

UNGASS COUNTRY PROGRESS REPORT

P. R. CHINA

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral
CARES	Comprehensive AIDS Response
CCM	Country Coordinating Mechanism (of GFATM)
CDC	(Chinese) Centre for Disease Control
CRMIS	Comprehensive Response Management Information System
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People Living with or Affected by HIV/AIDS
HIV	Human Immune-deficiency Virus
IDU	Injecting Drug Use
IDUs	Injecting Drug Users
IEC	Information, Education and Communication
JAR	Joint Assessment Report (of SCAW CO and UNTG)
MARP	Most-at-Risk Population(s)
M&E	Monitoring and Evaluation
MMT	Methadone Maintenance Treatment
MOH	Ministry of Health
MSM	Men who have Sex with Men
MTCT	Mother-to-Child Transmission
NCAIDS	National Centre for AIDS/STD Prevention and Control
OI	Opportunistic Infection
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
RNE	Resource Needs Estimation
SCAWCO	State Council AIDS Working Committee Office
STI	Sexually Transmitted Infections
SW	Sex Worker
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United National Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session (on AIDS)
UNICEF	United Nations Children's Fund
UNTG	United Nations Theme Group on AIDS
VCT	Voluntary Counselling and Testing

EXECUTIVE SUMMARY

To achieve the overall objective of the China's Action Plan for Reducing and Preventing the Spread of HIV/AIDS (2006-2010), the Chinese government strengthened leadership in the prevention and control of the HIV epidemic, developed comprehensive prevention, treatment, care and support initiatives, and monitored on-going progress. This report, prepared by State Council AIDS Working Committee Office and the United Nations Theme Group on AIDS, covers the epidemic situation and the response since 2006, and identifies the ongoing challenges from which recommendations for future guidance are formulated.

1. The AIDS situation in China

The cumulative number HIV positives reported at the end of October 2007 was 223,501, including 62,838 AIDS cases and 22,205 recorded deaths. In 2007 the Ministry of Health, UNAIDS and WHO have prepared this updated assessment of the AIDS epidemic in China. The estimation result showed by the end of 2007, approximately 700,000 are now HIV positive (range 550,000-850,000). The HIV infection rate among China's population is 0.05 per cent (range 0.04-0.07%). The estimated number of AIDS cases is 85,000 (range 80,000-90,000). The estimated new HIV infections in 2007 are 50,000 (range 40,000-60,000) and there are estimated 20,000 AIDS-related deaths (range 15,000-25,000). Among the living HIV positives, 40.6 per cent were infected through heterosexual transmission.

Currently, China's HIV epidemic remains one of low prevalence overall, but with pockets of high infection among specific sub-populations and in some localities. The characteristic of the epidemic in China are: The epidemic continues to expand, but the rate is slowing; sexual transmission is now the main mode for the spread of HIV; geographic distribution is highly varied; and the epidemic continues to be driven by high-risk behaviour within particular sub-populations.

In high-prevalence locations there are apparent impacts on individuals and families affected by AIDS, but data from applied research surveys on

2. Accomplishments of the AIDS response

The State Council strengthened the AIDS policy framework by issuing the Regulations on AIDS Prevention and Control and the new Five Year

Action Plan for Reducing and Preventing the Spread of AIDS (2006-2010) in early 2006. The Chinese Government actively demonstrated commitment to international society and implemented the 'Three Ones' principle. National leaders, including Premier Wen Jiabao and Vice-Premier Wu Yi, continuously set examples of supporting people living with HIV and children affected by AIDS through personal actions.

The government's resource commitments to AIDS have continued to increase and comprehensive training to strengthen the HIV awareness of leaders is being implemented. An achievement during the past two years has been strengthened coordination and integration across sectors to plan and implement HIV awareness and prevention campaigns and similar activities, including the National HIV Education and Communication Campaign among Rural Migrant Workers, the Chinese Campaign on HIV Prevention among Children and Youth, and a National University Students' Lecture Competition on HIV Knowledge.

Mass organizations, civil society organizations and business enterprises are actively involved in the national response to AIDS. Their range of involvement has become broader in its scope and depth. The number of community-based organizations is increasing and becoming an indispensable force in the national response to the epidemic. The role of celebrities in HIV awareness campaigns has helped generate interest among target groups.

Comprehensive HIV prevention initiatives are increasingly focused on behavioural change among the most-at-risk populations (MARPs). Coverage of interventions aimed at behavioural change by sex workers and their clients has increased and interventions to men who have sex with men were also strengthened through pilot projects. Among injecting drug users, the methadone maintenance treatment programme has been expanded, along with clean needle exchange in locations with high injecting drug use. HIV transmission through blood (plasma) donation and transfusion was effectively contained and the coverage of prevention of mother-to-child transmission was expanded. Voluntary counselling and testing services were progressively expanded.

Expanding access to free antiretroviral treatment under the 'Four Free One Care' policy has been a priority, with coverage extended to 1,190 counties in 31 provinces (autonomous regions and municipalities). Standardized ART was strengthened, the national drug resistance monitoring system was established and a pilot second-line drug trial was launched. Comprehensive treatment models, prevention of opportunistic

infection treatment and traditional Chinese medicine treatment were under exploration, while care and support have been further intensified.

Strengthening the national surveillance system continues. A Comprehensive Response Management Information System was developed to integrate data and information on AIDS. Development of a National Monitoring and Evaluation system for AIDS is a priority area. A significant step was achieved when the national AIDS Monitoring and Evaluation Protocol was formally issued.

Other measures implemented include strengthened resource integration and utilization; and better integration of international cooperation resources with national priorities. China has also played an increasing role in providing international assistance in the field of AIDS. Scientific research has been further developed.

3. Challenges and recommendations

While there have been impressive achievements in the national response to AIDS, a number of core challenges remain. These are outlined under seven key areas, namely: (1) programme management and accountability; (2) awareness campaigns and anti-discrimination; (3) comprehensive interventions; (4) treatment, care and support; (5) all society involvement; (6) capacity-building of response teams; and (7) monitoring and evaluation systems.

From the challenges, a series of action recommendations have been formulated. These are presented in Chapter 3.

CHAPTER 1 THE AIDS SITUATION IN CHINA

The Ministry of Health (MOH), UNAIDS and WHO jointly released the '2005 Update on the HIV Epidemic and Response in China'. This showed that HIV was widespread, but with significant geographic differences in the epidemic. HIV prevalence was still expanding with parallel transmission modes, the most important at that time being injecting drug use and sexual transmission. Moreover, the situation in terms of people living with HIV (PLHIV) developing AIDS and AIDS-related deaths had become serious. There was evidence that the epidemic was spreading from high-risk groups to the general population, creating the potential risk that the epidemic would spread further.

In the past two years, progress has been made in strengthening surveillance, case reporting systems, expanding voluntary counselling and testing, addressing comprehensive prevention interventions, treatment and care, and strengthening international cooperation. Particular attention has also been given to strengthening epidemiology parameters, size estimation of the most-at-risk populations (MARPs) and estimation and projections of the epidemic. These measures have strengthened knowledge of the current AIDS situation in China. The results of the reporting information system, sentinel surveillance data, behavioural surveys, specific investigations and the 2007 estimation of the HIV epidemic are presented in the following sections:¹

1.1 Reported HIV Infections

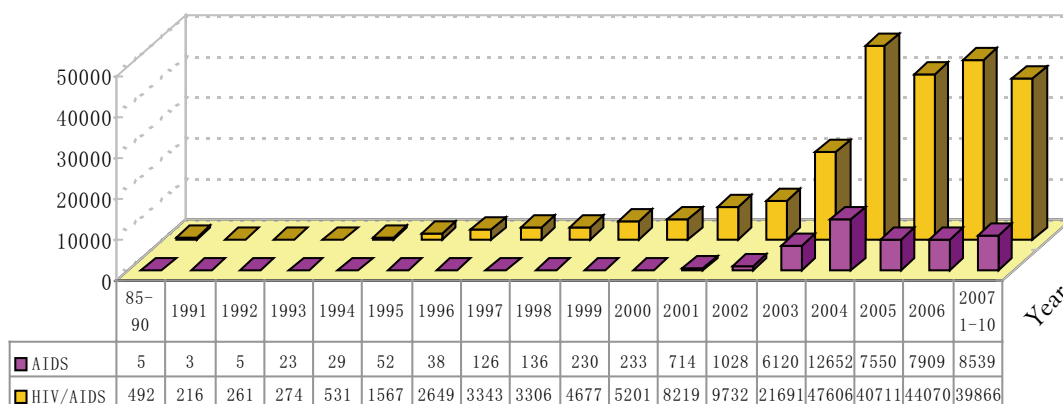
1.1.1 Overall trends

By the end of October 2007, the cumulative total of reported HIV positives was 223,501, including 62,838 AIDS cases and 22,205 recorded deaths.

From January to the end of October 2007 the number HIV positives reported was 39,866, including 8,539 AIDS cases and 4,232 deaths. Figure 1.1 shows the annual reported HIV positives and AIDS cases in China since 1985. The large increase in HIV positives shown for 2004 is mainly due to intensive screening of former blood donors and expanded and strengthened surveillance and testing.

¹ The data in this report does not include Hong Kong, Macao or Taiwan

Figure 1.1 Annual reported HIV positives and AIDS cases in China 1985-2007 (as of October 2007)



1.1.2 Geographic distribution

The cumulative number of people living with HIV in Yunnan, Henan, Guangxi, Xinjiang, Guangdong and Sichuan accounts for 80.5 per cent of the total reported numbers in China (see Figure 1.2). The number of AIDS cases in Henan, Yunnan, Guangxi, Anhui, Guangdong and Hubei accounts for 83 per cent of the total reported number (Figure 1.3), while the number of AIDS-related deaths in Henan, Yunnan, Guangxi, Hubei, Anhui, Guangdong and Sichuan accounts for 80.5 per cent the total.

