HIV AND AIDS DATA HUB FOR ASIA-PACIFIC
EVIDENCE TO ACTION

Asia-Pacific

Country Reviews March 2011

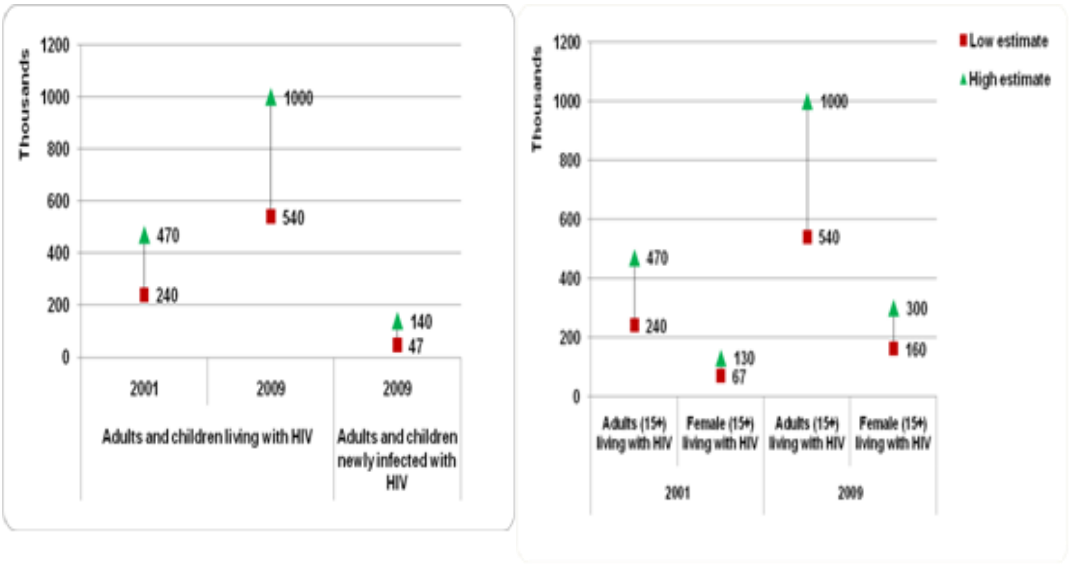
CHINA AT A GLANCE

Total population	1,354,146.443 (2010) [1]
Annual population growth rate	0.6% (2010-2015) [1]
Population aged 15-49 (thousands)	760,855 (2008) [2]
Percentage of population in urban areas	47% (2010) [3]
Crude birth rate (births per 1,000 population)	12.1 (2008) [4]
Under-5 mortality rate (per 1,000 live births)	21 (2008) [5]
Human Development Index (HDI) Rank/Value	89/0.6633 (2010) [6]
Life expectancy at birth (years)	73.5 (2010) [6]
Adult literacy rate	93.7% (2005–2008) [6]
Ratio of girls to boys in primary and secondary education (%)	104 (2008) [4]
GDP per capita (PPP, $US)	6,827.95 (2009) [4]
Per capita total health expenditure (Int.$)	233 (2007) [5]

HIV PREVALENCE & EPIDEMIOLOGICAL STATUS

HIV was first identified in an American tourist in 1985 and the first epidemic of HIV infections was detected among drug users in the border regions of China in 1989. China is experiencing a low-prevalence epidemic, although some key regions are experiencing high prevalence epidemics. Overall in 2009, prevalence among the general population was 0.057%[7] and was 0.2% among young people aged 15-24[8].

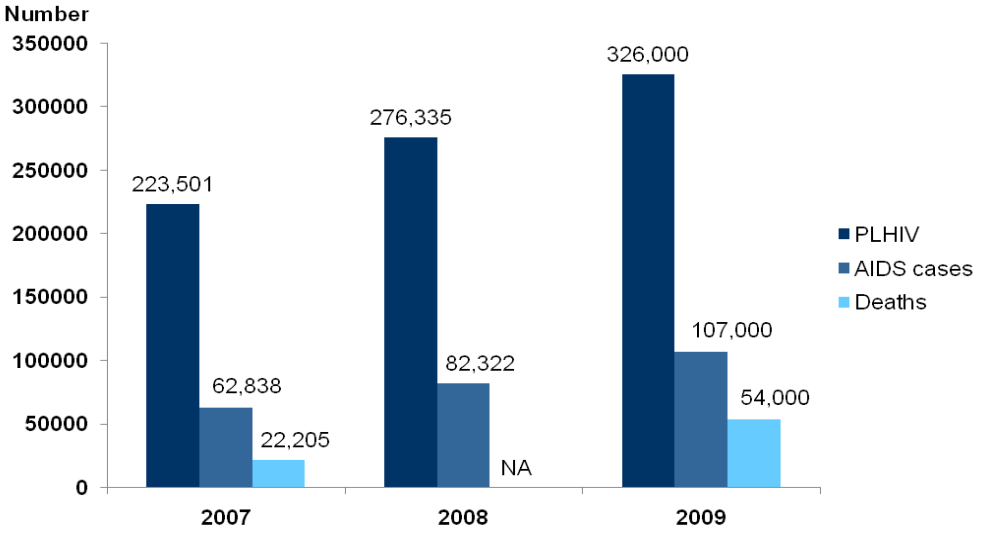
Figure 1(a). Estimated number of adults and children living with HIV, women (15+ yr) living with HIV and estimated new HIV infections, 2001 and 2009



Source: UNAIDS, Report on the Global AIDS Epidemic, 2010

By the end of 2009, 740,000 adults and children were estimated to be living with HIV whereas a high estimate of 140 thousand people are newly infected with HIV[9]. There were an estimated 26,000 [24,000-49,000] AIDS related deaths in adults and children in 2009. Cumulatively, a total of 326,000 cases of PLHIV had been reported and 54,000 people died due to AIDS by the end of 2009 (Fig. 1b)[9]. Women accounted for 29.8% of reported HIV cases[9]. An estimated 160,000 to 300,000 women are living with HIV by the end of year 2009[9].

