	17.50%	N/A
<b>Why aren't you registered?</b>			
I don't need ART yet.	3	42.86%	N/A
I do not have access to ART provision centre	2	28.57%	N/A

## Frequency and Evaluation of Using Services Provided by the Project

*Wuga is a Yi ethnic minority. He is from A'ba prefecture and now lives in Jinniu District in Chengdu. He is now 26 years old.*

*On January 22 2014, Wuga was brought in to Chenghua Health Counselling Centre to use the needle exchange service. On that day, he took some clean needles, sterile tools and naloxone.*

*Before participating in the project, Wuga needed five to ten syringes a day. Whenever they were not handy, he would share with his friends. After joining in, he can get thirty (per person) clean needles, sterile pads and clean water for injection. Like others, he also took free HIV and HCV tests, as well as health counselling. Wuga also learned quite a lot about MMT, HIV and health.*

*Now, Wuga is looking forward to finding a secure job to support his living in Chengdu. He also hopes that there will be less discrimination towards people like him. Plus, he hopes that the centre could maybe provide some living necessities.*

80.51% of the 313 respondents said they had accessed/received services provided by the organisations under the project. Among them, 216 (85.71%) used services within the past 12 months, which demonstrated a significant increase from 67.23% for the baseline. Among them, 80 (37%) said they accessed the services twice a week and 64 (30%) said they accessed services on daily basis. For the baseline, the largest proportion (52.54%) of the respondents said they accessed the services twice a week or more in the past year<sup>16</sup>.

<b>Have you received services provided by this organisation?</b>		
Yes	252	80.51%
No	61	19.49%
<b>Did you receive services provided by this organisation in the past 12 months?</b>		
Yes	216	85.71%
No	33	13.10%
<b>How often in the past 12 months?</b>		
Once or twice in the last year	17	7.87%
3-5 times in the last year	22	10.19%
6 - 11 times in the last year	11	5.09%
About once a month in the past year	6	2.78%
Two – three times a month in the last year	10	4.63%
About once a week in the last year	6	2.78%
Twice a week or more often in the last year	80	37.04%

<sup>16</sup> Frequency was further separated in the EoP questionnaire. For example, one option, daily access to the service, was not included in the baseline.

Every day in the last one year	64	29.63%
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One and a half (as one question was split into two in the EoP study) types of services were ranked as most accessed, both for baseline and EoP studies, namely ‘targeted IEC of safer injecting’ and ‘HIV testing and counselling’.

The most accessed services, according to the EoP study, are as follow.

1. HIV testing and counselling
2. Targeted information, education and communication about safer injecting
3. Overdose prevention and management education

According to the baseline, the most accessed services are as follow.

1. Access / adherence to opioid substitution treatment or other drug dependence treatment
2. HIV testing and counselling
3. Targeted information, education and communication about safe sex and safe injecting

The most satisfied services for the EoP respondents are as follow.

1. Targeted information, education and communication about safer injecting
2. Overdose prevention and management education
3. Naloxone distribution

According to the baseline, the most satisfied services voted by the respondents were as follow. Yet it was unclear what exact ‘home based care and support’ and ‘family support’ was there at the time of baseline interview in the two districts covered.

1. Needles and syringes
2. Home based care and support for HIV positive drug users
3. Family support (for you and your relatives)

Service received during the past 12 months and level of satisfaction	Yes, I received this.	Very unsatisfied	Average quality	Very satisfied	No answer
	Baseline				
1. Needles and syringes	145(67.13%) 38.4%	4(1.85%)	23(10.65%)	128(59.26%)	61(28.24%)
101. Alcohol swabs <sup>17</sup>	124(57.41%)	4(1.85%)	21(9.72%)	109(50.46%)	82(37.96%)
102. Injecting water <sup>18</sup>	131(60.65%)	4(1.85%)	20(9.26%)	117(54.17%)	75(34.72%)

