

Children in China: An Atlas of Social Indicators

2010



NWCCW

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NBS

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2 Children in China: An Atlas of Social Indicators

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**Children in China:
An Atlas of Social Indicators
2010**

FOREWORD

This Atlas of Social Indicators of Children in China reflects the joint efforts of the National Working Committee on Children and Women (NWCCW) under the State Council, the National Bureau of Statistics and the United Nations Children's Fund (UNICEF).

The Atlas provides an overview of the situation of children in China, using charts based on key indicators of child survival, protection and development and highlighting relevant socio-economic information. It reflects China's achievements for children, and highlights disparities amongst children from different regions and population groups. The Atlas therefore serves as a comprehensive and detailed resource for relevant government departments, child rights practitioners and the general public.

The Government of China attaches great importance to the protection and promotion of children's rights. Since signing the UN Convention on the Rights of the Child in 1990, the Government of China has been following and abiding by the mission and spirit of the Convention, fulfilling its obligations with concrete actions and adhering to the 1990 World Summit for Children's principle of "First Call for Children." In addition, China has worked to prioritize child development and foster the realization of children's rights of survival, protection, development and participation through the development and implementation of the National Programme of Action for Children. China has already achieved major milestones

in implementing the National Programme of Action for Children for the period 2001-2010. However, social-economic, cultural, conceptual and other factors still pose great challenges for the protection and promotion of children's rights. Promoting child equity will become the predominant task for the coming decade in China, especially in terms of reducing disparities between rural and urban areas, across regions and among individuals.

At present, the Government of China is formulating the 2011-2020 National Programme of Action for Children. We hope that this Atlas can serve as a reference for the Government and relevant institutions in monitoring and evaluating child development status, in working towards the goals of the National Programme of Action for Children and in developing future plans to promote and protect the rights of children. We also hope that this Atlas, in drawing attention to China's significant achievements for children, will raise public awareness and support for children.

We would like to express our appreciation and gratitude to UNICEF for its close partnership with the Government of China and its outstanding contributions to children in China over the years. We particularly wish to thank the Department of Social, Science and Technology Statistics of the National Bureau of Statistics and Dr. Yin Yin Nwe, Representative of UNICEF China, together with her colleagues, for their unremitting efforts and hard work in compiling and publishing this Atlas.



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FOREWORD

It is a great pleasure and privilege for UNICEF to join hands with the National Working Committee on Children and Women and the National Bureau of Statistics in presenting this Atlas of Social Indicators on Children in China. UNICEF thanks all partners for making the data available for this Atlas.

The Atlas shows the remarkable achievements that China has made in improving the survival, development and protection of children. A few examples clearly demonstrate this progress. In the last two decades alone, China's child mortality rate has plummeted by about two-thirds. The Compulsory Education Law and the increase in central government funding for basic education in rural areas have yielded impressive results, such as the achievement of universal basic education and the elimination of gender disparity in primary net enrolment ratios. China is also enhancing its legislative and policy frameworks and implementing measures to better protect children and women against violence, abuse and trafficking. Mechanisms to support the most vulnerable children are being established – the most recent example being social assistance grants to provide orphans with care based on community and family approaches.

In short, China's tremendous progress for children and women puts it well on track to achieve many of the Millennium Development Goals. Indeed, at national

level, it has already achieved an impressive number of targets related to these goals. UNICEF is proud to have contributed towards many of the achievements for children throughout the 30 years of its cooperation programmes with the Government of China.

As in other developing countries, many challenges still lie ahead. Huge in-country disparities mean that development outcomes for children and women in the poor rural areas of China are similar to those in low-income countries.

In the years to come, UNICEF looks forward to working closely with all partners in helping to address these challenges. In particular, UNICEF greatly appreciates the close cooperation with the State Council's National Working Committee on Children and Women in promoting the realization of child rights and women's rights through the implementation and monitoring of the 2001-2010 National Programme of Action for Children at national and local levels, across all counties in China.

UNICEF stands committed to further support the Government of China in the development, implementation and monitoring of the next National Programme of Action for Children (2011-2020).



Dr. Yin Yin Nwe
UNICEF Representative in China

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Overall guidance and strategic direction were provided by Yin Yin Nwe of UNICEF China, Su Fengjie of NWCCW and Ma Jingkui of NBS.

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POPULATION DEMOGRAPHICS

OVERVIEW

Located in the east of the Asian continent, and on the western shore of the Pacific Ocean, the People's Republic of China is the largest country in the world in terms of population, and the third largest in terms of land area (9.6 million sq km¹).

China's territory stretches about 5,500 km north to south and around 5,000 km east to west, and shares land borders with 14 countries. China's neighbouring countries are North Korea to the northeast; Russia and Mongolia to the north; Kazakhstan, Kyrgyzstan, Tajikistan, Afghanistan and Pakistan to the west; and India, Nepal, Bhutan, Myanmar, Laos and Vietnam to the south.

China is a multiethnic country comprising 56 ethnic groups. The Han ethnic group represents 92 per cent of China's population, while 55 ethnic minority groups² account for the remaining 8 per cent.

China's population has more than doubled during the last 5 decades³, from 587 million inhabitants in 1953 to an estimated 1.3 billion people in 2008. Today, China is home to about 20 per cent of the world's population.

While China's population continues to increase, the growth rate has slowed with the gradual decline in fertility and birth rates⁴. Since the 1970s, when China began to implement policies to limit population growth, the birth rate has decreased. In 2008, the birth rate was 12 per thousand, 33 per cent lower than in

1978. With a 13 per cent increase in the death rate during this period, the rate of natural increase⁵ in 2008 dropped to 5 per thousand, half that in 1978⁶.

China's family planning policy has led to a decrease in fertility rate⁷, but has been more flexibly implemented in rural areas and areas that are home to ethnic minority groups. In rural areas, it is not uncommon for couples to have two or three children.

In 2008, China had the world's second largest child population⁸. Although the number of children in China declined 11 per cent between 2000 and 2008, China's child population was estimated at 309 million in 2008⁹.

China's population is currently ageing. While the population aged 0–14 represented 36 per cent of the total population in 1953, that same age group constituted 19 per cent of China's population in 2008. In contrast, people aged 65 or over doubled between 1953 and 2008¹⁰, and now represent 8 per cent of the total population.

The sex ratio at birth has been increasing gradually since the 1980s. Data for 2008 show a sex ratio at birth of 121 males for 100 females¹¹, rising from 109 in 1982¹². In 2008, there were 39 million¹³ fewer females than males in China, which will have some impact on the future social and economic development of China.

Figure 1.1
Geographic regions of China



Source: (Derived from) National Bureau of Statistics

Figure 1.1

China is administratively divided into provinces, Autonomous Regions (Guangxi, Inner Mongolia, Ningxia, Tibet, Xinjiang), municipalities (Beijing, Chongqing, Shanghai, Tianjin) and Special Administrative Regions (Hong Kong, Macao)¹⁴. China can be divided into eastern, northeastern, central and western regions. Many economic and human development indicators are highest in the eastern regions and lowest in the western regions.