Figure 1(b). Cumulative number of HIV and AIDS cases and deaths, 2007-2009



Source: Prepared by www.aidsdatahub.org based on UNAIDS, AIDS in China: Background information on the epidemic and the response, 2009 and China, UNGASS Country Progress Reports, 2008 and 2010

The 6 provinces with the greatest reported numbers of HIV and AIDS cases are Yunnan, Guangxi, Henan, Sichuan, Xinjiang and Guangdong, together accounting for 70%-80% of the total number of cases reported nationwide[7].

Surveillance systems:

• Sentinel surveillance: the number of sentinel surveillance sites increased from 845 in 2007 to 1,080 in 2008 and 1,318 in 2009[7,9].

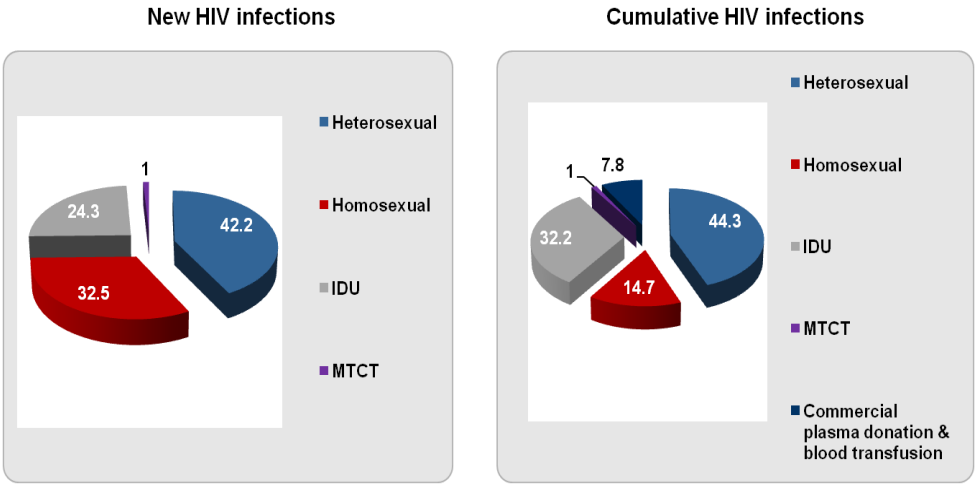
• Most cities and provinces have conducted mapping exercises to define population sizes of key affected populations[9].

• Sentinel surveillance sites report data on 14 populations, including drug users, sex workers, males seeking treatment in STI clinics, MSM, clients of sex workers, long-distance truck drivers, pregnant women, people with tuberculosis, young students, migrants, spouses of people living with HIV, people undergoing pre-marital health checks, people entering and leaving China and people seeking treatment in hospitals[7].

WHO IS AT RISK OF HIV INFECTION IN CHINA?

Among the estimated 740,000 people living with HIV in 2009, the percentage infected through sexual transmission was 59% (44.3% through heterosexual; 14.7% through homosexual transmission) (Fig. 2)[7]. Of those infected through heterosexual transmission, approximately one-third were infected by their spouses[7]. The new infections estimated for 2009 were mainly acquired via heterosexual transmission (42.2%), while homosexual transmission increased markedly to account for 32.5% (up from 12% in 2007) (Fig. 2)[7].

Figure 2. Percentage distribution of estimated new and cumulative HIV infections by mode of transmission, 2009

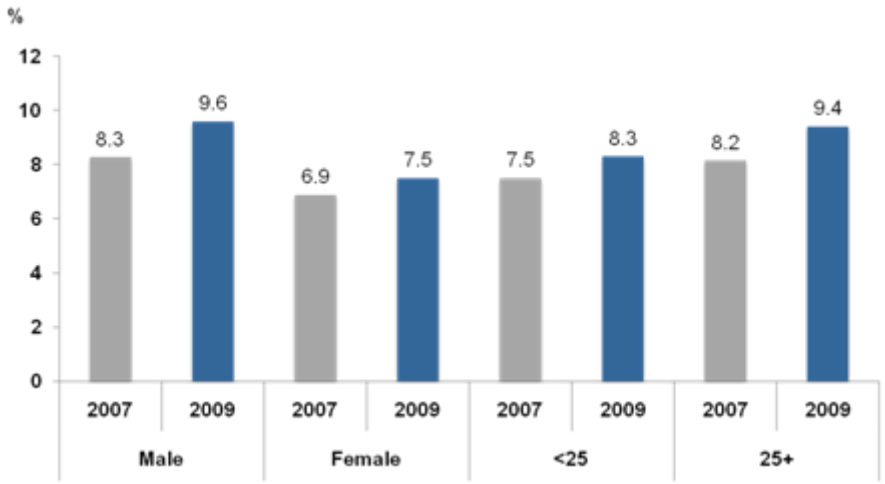


Source: Prepared by www.aidsdatahub.org based on 2009 Estimates for the HIV/AIDS Epidemic in China, by Ministry of Health, Joint United Nations Programmes on HIV/AIDS, World Health Organization

Injecting drug users

It has been estimated that the population size of injecting drug users (IDUs) is 2.26 million (range: 1.5-3 million)[9]. The first outbreak of HIV among IDUs occurred in Ruili, Yunnan Province in 1989. The HIV prevalence among IDUs has been rising since 1995. In 2002, the overall prevalence was 6%-8% among IDUs from national sentinel sites in 31 provinces (autonomous regions and municipalities). In 2007, there were seven provinces and autonomous regions in which the number of individuals infected with HIV through injecting drug use is over 10,000; namely Yunnan, Xinjiang, Guangxi, Guangdong, Guizhou, Sichuan and Hunan. These provinces contain 88% of people infected through IDU[10]. More recently in 2009, HIV prevalence was 9.3% among IDUs[8].