<sup>17</sup> Not available for baseline

<sup>18</sup> Ditto

103. Cookers/spoons <sup>19</sup>	3(1.39%)	4(1.85%)	4(1.85%)	14(6.48%)	194(89.81%)
104. Cotton balls <sup>20</sup>	85(39.35%)	5(2.31%)	12(5.56%)	73(33.8%)	126(58.33%)
2. Access / adherence to opioid substitution treatment	79(36.57%)	0(0%)	10(4.63%)	78(36.11%)	128(59.26%)
	54.8%				
21. Access / adherence to other drug dependence treatment <sup>21</sup>	37(17.13%)	1(0.46%)	7(3.24%)	45(20.83%)	163(75.46%)
3. HIV testing and counselling	172(79.63%)	0(0%)	16(7.41%)	151(69.91%)	49(22.69%)
	53.7%				
4. Access / adherence to antiretroviral therapy	42(19.44%) 9.0%	1(0.46%)	3(1.39%)	34(15.74%)	178(82.41%)
5. Access to prevention and treatment of sexually transmitted infections	101(46.76%)	1(0.46%)	11(5.09%)	80(37.04%)	125(57.87%)
	31.1%				
6. Condoms	107(49.54%) 32.2%	2(0.93%)	11(5.09%)	92(42.59%)	112(51.85%)
61. Lubricants	20(9.26%)	1(0.46%)	4(1.85%)	24(11.11%)	188(87.04%)
7. Targeted information, education and communication about safer injecting	159(73.61%)	0(0%)	20(9.26%)	143(66.2%)	53(24.54%)
	48.0%				
71. Targeted information, education and communication about safe sex	135(62.5%)	2(0.93%)	19(8.8%)	108(50%)	87(40.28%)
	48.0% <sup>22</sup>				
8. Access to diagnosis, treatment and vaccination of viral hepatitis	45(20.83%)	0(0%)	20(9.26%)	33(15.28%)	163(75.46%)
	36.7%				
9. Access to prevention, diagnosis and treatment of TB	42(19.44%)	0(0%)	15(6.94%)	33(15.28%)	168(77.78%)
	20.9%				
10. Shelter, shower, food, other services that satisfy basic needs	43(19.91%)	3(1.39%)	19(8.8%)	36(16.67%)	158(73.15%)
	12.4%				
11. Basic health services (including vein care) <sup>23</sup>	66(30.56%)	2(0.93%)	11(5.09%)	68(31.48%)	135(62.5%)
111. Overdose prevention and management education <sup>24</sup>	157(72.69%)	0(0%)	20(9.26%)	146(67.59%)	50(23.15%)

<sup>19</sup> Ditto

<sup>20</sup> Ditto

<sup>21</sup> This question was combined in Question 2, for the baseline.

<sup>22</sup> This question was combined with the previous one on safer injecting.

<sup>23</sup> Questions 11 and 111 were combined in the baseline, which shows an accessing rate of 27.1%.

<sup>24</sup> Ditto

112. Naloxone <sup>25</sup>	150(69.44%)	0(0%)	10(4.63%)	140(64.81%)	66(30.56%)
12. PMTCT <sup>26</sup>	32(14.81%)	4(1.85%)	10(4.63%)	26(12.04%)	176(81.48%)
121. Family planning <sup>27</sup>	5(2.31%)	3(1.39%)	7(3.24%)	10(4.63%)	196(90.74%)
122. Access to safer abortion <sup>28</sup>	3(1.39%)	3(1.39%)	7(3.24%)	3(1.39%)	203(93.98%)
123. Maternal health services <sup>29</sup>	3(1.39%)	3(1.39%)	7(3.24%)	4(1.85%)	202(93.52%)
124. other SRH services <sup>30</sup>	11(5.09%)	4(1.85%)	9(4.17%)	6(2.78%)	198(91.67%)
13. Home based care and support for HIV positive drug users	23(10.65%)	2(0.93%)	11(5.09%)	14(6.48%)	189(87.5%)
	17%				
14. Family support (for you and your relatives)	33(15.28%)	2(0.93%)	11(5.09%)	22(10.19%)	181(83.8%)
	23.7%				

According to the respondents, the following services were most needed. Questions for the EoP study were segregated more specifically so that the respondents were also able to name their needed services more accurately. All three services are tightly related to clean injecting practice.

1. Needles and syringes (voted by 72.2% of respondents)
2. Alcohol swabs (65.7%)
3. Injecting water (64.26%)

The three most needed services voted by the baseline respondents are all different from those from the EoP study. It is interesting that even over 70% of the respondents were already receiving MMT at the time of interview, 95% of them still ranked this as their top needed service.