Figure 1.4
Population density, 2008

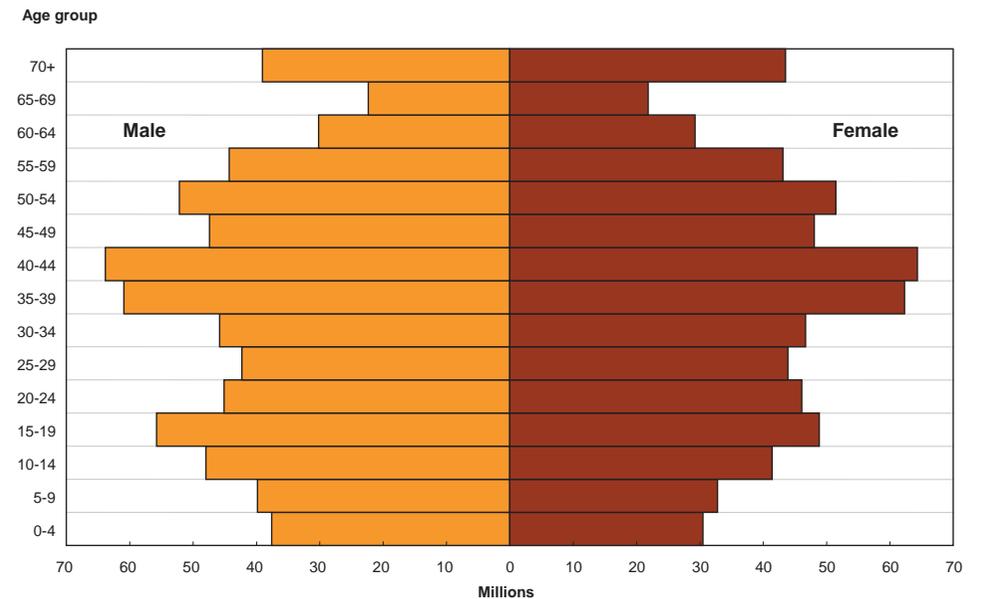


Source: (Derived from) National Bureau of Statistics, *China Statistical Yearbook*, 2009

Figure 1.4

The average population density is 138 people per sq km in China, but varies greatly across the country. While Shanghai has more than 2,900 persons per sq km, many western provinces have fewer than 60 persons per sq km. The vast majority of people live in the country's historic heartland – the plateaus, plains and basins of eastern and central China – where fertile soils and water resources make it the country's most productive agricultural region. In contrast, western China, with its high mountains and harsh weather conditions, is sparsely settled and some areas have a population density of less than 20 persons per sq km¹⁶.

Figure 1.5
Population pyramid, 2008



Source: (Derived from) National Bureau of Statistics, *China Statistical Yearbook*, 2009

Figure 1.5

The population aged 35–49 accounts for only 26 per cent of the total population¹⁷, even though it includes the "baby boom" generation born in the 1960s and early 1970s. Overall, China's population is ageing due to the decline in the fertility rate¹⁸ and the increase in life expectancy¹⁹. In 2008, the population over 60 years represented 14 per cent of the total population²⁰.

Figure 1.6
Life expectancy at birth, 1981–2005

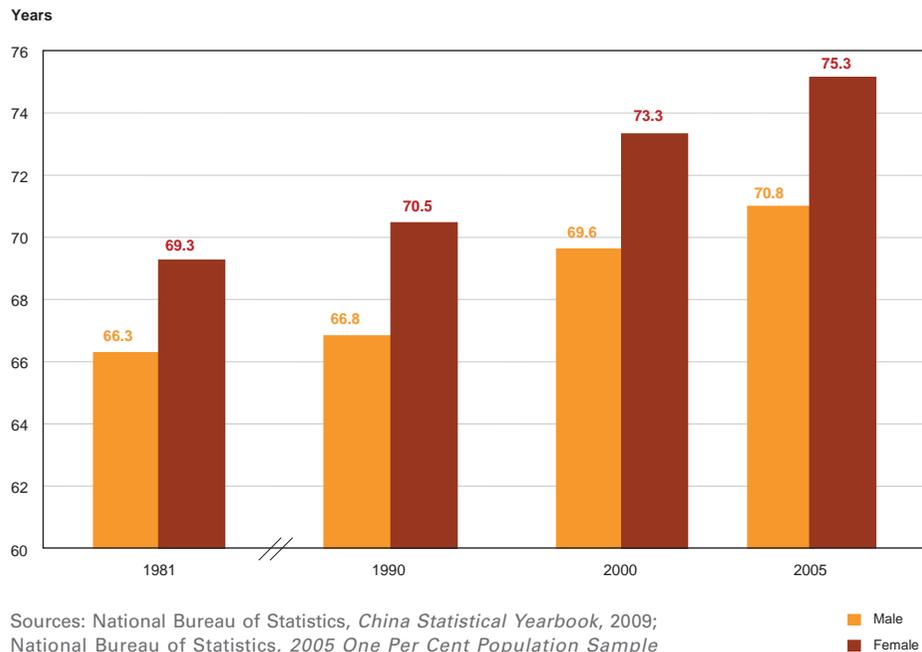


Figure 1.6
According to the Ministry of Health, the average life expectancy at birth²¹ was only 35 years in 1949²², when the People's Republic of China was founded. By 2005, this had risen to 73 years²³. Between 1981 and 2005, life expectancy increased by six years and four years respectively for women and men²⁴. Average life expectancy at birth in China is now higher than many other countries with similar GNI per capita²⁵.

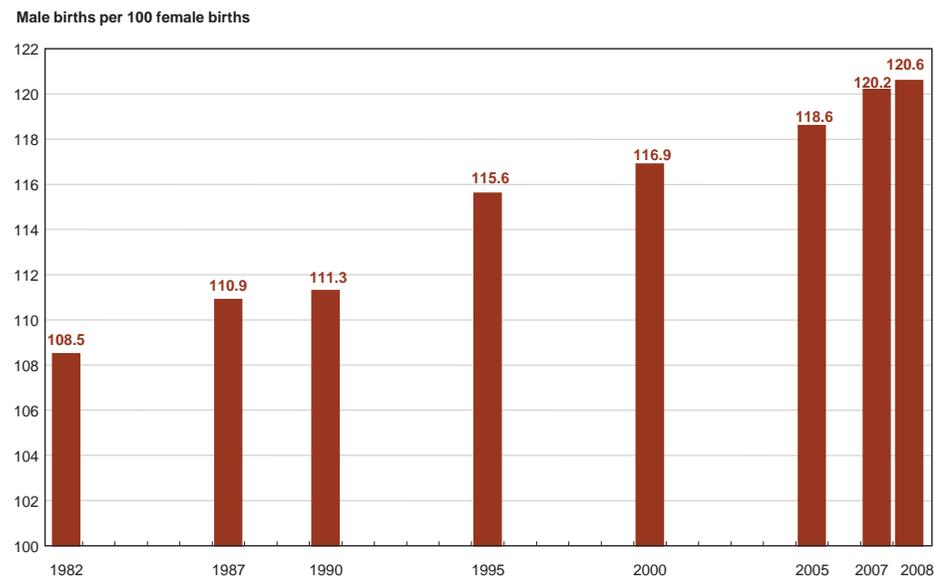
Figure 1.7
Life expectancy at birth, 2000



Source: National Bureau of Statistics, *China Statistical Yearbook*, 2009

Figure 1.7
There are significant disparities in life expectancy between western and eastern provinces. Life expectancy in western provinces such as Qinghai, Xinjiang and Tibet increased by five years between 1990 and 2000, but still lags more than 10 years behind Beijing and Shanghai, which record average life expectancy of 76 and 78 years respectively²⁶.