Figure 1.2 Geographic distribution of cumulative reported HIV positives in China (as of October 2007)

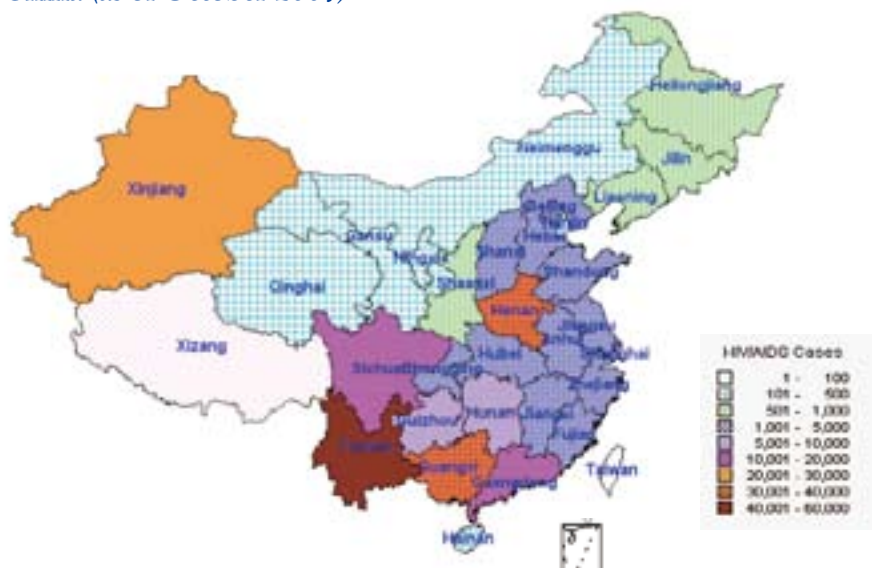


Figure 1.3 Geographic distribution of cumulative reported AIDS cases in China (as of October 2007)



1.1.3 Transmission mode

By the end of October 2007, among the cumulative number of PLHIV, 38.5 per cent were infected via injecting drug use (IDU), 19.3 per cent was via former blood and plasma collection, 17.8 per cent was through heterosexual transmissions, 1 per cent through homosexual transmission, 4.3 per cent via blood transfusion and blood products, and 1.2 per cent through mother-to-child transmission (MTCT). The transmission mode for the remaining 17.9 per cent is unknown.

Among those living with HIV reported between January and October 2007, 37.9 per cent was through heterosexual transmissions, 3.3 per cent through homosexual transmission, 29.4 per cent were infected via IDU, 6.1 per cent was via blood and plasma collection, 4.2 per cent via blood transfusion and blood products, and 1.6 per cent through MTCT, with 17.5 per cent unknown.

1.1.4 Age distribution

Cumulative cases by the end of October 2007 showed that HIV infections are concentrated in the 20 to 39 age group, who account for 70 per cent of the total. AIDS cases are mainly aged between 20 and 49, this group accounting for 69.9 per cent of the total and AIDS-related deaths are also concentrated in this age group (72 per cent of the cumulative deaths).

Table 1.1 Age distribution of HIV infections, AIDS cases and AIDS-related deaths

Age Group (Age)	HIV infections		AIDS Cases		AIDS-related deaths	
	2007 reported*	Cumulative reported **	2007 reported*	Cumulative reported **	2007 reported*	Cumulative reported **
0~	1.3	1.1	1.6	1.6	1.7	1.6
10~	3.0	3.5	2.2	1.8	1.6	2.3
20~	33.3	34.2	20.8	15.6	16.2	19.5
30~	39.5	35.8	37.9	34.0	35.8	33.3
40~	13.5	12.2	20.1	20.3	21.2	19.2
50~	5.2	4.4	10.1	9.3	11.3	9.5
60~	4.2	2.2	7.3	3.2	7.3	4.2
Unknown	0.0	6.6	0.0	14.2	4.9	10.4
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0

*HIV infections, AIDS cases and AIDS-related deaths reported during January to October 2007;

** Cumulative HIV infections, AIDS cases and AIDS-related deaths by end of October 2007.

Note: HIV infections means those who have been infected by HIV but has not developed into AIDS.

1.1.5 Gender distribution

By the end of October 2007, 71.3 per cent of the cumulative total of PLHIV was male and 28.7 were female. Among the AIDS cases 60.6 per cent were male and 39.4 per cent female.

Among the HIV infections reported between January and October 2007, 70.5 per cent was male and 29.5 were female. Among the AIDS cases 64.7 per cent were male and 35.3 per cent female.

1.2 The 2007 AIDS Epidemic Estimation

In 2007 MOH, UNAIDS and WHO have prepared this updated assessment of the AIDS epidemic in China.

1.2.1 Key findings of estimation

Number of people living with HIV: The estimation results indicate that by the end of December 2007, the current HIV positives were approximately 700,000 (range 550,000-850,000). The proportion of females is 30.8 per cent. The HIV infection rate among China's population is 0.05 per cent (range 0.04-0.07%). The estimated number of AIDS cases is 85,000 (range 80,000-90,000). The estimated new HIV positive cases in 2007 were 50,000 (range 40,000-60,000) and there are an estimated 20,000 AIDS-related deaths (range 15,000-25,000).

Distribution characteristics: Of the 700,000 HIV positives still living, 40.6 per cent were infected through heterosexual transmission, and 11.0 per cent through homosexual transmission. Heterosexual transmission was mainly focused in high prevalence provinces. Homosexual transmission

was mainly focused in large and middle-sized cities and areas with large concentrations of migrants.

Among the estimated HIV positives, 38.1 per cent were infected through IDU. There are seven provinces and autonomous regions in which the number of HIV positives infected through IDU is over 10,000; namely Yunnan, Xinjiang, Guangxi, Guangdong, Guizhou, Sichuan and Hunan. These provinces contain 87.9 per cent of people infected through IDU.

Also among the estimated 700,000 HIV positives, 9.3 per cent were infected through commercial plasma donation and transfusion of infected blood and blood products. Of these 87.6 per cent were located in four provinces: Henan, Anhui, Hubei and Shanxi. Just 1 per cent of infections were through MTCT.

Among the estimated living 85,000 AIDS cases, some 35,000 are former commercial blood donors and people infected through blood transfusion. The remainder (50,000) were infected through IDU, sexual and mother-to-child transmission.

New infections in 2007: It is estimated that there were 50,000 new infections in 2007, mainly concentrated among injecting drug users (IDUs), sex workers (SWs) and their clients, men who have sex with men (MSM) and the partners of HIV positive people.

1.2.2 Comparison with 2005 estimates

The estimated number of people infected with HIV through heterosexual transmission increased by 50,000 in 2007 compared with 2005. In addition the HIV prevalence rate among the clients of sex workers increased 1-2 per cent over the figure for 2005.

In 2007 the HIV positives among MSM was about 30,000 more than the 2005 estimate. This was primarily due to the availability of more up-to-date estimates of the MSM population size and prevalence data for the past two years. The new estimation better represents the actual situation than the previous estimation.

The estimate of HIV positive people among IDUs decreased by more than 20,000 compared with the 2005 figure. This is primarily due to more complete and accurate information on the IDU population through more intensive screening for HIV among this group. The lower end of the estimated IDU population range for 2007 is only 86 per cent of the low range figure used for the 2005 estimation.

The estimate of HIV positive people among the former blood and plasma donors was 12,000 less than the 2005 estimation. This is mainly due to enhanced screening and better estimation of the size of this population.

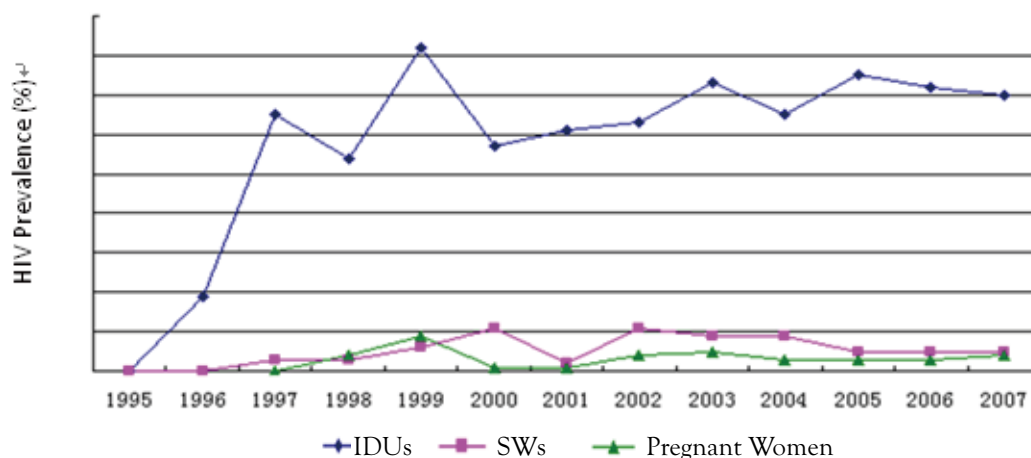
1.3 Characteristic of the Epidemic in China

1.3.1 The epidemic continues to expand, but the rate is slowing

The epidemic estimation results show the number of PLHIV has increased by 50,000 since 2005 and the AIDS cases has increased from 75,000 to 85,000 in 2007. The number of new infections is estimated at 50,000, which is 20,000 less than the 2005 figure.

Sentinel surveillance data shows that the infection rate among IDUs, SWs and pregnant women continues to increase, but the rate of increase has slowed as indicated in Figure 1.4.

Figure 1.4 Sentinel surveillance data on IDUs, sex workers and pregnant women 1995 - 2007



1.3.2 Sexual transmission is now the main mode

Among the 50,000 estimated new infections during 2007, heterosexual transmission was 44.7 per cent, homosexual transmission was 12.2 per cent and transmission through IDU was 42 per cent, while MTCT transmission was 1.1 per cent.

Among the transmission modes, the ratio of sexual transmission is increasing each year. Heterosexual transmission was 10.7 per cent of the total in 2005 and reached 37.9 per cent in 2007. Similarly, homosexual transmission was 0.4 per cent in 2005 and showed a dramatic increase to 3.3 per cent in 2007 (Figure 1.5).

The cumulative transmission mode for HIV positives at the end of 2006 and for the period January to October 2007 is given in Figure 1.6.