1. Access / adherence to opioid substitution treatment or other drug dependence treatment (95%)
2. HIV testing and counselling (84%)
3. Economic strengthening activities (82.4%)

<sup>25</sup> Not included in the baseline

<sup>26</sup> For questions 121 to 124, the baseline used a combined question, without segregating specific categories for SRH. It shows that 24.3% of the respondents had ever accessed them. Denominator for this group of question should be all FEMALE respondents, instead of ALL respondents. To make the comparison possible, this report follows the method used by the baseline, in which the number of ALL respondents was used as the denominator.

<sup>27</sup> Ditto

<sup>28</sup> Ditto

<sup>29</sup> Ditto

<sup>30</sup> Ditto

Which of the following services do you need?	I do not need this service	I need this service sometimes / I more less need it	I need this service very much
1. Needles and syringes	24(8.66%)	23(8.3%)	200(72.2%)
101. Alcohol swabs	30(10.83%)	31(11.19%)	182(65.7%)
102. Injecting water	36(13%)	30(10.83%)	178(64.26%)
103. Cookers/spoons	115(41.52%)	43(15.52%)	67(24.19%)
104. Cotton balls	93(33.57%)	49(17.69%)	95(34.3%)
2. Access / adherence to opioid substitution treatment or other drug dependence treatment	46(16.61%)	47(16.97%)	165(59.57%)
21. Access / adherence to other drug dependence treatment	81(29.24%)	89(32.13%)	62(22.38%)
3. HIV testing and counselling	64(23.1%)	88(31.77%)	93(33.57%)
4. Access / adherence to antiretroviral therapy	154(55.6%)	26(9.39%)	41(14.8%)
5. Access to prevention and treatment of sexually transmitted infections	134(48.38%)	62(22.38%)	31(11.19%)
6. Condoms	141(50.9%)	57(20.58%)	28(10.11%)
61. Lubricants	164(59.21%)	37(13.36%)	16(5.78%)
7. Targeted information, education and communication about safer injecting	90(32.49%)	82(29.6%)	74(26.71%)
71. Targeted information, education and communication about safe sex	100(36.1%)	82(29.6%)	59(21.3%)
8. Access to diagnosis, treatment and vaccination of viral hepatitis	88(31.77%)	79(28.52%)	76(27.44%)
9. Access to prevention, diagnosis and treatment of TB	86(31.05%)	92(33.21%)	57(20.58%)
10. Shelter, shower, food, other services that satisfy basic needs	102(36.82%)	86(31.05%)	34(12.27%)
11. Basic health services (including vein care, and overdose prevention and management)	87(31.41%)	111(40.07%)	38(13.72%)
111. Overdose prevention and management Education	83(29.96%)	102(36.82%)	73(26.35%)
112. Naloxone	63(22.74%)	111(40.07%)	80(28.88%)



12. PMTCT	183(66.06%)	22(7.94%)	8(2.89%)
121. Family planning	194(70.04%)	11(3.97%)	6(2.17%)
122. Access to safe abortion	201(72.56%)	6(2.17%)	4(1.44%)
123. Maternal health services	201(72.56%)	6(2.17%)	5(1.81%)
124. Other SRH services	196(70.76%)	10(3.61%)	7(2.53%)
13. Home based care and support for HIV positive drug users	135(48.74%)	46(16.61%)	36(13%)
14. Family support (for you and your relatives)	117(42.24%)	59(21.3%)	53(19.13%)
15. Access to justice/legal services	100(36.1%)	73(26.35%)	53(19.13%)
16. Economic strengthening activities	55(19.86%)	43(15.52%)	139(50.18%)

When asked about what were important to their accessing various services, the respondents ranked 'cost', 'confidentiality' and 'accessibility' as the top three factors, exactly the same as the baseline presented.