Figure 1.8
Sex ratio at birth, 1982–2008

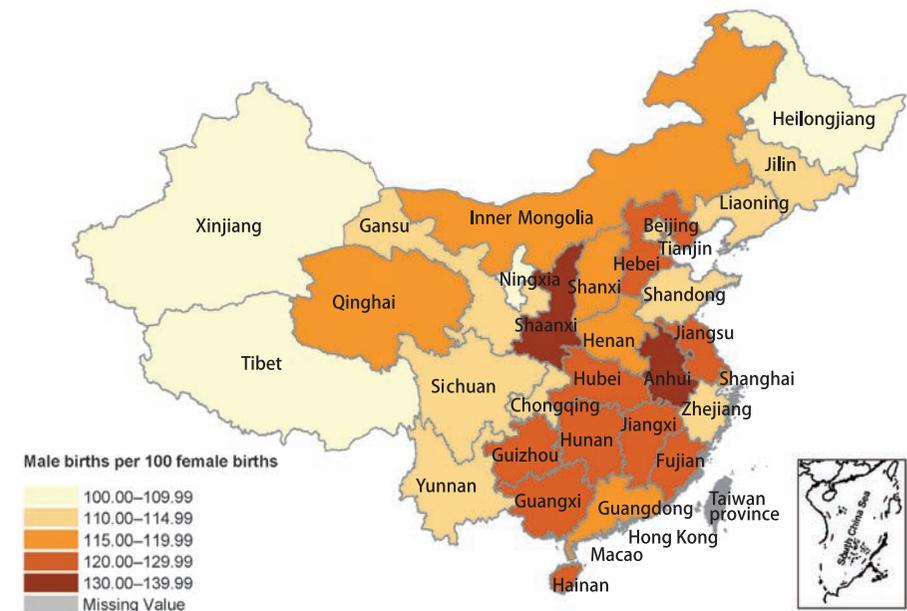


Sources: National Bureau of Statistics, *2008 China Population*; National Bureau of Statistics, *Social Progress in China, 2008* (1987 and 1990 data); National Bureau of Statistics, *2005 One Per Cent Population Sample Survey, 2007* (2005 data)

Figure 1.8

In the absence of intervention, the human sex ratio at birth²⁷ lies between 103 and 107 male births per 100 female births²⁸. As men have a higher mortality rate than women, the sex ratio at birth is higher than that observed later in life, such as at reproductive age. In China, the sex ratio at birth has become increasingly skewed, growing from 109 males per 100 females in 1982 to 121 males per 100 females in 2008²⁹.

Figure 1.9
Sex ratio at birth, 2005



Source: National Bureau of Statistics, *2005 One Per Cent Population Sample Survey, 2007*

Figure 1.9

The sex ratio at birth in 2005 was above 110 in all but four provinces (Tibet, Xinjiang, Ningxia and Heilongjiang). In Shaanxi and Anhui the sex ratio exceeded 130 males per 100 females³⁰.

Figure 1.10
Sex ratio at birth, urban and rural, 1982–2005

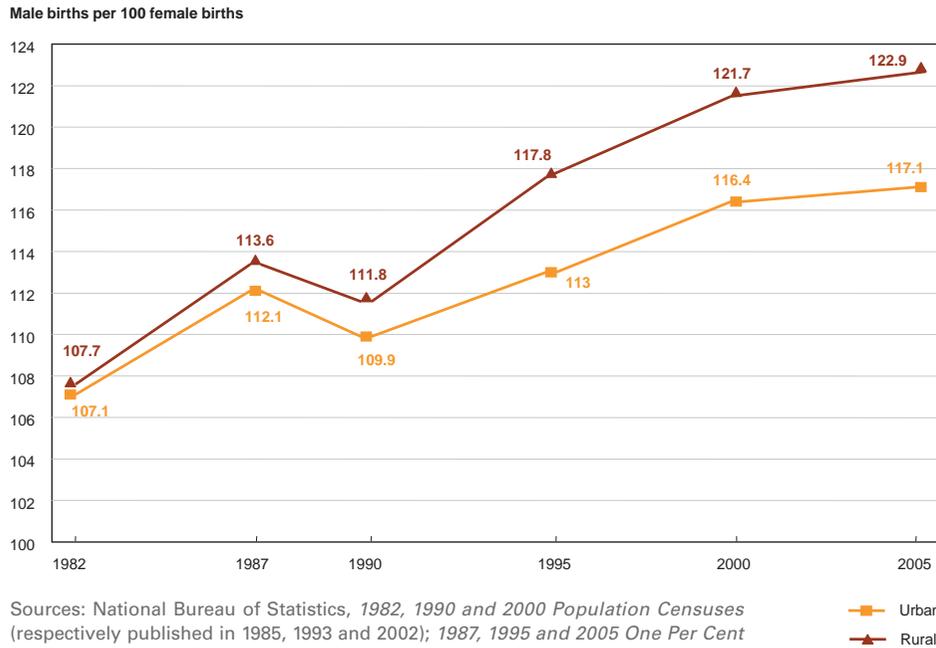


Figure 1.10
The sex ratio at birth is higher in rural areas than in urban areas. Over the last two decades, the sex ratio at birth has increased in both urban and rural areas, but more rapidly in rural areas. This has led to a growing urban-rural disparity, which reached its highest in 2005³¹.