Figure 1.5 Distribution of sexual and IDU transmissions of HIV from web-based reporting

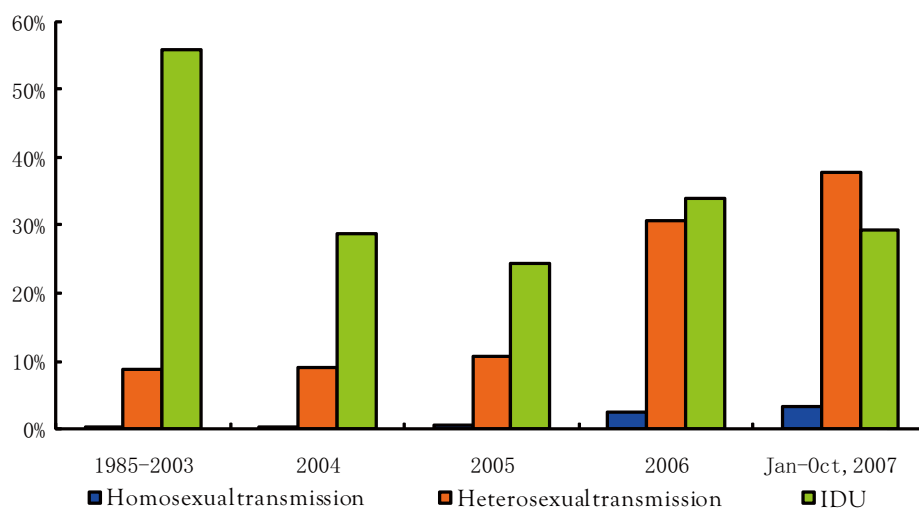
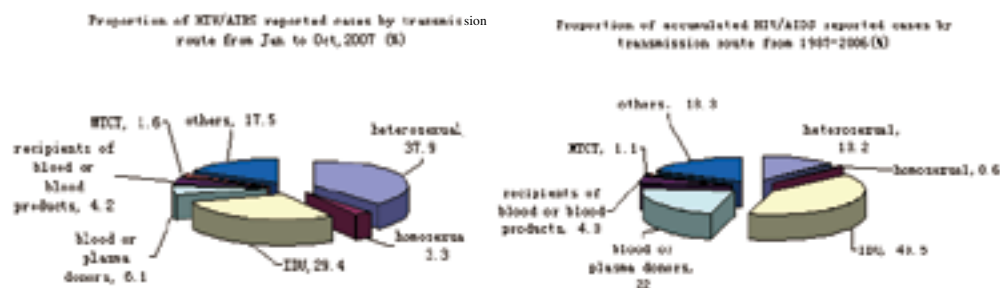


Figure 1.6 Transmission mode distribution among reported HIV positives in 2007 and cumulative reported cases by the end of 2006



1.3.3 Geographic distribution is highly varied

Since 1998 all 31 provinces, autonomous regions and municipalities have reported HIV cases. By October 2007, 74 per cent of counties/districts reported HIV positive people. The web reporting data shows great differences in reported cases between different localities. The top five provinces of reported HIV positives account for 70-80 per cent of the total national reported cases (see Figures 1.2 and 1.3).

The 2007 epidemic estimation shows five provinces with more than 50,000 HIV positives and nine provinces with 10,000-50,000 PLHIV. Only four provinces have less than 2,000 PLHIV. The top five provinces account for 53.4 per cent of the national estimated number, while the bottom five provinces only account for 0.9 per cent of the total (see Figure 1.7).

Figure 1.7 Geographic distribution of 2007 estimated cases



1.3.4 Factors driving the epidemic

Comprehensive surveillance data shows that 40 per cent of IDUs share needles, while 60 per cent of sex workers do not use condoms every time. Risky behaviour among MSM includes 70 per cent of the group having sex with more than one partner in the past 6 months and only 30 per cent use condoms for anal sex, while 50 per cent use condoms when they have commercial homo-sex.

Reported cases and epidemic estimation show that about 500,000 PLHIV have not been identified, while among the 220,000 reported PLHIV the follow-up rate is low due to the high mobility of the individuals and other difficulties in tracking and follow-up. The high proportion of PLHIV who do not know their status and the difficulties of following-up HIV positives are major risk-factors behind the potential for the further spread of infections.

In recent years the prevalence rate of syphilis has increased rapidly demonstrating the re-emergence of an epidemic. The national syphilis reported incidence rate increased from 0.08 per 100,000 in 1987 to 13.3 per 100,000 in 2006, an annual rate of increase of 30.7 per cent. Sexually transmitted infections (STI) sentinel monitoring reporting shows 28.9 per cent of sites identified PLHIV.

Stigma and discrimination of PLHIV remains a serious problem. Because of this, individuals with high risk behaviour avoid voluntary HIV testing and PLHIV are afraid to disclose their HIV status. This increases the risk of HIV spreading further.

1.4 Impacts of AIDS

In high-prevalence locations there are apparent social impacts due to AIDS, but data from applied research surveys on the social and economic impacts of AIDS is limited.

1.4.1 Impact of AIDS on well-being of individuals

National infectious disease statistics show that, in 2006, fatality rate of AIDS cases was 20 per cent, the third highest fatality rate among national infectious diseases (class I and II). The mortality rate of AIDS is 0.1 per 100,000, which ranks AIDS as number four nation-wide. These deaths mainly focused on the working age group (nearly three-quarters of the 20-49 age category), with an average death age of 37.6.

1.4.2 Impact of AIDS on mental health

Field investigations show that two-thirds of PLHIV experience severe depression and may consider suicide, although few do. Nearly 70 per cent of children lost hope for the future and self-value recognition when they knew their parents developed AIDS symptoms. Several case studies show that children affected by AIDS in some communities are unable to attend school or community activities.

Stigma and discrimination against PLHIV is severe. Field investigations showed nearly 40 per cent of people shun contact with PLHIV.

1.4.3 AIDS impact on households

The economic impacts of families can be significant as fewer members are available for income-generating activities and finances are diverted to treatment and care of AIDS patients. For instance, a study found that the average income per person in households affected by AIDS was 44 to 47 per cent of persons in families not affected by AIDS. In some areas PLHIV need to pay additional cost, such as treatment for opportunistic infection (OI), which increase the economic burden for families affected by AIDS.

The care of PLHIV mainly relies on local government welfare payment, but migrants have difficulty in obtaining care and support.

CHAPTER 2 ACCOMPLISHMENTS OF THE AIDS RESPONSE

The 2004 Joint Assessment (JAR) and the 2005 Update on the AIDS Epidemic and response in China highlighted a number of challenges hindering effective AIDS prevention, treatment and care in China. These included the need for strong leadership and political commitment from all levels of government, legislative reform, information exchange and utilization, improved surveillance systems, improved advocacy and education interventions, strengthened monitoring and evaluation and increased financial support. The years 2006 and 2007 have seen obvious progress on responding to these challenges, which are highlighted in this report.

2.1 Government Commitment and Leadership Building

The 2004 JAR identified uneven implementation of the AIDS response across ministries and provinces. Cross-sector cooperation was only superficial, while a number of provinces and sectors did not have strategic plans in place, provincial plans were at different stages of development and mechanisms to monitor and evaluate performance were weak.

In the past two years, the Chinese Government gave high priority to expanding the response at all levels to AIDS prevention, treatment and care, and ensuring more effective implementation of the programme.

2.1.1 The legal and policy framework has been strengthened

The Regulation on AIDS Prevention and Treatment (Decree No. 457) was issued by the State Council in early 2006. The Regulation was the first legal framework developed in China for a specific disease or epidemic. This provides a legal framework for AIDS initiatives, emphasising the accountability of governments and Ministries at different levels. They also set out the rights and responsibilities of people living with HIV, ensure the funding of AIDS measures and provide the legal foundations for AIDS policy formulation and its effective implementation.

China has actively followed 'Three Ones' principle—One national plan; One coordinating mechanism; and One monitoring and evaluation (M&E) system. The State Council AIDS Working Committee has established 'one national coordinating mechanism'. China's Action Plan for Reducing and Preventing the Spread of HIV/AIDS (2006-2010), issued by the State Council Office in March 2006, provides one national planning framework, while the release of China's AIDS Monitoring & Evaluation Protocol in June 2007 provided the third pillar.

Research into the prevention and control of AIDS and other focal infectious disease is one of 16 priority tasks in ‘China’s Development Programme of mid- and long-term Science and Technology Development (2006 -2020)’.

The Ministry of Civil Affairs, the Ministry of Justice, the Ministry of Railways, the General Administration of Quality Supervision, Inspection & Quarantine, General Administration of Traditional Chinese Medicine, All China Trade Union, the Red Cross Society of China and other sectors have developed action or strategic plans to respond to AIDS.

Yunnan, Zhejiang, Shandong and some other provinces formulated their local AIDS prevention regulations or measures, while each province developed their own 5-year action or implementation plans for 2006-2010.

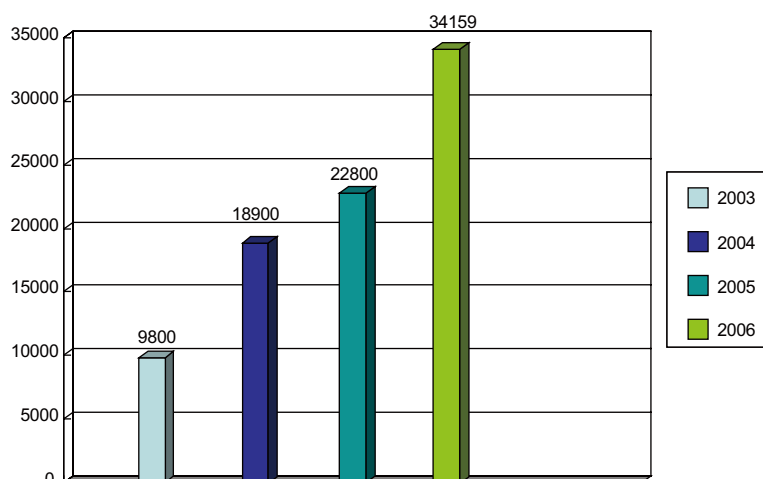
2.1.2 National leadership is setting the example

The Chinese Government leaders demonstrated their commitment to AIDS prevention and set examples through personal actions with people affected by the disease. On 1 December 2006 Premier Wen Jiabao and Vice-Premier Wu Yi invited 17 children orphaned by AIDS and living with HIV, together with doctors and teachers from Henan, Yunnan and other provinces as guests of Zhong Nan Hai and to attend the ‘Our Care-Attention to Children Orphaned by AIDS-Evening Gala Concert’. Premier Wen Jiabao took the lead in donating to children orphaned by AIDS.

2.1.3 Increased financial commitment

In recent years the Central Government financial input to AIDS prevention and care has been significantly increased. Central government resources devoted to AIDS was RMB 854 million in 2006, which increased to 944 million in 2007. In accordance with the incomplete data from local AIDS Working Committee Office, local financial commitments showed a corresponding increase.

Figure 2.1 AIDS budget contributions by provincial governments 2003-2006 (10,000 Yuan, incomplete data)



2.1.4 Strengthening awareness of leadership

The State Council AIDS Working Committee Office (SCAWCO) organised workshops on the Regulations and the Five-Year Action Plan to brief leaders on their implications for implementation and learning requirements. SCAWCO conducted a series of training activities on HIV policy. The initial presentation was made at the Central Party School in June 2006, and was extended nationally through the Schools' long distance education network broadcast. In this way, 100,000 political and government leaders were reached in local Party Schools.