<b>In general, what are the key factors that are important to you in relation to service delivery?</b>		
1. Accessibility – close to my home, and open when I need it	223	71.25%
2. Staff friendliness	189	60.38%
21. Staff professionalism	169	53.99%
3. Range / menu of services being provided	167	53.35%
4. Confidentiality – information about my drug use and HIV status will be anonymous and won't be given to Government authorities	237	75.72%
5. Cost of services / services being free	263	84.03%
51. Availability of peer support	158	50.48%

## Well-Being and Quality of Life

*Li Hu is a fifty-year old man. He lives with her girlfriend in Chenghua District of Chengdu City. In June 2013, he participated in one PDI activity and took some clean syringes, sterile pads and naloxone from the needle exchange spot. A few days after that, he took free HIV and HCV tests, as well as counselling from the staff members.*

*Before join the group, he needed 16 syringes to use with his girlfriend and other friends. Sometimes, they shared injecting tools, and used tap water. After he joined the group, he can get 30 syringes, together with sterile tools and clean water for injection. With this, he and his friend could save some money. They also registered for MMT provided by the project organisation. Now their life is more normal, with less pressure. Sometimes, they work as casual labourers and stopped doing illegal things for heroin.*

*Li Hu has brought a few friends to the PDI activities and health camps, in which they learned about HIV, MMT and others related to health.*

*Currently, Li Hu is hoping that the community organisation can help him find a more stable job, things like delivery, so that he is able to secure income for living. About the project, he hopes that the needle exchange service can sustain for long.*

*Li Hu is looking forward to a discrimination-free and more supportive environment for people like him.*

28.75% of the respondents said that their basic needs had NOT been met, while 22.6% said so in the baseline study. Lower ratio of respondents said they felt very vulnerable (EoP 28%, baseline 35.6%). Significantly fewer respondents for EoP study were strongly dissatisfied with their economic well-being than that of the baseline (10.22% vs. 35%). 3.83% of the respondents said they had extreme pain or discomfort, while only 2.8% said so in the baseline. Compare to this, 6.71% of respondents said they were extremely anxious or depressed, while 17.5% said it in the baseline.

<b>Are your basic needs (food, shelter, clothing, etc.) fully met?</b>			<b>Baseline</b>
1. My basic needs are currently fully met	25	7.99%	34.46%
2. My basic needs are somewhat met	171	54.63%	42.9%
3. My basic needs are not met	90	28.75%	22.6%
<b>Do you feel safe and secure?</b>			
1. I constantly feel myself safe and secure	23	7.35%	26.55%
2. I feel myself somewhat safe and secure	171	54.63%	37.85%
3. I feel myself very vulnerable	89	28.43%	35.59%
<b>How satisfied are you with your economic well-being?</b>			
1. Fully satisfied	5	1.60%	2.82%
2. Satisfied	22	7.03%	13.56%
3. Somewhat satisfied	132	42.17%	16.95%
4. Not satisfied	119	38.02%	32.20%

5. Strongly dissatisfied	32	10.22%	34.46%
<b>Do you feel pain/discomfort?</b>			
1. I have no pain or discomfort	127	40.58%	67.79%
2. I have moderate pain or discomfort	157	50.16%	29.37%
3. I have extreme pain or discomfort	12	3.83%	2.82%
<b>Do you feel Anxiety/Depression?</b>			
1. I am not anxious or depressed	81	25.88%	32.76%
2. I am moderately anxious or depressed	192	61.34%	49.15%
3. I am extremely anxious or depressed	21	6.71%	18.07%

On stigmatisation and discrimination, 12.14% of the respondents said that they felt highly stigmatised – for which the ratio was much higher in the baseline at 39.6%. Still, 62% of the respondents said they felt stigmatised. Nearly 87% of the respondents said they were not discriminated by medical workers.

A much higher proportion of respondents for the baseline (20.9%) said they had experienced extremely negative attitudes/actions taken by the police and other law enforcement staff (7.67%).

<b>Do you feel being stigmatised?</b>			<b>Baseline</b>
1. I don't feel I am stigmatised at all	60	19.17%	15.81%
2. I feel some degree of stigmatisation / I fear being stigmatised and that is why I hide my drug use/HIV status	193	61.66%	44.63%
3. I feel that I am highly stigmatised	38	12.14%	39.54%
<b>Do you feel discriminated by health/medical workers?</b>			
Yes	40	12.78%	
No	272	86.90%	
<b>Do you experience any negative attitudes / actions taken by the police and law enforcement attitudes in regard to you?</b>			
1. I do not experience any negative attitudes / actions taken by the police and law enforcement attitudes in regard to me	124	39.62%	49.72%
2. I experience some negative attitudes / actions taken by the police and law enforcement attitudes in regard to me	111	35.46%	29.38%
3. I experience extremely negative attitudes / actions taken by the police and law enforcement attitudes in regard to me	24	7.67%	20.90%

As part of the efforts to support PWID economically on their MMT, the project advocated for MMT cost to be (partially or fully) covered by the rural medical insurance scheme, i.e. the New Rural Cooperative. For those who had their MMT cost covered, reduced economic burden was the main benefit (85.71%). 64.71% of the respondents said they also would like to have their MMT cost covered.