Figure 1.11
Sex ratio at birth, by birth order, 1982–2005

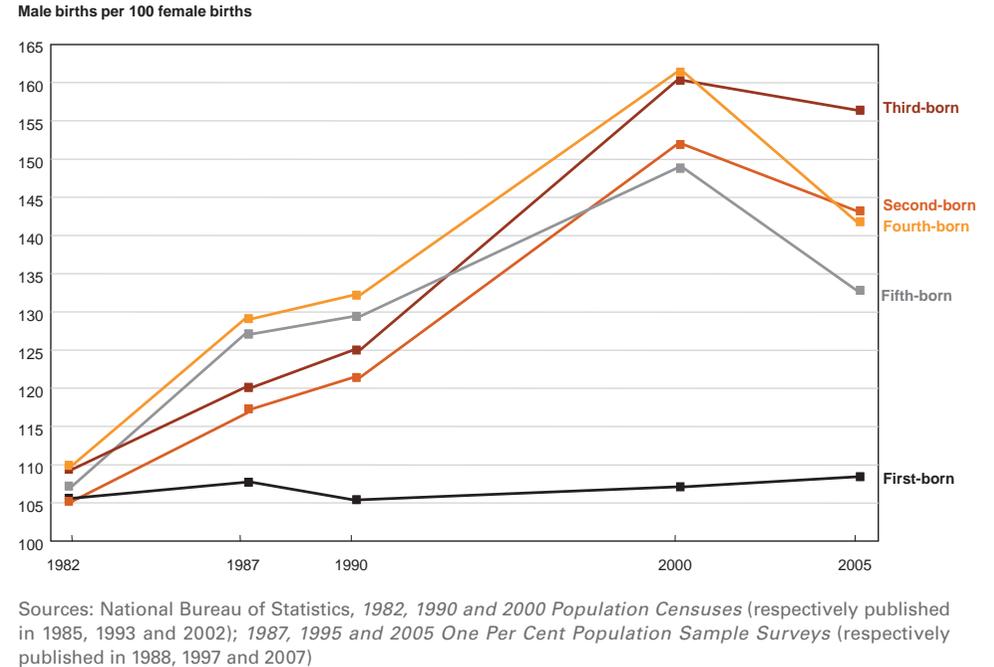
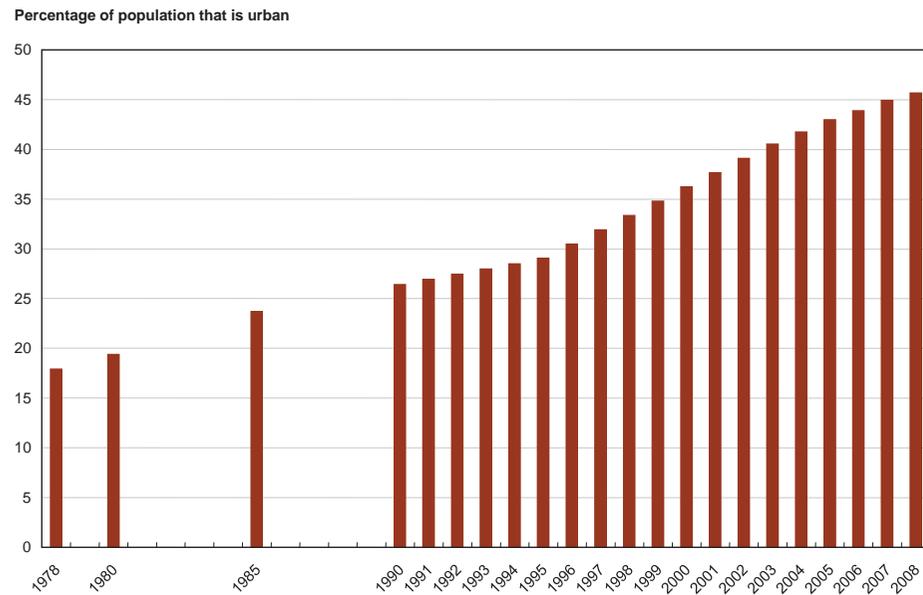


Figure 1.11
Disaggregated data indicate that the sex ratio at birth increases with birth order in China. Between 1982 and 2005, the sex ratio at birth was within the normal range for first-order births, but was high among second-order births and above. For example, in the year 2000, the sex ratio at birth was around 107 for first-order births, but rose to 152 for second-order births and exceeded 160 for third and fourth-order births³².

Figure 1.12
Urbanization, 1978–2008



Source: National Bureau of Statistics, *China Statistical Yearbook*, 2009

Figure 1.12

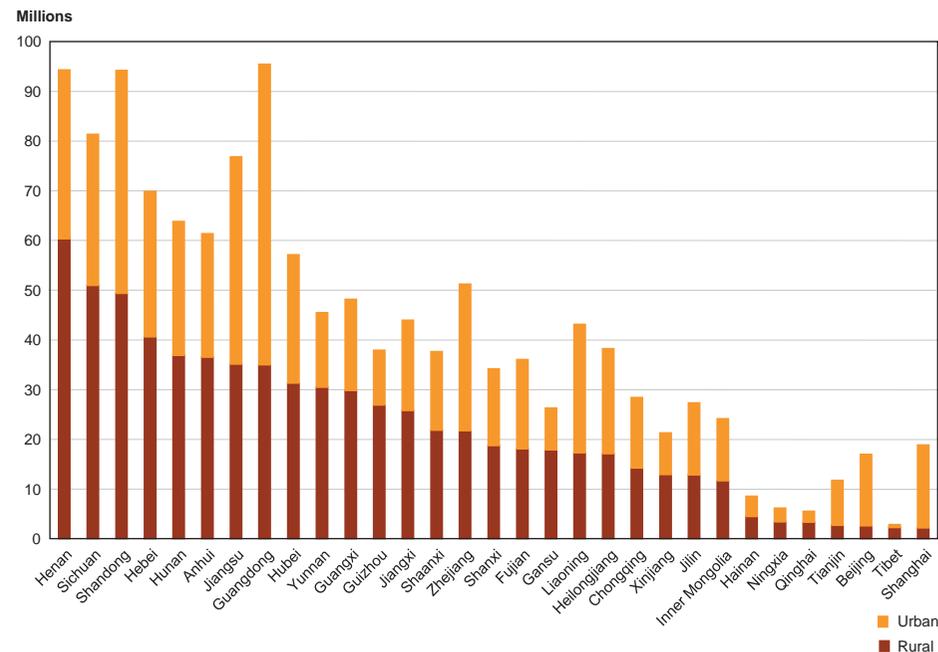
The urban share of China's population³³ increased between 1978 and 2008 from 18 per cent to 46 per cent³⁴. Beginning in the early 1980s, this increase was fuelled by the migration of large numbers of surplus agricultural workers and people seeking better economic opportunities. Since 1987, China has been implementing a strategy to manage urbanization by limiting the size of big cities (500,000 or more people), developing medium-sized cities (200,000 to 500,000 people) and supporting the growth of small cities (100,000 to 200,000 people).

Figure 1.13
Urbanization, 2008



Source: National Bureau of Statistics, *China Statistical Yearbook*, 2009

Figure 1.14
Population size, urban and rural, by province, 2008



Source: National Bureau of Statistics, *China Statistical Yearbook*, 2009

Figures 1.13 and 1.14

China's eastern regions account for the highest rates of urbanization. Some provinces and municipalities, such as Guangdong, Shanghai, Beijing and Tianjin have urbanization rates between 63 and 89 per cent³⁵.

Figure 1.15
Years in which the number of fatalities caused by disasters exceeded 6,000, 1976-2008

Years	Fatalities
1976*	242,000
1979	6,962
1980	6,821
1981	7,422
1982	7,935
1983	10,952
1984	6,927
1988	7,306
1990	7,338
1991	7,315
1993	6,125
1994	8,549
1996	7,273
2008	88,928

Source: Ministry of Civil Affairs, *China Civil Affairs' Statistical Yearbook*, 2009; China Earthquake Data Centre (1976 data)

Figure 1.16
Years in which the direct economic loss caused by disasters exceeded RMB 150 billion, 1983-2008

Years	Direct economic loss (billion RMB)
1994	188
1995	186
1996	288
1997	198
1998	301
1999	196
2000	205
2001	194
2002	172
2003	188
2004	160
2005	204
2006	253
2007	236
2008	1,175

Source: Ministry of Civil Affairs, *China Civil Affairs' Statistical Yearbook*, 2009

Figures 1.15 and 1.16

China is a country with recurrent and major natural disasters, including floods, snowstorms, droughts and earthquakes. Globally, China ranks among the top ten countries suffering the greatest toll from disasters, both in number of fatalities and in the cost of economic damage³⁶.