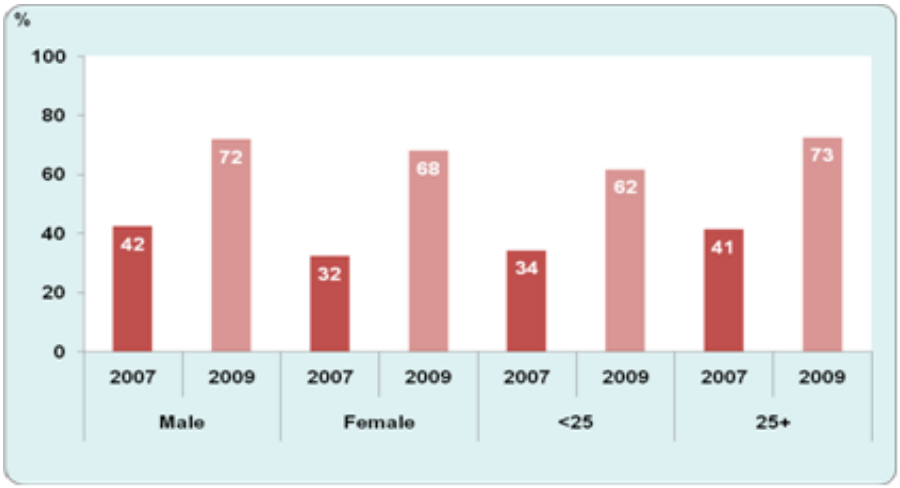
Figure 3(a). HIV prevalence among IDUs by age group and gender, 2007 and 2009



Source: Prepared by www.aidsdatahub.org based on China, UNGASS Country Progress Reports, 2008 and 2010

As shown in Figure 3(a), HIV prevalence among IDUs has increased among both males and females as well as among subpopulations younger than 25 years and those 25 years and older[7; 10]. Also in 2009, 72% of male IDUs reported the use of sterile injecting equipment the last time they injected (up from 42% in 2007)[8].

Figure 3(b). % of IDUs who reported the use of sterile injecting equipment at the last injection by age group and gender, 2007 and 2009



Source: Prepared by www.aidsdatahub.org based on China, UNGASS Country Progress Reports 2008 and 2010

Table 1. Selection of findings from recent journal publications: Drug users

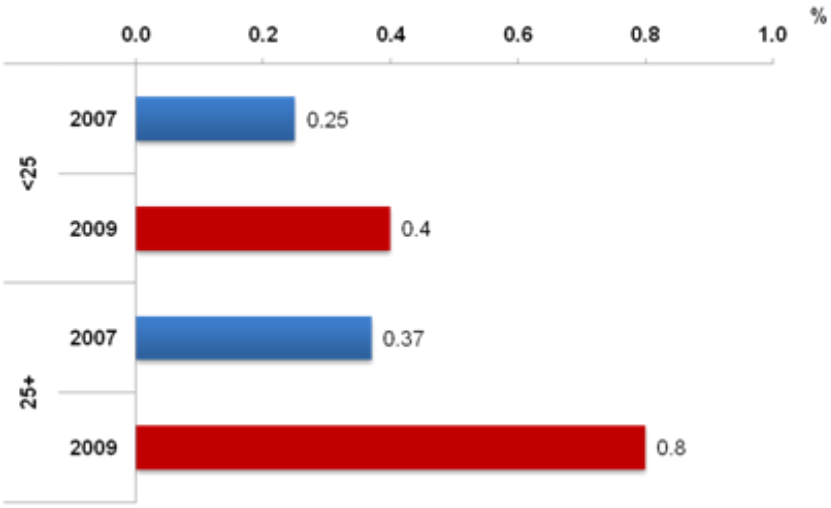
Population	Geographic location	Year of study	Epidemiological findings	Behavioural findings	Ref.
Drug users (n=795; IDUs n= 863)	Beijing	2007	• HIV: 2.9% (5.2% in mandatory detoxification centres vs. 2.3% among community drug users) • Syphilis: 4.6%	• 20% shared injection equipment in the last 6 months	11
Female IDUs (n=1,422)	Sichuan	2003-2005		• 43.5% shared syringes in the last month • 59%, 38.5% and 55.7% had regular, non-regular and commercial partners, respectively in the last 12 months • 75%, 51% and 39% had unprotected sex at last sex with a regular partner, non-regular partner and commercial partner, respectively.	12

Female sex workers

Although sex work is officially illegal in China, it continues to thrive in several parts of the country. As the country's economy grows, so does the sex industry, especially in prosperous cities like Shenzhen. In 2009 it was estimated that there were 2.68 million female sex workers (FSWs) and 26.5 million clients of FSWs in China[9].

HIV prevalence among FSWs was 0.6% in 2009[8]. However, several surveillance sites showed prevalence of HIV that exceeded 1% – mainly concentrated in the provinces of Yunnan, Xinjiang, Guangxi, Sichuan and Guizhou[8]. As shown in Figure 4, HIV prevalence among FSWs has risen significantly among both those younger than 25 years and their older counterparts.

Figure 4. HIV prevalence among FSWs by age group, 2007 and 2009



Source: Prepared by www.aidsdatahub.org based on China, UNGASS Country Progress Reports, 2008 and 2010

Sexually transmitted infections other than HIV are of concern among both sex workers and their clients. For instance, Hepatitis C was found to be 10.8%, 3.2% and 2.7% among street-based, hotel and karaoke-based and barbershop-based FSWs, respectively in 2007[13]. Further, syphilis prevalence was 43.1% among street-based FSWs, 3.2% among hotel and karaoke-based FSWs and 4.5% among barbershop-based FSWs[13]. Another cross-sectional study among FSWs in Yunnan Province (n= 96) showed high prevalences of syphilis (12.5%), gonorrhea (36.8%), and Chlamydia (46.3%)[14]. Moreover, a 2005 cross-sectional study of establishment-based FSWs in the Guangxi region of Southern China found that, of 362 participants, the prevalence of syphilis was 11%[15]. In Guangdong province, 320 FSWs were sampled and the prevalence of syphilis, gonorrhea, and chlamydia were 8%, 9.5% and 3.9% respectively[16].