The HIV Policy Advocacy Group then travelled to 16 provinces (autonomous regions and municipalities) where presentations were made, while at the same time some provinces (autonomous regions and municipalities), including Zhejiang, Shanxi, Hubei, Sichuan, Guizhou and Xinjiang, organised local HIV policy promotion teams to conduct publicity activities at local levels.

The Central Department of Publicity and other agencies held two workshops for publicity department personnel nation wide, including 19 major national media outlets. In follow up through the Central Party School, over ten local Party Schools integrated HIV policy and knowledge into their curricula for leaders at various levels. The National Administration College of the Ministry of Education, party schools of the Ministry of Communications and of the State Administration of Industry & Commerce also integrated HIV policy and knowledge into their training curricula.

2.1.5 Cross-sector cooperation has been strengthened

During the past two years, there has been significant advancement in the coordination and cooperation across sectors. Various large-scale initiatives were jointly conducted, which are summarized in Table 2.1.

Table 2.1: Summary of Key Cross-sector Initiatives

Activities	Sectors involved
The National HIV Education & Communication Campaign among Rural Migrant Workers	SCAWCO, Central Department of Publicity, Ministry of Labour & Social Security, Ministry of Construction, Ministry of Agriculture, MOH, State Population & Family Planning Commission, State Administration of Industry and Commerce, All China Trade Union, Central Youth League, All China Women's Federation and All China Confederation of Industry and Commerce
Attention to Women, Against AIDS	Central Department of Publicity, MOH, State Population & Family Planning Commission and All China Women's Federation
Women "Face to Face" Education Campaign in China CARES Areas	All China Women's Federation and MOH
Youth Red Ribbon Action – Youth Volunteer Face to Face Education Campaign	Central Youth League and MOH
Employee Red Ribbon Health Action	All China Trade Union, Ministry of Labour & Social Security, MOH, China Enterprises Confederation/China Association of Entrepreneurs
The Chinese Campaign on HIV Prevention among Children and Youth	SCAWCO, MOH, Ministry of Education, Ministry of Civil Affairs, State Population & Family Planning Commission, Central Youth League, All China Women's Federation and Chinese National Committee for the Care of Children
Support and Care activities to PLHIV and their families	SCAWCO, MOH, Ministry of Civil Affairs, State Population & Family Planning Commission, All China Women's Federation and Red Cross Society of China
12.1 Attention to Orphans and 10,000 Home of Love Welfare activities	All China Women's Federation, MOH and SCAWCO
Awareness Campaign on HIV Knowledge among University Students	SCAWCO, MOH, Ministry of Education and Central Youth League
Support to HIV Prevention and Control Work in Yunnan Province	More than 30 national ministries and agencies, including Central Department of Publicity, State Commission for Public Sector Reform, Ministry of Foreign Affairs, National Development & Reform Committee, Ministry of Finance, Ministry of Science & Technology and State Ethnic Affairs Commission
Working Protocol on Opium Abusers Community Drug Maintenance Treatment	MOH, Ministry of Public Security and State Food & Drug Administration

2.2 All Society Involvement

The 2004 JAR noted that was limited involvement of community-based organizations and they were weak in terms of capacity in implementation and management of projects, particularly at the local level.

More and more mass organizations, civil society organizations and enterprises and business are actively involved in the national response to AIDS over the past two years. Their range of involvement has become broader in its scope and depth and they have become an important player and indispensable force in the national response to the epidemic.

2.2.1 Govern- ment advocacy and support for civil society involvement

The Regulation on AIDS Prevention and Treatment decrees that national government encourage and support organizations, including Trade Unions, Youth Leagues, Women's Federations and Red Cross Societies, to take cooperative activities on AIDS prevention and treatment with various levels of people's government. It encourages and supports relevant organizations and individuals to participate in AIDS prevention and treatment in accordance with the Regulation and the national programme and action plan on AIDS prevention and control.

The Central Government has established special funds for social mobilization for AIDS, while utilizing international cooperation funds, especially the Global Fund, to support the involvement of mass organizations and civil society groups. In the four years 2002 to 2006, some 287 social mobilisation projects from across China were approved, with funding amounting to 26.9 million Yuan.

The Global Fund Rounds 3, 4 and 5 provided total support to civil society organizations of 43 million RMB. The newly approved Round 6 has earmarked US\$10.08 million for civil society activities, some 70 per cent of the total budget for this round.

2.2.2 Mass organisations and civil soci- ety participa- tion

Many national level mass organizations and civil society groups are actively involved in HIV work and are providing support for the development and capacity building of community-based groups. Provincial STD/AIDS associations have also been strengthened. By the end of October 2007, STD/AIDS associations had been established and further developed in 18 provinces, while many districts and cities had also been motivated to establish STD/AIDS associations.

Civil society organizations and community-based groups are implementing an increasing number of AIDS interventions at various levels. The number of community-based groups, including PLHIV support groups, women's groups and most-at-risk intervention groups increased from around 100 to over 400 by 2007. More than 6,000 volunteers are working within MSM community groups nationwide at the present time.

By participating in project design, implementation and monitoring, the initiatives and commitment of community-based and PLHIV groups continues to be strengthened, which reflects the GIPA principle. Some civil society organizations played an active role in the Global Fund Country Coordinating Mechanism (CCM) reforms.

The faith-based organizations, such as Buddhist, Islamic and Christian groups, also participated in the HIV awareness campaigns and support activities in Xinjiang, Yunnan, Ningxia, Shaanxi, Hunan, Liaoning and other areas.

ART Compliance Education by Farmer's Health Group

In Xincui County, Henan Province, 25 PLHIV volunteered to form a Farmer's Health Group and carried out various support activities, including AIDS awareness, OI treatment and ART compliance education, promotion of family-based nutrition, care and psychosocial support. Over the past two years, their face to face communication sessions reached over 1,200 contacts. They used their personal experiences to demonstrate the change before and after ART and convinced other PLHIV and their family members of the importance of standardized drug-taking and improved their compliance to the ART.

2.2.3 Enterprise and business involvement

In June 2007 SCAWCO issued a Notification on mobilizing business commitment to and participation in HIV prevention. The Ministry of Finance and the State Administration of Taxation issued a taxpayer deduction policy for donation to HIV prevention and AIDS care activities.

The All China Confederation of Industry & Commerce, the China Enterprises Confederation (CEC), the China Private Business Association and the Global Business Coalition (GBC) on AIDS all played an active role in coordinating the involvement of enterprises in the AIDS response.

After the Summit of Global Business against AIDS in Beijing in 2005 - co-organised by the Chinese Government and GBC - many enterprises increased their efforts in workplace AIDS education programmes to promote knowledge and awareness, and developed workplace AIDS policies to reduce stigma and discrimination.

Businesses also provided financial and in-kind donations of 28 million RMB through various channels. Pharmaceutical enterprises were actively involved in the development and production of ARV drugs, giving strong support to the ongoing development of ART. Some enterprises cooperated with the government to undertake comprehensive campaign on HIV prevention and control.

2.2.4 Role of celebrities

In 2006 SCAWCO held a seminar titled 'United Celebrities, Media and Businesses against AIDS'. In follow up with the Goodwill Ambassadors for AIDS - Pu Cunxin, Xu Fan, Zhou Tao, Zhang Chaoyang and Cai

Guoqing, celebrities in arts and sports, such as Peng Liyuan, Li Danyang, Jiang Wenli, Yao Ming and Hou Yaowen also joined the HIV awareness campaigns. The Goodwill Ambassadors were actively involved in policy lectures, education activities and charity performances for migrant workers, children, youth and university students. They also posed for posters, public service announcements and charity songs. Ambassadors travelled to grass-roots locations to visit PLHIV and children orphaned by AIDS, visited detoxification and re-education centres through labour, and entertainment venues to promote HIV knowledge. The celebrity status of the ambassadors drew widespread interest and expanded the coverage of these events.

2.3 Comprehensive HIV Prevention Responses

The 2004 JAR noted that overall awareness of HIV remained low and that stigma and discrimination was a constraint. It found that IEC intervention needed to be improved in terms of its depth, breadth and innovation. The coverage of targeted interventions was limited, with few effective models or 'best practices' for reaching specific high risk behaviour groups and to improve the quality of existing interventions, such as 100 per cent condom use promotion, MMT and needle exchange. Further efforts were required to guarantee blood safety and reduce iatrogenic infection.

2.3.1 HIV awareness initiatives

2.3.1.1 General population HIV awareness campaigns

For the 2006 World AIDS Day, SCAWCO, the Central Department of Publicity, the State Administration of Radio, Film and Television and other ministries jointly organised the 'Our Care Evening Gala Concert', which were broadcast by CCTV channels. The programs 'Road to Health: Three Supports into Countryside-A Special Program on AIDS', a 100-part TV program 'Red Ribbon' and a World AIDS Day special program, 'Red Ribbon-Our Commitment' and Symphony-'Floating Red Ribbon' were broadcast by CCTV. The Qu Opera-'Floating Red Ribbon', presented by Henan Qu Opera Troupe, toured 14 provinces (autonomous regions and municipalities) over a six-month period and reached a total audience of 300,000. In addition, Ping Opera-'Red Ribbon Flying', presented by the Hebei Dachang Ping Opera Troupe, travelled to 20 provinces and performed at over 70 sites.

The Central Department of Publicity launched large-scale 'Red Ribbon' campaigns in Yunnan, Xinjiang, Shaanxi, Guizhou, Gansu and Sichuan. On-line discussions were also conducted on major websites, including Xinhua, on issues of children orphaned by AIDS, HIV prevention among university students and migrant workers.

The State Administration of Radio, Film and TV, the State Council Information Office and others actively organised and coordinated the media to report on AIDS related issues, with extensive coverage achieved

by radio, television, films, newspapers, journals and websites to promote HIV knowledge.

Various sectors, including railways, communications, civil aviation and border control and quarantine regularly developed and published public billboards and exhibits panels on HIV knowledge at bus stations, shipping ports and airports; and also initiated education activities to their passengers. All public places in China CARES areas have large billboards and every village has publicity slogans on the walls.

2.3.1.2 Focal populations

SCAWCO and related ministries conducted a number of advocacy campaigns targeted to migrants, youth, women and minority populations. A wide range of IEC materials, such as prints, visual products and substantial materials, were designed and produced. Some IEC materials were translated, produced and disseminated in nine minority languages, including Uyghur, Ha, Mongolian, Zang (Tibetan) and Korean. The State Ethnic Affairs Commission conducted a situation analysis and response research on HIV prevention and control in minority areas. The Commission produced video programs on HIV awareness in minority languages.