* Data reflect fatalities from the 1976 Tangshan earthquake only.



2

ECONOMIC AND SOCIAL DEVELOPMENT

OVERVIEW

China has a long tradition of providing women and children with access to basic public services and achieving human development indicators that are higher than expected for a country at its level of economic development. During the past 30 years, however, the improvements in public services and human/social development outcomes have been slower compared to the preceding 30 years and compared to China's spectacular economic development. Furthermore, public service delivery performance and improvements in human/social development have shown increasing disparity among different population groups. China has set for itself an overarching development objective to create a Harmonious Society, which emphasizes sustainability, equity and citizens' satisfaction. The Government of China has recognized that achieving this objective would be impossible without making public services work for the poor and for vulnerable children and women.

Recent years have seen many significant improvements. The Government has adopted a series of policy measures to enhance equity and quality in the delivery of essential social services. With the objective of achieving free nine-year basic education, the Government has abolished tuition and miscellaneous fees across China's rural and urban areas, and has been providing free textbooks and boarding subsidies for the poor in rural areas. Social protection has improved as the urban and rural *dibao*³⁷ cash transfer schemes have received greater funding and increased their population coverage and benefit levels. The new Rural Cooperative Medical Scheme (RCMS), subsidized by the Government budget, has reached nearly all rural residents, facilitating their access to medical care. In urban areas, residents previously excluded from medical insurance, including children, the unemployed and senior citizens, have benefited from a newly launched basic medical insurance scheme for urban residents. Immunization against 15 diseases and treatment for selected communicable diseases, including AIDS, tuberculosis and schistosomiasis, are now provided free of charge. To alleviate the impact of the global financial crisis and economic slowdown, the Government announced a RMB 4 trillion (US\$586 billion) fiscal stimulus package in late 2008, which is also contributing to provision of health care, education, social assistance, housing for the poor, and improvement of overall living conditions in rural areas.

Economic Development

Over the past 30 years, as China adopted a policy of reform and opening up, it experienced unprecedented rates of economic growth. In transitioning from a planned economy to a market-oriented economy, China adopted a series of market-oriented reforms, including the Household Responsibility System in Agriculture, the creation of a conducive environment for the rise of Township and Village Enterprises in rural areas, the restructuring of the state industrial sector, and opening up to global trade and investment. According to 2008 data, China is the third largest economy in the world after the United States and Japan when measured on currency exchange rate terms, and the second largest economy after the United States when measured on purchasing power parity terms³⁸. The GDP per capita has grown at an average annual rate of more than 8 per cent over the last three decades, and stood at US\$3,260 in 2008³⁹. However, based on its GNI per capita, China has yet to break the ceiling of the lower-middle-income country group by world standards⁴⁰.

Income Disparities

Economic growth has been uneven across China. Consequently, the income disparities between rural and urban residents and between residents living in the eastern, northeastern, central and western regions of China have been rising. For example, the per capita income ratio between urban and rural residents rose from 1.86 in 1985 to 3.31 in 2008. Meanwhile, real income growth rates over the period varied considerably for households at different levels of income distribution. For example, the income growth rate between 1990 and 2004 shows that the richest percentile's income grew by 8 per cent on average, while the poorest percentile grew by only 3 per cent⁴¹.

From a global perspective, China today is no longer a country where income inequality is low, as it was at the start of the reforms. The Gini index of income inequality has risen from 31 per cent in 1981 to 45 per cent in 2003. But neither can China be considered a country where income inequality is high. The measured level of inequality in China is, in fact, comparable to that in many middle-income economies globally, including Thailand and Malaysia, and is still lower than in many Latin American countries⁴².

Poverty Reduction Performance

Along with the progress in other human development indicators, China's progress in poverty reduction over the past quarter century is enviable and impressive⁴³. In terms of a wide range of indicators, such as income and consumption poverty, the progress of poverty reduction has been remarkable, by both China's official poverty standard, and the internationally-used World Bank poverty standard. The strong poverty alleviation performance reflects the spectacular economic growth performance and the success of the series of market-oriented policies adopted by the Government over the past three decades, as well as the more recent policies to support rural incomes, human development and social protection programmes in both urban and rural areas.

Overall, poverty reduction performance has been remarkable, yet some major challenges remain:

- Extreme poverty, in the sense of not being able to meet the most elementary food and clothing needs, has been generally eliminated in China, but the task of poverty reduction continues and in some respects has become more demanding. Measured by international standards, the absolute number of poor people in China remains significant and poor households are scattered in hundreds of thousands of often remote villages and communities.
- Vulnerability to poverty remains significant, especially in rural China; the number of people vulnerable to the risk of falling into poverty is estimated to be about twice as high as the number of poor.
- The rural migrant population poses continuing challenges in the targeting of social policies and programmes aimed at reducing poverty and improving children's wellbeing.

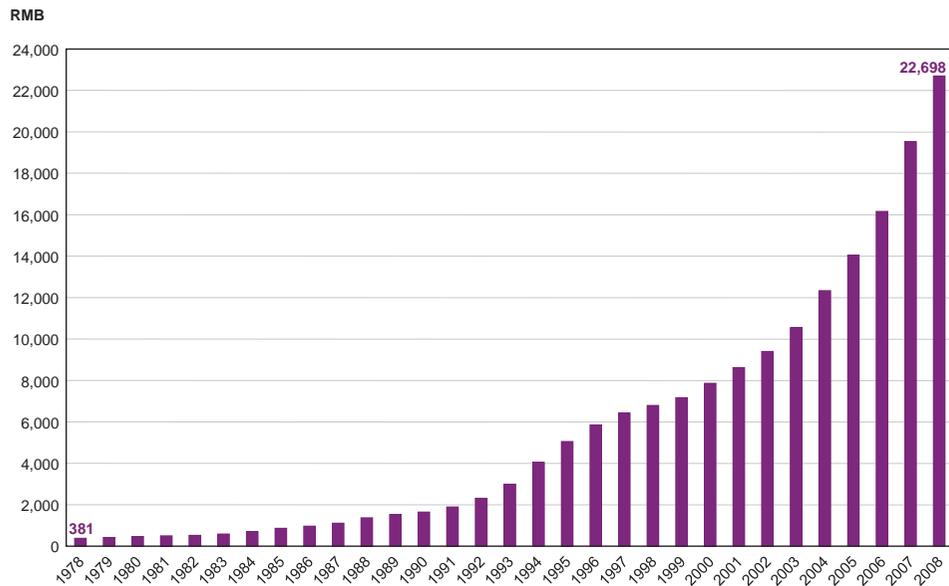
Social Assistance

A major component of China's social safety net is the "Minimum Livelihood Guarantee Scheme", adopted nationwide in urban areas in 1999 and in rural areas in 2007, and commonly known as the *dibao* programme. By international standards, both the urban and rural *dibao* schemes show a good targeting performance. Surveys indicate that the beneficiaries of the *dibao* cash benefits are highly concentrated among the poorest urban groups.