Prevalence of HIV and other STIs among clients of sex workers have been shown to be higher than in the general population. In the Sichuan study, HIV prevalence was determined to be 1.7% among the group of clients[17]. Moreover, a 2006 study of 339 miner clients of FSWs in a mining region of Yunnan Province found that HIV prevalence among the group was 1.8%, and 23.2% were infected with an STI[14].

Literature reporting the HIV prevalence and related characteristics of male sex workers (MSWs) in China very limited[18]. One recent 2008 study of 394 MSWs in Shenzhen[19] found HIV prevalence to be 5.1% among the group, or 6.9% in those working in parks, 11.3% in small family clubs and 1.7% in entertainment venues. Fourteen percent tested positive for syphilis.

Table 2. Selection of findings from recent journal publications: Female sex workers and their clients

Population	Geographic location	Year of study	Epidemiological findings	Behaviour and coverage findings	Ref.
FSWs From massage parlours and hair salons (n=324)	Shanghai (5 districts)	2009		• 75.3% reported condom use at last sex with a client • >50% believed HIV-infected individuals should be forcibly isolated; yet >80% thought that it was reasonable to help an HIV-infected individual. • 61% could correctly answer a range of questions regarding HIV prevention and transmission	20
FSWs (n=1,642)	2 cities in Yunnan Province	2006-2007		• 18% had been previously tested for HIV and 53% returned for post-test follow-up.	21
FSWs (n=320)	Guangdong	Published 2010	Syphilis: 8% Gonorrhea: 9.5% Chlamydia: 3.9% any STIs: 19.7% HIV: 0%	• Median number of clients during the previous week: 5; • Consistent condom use with clients during the previous week: 58%	16
Clients of FSWs (miners) (n=1,798)	2 townships of Gejiu City, Yunnan	2006	• HIV: 0.7% • Chlamydia: 4.8% • Gonorrhoea: 0.8% • Syphilis: 1.8% • Herpes simplex virus-2: 9.6% • any STIs: 14.9% • Miners who visited FSWs had a higher prevalence of HIV (1.8% vs. 0.5%) and any STI (23.2% vs. 4.3%), including Chlamydia (6.9% vs. 4.3%), gonorrhoea (2.1% vs. 0.5%), and herpes simplex virus-2 (14.9% vs. 8.4)	• 19% had ever has sex with a FSW • 72% never used a condom with a FSW.	22
Migrant FSWs (n=348)	Beijing	2008-2009		• 76% reported clients' refusal to use condoms • 32% reported unsafe sex with clients; 76% with non-paid regular partners • 22% had ever been tested for HIV • 71% had ever been verbally abused • 29% had ever been physically abused • 48% had ever been forced into sex • 31% had ever been arrested by police	23
Clients of FSWs (n=600)	Sichuan province (3 urban areas)		• HIV: 1.5% • Syphilis: 5.3% • Hepatitis C virus: 8.7%	• Consistent condom use with FSWs: 30.5%.	24

Men who have sex with men

With an estimated population size of 4.1 million (as of 2009), men who have sex with men (MSM) make up the largest key affected population in China[9]. A 2004 study of MSM (n=576) found that 93% of men believed that there was no or little possibility that they could get HIV[25]. In 2009, HIV prevalence was 5% among MSM (4.1% among those younger than 25 years of age, 5.7% among those 25 years and older)[8]. This is a significant increase in prevalence from 2.1% reported in 2007 and 1.5% in 2005[7; 10; 26]. Despite the overall prevalence of 5%, large variations exist among different regions: up to 20% in some south western urban cities, 5-11% in Shanghai and its neighbouring cities, 4.3-10% in Shenyang and its neighbouring cities, and 4.6-8.3% in Beijing and Tianjin[9].

Table 3 summarizes HIV and syphilis prevalence among MSM in various cities. Of note, syphilis prevalence was high in several cities – Beijing (24%), Shanghai (13.5%) and Yuzhong/Chongquing (10.2%) in particular.

Table 3. HIV and syphilis prevalence among MSM in selected cities

City	HIV (%)	Syphilis (%)	Year
Beijing	2.1	24	2007
Chengdu	10.6	n/a	2007
Chongqing	19.2	n/a	2009
Yuzhong, Chongquing	16.7	10.2	2007
Guiyang	5.9	2	2007
Hangzhou	1.8	n/a	2007
Ningxia	0	0	2007
Shanghai	1.5	13.5	2007
Tianjing	2	n/a	2007

Sources: Prepared by www.aidsdatahub.org based on Gao Xing, Wang Liyan, Wang Lu, et al. Characteristics of Sexual Behavior and HIV Prevalence among MSM in Selected cities of China, China J AIDS STD, 14 (6), Dec 2008; Lu Hong-yan, Ma Xiao-yan, Liu Yan-chun, et al. A survey of HIV/STD prevalence in 200 MSM and Related Factors in Beijing, 14 (6), Dec 2008; Choi KH, Ning Z, Gregorich SE, et al. The Influence of Social and Sexual Networks in the Spread of HIV and Syphilis among Men who have Sex with Men in Shanghai, China. J Acquir Immune; UNAIDS ,2009 Estimates for the HIV/AIDS Epidemic in China, by Ministry of Health, Joint United Nations Programmes on HIV/AIDS, World Health Organization)

Table 4. Selection of findings from recent journal publications: Men who have sex with men