(a) Children and youth

The 'Chinese Campaign on HIV Prevention among Children and Youth', was launched in September 2006. The Ministry of Education and the MOH developed, printed and disseminated key messages and material on HIV for children and youth.

A HIV awareness campaign for university students themed 'Against AIDS for a Wonderful Campus' was jointly launched by SCAWCO, the Ministry of Education, MOH and the Central Youth League in June 2007. A Students Reading Booklet on HIV Awareness was compiled and printed; a national university students' lecture competition on HIV knowledge was held and university students were recruited for voluntary participation in the face to face education campaign.

The Ministry of Education equipped over 4,000 schools with AIDS education materials. Specific trainings on HIV knowledge was presented to more than 10,000 teachers and was also integrated into pre-employment trainings for the graduates of teacher's colleges. National field visits and seminars were organized and online quiz on HIV awareness of young people was conducted, with more than 18 million visits.

The Central Youth League launched an awareness campaign entitled Youth Red Ribbon. It is estimated that over 14,000 youth joined the in-school peer education network in 2006. More than 200,000 youth joined the face to face communication and 3.2 million youth were covered

through the internet.

(b) Migrant workers

Following the launch of the National HIV Education & Communication campaign among rural migrant workers in 2006, relevant ministries developed their annual work-plans and established 6,071 leading groups on HIV communication initiatives for migrant workers within their field of work. SCAWCO, the Central Department of Publicity, Ministry of Construction, MOH and the Beijing AIDS Working Committee jointly organized performances-'Hand-in-Hand against AIDS'-for Migrant Workers at construction sites in Beijing.

The Ministry of Labour & Social Security (MOLSS) distributed IEC materials, such as pamphlets and posters at training centres or vocational referrals with concentrated migrant workers. The Ministry of Construction initiated HIV knowledge training and education for some 1,000 management personnel, conducted training for 30,000 migrant workers by using part-time schools in six provinces and five cities, including Hunan and Jiangxi, and trained 1,500 peer educators. A reading booklet-'Common Knowledge for Migrant Workers at Construction Sites'-incorporating HIV knowledge was compiled and 100,000 copies was distributed.

The Ministry of Agriculture conducted an awareness campaign-'Red Ribbon into Village and Household'. In 2006, the 'Sunlight Campaign' directly trained 3.5 million rural people and over 5 million people received indirect training on HIV awareness. The Ministry had more than 30 articles on HIV prevention published in the Farmers' Daily newspaper.

The State Population & Family Planning Commission integrated HIV knowledge into the family planning IEC materials for migrant populations, compiled and distributed 100,000 copies, with focus on the six provinces with large numbers of migrant populations, such as Henan.

All China Trade Union initiated campaigns on HIV knowledge into thousands of workplaces, covering over 10,000 evening schools and reached 3 million migrant workers. Its Art Troupe travelled to Hebei, Guangdong, Henan and other provinces and presented over 20 performances with 80,000 viewers. The Youth League conducted Youth Red Ribbon campaign on promoting HIV awareness while film showing at the workplaces, covering nearly 400,000 migrant workers, and more than 300,000 copies IEC materials was distributed.

The Ministry of Railways set up billboards at 270 railway stations and initiated station-based education activities. They also conducted on-train

HIV education on special trains for migrant cotton pickers. The General Administration of Quality Supervision, Inspection & Quarantine initiated AIDS education and behaviour intervention at 420 frontier ports, reaching 1 million contract workers sent abroad.

(c) Women

The All China Women's Federation (ACWF) launched a national programme on 'HIV Prevention for a Healthy Family', which targeted housewives to empower their families for HIV prevention and care.

The ACWF expanded the face-to-face education activities into 127 China CARES areas, over 120,000 volunteers were organized, 9,710,000 participants were trained, and 27.25 million women were exposed to various HIV information and education activities, accounting for 67 per cent of the total female population in the China CARES areas. Of those reached women, 16.52 million were aged 15-49, 83 per cent of the cohort. The HIV awareness rate reached 81 per cent among the target women, and 92 per cent among those between 15 and 49 years old. In 2007, the HIV face to face education approach was extended to an additional 148 counties covered by the Global Fund projects.

(d) In the work place

The Ministry of Public Security conducted trainings on HIV policy and knowledge through long-distance education network, reaching more than 100,000 policeman nation-wide. The Ministry of Public Security and the Ministry of Justice conducted training for officials working in closed settings.

The MOLSS integrated HIV knowledge into their training curriculum of vocational schools and provide free training materials to 11 provinces. MOLSS and CEC launched the HIV Workplace Education Programme in three pilot provinces to reduce workplace stigma and discrimination and increase coverage of workplace intervention.

The Ministry of Railways provided HIV training to 5,700 leaders, 3,400 health care professionals and 160,000 of its staff across China. Similarly, the Ministry of Communications and the ACWF jointly promoted HIV awareness activities for their staff and family members.

The Ministry of Commerce integrated HIV knowledge into their regular training courses for personnel assigned to working abroad. They also conducted HIV awareness campaigns through exhibits, picture journals and newsletters.

The State Population & Family Planning Commission conducted training on HIV knowledge, policies and their responsibilities in the AIDS response and the General Administration of Quality Supervision, Inspection & Quarantine conducted trainings on HIV knowledge and policies to its 36,000 staff. The General Administration of Civil Aviation held three training courses on HIV knowledge to their doctors.

The State Administration of Industry & Commerce set up a task force on HIV Prevention with over 30,000 focal points and conducted training to focal points at provincial level. They also explored education models which work for private sectors with concentrated migrant workers. All China Trade Union held training courses for over 200 chairs of trade unions at middle sized enterprises and above across prefecture level in 31 provinces (autonomous regions and municipalities).

The armed forces followed a central plan to educate their mass employment base in AIDS related issues.

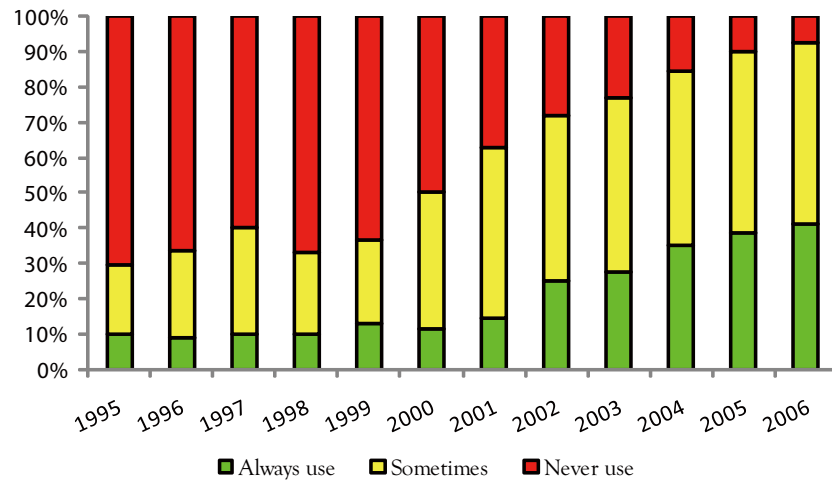
2.3.2 Behaviour change interventions among most-at-risk populations (MARPs)

2.3.2.1 Sex workers (SWs) and their clients

In 2006, four provinces—Hubei, Hunan, Yunnan and Hainan—conducted condom use promotion campaigns at entertainment places across the whole province. Other provinces (autonomous regions), such as Xinjiang, Guizhou, Shanxi, Sichuan, Guangxi, Jiangsu, Fujian, Zhejiang and Shandong, also conducted similar campaigns across relatively large areas. All 127 China CARES areas launched comprehensive interventions, mainly focused on condom promotion. The coverage of intervention programmes for SWs and their clients had been expanded to all counties by 2007. Interventions reached 462,357 SWs by the third quarter of 2007. Thus, intervention coverage for SWs increased to 38 per cent from only 26 per cent in 2005.

The national behaviour surveillance survey data showed that the rate of female SWs using condoms every time in commercial sex during the last month had increased from 14.7 per cent in 2001 to 41.4 per cent in 2006. The rate for SWs never using condoms decreased from 37.4 per cent in 2001 to 7.5 per cent in 2006. The change since 1995 is illustrated in Figure 2.2.

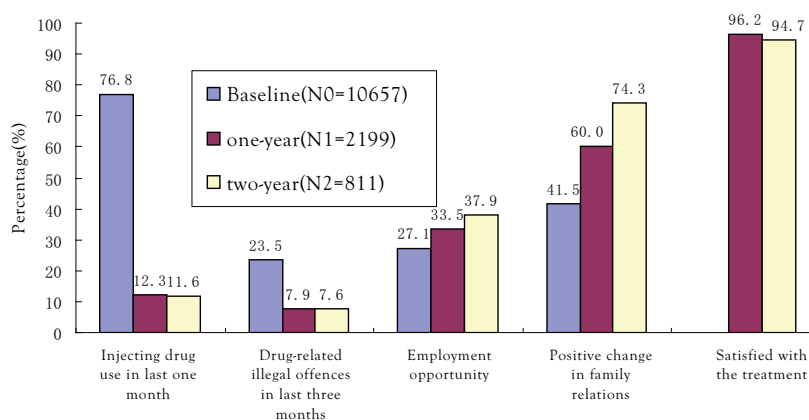
*Figure 2.2 Condom use among sex workers, 1995-2006
(National Behaviour Surveillance Survey Data)*



**2.3.2.2
Injecting
drug users
(IDUs)**

In July 2006 the MOH, Ministry of Public Security and the State Food & Drug Administration revised and issued the Opium Abusers Community-Based Drug Maintenance Treatment Protocol, which highlighted the expansion of the MMT programme from the pilot phase to general application. By the end of October 2007, 397 MMT clinics were open in 22 provinces (autonomous regions and municipalities). By now, 88,313 drug users had joined the MMT treatment program. Among 51,758 participants who are now on treatment, the annual retention rate is 64.5 per cent. The clinics also provide free HIV testing and counselling service on a regular basis to all individuals who joined the MMT program.

The evaluation survey to some of the MMT clinics conducted in 2007 found positive change in the rate of injecting drug use, drug-related illegal offences, employment opportunities and family relations as shown in the Figure 2.3.

Figure 2.3 Participant response to MMT

In 2006, a total of 729 needle exchange stations have been established in 204 counties or districts in 17 provinces. By third quarter of 2007, about 49,108 IDUs had joined clean needle exchange programmes.