Remaining challenges include the following:

- The coverage and benefit levels of social assistance to the poor will need to be further increased, with financial support from central and provincial governments in both rural and urban areas.
- The benefit level needs to reflect the basic needs of children.
- Building on the successful implementation of the *dibao* cash transfer scheme, China may consider developing a more comprehensive social welfare system for children with a view to: a) alleviating the impact of poverty, deprivation and vulnerability, and reducing the risk factors that perpetuate the inter-generational cycle of poverty and inequity; b) promoting and protecting children's rights and healthy development; and c) preventing and responding to abuse, neglect, exploitation and violence.

Figure 2.1
GDP per capita, 1978–2008

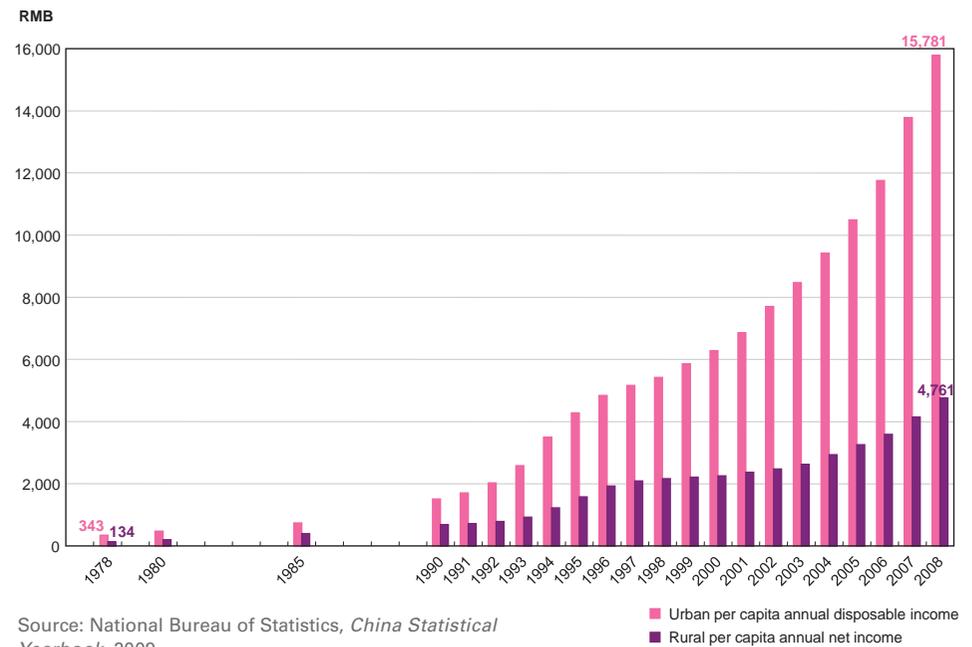


Source: National Bureau of Statistics, *China Statistical Yearbook*, 2009

Figure 2.1

China, one of the poorest countries in the world three decades ago, with a GDP per capita⁴⁴ of only US\$175 in 1978, is now a lower-middle-income country with per capita GDP exceeding US\$3,000.

Figure 2.2
Per capita income, urban and rural, 1978–2008

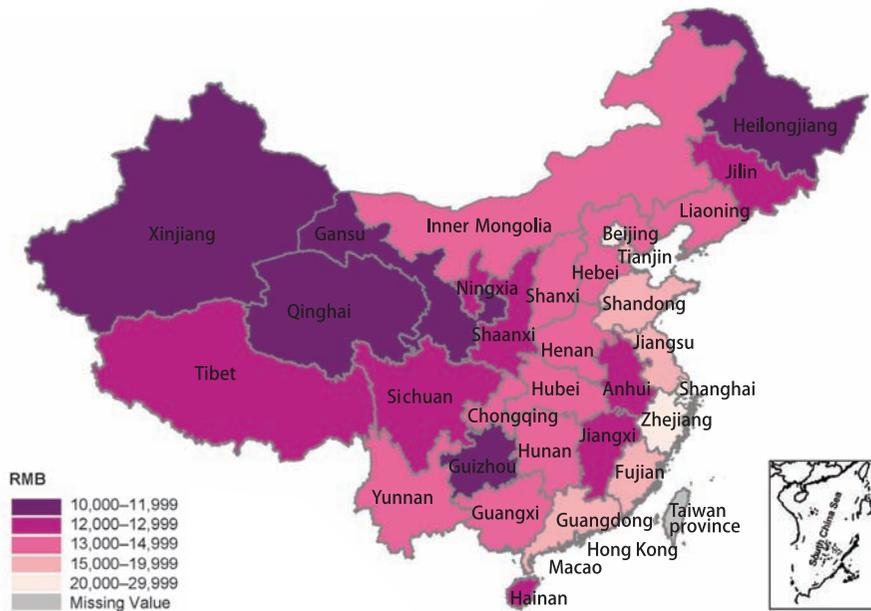


Source: National Bureau of Statistics, *China Statistical Yearbook*, 2009

Figure 2.2

Per capita income has grown in both urban⁴⁵ and rural areas⁴⁶, but urban-rural income inequities have intensified, exceeding the ratio of 3.3 to 1 in 2008.

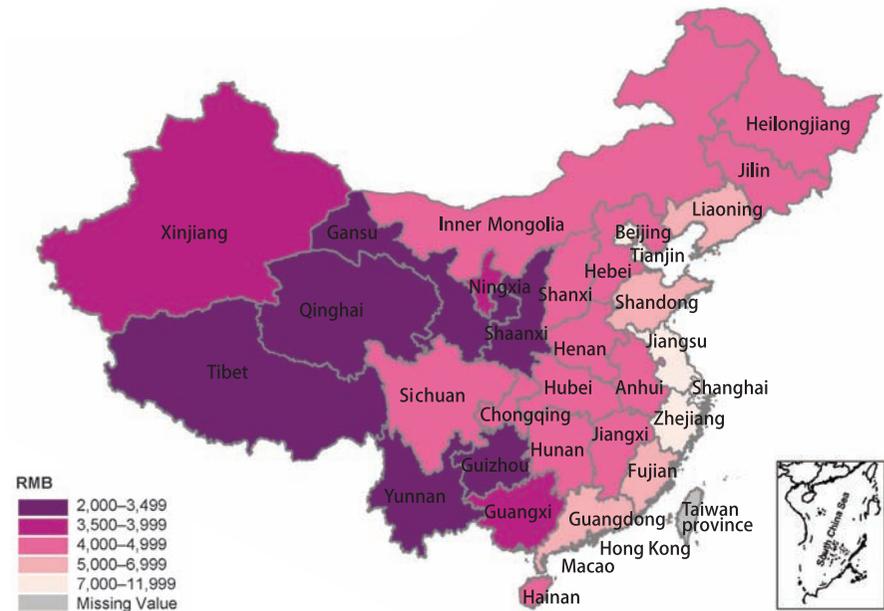
Figure 2.3
Urban per capita disposable income, 2008



Source: National Bureau of Statistics, *China Statistical Yearbook*, 2009

Figure 2.3
Per capita disposable income in urban areas differs across provinces and is significantly lower in western regions.