Population	Geographic location	Year of study	Epidemiological findings	Behavioural findings	Ref.
MSM (n=1,353)	Heilongjiang province	2008	HIV: 2.3%	48.7% had multiple male sexual partners in the past 6 months; 37.3% of the subjects had consistent condom use (use every time) in the past 6 months	27
MSM (n=351)	Shenzhen	2007		• 49% reported having concurrent sexual partnerships during the past 6 months. Among them, 62% had only male partners and 38% had both male and female partners. • 42% of MSM with concurrent partners used condoms consistently in the last 6 months compared to 30% without concurrent partners	28
MSM (n=513)	Chengdu	2007	• HIV: 9.1% • Herpes simplex virus-2: 24.7% • Syphilis: 28.1%	• Consistent condom use (always used a condom when having sex) was highest with casual male partners (38.6%), and was lowest with wives or girlfriends (17.8%).	29
MSM (n=507; all HIV-seronegative)	Beijing	2006-2007	12 month follow-up incidence rates: HIV: 2.6 per 100 person-years Syphilis: 16.9 per 100 person-years Hepatitis B virus: 3.3 per 100 person-years	Syphilis and no perceived risk of HIV infection were independently associated with HIV seroconversion.	30

KNOWLEDGE, VULNERABILITY & RISK BEHAVIOURS

Vulnerability Factors

• The estimated size of the population of rural-to-urban migrant workers was 211 million (in 2009)[9]. A survey among 15,622 migrants (long-distant truck drivers, construction workers and etc.) in 18 cities of 7 north and north-east provinces in June 2008 found that 12.2% reported having commercial sex in the last 12 months, 36.4% did not use condoms in the last commercial sex. Migrants without a local Hukou (household registration) are unable to access antiretroviral drugs, public education and subsidized health care[9]. Meanwhile, only 4.5% migrants were reached by prevention interventions in July 2009[9].

• Increasing levels of sexually transmitted infections.

• Stigma and discrimination towards people living with HIV and key affected populations is severe.

• Low levels of HIV knowledge among key affected populations, particularly among female sex workers.

• Limited coverage of comprehensive prevention packages to address high-risk behaviours, especially injecting drug users;

• Minimal involvement of civil society in the AIDS response;

• Limited utilization of VCT and STI services;

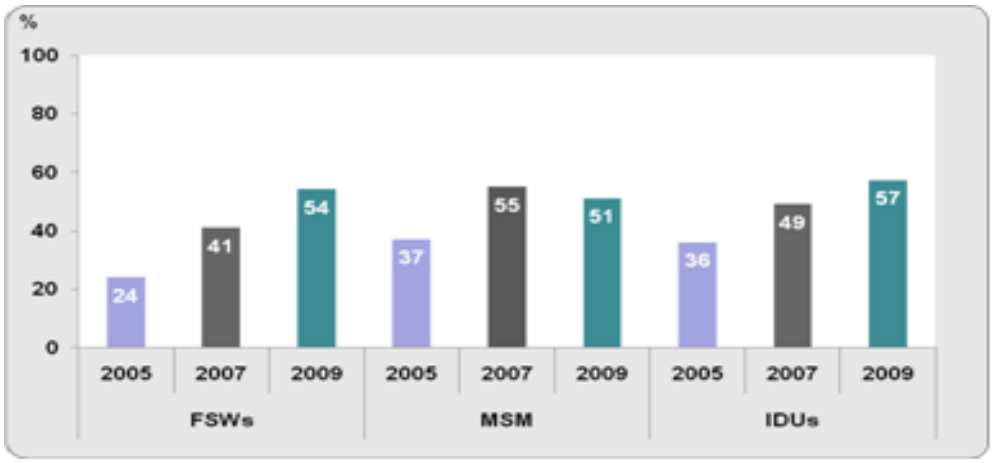
• Weak linkage between the identification of HIV status and referral to different parts of the treatment and care response;

• Limited access to psychological support services for HIV-positive children who suffer trauma, abandonment and discrimination[31].

Knowledge of HIV and AIDS

According to the 2009 National HIV/AIDS Sentinel Surveillance Results, comprehensive knowledge about HIV – that is, the ability to both correctly identify ways of preventing the sexual transmission of HIV and to reject major misconceptions about HIV transmission – remains low among key affected populations. Although it has increased since 2005, only slightly over half of each of the populations has comprehensive HIV knowledge (Fig. 5). Most recently, in 2009, comprehensive knowledge was 54% among FSWs, 51% among MSM and 57% among IDUs.

Figure 5. Percentage of key affected populations who had comprehensive knowledge of HIV, 2005-2009



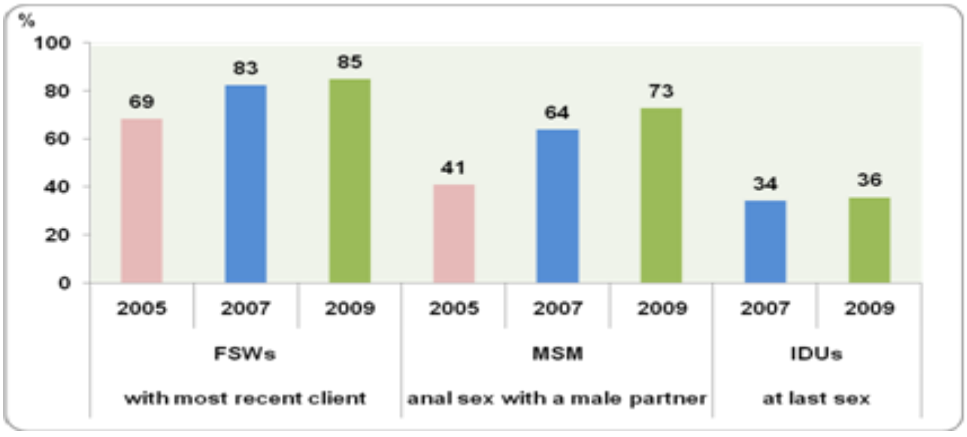
Source: UNAIDS, Report on the Global AIDS Epidemic, 2010

In 2007, very few young people aged 15-24 (42%) had comprehensive knowledge of HIV[10]. However, a 2009 study found much more promising levels of knowledge among young people both with and without education. Eight-five percent of those in school and 82% of those not in school had comprehensive knowledge [10; 32].