*Xiao Ma is a Muslim man, 38 year-old. He is HIV and HCV positive.*

*Xiao Ma started taking heroin in 1995. His wife was the only bread-winner in the family, being a maid for a medical doctor. The doctor asked her to get tested, after hearing about her husband's status. So she did and was diagnosed positive too. She was fired by the doctor. Since then, they have lived a very difficult life.*

*Both Xiao Ma and her wife are on ART – although it was free they had to pay other costs such as transportation, not to mention that they also had to support their child's education. It became even worse after Xiao Ma initiated his MMT. Under the heavy economic burden, the wife started to complain and they often got into fight.*

*After a long time of efforts and advocacy, AIDS Care China pushed the local authority change their policy by including MMT cost into the Rural Health Insurance scheme. On January 1 2014, this policy was announced and in February it was put into practice. Now Xiao Ma can save as much as CNY300 (about USD50) a month.*

*This not only has reduced the burden on his wife and improved their relationship, but also facilitated strengthening of their adherence to ART.*

<b>Do you get MMT cost covered partially or fully by rural health insurance?</b>		
Yes	7	23.33%
No	17	56.67%
<b>Coverage proportion</b>		
50 -100%	2	28.57%
<50%	5	71.43%
<b>What are the benefits of having MMT cost covered?</b>		
Reduced economic burden	6	85.71%
Better MMT retention	4	57.14%
<b>Do you want to get MMT cost covered by rural health insurance?</b>		
Yes	11	64.71%
No	6	35.29%
<b>What are the barriers?</b>		
I haven't joined the rural health insurance scheme.	16	55.17%
I don't know how and where to apply for this.	12	41.38%
I am afraid that my status would be disclosed.	4	13.79%

Nearly 17% of the respondents said that health services that they needed were not accessible – this was significantly higher in the baseline at 31.6%. 12.14% of the respondents said that the health services they needed were fully accessible. 5.43% of the respondents felt that although health services were accessible to them, they experienced negative attitudes/actions from the providers.

<b>How accessible are health services to you?</b>			<b>Baseline</b>
1. I feel that health services that I need are fully accessible to me	38	12.14%	34.46%
2. I feel that health services that I need are somewhat accessible to me	173	55.27%	31.07%
3. Health services that I need are accessible but I experience negative attitudes and actions by health service providers	17	5.43%	2.26%
4. I feel that health services that I need are not accessible to me	53	16.93%	31.64%

29.07% of the respondents said that they did NOT feel any support from the community, while 51% of the respondents said this for the baseline. However, a lot more respondents (23%) felt that their family did not want to have any relations with them – in the baseline, only 4.0% said so.

<b>Do you feel you are supported by your community</b>			<b>Baseline</b>
1. I feel high level of support from the community	29	9.27%	14.69%
2. I feel some support from the community	145	46.33%	33.33%
3. I don't feel my community supports me at all	91	29.07%	51.41%
<b>Do you feel your family supports you?</b>			
1. I feel that my family supports me	45	14.38%	75.14%
2. I feel that my family partially supports me	91	29.07%	5.65%
3. I feel that my family does not support me	58	18.53%	14.12%
4. I feel that my family does not want to have any relations with me	73	23.32%	3.95%

## Key Findings

Information, education and communication from the CAHR project helped the respondents to obtain a good level of overall knowledge and understanding on related aspects. Compared to the baseline, the respondents demonstrated better understanding and higher awareness in 7 out of 13 questions, while some slight decrease in the other 6 questions. Although it is fair to say that the EoP respondents might not have obtained a higher level of 'paper-based' knowledge, their practice confirms that the OUTCOMES have been positive.