Figure 2.4
Rural per capita net income, 2008



Source: National Bureau of Statistics, *China Statistical Yearbook*, 2009

Figure 2.4
Similarly, per capita net income in rural areas shows large variability across provinces.

Figure 2.5
General, health and education government expenditure as a percentage of GDP, 1980–2008

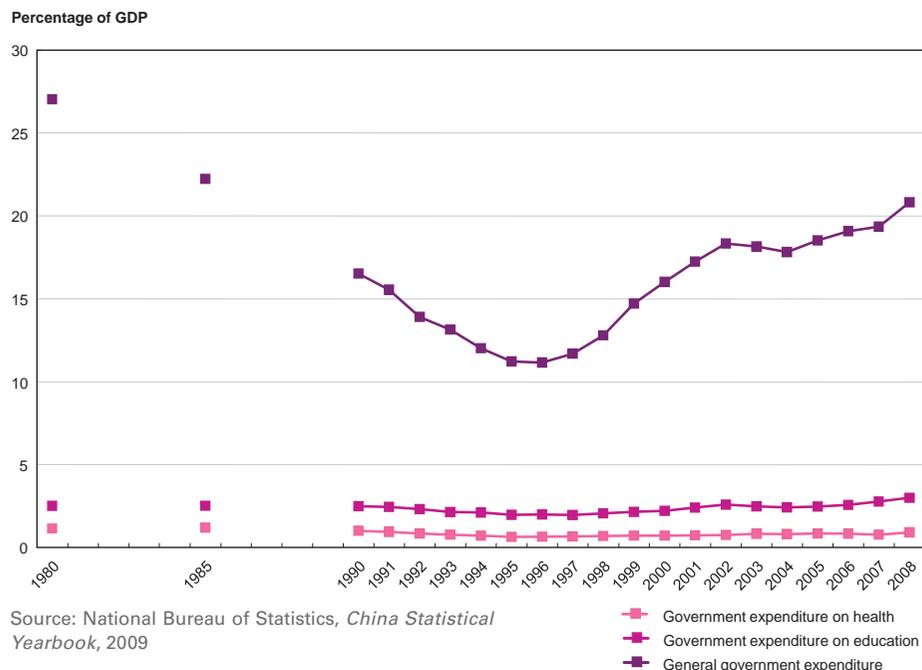


Figure 2.5
Over the past three decades, the Government's overall fiscal capacity has grown, but government spending on social sectors, including health and education, has remained largely stable as a share of the GDP.

Figure 2.6
Government expenditure on social security and employment, health and education as a percentage of general government expenditure, 2002–2008

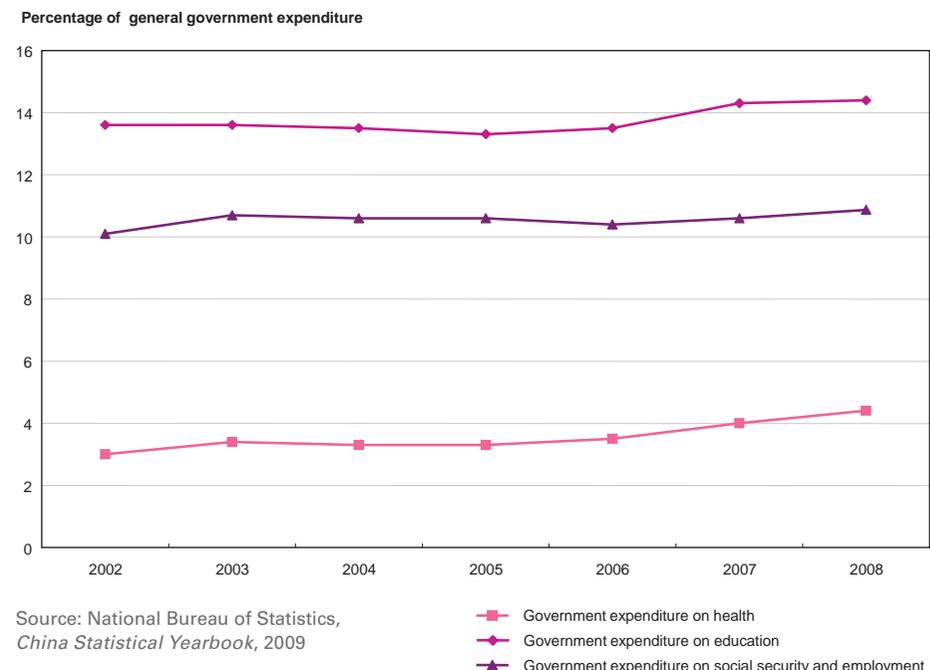


Figure 2.6
Government spending in social sectors has remained stable as a share of total government spending.

Figure 2.7
Rural poverty, 1978–2008

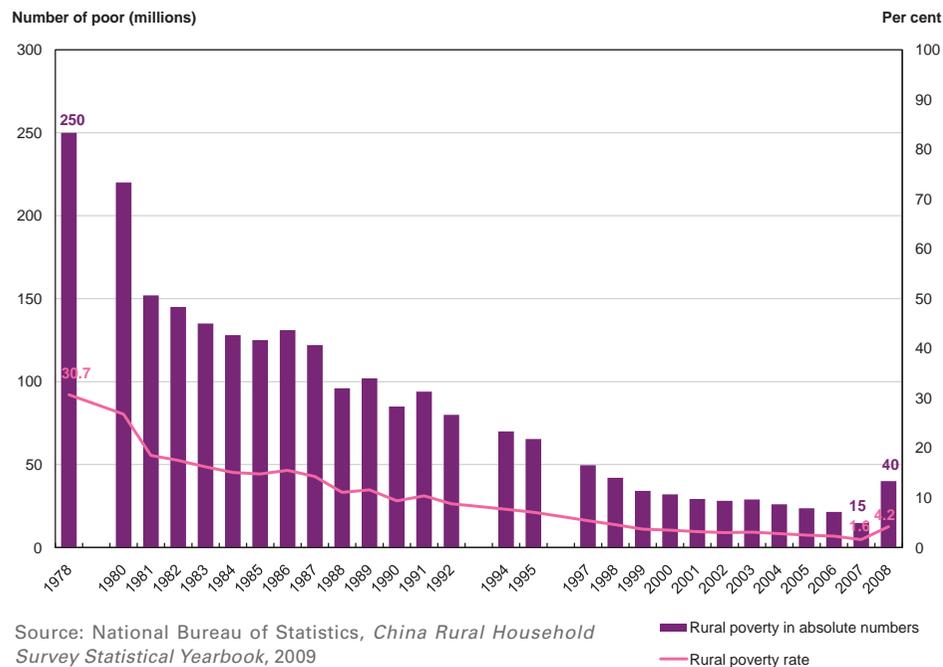


Figure 2.7

Over the past three decades, the progress of rural poverty reduction has been tremendous measured by China’s official poverty standard. The number of poor people (generally living in China’s rural areas) and the share of the poor in the population declined to very low levels by 2007. The rising food prices and the global financial crisis and economic slowdown, however, had pushed some into poverty. More importantly, however, the increase in poverty recorded in 2008 relates to the significant elevation of the official poverty line.