Condom use

In 2009, condom use at last sex ranged widely across key affected populations (from 36% among IDUs to 73% among MSM at last anal sex with a male partner to 85% among FSWs at last sex with a client)[8]. This represents a significant improvement in condom use over recent years among FSWs and MSM, with only a negligible increase among IDUs (Fig. 6)[7;10;26].

Figure 6. Percentage of key affected populations who reported condom use at last sex, 2005 - 2009



Source: UNAIDS, Report on the Global AIDS Epidemic, 2010

HOW MIGHT HIV AFFECT CHINA IN THE FUTURE?

In 2006, national infectious disease statistics showed that the fatality rate of AIDS cases was 20% – the third highest among national infectious diseases (class I and II). The mortality rate of AIDS was 0.1 per 100,000, which ranks AIDS at number four nation-wide. These deaths were mainly among the working age group (nearly three-quarters in the 20-49 age category), with an average death age of 37.6[10].

HIV has significant economic impacts on families as fewer members are available for income-generating activities and finances are diverted to the treatment and care of AIDS patients. For instance, one study found that the average income per person in households affected by AIDS was 44% to 47% of persons in families not affected by AIDS. In some areas people living with HIV (PLHIV) need to pay additional cost, such as treatment for opportunistic infections, further increasing the economic burden for families affected by AIDS[10].

Research on the demographic impact of AIDS revealed that, while there would be no change in crude death rates in 2005 and 2015, there will be a small change in life expectancy due to AIDS in China. Accordingly, life expectancy of Chinese people was expected to reduce by 0.1 in 2005 and by 0.2 in 2015 [33;34].

NATIONAL RESPONSE

Law, policy and human rights

Historically, China has not experienced wide-scale prosecution of MSM, nor have laws forbidding or punishing MSM been enacted. However, under the strong influence of Confucian and Taoist philosophy, Chinese society emphasizes procreation and social order, and therefore stigmatizes homosexual behaviour.

However, a number of criminal laws make other key affected populations hard to map, monitor and reach with HIV prevention programs. Sex work is illegal and unregulated. Security Administration Punishment Law subjects sex workers to administrative detention from one to 15 days, with penalties of less than 5,000 Yuan (US$ 730) [35].

Injecting drug use is illegal; punishments include detention or being sent to detoxification centres or labour camps[36]. The Narcotic Control Law of 2008 has introduced significant reforms on drug treatment and rehabilitation as compared to the compulsory detoxification treatment previously enforced. According to the new law, drug users are no longer required to stay in detoxification centers and they now have the right to select their treatment options [37].

The Statute on AIDS Prevention (2006) requires that local governments provide confidential HIV testing and free antiretroviral (ARV) drugs. It also provides for anti-discrimination measures[36]. Furthermore, the Regulations on AIDS Prevention and Treatment protects the rights of PLHIV and their families. It enshrines the right to employment, medical care and education. In addition, certain regional laws have been implemented to resolve conflicts between current HIV policies and criminal laws. For example, the Responsive Measures for HIV/AIDS Prevention in Yunnan Province Law, 2004, legalized needle and syringe exchanges and required hotels to make condoms available in the high HIV prevalence province [38].

Stigma and discrimination experienced by PLHIV is severe. The China Stigma Index survey conducted among more than 2,000 PLHIV in 2009 showed [39]:

- 32% of all respondents said that their status had been revealed to others without their permission.
- 41.7% reported having faced severe HIV-related discrimination.
- More than 76% of all survey respondents said that their family members had experienced discrimination as a result of their HIV status.
- 15% said they had been refused employment or a work opportunity because of their HIV status.
- Of those respondents with children, 9.1% said that their children, who were not necessarily HIV positive themselves, had been forced to leave school because of the HIV status of their parents.
- Termination of a pregnancy is regularly recommended to pregnant women living with HIV. 11.9% of women living with HIV who had partners since they were diagnosed with HIV had been pressurized into terminating a pregnancy by health staff.

In addition to the stigma experienced by PLHIV, a separate 2008 survey found a high degree of stigma towards PLHIV among the general population (n=6,000 in six cities)[40] :

- 41.3% were unwilling or strongly unwilling to work in the same place as a HIV positive person.
- 64.9% were unwilling or strongly unwilling to live in the same room as a HIV positive person.
- 47.8% were unwilling or strongly unwilling to eat food the same place as a person living with HIV.
- 63.6% were unwilling or strongly unwilling to receive services, e.g. a haircut, from a person living with HIV.

One 2005-2007 study by the National Institute of Mental Health Collaborative HIV/Sexually Transmitted Disease Prevention Trial showed that levels of stigmas towards PLHIV could be reduced with scaled up provision of prevention information and improved knowledge about HIV[41]. The study sampled 4,510 market workers in Fuzhou with 3,785 participants in a 12-month follow-up and 3,716 participants in a 24-month follow-up. Compared with no change over time for the control group, the intervention successfully reduced the level of HIV-related stigma at the 12-month follow-up, and the effect increased by two-fold at the 24-month follow-up.