Injecting behaviours of the respondents changed, which led to a safer practice on injecting, as well as sex. More respondents (3.38%) said they never injected any drugs within 30 days prior to the interview, compared with a much lower proportion (0.6%) of the baseline. This is further supported by the fact that significantly less proportion of respondents said they injected drugs once a day, both for a 30 day (15.54% vs. 53.7%) and one year interval (25% vs. 37.3%). Although slightly less respondents (90%) said they always used clean syringe in their most recent injecting, compared to that of baseline (92.7%), the proportion of

respondents who injected with a syringe previously used by another person was much lower than that of the baseline (12.43% vs. 3.51%). The ratio of respondents participating in 'blood-filling' was also significantly lower than the baseline (52.4% vs. 76.8%). In terms of safe sex, higher proportion of respondents used condom in their most recent sexual intercourse with their permanent partners than that from baseline study (35.85% vs. 27.9%), while the EoP ratios were slightly lower than those of the baseline, for the categories of 'casual' and 'commercial' sex partners. Significantly more respondents said that they 'always' used condom in sexual intercourse one month prior to the interviews than that of the baseline (43.14% vs. 24.6%).

Additional 'tools' were introduced to the respondents to reinforce their changes in understanding and practice. As an additional measure to support safe injecting, about one fifth (18.21%) of the respondents said they had received low death space syringes provided by the project. Among them, all but one said they had used such syringes after receiving them. 62.5% of these respondents reflected that by using low death space syringes, transmission of diseases could be reduced.

While overdose seemed reportedly inevitable, a critical measure was introduced to the respondents so that they could save their own and other people's lives. A slightly higher proportion of respondents said they had opiates overdose during the past 12 months before the interview, compared to the baseline (10.22% vs. 9.7%). Among them, 21.88% said they were injected with naloxone by someone else. 8.31% of them also said they injected others with naloxone for overdose. This was to say that over 30% of the respondents used naloxone to treat fatal overdose, as a result of the project initiative.

While the baseline and EoP studies both demonstrated a high proportion of MMT registration among the respondents, the latter initiated more specific and humane measures to support PWID to maintain a satisfactory treatment outcome and strengthen their adherence. Supported by the project, 81 (71.68%) of the 113 respondents on MMT had their dose increased. With a more appropriate dose, 60% of the respondents said the side-effects caused by low dose were reduced, and 35% said that there had been less occasions for injecting. According to them, the main benefits were improved compliance to treatment and normalised life. This was confirmed by an in-house research, which showed that those whose dose was increased had lower positive rate of urine tests and less occurrence of lapsing. The other MMT-related initiative, take-away methadone, allows approved PWID to take their dose away when needed. This measure further increased the adherence rate and much lower urine test positive rate<sup>31</sup>.

In terms of normalising life and overall wellbeing, by working with multiple key departments, the project achieved recognisable outcomes for the respondents. Lower proportion of respondents (48.88%) had the experience of being arrested for drug-related crimes, compared to that of the baseline (61.6%). 53.67% of the EoP respondents said they had the experience of being kept in a compulsory drug detention centre, lower than the baseline ratio of 68.9%. However, it is interesting to note that the reverse pattern occurred, when

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<sup>31</sup> ACC in-house comparative study, 2014

comparing the ratios for the defined period of 12 months prior to the interview, i.e. the baseline ratios were both lower than those of the EoP study.

Accessibility of key services such as HIV/AIDS testing was improved, so that PWID could use the services, without having to worry about their identities being exposed. 88.50% of the EoP respondents had been tested for HIV/AIDS, 11% higher than the baseline (77.4%). Almost 20% more of the respondents than baseline said they knew where to access HIV testing (91.05% vs. 73%). 83.07% also said that they could have the testing anonymously, nearly 10% higher than that (73%) of the baseline.

Having covered a large number of as well as multi-national PWID over a short period of time, CAHR in China obtained an outstanding level of accessibility, diversity and satisfaction for the services provided. 80.51% of the 313 respondents said they had accessed/received services provided by the organisations under the project, i.e. ACC. Retention of PWID in the services maintained a high ratio, for which 216 (85.71%) used services within the past 12 months, significantly higher than 67.23% of the baseline. Although a direct comparison on the levels of satisfaction for different services was not possible, it is clear that the EoP respondents were most satisfied with services related to 'safer injecting', 'overdose management' and 'overdose treatment'<sup>32</sup>, while the baseline respondents were most satisfied with 'needle/syringe distribution/exchange', 'home-based care' and 'family support'<sup>33</sup>. Slightly more EoP respondents said that their basic needs had NOT been met, compared to that of the baseline (28.75% vs. 22.6%). Apart from this, ratios from all other categories for well-being demonstrated better results.