2.3.2.3 Men who have sex with men (MSM)

Since 2005, the Chinese Government has strengthened its intervention efforts to MSM, developed national working protocols and guidelines on HIV prevention and control among MSM, and convened national technical workshops on comprehensive HIV prevention interventions among MSM. Various programmes were conducted on condom promotion, counselling and testing, peer education, STI services and follow-up outreach and care services for PLHIV. The third quarter 2007 statistics showed that 88,082 MSM were reached by comprehensive HIV prevention interventions, a coverage of around 8.2 per cent of the MSM population.

MSM interventions by CDC and community-based organisations

Chengdu CDC in Sichuan Province has worked with Chengdu Tongle Health Counselling Service Centre to conduct interventions among MSM, such as setting up volunteer groups among university students, middle-aged or elders and internet-connectors, conducting capacity building and some small-scaled activities, by taking advantage of the frequent daily communication between MSM sub-groups. Based on different group's respective interests and behaviour, appropriate peer education models were explored. CDC provided technical support and monitoring and evaluation support to the interventions, and intensified VCT services to the MSM population by expanding sentinel sites and VCT sites on the platform provided by Tongle.

2.3.3 Strengthened blood safety management

Nationwide advocacy of voluntary donations was maintained. The clinical use of non-paid donated blood has increased from 22 per cent nationwide in 1998 to around 98 per cent in mid-2007, of which voluntary blood donations were 5.5 per cent in 1998 and reached 95 per cent in mid-2007. By then, 100 cities had achieved 100 per cent clinical blood use from voluntary donation.

Implementation of the 2007 Working Protocol on National Enforcement against Illegal Blood and Plasma Collection enhanced supervision of plasma donation stations, ensured the well-being of plasma donors and quality control of the blood and plasma collected. The blood quality supervision and control systems at blood stations, plasma collecting stations and blood product manufacturing units were further strengthened.

2.3.4 Prevention of mother-to-child transmission (PMTCT)

Guidelines for strengthening PMTCT were developed and released in 2006. PMTCT activities have been expanded to 271 counties in 110 prefectures in all provinces (autonomous regions and municipalities). PMTCT was integrated into women's and infants' health care at provincial level on the basis of the three-level health network for women and infants. In addition, PMTCT services were provided concurrently with pre-natal services.

By the end of December 2006, surveys of PMTCT programmes had covered more than 2.65 million pregnant women, 77.7 per cent of whom received AIDS counselling, while the testing rate was 74 per cent. The cumulative number of HIV positive pregnant women was 2,706. Among women with HIV who delivered, 72.4 per cent received ARV drugs and the rate of ARV treatment for their babies was 80.4 per cent. The non-breast feeding rate is 84.6 per cent. The AIDS transmission rate from mother-to-child decreased nearly 60 per cent through the prevention measures.

2.3.5 Voluntary counselling and testing (VCT)

4,293 VCT stations had been established nationwide. Of these, 803 are VCT clinics in hospitals, accounting for 19.1 per cent. The service coverage of the clinics is presented in Table 2.2.

Table 2.2 VCT coverage, January 2006 to September 2007

	Receiving Counselling	Receiving Testing	Screening Positive	After Testing Counselling
Number	2,390,314	2,098,458	37,619	1,517,915
Percentage	~	87.7	1.79	72.3

2.3.6 STI prevention and treatment

MOH issued notification on further strengthening STI surveillance in 2007 and revised the national STI Monitoring Protocols and Guidelines. STI monitoring sites have been increased from 26 to the current 105. Various locations strengthened STI surveillance, incidence rate and epidemiological surveys and quality control of the STI testing laboratory was further improved. MOH also developed drug-resistance monitoring and provided guidelines on STI clinic medicine.

Management of STI clinics was strengthened and STI clinic treatment and counselling services were standardized. Syphilis screening and control was strengthened in health facilities providing STI clinical services, while awareness and education programmes on STI and HIV prevention were expanded. Integration of condom promotion with standardized STI clinic services was expanded to facilitate targeting interventions to most-at-risk populations.

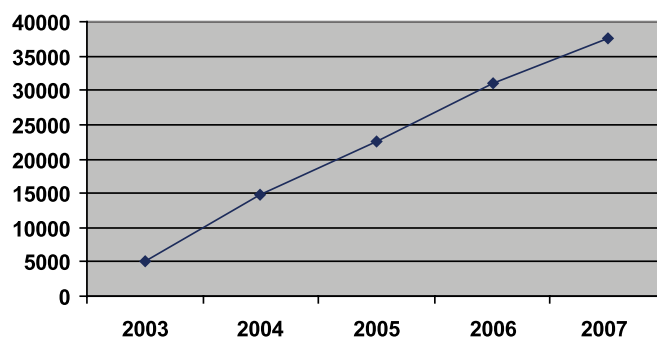
2.4 Treatment, Care and Support

The 2004 JAR reported that the provision of affordable and accessible ARV therapy that patients can tolerate and doctors can readily supervise was a key challenge.

2.4.1 Antiretroviral treatment (ART)

By the end of October 2007, the provision of ART was expanded to 1,190 counties in 31 provinces (autonomous regions and municipalities). The cumulative number of people aged 15 and above who commenced treatment was 39,298 with 31,849 currently receiving ART. The proportion of ART patients who was infected via sex transmission has increased from 4.9 per cent in 2004 to 22.7 per cent in 2007, while via injecting drug use increased from 1.0 per cent in 2004 to 10.7 per cent in 2007, as illustrated in Figures 2.4 and 2.5. The pilot project of second line drugs treatment was launched.

Figure 2.4 Cumulative number of AIDS patients receiving ART

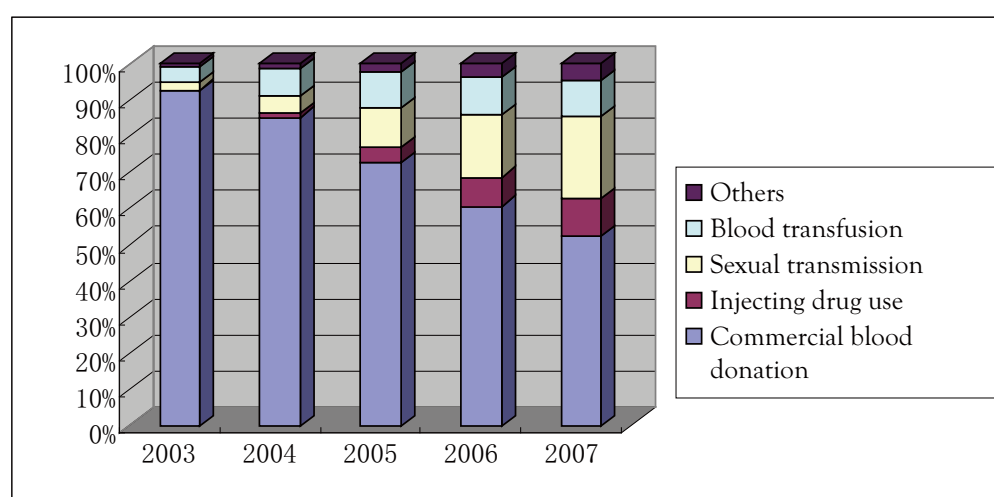


In 2005, MOH launched a pilot project to provide ART to children below 15 years. By the end of October 2007, a total of 805 children from 141 counties and districts of 22 provinces (autonomous regions and municipalities) had received ART, with 761 remaining on ART.

By now, 13 clinical training centres and one clinical laboratory training centre have been established with some 1,500 technical staff trained from 447 counties or districts in 28 provinces (autonomous regions and municipalities). A national AIDS patient management database was established, which provides complete linkage between the treatment database and the epidemic database.

Surveys of former blood and plasma donors in the six provinces of Central China showed the mortality rate of PLHIV decreased from 28.8 per hundred person-year before the launch of ART, to 6.8 per hundred person-year following treatment. In the survey areas the death rate of PLHIV was 3.4 per 100 person-year in 2006.

Figure 2.5 Transmission mode distributions among cumulative AIDS cases receiving ART (2003 – 2007)



2.4.2 Opportunistic infection (OI) treatment and traditional Chinese medicine

Free OI treatment is provided in some provinces. By June 2007, over 36,000 PLHIV had received OI prevention and treatment services in areas covered by the Global Fund projects.

Pilot projects on case finding and treatment for HIV/TB co-infection patients have also been developed. They provide early diagnosis of active TB among PLHIV, while conducting HIV testing among TB patients, together with co-infection treatment and management.

An advisory committee and an expert group on Chinese traditional medicine and HIV were established to amend the evaluation protocol for clinical use of traditional Chinese medicine (TCM) for AIDS patients. The project has been extended to 15 provinces, where over 6,000 patients are receiving this treatment. Under the treatment, most patients' status has improved and some of them can return to work.

2.4.3 ARV drug supply and resistance monitoring

With the coordination and joint efforts by SCAWCO, the Ministry of Finance, the State Administration of Taxation, the National Development & Reform Commission and the General Administration of Customs, the State Council maintaining customs exemption for the import of ARV drugs and approving tax exemptions for the local production of ARV drugs in 2007. The exemption helped stabilize the price of ARV drugs and the price of some drugs decreased. As the number of paediatric cases increased, some paediatric drugs have been included in the plan for domestic production.

A national network to monitor drug resistance was set up. Three nationwide surveys on drug resistant HIV strains have been completed. At the same time, pilot sentinel surveillance of drug resistant was initiated to detect early warning of drug resistance. The monitoring results suggested that approximately 17 per cent PLHIV on ART develop drug resistance.

2.4.4 Care and support

In order to strengthen support to PLHIV and their families, SCAWCO, MOH, Ministry of Civil Affairs, the State Population & Family Planning Commission, ACWF and the Red Cross Society of China conducted care and support for this group in 2006. They also issued a policy document, and on this basis, the ACWF, MOH and SCAWCO launched a campaign '12.1 Attention to Orphans and Home of Love' for care for orphans and their families. They mobilised 2 million RMB and developed specific work plans in November 2006.

In March 2006, the Ministry of Civil Affairs and 14 other agencies issued a specific 'Suggestion on Strengthening Care to Orphans' (including children orphaned by AIDS), providing favourable conditions in nine aspects of life, including life, education, medical care, recovering, housing and employment. Specific funding of 50 million RMB was allocated, mainly for children orphaned by AIDS in Henan, Yunnan and other provinces to set up advisory centres on better care and placement of children orphaned by AIDS. A multi-level network on displacement of children orphaned by AIDS will be gradually built up, with a vertical working system from province, prefecture, county, township and down to village. At the same time, various forms of displacement models on children affected by AIDS, including adoption, foster family bringing-up and institutional support, were under active exploration. At present 90 per cent of reported children orphaned by AIDS receive family support and schooling. Some older children also received vocational training. The Chinese National Committee for the Care of Children held summer camps annually since 2004 for children for children orphaned by AIDS.