Governance

Over the years, the Chinese Government has taken a strong lead in the prevention and control of HIV. Among its most recent measures are the following:

- Strengthening the AIDS policy framework by such means as issuing the Regulations on AIDS prevention and control, the first legal framework developed in China for a specific disease or epidemic, and the China's Action Plan for Reducing and Preventing the Spread of HIV/AIDS (2006-2010), which seeks to adopt the 'Three Ones' principle – one national plan, one coordinating mechanism, and one monitoring and evaluation system;

- Increasing financial commitment to AIDS prevention and care;

- Strengthening AIDS awareness and response capability of leadership at various levels;

- Enhancing cross-sector cooperation and coordination by jointly conducting large-scale initiatives;

- Encouraging and supporting involvement of various groups (civil society, mass organizations, faith-based organizations, enterprise and business) in AIDS prevention, care and treatment;

- Focusing behavioural change interventions among most-at-risk populations;

- Expanding access to free ARV treatment under the "Four Frees and One Care" policy: 1) free ARV drugs to HIV patients who are rural residents or people with financial difficulties living in urban areas; 2) free Voluntary Counselling and Testing (VCT); 3) free drugs to HIV infected pregnant women to prevent parent-to-child transmission, and HIV testing of newborn babies; 4) free schooling for children orphaned by AIDS; and 5) care and economic assistance to the households of PLHIV;

- Strengthening the national surveillance system.

The China Comprehensive AIDS Response (China CARES) programme is an ambitious programme to expand access to comprehensive HIV and AIDS treatment and care services that covers 127 sites in priority provinces most affected.

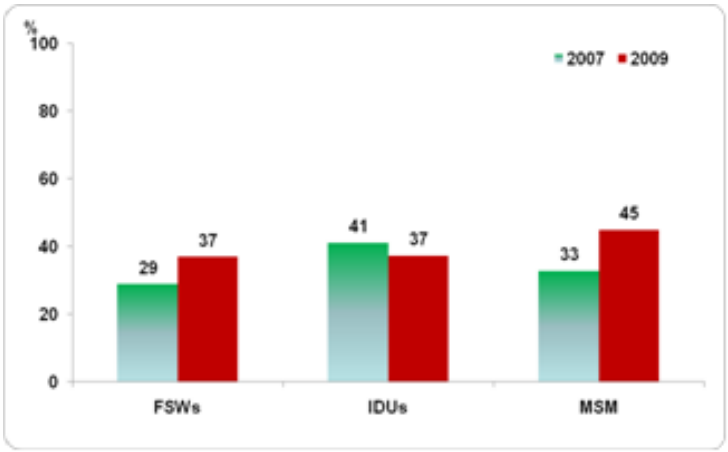
The Department of Disease Control at the Ministry of Health is the focal point of China's AIDS efforts. It is designated as the primary agency for: preventing and controlling AIDS; developing, coordinating and implementing projects for national AIDS prevention and control; formulating laws and regulations; and overseeing surveillance and administration of the AIDS situation. Recently, in April 2010, China lifted its travel ban for PLHIV[42].

China's Health Ministry launched a nationwide system to collect AIDS data from country health authorities directly via the Internet instead of via paper reports passed through a hierarchy of officials. In addition, the Ministry stipulated the responsibilities of local disease prevention authorities who are tasked with visiting HIV patients twice a year and AIDS patients four times a year, with a written report of each visit.

HIV prevention programmes

Among key affected populations, 37% of both FSWs and IDUs populations as well as 45% of MSM received an HIV test in the past 12 months and knew the results in 2009[8]. While testing coverage is now higher among FSWs and MSM compared to 2007, fewer IDUs are receiving testing (Fig. 7)[7;10;43;44].

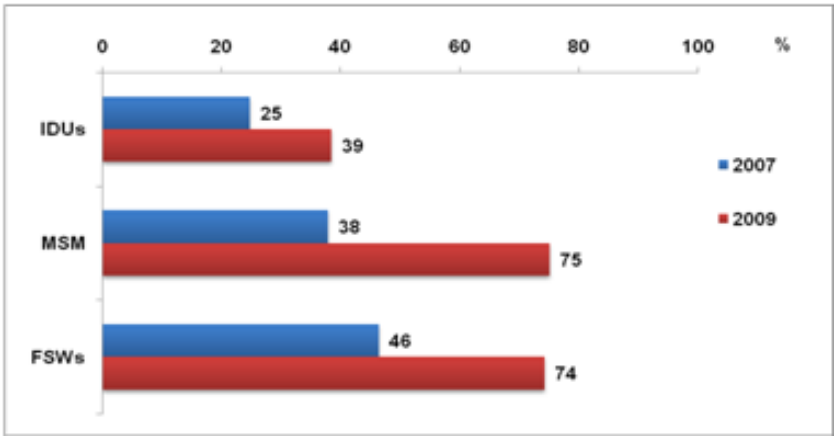
Figure 7. Percentage of key affected populations who received an HIV test in the past 12 months and knew the results, 2007-2009



Source: UNAIDS, Report on the Global AIDS Epidemic, 2010

Figure 8 shows the progress of prevention programme reach in China. Sizeable increases in levels of reach have been observed over the 2007-2009 period, with HIV prevention coverage reaching 74% and 75% among FSWs and MSM, respectively[8].

Figure 8. Percentage of key affected populations reached with HIV prevention programme, 2007-2009



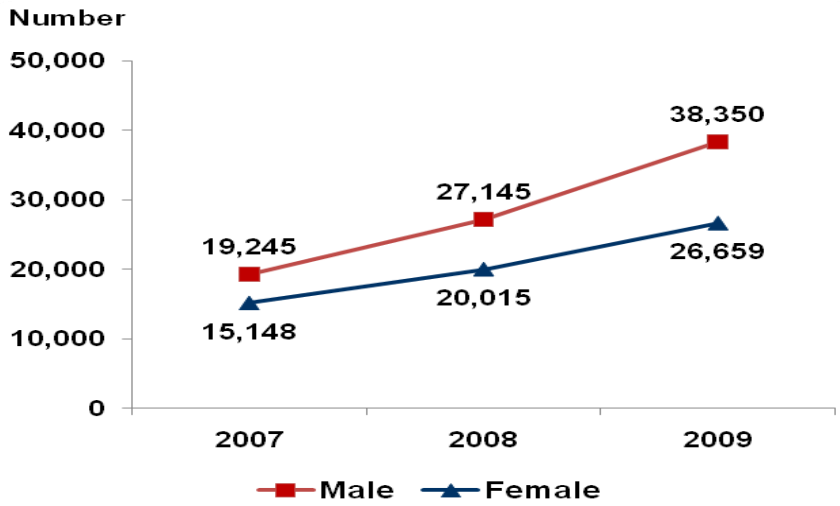
Source: UNAIDS, Report on the Global AIDS Epidemic, 2010