To help the PWID with their economic wellbeing, the project had another additional activity to advocate for the inclusion of MMT costs under the national medical insurance. As a very new initiative, this was made possible not long before the EoP study, only in one project site and covered a few respondents. Regardless, 'reduced economic burden' was the most common outcome perceived by the respondents. Objectively, this initiative also helped PWID build improved behaviours related to injecting and treatment adherence. An in-house comparison study showed that when MMT costs were covered by insurance, drug positive rate decreased by 7.7%, and retention rate increased by 11.2%. 64.71% of the respondents who were not under this arrangement at the time of interview said they also would like to receive this benefit in the near future.

## **Feedback and Recommendations**

Through discussions with the EoP respondents and project staff in China, the following feedback and recommendations are made.

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<sup>32</sup> Targeted information, education and communication about safer injecting, overdose prevention and management education, and naloxone distribution.

<sup>33</sup> Needles and syringes, home based care and support for HIV positive drug users, family support (for you and your relatives).

1. Comparing data from baseline and EoP:
  - a. According to the person responsible for methadone maintenance treatment in Chenghua District in Chengdu, he was not aware of the existence of the baseline study. This could direct to the fact that the baseline was 'managed' by the local CDCs, in which case only the PWID considered to be 'good' were 'selected' to participate in the interviews.
  - b. This is by no means to question the validity of the baseline, but to alert us to a more sophisticated approach when trying to obtain genuine data from the genuine populations.
  - c. Another fact that we need to consider when comparing the two sets of data is that the EoP covered a large proportion of PWID in Yunnan Province, where the circumstances are significantly more complicated and complex, not to mention the complexity added by involving cross-the-border Burmese respondents. The audience should be aware of the fact that Yunnan is the key hub of transportation and consumption of drugs, between the Golden Triangle and the rest of the world.
2. Against the odds
  - a. Influenced by a few important events, both domestically and internationally, funds from international organisations in China have demonstrated a drastically rapid decline in China. One specific example is that the State Department stated in 2013 that no US money will be spent on needle exchange programmes. Internally, needle exchange is not as welcome as before, due to its conflicting presentation in different governmental authorities.
  - b. The contradictions of policies and indicators between different governmental authorities have no doubt undermined the CAHR efforts. One example is that the policy department resumed their operations of 'ambushing' PWID for injecting at the spots of MMT clinics and needle exchange services, which scared them off from accessing the services. Having pointed to this, we should reinforce that ACC has successfully identified the key catalysts in the projects sites. In other words, it takes time to build relationship with people who support the CAHR approach and make a change – much longer than simply providing a few needles. MMT dose increase, methadone take-away and insurance coverage of MMT costs are all strong examples for such achievements.
  - c. Against all these odds, it is suggested that CAHR should continue, for at least another three years, to keep the momentum of success that the report has capture a fraction of. Taking into consideration of the baseline, management transition and preparations, CAHR has made a significant change to the lives of the PWID covered. It would be a shame if all these are lost for lacking funds. It was strongly suggested, despite of the challenges ahead, CAHR should put its operational continuity and sustainability as the prioritised strategy.
3. Next steps – if the CAHR project is to continue in China, ACC is planning to initiate or strengthen the following activities.
  - a. Strengthening of MMT accessibility will be continued, by means of expanding methadone take-away, dose increase and covering costs through national medical insurance scheme. An action research will be conducted to demonstrate



to the government the economic effectiveness of these approaches as well as increasing overall MMT coverage, to push for increased governmental investments in MMT.

- b. ACC will open a not-for-profit NGO-run MMT clinic in Longchuan County in Yunnan this June and is planning to develop the same in Cangyuan County (also in Yunnan). If this model is proven effective, it is hoped that the government will allow NGO (CSO) participation in receiving grants and operating MMT clinics in China, an important initiative to create an alternative service model thus improved quality for PWID.
- c. ACC will continue working with the Public Security Bureau (PSB) closely so that it can gradually embrace the community-based rehabilitation model which was already initiated in some of the CAHR sites. This is hoped to eventually lead to not only an expanded community-based approach, but also changes in the PSB performance assessment system which is currently largely punitive and arrestment-making focused.
- d. Although it is fair to say that needle exchange activities have not been the priority for CAHR in China due to stringent arrestment-making action as stated above, it is suggested a more peer-to-peer distribution of clean needles and syringes are established, borrowing from the PDI approach. With this, it is hoped that the quality of needle exchange activities are improved, while participating PWID do not have to worry about their safety by doing so. Many interviewed staff and PWID reflected that the current 'recycling' model not effective and practical anymore, under the difficult circumstances.
- e. With experiences from both before and after the CAHR project, it is clear that testing and treatment for HCV among PWID is a critical point for action, the sooner the better. ACC is planning to initiate such activities under the next phase of CAHR, if it is to be continued.