In September 2007, the Ministry of Civil Affairs, SCAWCO, Henan Provincial Government and UNICEF held an international seminar on Care and Placement of Children Orphaned and Made Vulnerable by AIDS in Zhengzhou City, Henan. In 2007, Henan Provincial Government issued a document 'Recommendations on Strengthening Care and Placement of PLHIV', increased local financial inputs, conducted targeted care and support and facilitated the development of care and placement assistance for those living in poverty due to AIDS.

In recent years various China CARES areas explored means of establishing working mechanisms that combine ART, care and self-production support. One-to-one support activities were organized and funds was raised to promote PLHIV and their family's lives, and to help them to undertake self-support production. By March 2007, there were 4,395 reported children double-orphaned by AIDS in 127 China CARES centres; 277 care institutions (such as tender home or home of sunshine) were established; 3,167 orphans (93 per cent of the total school-aged) receiving '2 frees and 1 subsidy (providing free books and waiving other fees and providing life allowance for boarding students)' while 20,879 of the reported PLHIV received life assistance; and 6,255 received assistance to conduct self-support production.

With support of the Comprehensive Family and Community Care Pilot Project for Positive People and Their Families, assistance was provided for family income generating activities and temporary financial relief programs from local civil affairs. In this way, the economic income gap between families affected by AIDS and ordinary families has been narrowed.

Care and support for PLHIV in China CARES village, Daye of Hubei

A relief fund on promoting self-support production of PLHIV has been established in Daye, with initial amount of RMB 800,000 raised and deposited into a special account under centralized management. One-to-one assistance activities are carried out to help PLHIV and their families to improve their living conditions and environment. PLHIV and families capable of economic activities are assisted to develop income-generating projects and families with school-aged children are supported to get their children in school.

Children orphaned by AIDS are provided with subsistence support and monthly living allowances. Financial support is given to hospitalised AIDS patients. The Civil Affairs Bureau helps PLHIV into the social security scheme to ensure their subsistence and livelihood support. Some families affected by AIDS received assistance and production support, amounting 100,000 RMB. A few families have become better off. Some PLHIV supported by institutions have become well-known watermelon producers or pig farmers.

2.5 Surveillance, Testing, Monitoring and Evaluation

The 2004 JAR concluded that the effective analysis, management, integration, sharing and dissemination of such information remained a major challenge. It recommended the development of a national database that integrated information from AIDS case reports, sentinel surveillance, behaviour surveillance and specific surveys, as well as VCT and treatment reporting.

2.5.1 Surveillance system

The national surveillance and sentinel sites were increased from 247 at the end of 2004 to 393 by the end of 2006. The provincial sentinel sites increased from 400 to nearly 500 over the same period, basically covering areas all districts and different focal populations. These provide basic data for the 2007 epidemic estimations.

The national comprehensive surveillance sites increased from 42 in 2004 to 159 in 2006. These are located in 27 provinces (autonomous regions and municipalities) and cover six population groups at higher risk, namely sex workers, IDUs, STI clinic clients, MSM, long-distance transport workers and adolescent students.

2.5.2 Laboratory testing network

By September 2007, there were 6,066 screening laboratories and 165 confirmation laboratories.

China established and developed an immunology and virology testing platform and conducted research and evaluation into new HIV infections. The central government supported the purchase of 218 flowcytometers for CD4 testing. For patients under treatment, two free CD4 tests are provided each year. Patients receiving CD4 testing before treatment increased from 54.4 per cent in 2005 to the current 85.2 per cent. 90 viral load testing machines were provided to 20 provinces and an AIDS laboratory testing quality control system was established.

2.5.3 Information collection, exchange and utilisation

A Comprehensive Response Management Information System (CRMIS) and the Traditional Chinese Medicine on AIDS Treatment Database and Analyse System were developed to integrate data and information on AIDS. These management systems facilitated data collection and automatically generated reporting tables on HIV response. The collecting, reporting and analysing of standardized information greatly improved efficiency. More data and information is now generated and applied for policy advocacy, resource management, programme planning and monitoring and evaluation. This will assist the 2008 UNGASS report as well.

Information exchange was promoted and facilitated, and large numbers of journals, materials and newsletters were written, published and distributed. A number of AIDS websites have also been established, such as the NCAIDS website. Visitation to the NCAIDS site is more than 2 million since 2002.

2.5.4 Monitoring and evaluation (M&E) systems The China AIDS Monitoring and Evaluation Protocol (provisional) sets out M&E principles and measures, specific content and indicators, institutional and management mechanism. A national M&E expert team was formed and a national technical support facility was appointed. Clear requirements for the local authorities in establishing specific units and carrying out M&E activities were also compiled .

During 2007 the government undertook training to strengthen M&E capacity at provincial levels and improved coordination of M&E activities in local areas. Various joint cross-sector monitoring, comprehensive technical monitoring and special monitoring missions in particular aspects of programme implementation were conducted for specific aspects of the programme at different levels. These missions assisted in improving the efficiency of monitoring work to facilitate the AIDS response.

2.6 Resource Mobilization and Integration

The 2004 JAR highlighted poor estimation of resource needs, together with inadequate management of resources at provincial level and below as major challenges to the effective allocation of resources to meet local needs for AIDS prevention, treatment and care. A further challenge was to ensure sound management of financial resources.

2.6.1 Resource mobilization The National Development & Reform Commission established the central debt funds in 2005 to strengthen the health infrastructure in rural areas, in which township-level health centres and county-level hospitals in the China CARES areas were prioritized. While the central level increased its AIDS budget allocations, they also broadened fund-raising channels and utilized resources from international sources.

International inputs to China's AIDS response has increased and now comes through multi-channels. International organizations, developed countries, international non-governmental organizations and some foreign enterprises have also become the important contributors and played supplementary roles.

2.6.2 Resource integration AIDS resources are drawn from central, local and international sources - central and provincial budgeting account for two-thirds of the total with international sources contributing the remainder. In order to better integrate resources, the central government fully considers national, local and international resources and their adequacy to address the key needs of and issues for different populations and geographical areas. In preparation of its annual budget for AIDS, the Central Government focuses on capacity building, education, interventions, ARV drugs and testing reagents, China CARES operational costs and monitoring and evaluation. In the 2006 central earmarked transfers, ART and follow-up accounted for 30.6 per cent;

education and interventions 25.8 per cent; laboratory strengthening 11.5 per cent; China CARES and focal area, 10.8 per cent; screening and VCT, 7.1 per cent; PMTCT 6.2 per cent; blood safety 4.1 per cent; and TCM 3.9 per cent.

External support has been integrated with these priorities for specific populations and at different locations. Global Fund projects in 21 provinces conducted comprehensive treatment and care, comprehensive interventions to IDUs and sex workers, capacity building of civil society organizations and anti-discrimination activities. The China-UK CHARTS project focuses on policy advocacy, information exchange and capacity building, while the US CDC Global AIDS Program is strengthening the surveillance and laboratory systems and the integration of VCT and surveillance.

Under the coordination of SCAWCO and UNAIDS for the UNTG, the UN Joint Programme on AIDS in China (2007 - 2010) was launched, which effectively realigned national and international resources and fully integrated them with national priorities and targets. Significant achievements were made in care for children affect by AIDS, prevention mother-to-child transmission, HIV prevention and treatment for migrant populations by UNICEF and UNFPA supported projects under the framework of UN Joint Programme.

2.6.3 Resource management The Central Government developed protocols and regulations on budget use and management. The annual central earmarked transfers for AIDS are based on the workload and unit cost planned activities at local level, which are incorporated into the central implementation plan. At the same time central and local governments audit the utilization of their AIDS funds.

For improved prioritization and better utilization of AIDS resources, 13 provinces estimated their needs using the Resource Needs Estimation (RNE) model in 2006 and 2007.

2.7 International Cooperation and Research

China's response to AIDS has expanded from being a recipient of international assistance to itself becoming a provider of international cooperation to other developing countries.

2.7.1 International cooperation The focus of international support has expanded from serious epidemic provinces such as Yunnan, Guangxi, Xinjiang and Sichuan to low prevalence provinces (autonomous regions and municipalities) such as Inner Mongolia, Heilongjiang, Jilin, Qinghai and Ningxia. The area being supported by international cooperation has expanded from monitoring and education to comprehensive prevention and control;

from treatment, care and preventive intervention as the focus to encourage and support participation by civil society organizations. The role of international cooperation is no longer limited to technical inputs, but also applies international 'best practice' experience in order to define effective AIDS prevention and control measures in China and facilitates the achievement of the Five-Year Action Plan objectives.

***2.7.2 China
on the inter-
national AIDS
stage***

China has played an increasing role in providing international assistance to developing countries. It has conducted training courses for HIV professionals from African countries, cooperated in the development of pilot AIDS projects in cross-border areas of China, Myanmar, Laos and Vietnam, donated US\$10 million to the Global Fund, demonstrated best practice in China through hosting delegations from countries to undertake study tours of AIDS interventions in China, and actively participated in sharing information at international conferences.

***2.7.3 Scientific
research***

The Ministry of Science & Technology has initiated special projects on HIV prevention and AIDS treatment within the National Key Technology Research & Development Program and the National High-tech Research Program (863 Program). There has been progress in the development of AIDS vaccines. The gene vaccines studied have completed phase I clinical testing, which reached international responding standards with other similar vaccines, and phase II has been initiated. There is significant progress in molecular epidemiological survey, identifying local HIV-I sub-type, transformed type and their prevalence characteristics. A batch of important HIV testing reagents was developed. ARV drugs are under active development. The use of traditional Chinese medicine in treatment for AIDS was also explored. More and more applied research facilitated the effective implementation of AIDS responses.

CHAPTER 3 CHALLENGES AND RECOMMENDATIONS

The past two years have seen achievements in the response to the AIDS epidemic in China, particularly in terms of commitment by national leadership, multi-sector cooperation, establishing a supportive national policy framework and legislations, improved understanding of the key elements of the epidemic, extending comprehensive prevention interventions to the most at risk groups and providing treatment, care and support. Nevertheless, a number challenges remain, especially realizing the Five-Year Action Plan objectives; capacity building, particularly at the ‘grass roots’ level, and strengthening monitoring and evaluation at all levels.