Harm reduction programmes for IDUs have been implemented, treating a cumulative total of 242,000 individuals by means of 680 methadone maintenance treatment programmes in 27 provinces (autonomous regions and municipalities) in place as of the end of 2009[7]. Also as of 2009, 962 needle exchange programmes were in place (up from 897 in 2008), with the monthly average number of visitors at 39,075[7]. While programme reach among IDUs remained low at 39% in 2009, this too represents an increase from 25% in previous reporting periods [7; 10; 43; 44].

Antiretroviral treatment, prevention of mother-to-child transmission

According to UNGASS reporting, antiretroviral therapy (ART) coverage has increased steadily in recent years, reaching 34.4% of adults and children with advanced HIV infection in 2009 compared to 19% in 2007[7]. Figure 9 shows increasing trends in the number of males and females receiving ART (38,350 males vs. 26,659 females in 2009)[7].

Figure 9. Number of adults and children with advanced HIV infection who received ART by gender, 2007-2009



Source: Prepared by www.aidsdatahub.org based on China, UNGASS Country Progress Reports

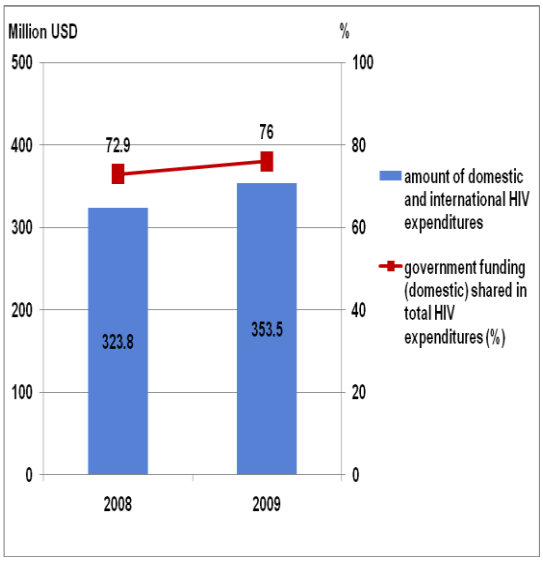
Since the first case of mother-to-child transmission (MTCT) was identified and reported in 1995, it has increased annually until recently. By the end of 2009, prevention of mother-to-child transmission (PMTCT) activities funded by central government had been expanded to 453 counties (up from 271 in 2007)[7]. According to UNGASS reporting, it was estimated that in 2009 only 22.4% of HIV infected pregnant women received ARVs to reduce the risk of MTCT, and correspondingly that 22.3% of infants born to HIV positive mother were HIV infected (compared to 75% which was also reported, calculated based on UNAIDS guidelines)[7]. According to Universal Access reporting, the percentage of HIV infected pregnant women receiving ARVs for PMTCT ranged from 14-59% [43].

ECONOMICS OF AIDS

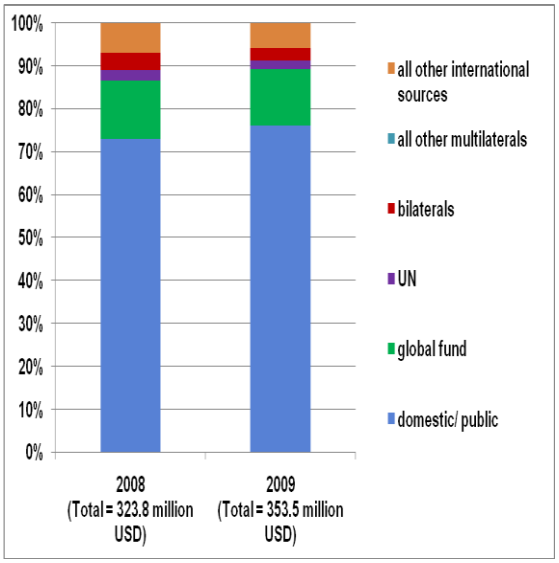
In 2007, AIDS investment in China from national public sources totalled RMB 940 million (~US$ 140 million), increasing to US$ 324 million in 2008 and US$ 354 in 2009[7]. Of total investment on AIDS in 2009, 76 % was financed by domestic and public sources, the Global Fund to Fight AIDS, Tuberculosis and Malaria (13 %), UN agencies (2%), bilaterals (3.1%) and 5.8 % by other international sources[7]. Figure 10 shows that AIDS investment has been increasing in recent years, with government funding remaining stable (76% of the total in 2009 up from 72.9% in 2008) [7; 45].

Figure 10 (a). Amount of domestic and international AIDS investment and % of government sharing in AIDS funds, 2008-2009: (b) % distribution of total HIV expenditures by financing source, 2008 - 2009

(a)



(b)



Source: UNAIDS, Report on the Global AIDS Epidemic, 2010

It has been estimated that US$ 2.8 billion will be required for a scaled-up, targeted and geographically prioritized AIDS response from 2010 to 2015 to cover 90% of key at risk population with interventions and provide ARV treatment to 150,000 PLHIV[9]. This estimate does not include interventions targeting migrants, young people, the general population, and blood safety[9]. And yet, the resources available resources for 2010 to 2015 are estimated at US$ 2.28 billion[9].

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