## Conclusion

It is a true challenge to compare what CAHR has achieved in China, by comparing data from the end-of-project study with that from the baseline. Only 177 samples from one city (Chengdu) were sampled for the baseline study, which 313 PWID were sample from the four cities of Chengdu, Ruili and Dali in two provinces. In addition, the demographical background of respondents was significantly more complex for the EoP study, including two nationalities (China and Burma) and many more ethnic minorities (*Han, Hui, Yi, Bai and so forth*).

Therefore, it is important to answer the questions of '*what changes has CAHR brought*' to provide a more vivid picture for this study.

### ***Change 1: Government (Authority) Policy and Government***

Working with its affiliated organisations and local health departments, ACC has made at least three policy changes, in the very widely perceived 'stubborn' and complex system for

drug control. The first one is to have MMT costs enlisted in the compensation categories in the rural health insurance scheme<sup>34</sup>. This is a national health scheme that covers the largest population on earth. There is no doubt that this pioneering policy in Yunnan can lead to massive benefits for PWID in China. The second is MMT take-away. Although only a limited number of PWID were granted with this entitlement, ACC's achievement in changing policy within the Public Security System in China has demonstrated that CAHR can bring about meaningful and sustainable outcomes valuable to a normalised life for any PWID. In the Yunnan Provincial MMT Annual meeting, Director of Drug Control of Yunnan Public Security Bureau said that MMT should be expanded through community health institutions, relevant costs should be covered by the national medical insurance and those who met relevant requirements should be allowed to take their methadone home. Thirdly, CAHR has successfully advocated to change a 'the lower the better' practice in MMT dose setting, to one which was more scientific and individualised. It has also brought the level of approved dose for PWID to the standards set by the World Health Organisation.

### ***Change 2: Accessible Integrated Services***

In the baseline study report, lack of integral service system was highlighted as one of the major problems for PWID in the five CAHR countries. With its well-established system based on ART, ACC has built up a network within which PWID can be referred to any other services that they need. This is by far a much more feasible and sustainable approach, than creating a new system without integral linkages amongst key and relevant departments. With China's large (PWID) population and big government, using, making changes to and linking existing facilities can help PWID access services in the most effective and efficient way.

### ***Change 3: Real Life Stories***

From interviews with the over 300 respondents for the EoP study, we have heard so many touching stories that would not be captured by numbers, bar charts, tables and any other 'cold' statistical means. It is the individual stories of thousands of PWID that any drug rehabilitation work should aim to change – and this is what exactly CAHR is making changes to. A child with two PWID parents, a son distanced by his families, a HIV positive wife who works endlessly to make money to treat herself and his sick husband – these are the faces of real lives of PWID in China. With its effortless staff members who work on a daily basis to make changes to people who have power, they are empowering the marginalised, neglected and discriminated ones.

### ***Change 4: Building Evidence***

Through the CAHR project, ACC has accumulated a significant database, both on paper and/or electronically. The collected information is not only proof of effectiveness of CAHR, but more importantly evidence for policy advocacy. Internally, ACC has conducted in-house researches covering the CAHR topics of methadone dose increase, take-away methadone, and inclusion of MMT costs into the national health scheme.

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<sup>34</sup> On December 19 2013, the reimbursement of MMT costs through medical insurance was first officially (and openly) promulgated in Dali, one of the CAHR project sites, by the local Health Bureau.

It is also foreseeable that such evidence will be eventually rolled on and used in other work and by other projects and institutions, including those out of China, to make more and stronger long-term changes for PWID.

**By talking to a Burmese who travel across the border on a daily basis merely to access the services s/he needs provided by CAHR in Ruili, one will see the true values of CAHR in China.**