3.1 Programme Management and Accountability

Challenges

Accountability: There are no clear responsibilities, power and resource allocation of some key sectors and lack of accountability for implementation of AIDS programmes. The limited commitment by some local level governments to the AIDS responses, results in not incorporating AIDS program into the government agencies’ routine work and social development plans.

Cross-sector responses: Currently the proactive involvement of some sectors remains weak particularly at local levels. The limited communication between agencies results in poor implementation of AIDS programmes.

Resource management: Resources are not effectively integrated into the priority areas of the AIDS response, nor are resources being utilized effectively at the local level. Some high prevalence areas lack comprehensive action plans. Delays in the transfer of central earmarked funds to local levels and insufficient local investment also restrict programme implantation.

Recommendations

- Further strengthen advocacy and training of leaders, especially those who have recently been appointed and the leaders of key agencies.
- To strengthen the accountability of agencies and work units to efficiently and effectively use their resources and strengthen assessment management so that upper level government officials can monitor achievement of policy implementation against targets and take responsibility for effective resource use. Assessment of government offices’ performance need to be carried out effectively and action taken to correct any shortcomings, including publicising the results.

- Work units at all levels need to strengthen their resource needs estimation procedures and capacity, better prioritize their required resources against the most effective outcomes and ensure that available resources are used efficiently.
- Promote strengthening of cross-sector communication and coordination to strengthen their proactive involvement. Relevant sectors need to prepare joint strategic plans that tackle priority responses with clear lines of responsibility.

3.2 Awareness Campaigns and Anti-discrimination

Challenges

Information, education and communication (IEC) interventions:

The scale and depth of the current IEC activities are unsatisfactory, especially in its reach to youth not in school, minorities, migrant workers, remote and rural areas with migrating populations. The challenge is to design and implement more effective IEC interventions that relate to the target audience, reach focal populations and bring about desired attitude changes among the target group. Evaluation the effective outcomes of IEC intervention need to be strengthened.

Tackling discrimination: Stigma and discrimination against PLHIV remain widespread in some communities and work places, including among health-care workers. The involvement of people affected by AIDS in the design and implementation of IEC messages remains weak and needs to be strengthened for more effective outcomes.

Recommendations

- Evaluate the effectiveness of various IEC models among different target groups and document those with outstanding results as ‘best practice’ that can applied with similar groups elsewhere. On the basis of this research, the national AIDS Publicity and Education Guidelines should be revised and updated.
- Better utilise existing sector networks, particularly those in ethnic affairs and youth education, to strengthen the technical and financial support to remote rural areas on IEC intervention.
- Strengthen training and advocacy for discrimination reduction among health care workers and encourage the involvement of beneficiaries, especially PLHIV in the design and implementation of IEC messages in HIV awareness and publicity initiatives to give greater authority to anti-discrimination messages.

3.3 Comprehensive Interventions²

Challenges

Limited knowledge of most-at-risk populations: Effective follow-up is constrained by the lack of reliable information on key target populations, particularly MSM, such as size of the population, behaviour patterns and HIV epidemic among MSM.

Comprehensive prevention packages to address high risk behaviour: Coverage of most-at-risk populations is limited, only some elements of the comprehensive package are available and due to the low frequency and intensity of contact. The capacity of comprehensive interventions remains an area of weakness.

PMTCT and STI services: The coverage of PMTCT is limited and the quality of service delivery has room for improvement. STI clinics can play a key role in HIV prevention and referral, but their weak management and poor integration with HIV interventions reduces their effectiveness.

Linkage and referral services: The linkage between the identification of HIV status and referral to different parts of the treatment and care response is weak and is not standardized. As a result, insufficient information is available to provide follow-up treatment, care and support.

Recommendations

- Additional epidemiological surveys of MSM populations are required to better understand their size, demographic characteristics and the epidemic situation, thereby assisting the design of effective comprehensive intervention models for MSM.
- Better targeted, in-depth and sustained comprehensive packages are required to address high risk behaviour in terms of HIV transmission, particularly, condom use promotion. Priority should be given to middle- and low-level sex workers and floating sex workers.
- Expand the range of comprehensive packages for behavioural change among IDUs, including clean needle exchange programmes as another tool for harm reduction and the use MMT clinics as a platform for cost-effective service delivery.
- To further strengthen the quality and increase the coverage of PMTCT programmes through the training of staff in service delivery.
- To strengthen STI screening and service delivery among the most-at-risk populations to promote appropriate health seeking behaviour, with integration of STI measures with reproductive health and HIV prevention.

² A comprehensive approach brings together proven preventive and treatment interventions and adapts them as the epidemic evolves in terms of changes in infection patterns and social norms. Comprehensive prevention packages, for example, use a combination of actions that promote safe sexual behaviour, reduce social and biological vulnerability to transmission, encourage the use of prevention technologies (such as condoms, clean needle exchange and MMT) and promote social norms that favour risk reduction.

- To increase the coverage and quality of comprehensive services. Explore integrated comprehensive management models for PLHIV, including testing, counselling and informing PLHIV of results, and follow-up management.

3.4 Treatment, Care and Support

Challenges

Improving access to and quality of treatment: Implementation of ‘Four Free, One Care’ initiatives has been uneven, with poor linkages between different services. Some locations lack clear policies on treatment-related testing and OI treatment, while the management of ART requires further strengthening. The side-effects of available drugs remains a challenge, with some AIDS patients dropping out of treatment because of this, while others have developed drug-resistance, often due to non-standard drug-taking. There are also difficulties in obtaining supplies of second line ART drugs. Also, some AIDS patients would like to receive the traditional Chinese medicine but currently cannot readily gain access to them.

Effective support for HIV positive people and their families: While some promising pilot projects have been implemented to preserve or recover livelihoods for families affected by AIDS, other care and support activities have been carried out at the local level without the full range of standard protocols to ensure they are carried out to professional standards.

Identifying the social and economic impacts of AIDS: A significant challenge is the limited amount of evidence-based data available on the social and economic impacts of AIDS. Expanding evaluative investigations in this will provide valuable insights into the nature of the epidemic and the interventions required to ameliorate the impact of AIDS on households and communities.

Adherence to standard protocols: Some units undertaking testing do not reach professional standards and some ART departments do not follow national protocols or follow up on patients.

Recommendations

- Increase support to local governments to strengthen treatment policies and increase investment to implement the ‘Four Free One Care’ policy. To explore long-term, stable and sustainable ART delivery mechanisms that are integrated with the development of the urban residents’ basic health care insurance reforms and the new countryside cooperative medical system.

- Review the procedures for AIDS treatment in order to increase the adherence of treatment. Continue to facilitate second-line drug research and development and their registration; and take measures to improve access for AIDS patients to traditional Chinese medicine treatment where this is required as a supplement to ART.
- Expand the scale and strengthen the quality of data collection and its analysis to assess the impact of AIDS on communities, households and individuals. Initiate further social research to provide guidance on the effectiveness of HIV prevention and AIDS treatment programmes.
- To further strengthen the procedures for HIV testing and AIDS treatment protocols, including guidance on confidentiality, in order to deliver comprehensive counselling, care and support services.

3.5 All Society Involvement

Challenges

Capacity development and engagement: All society involvement is insufficient. Mass organizations involvement is limited, while the capacity and experience of civil society organizations is not satisfactory. Difficulties in obtaining formal registration and legal status have limited the number of community-based organizations working in the AIDS field and constrain the further development and professionalism of these organizations.

Communication channels: There are inadequate communication channels and dialogue between individual civil society organizations, and between civil society, government and other bodies.

Private sector involvement: Involvement in AIDS work by business enterprises and individuals remains limited and the principles and opportunities to incorporate HIV awareness and prevention into the workplace are not widely understood.

Recommendations

- Further adjust and complete regulations and laws to establish an enabling policy environment for the development of civil society organizations dealing with AIDS.
- Through different methods, strengthen communication within civil society organizations and between these organizations and related government agencies.
- Given the role of civil society organizations in fund-raising, the government

also needs to provide support with supplementary financial and technical assistance in accordance with the actual needs. Technical support and guidance should assist civil society organizations to link with target groups that government agencies have difficulty accessing, thereby becoming key partners in the AIDS response, covering both implementation and evaluation of outcomes and impact.

- Corporate social responsibility contribution and individual commitment should be fostered, backed by more intensive workplace HIV awareness and anti-discrimination campaigns.
- Strengthen the capacity of volunteer groups for more effective involvement in the AIDS response and establish an enabling environment for all society participation.

3.6 Capacity-building of Response Teams

Challenges

Prevention and control team building: Some related response teams and related efforts do not play their full roles. Compared with the needs of the AIDS response, the number and capability of response teams at local level is not adequate and stable.

Strengthening staff`s knowledge and attitudes: Staff in many organisations at all levels still lack adequate knowledge and capacity of HIV transmission and prevention principles, especially in rural areas with poor health facilities.

Recommendations

- Integration of response efforts from different services, such as rural and urban community, family planning and women and child care workers needs to be addressed in order to achieve more effective prevention, treatment and care outcomes.
- Strengthen establishment and capacity-building of the professional teams. Professional teams dealing with AIDS should be built up at the provincial, prefecture and county level in key areas. In addition, speed up the establishment of healthcare service networks at the local level and strengthen the knowledge and competence of first-line health workers in dealing with AIDS.
- Set up motivation mechanism for grass roots response team and encourage graduates and township doctors to work at the grass roots level.

3.7 Monitoring and Evaluation (M&E) Systems

Challenges

Monitoring and evaluation: The monitoring and evaluation systems remain underdeveloped and are constrained by poor capacity to undertake quality M&E work. There is a lack of M&E professionals with good experience and the integration of M&E results with planning is inadequate, resulting in the limited utilization of the lessons from M&E into improved project and programme design. There is a lack of scientific evaluation of the effectiveness and impact of AIDS interventions.

Strengthening the quality of surveillance system data: While the coverage of surveillance data collection has been strengthened, the quality of data and its interpretation remains an area of weakness.

Recommendations

- The M&E Framework issued by SCAWCO needs to be fully implemented. Priority needs to be given to strengthening the M&E system and facilitate the CRMIS to be fully functional.
- Promote surveillance information collection system and strengthen the quality and analysis of data to provide basic information for effective monitoring and evaluation. A larger M&E staff establishment is required and their capacity need to be strengthened through supervision and training.
- M&E system should be integrated with planning and implementation to ensure that the results are fully utilized. Experience of success and failure from evaluation should be summarized and shared with policy and decision-makers and implementers in terms of what can be applied more widely as ‘best practice’.