Figure 2.8
Rural poverty line, 1978–2008

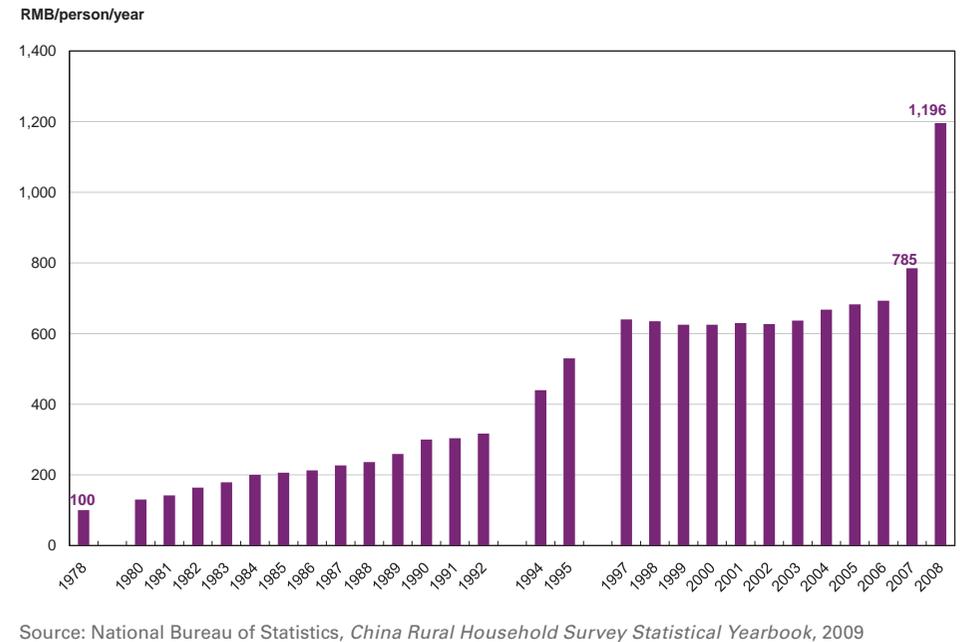
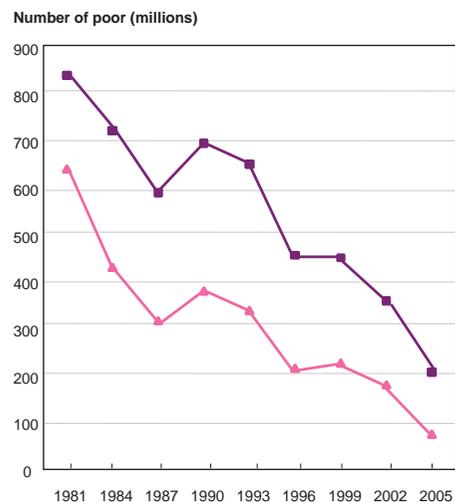


Figure 2.8

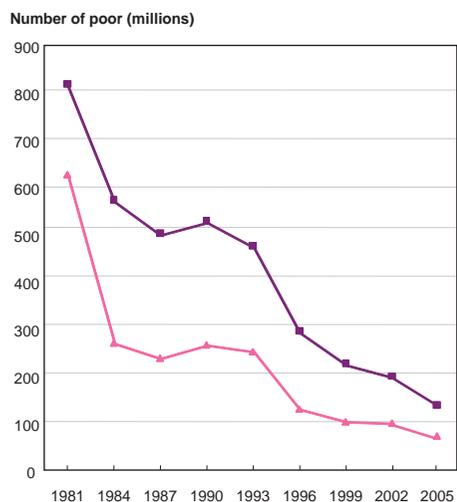
The official poverty line⁴⁷ rose slowly until 2008. Year 2008 saw dramatic increase to RMB 1,196 income per person per year, reflecting the rising cost of living and bringing China’s official poverty line closer to the international poverty standard of US\$1.25 consumption per person per day (using 2005 purchasing power parity figures).

Figure 2.9
Consumption poverty in absolute numbers, 1981–2005



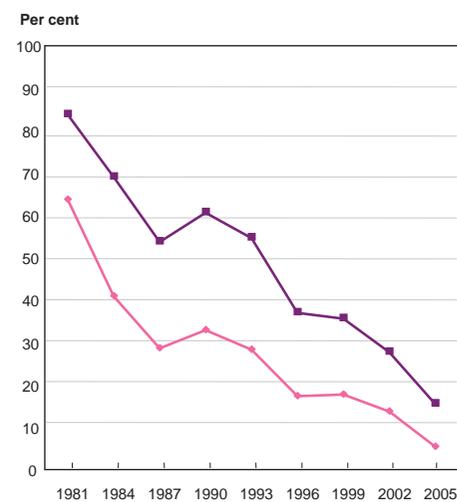
Source: Shaohua Chen and Martin Ravallion, *China is Poorer than we Thought, But No Less Successful in the Fight against Poverty*, Policy Research Working Paper No 4621, World Bank, May 2008

Figure 2.10
Income poverty in absolute numbers, 1981–2005



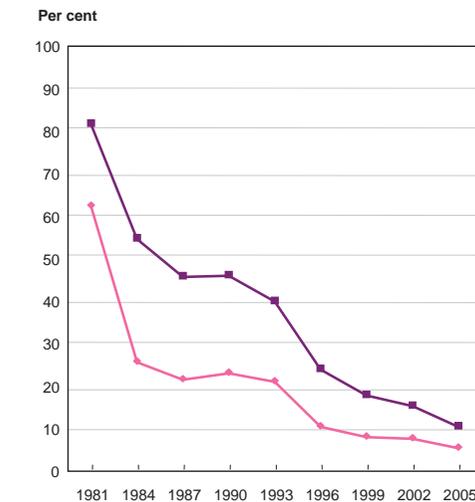
— Poverty as measured by 1993 PPP US\$1.08
— Poverty as measured by 2005 PPP US\$1.25 (with adjustment)

Figure 2.11
Consumption poverty rate, 1981–2005



Source: Shaohua Chen and Martin Ravallion, *China is Poorer than we Thought, But No Less Successful in the Fight against Poverty*, Policy Research Working Paper No 4621, World Bank, May 2008

Figure 2.12
Income poverty rate, 1981–2005



— Poverty as measured by 1993 PPP US\$1.08
— Poverty as measured by 2005 PPP US\$1.25 (with adjustment)

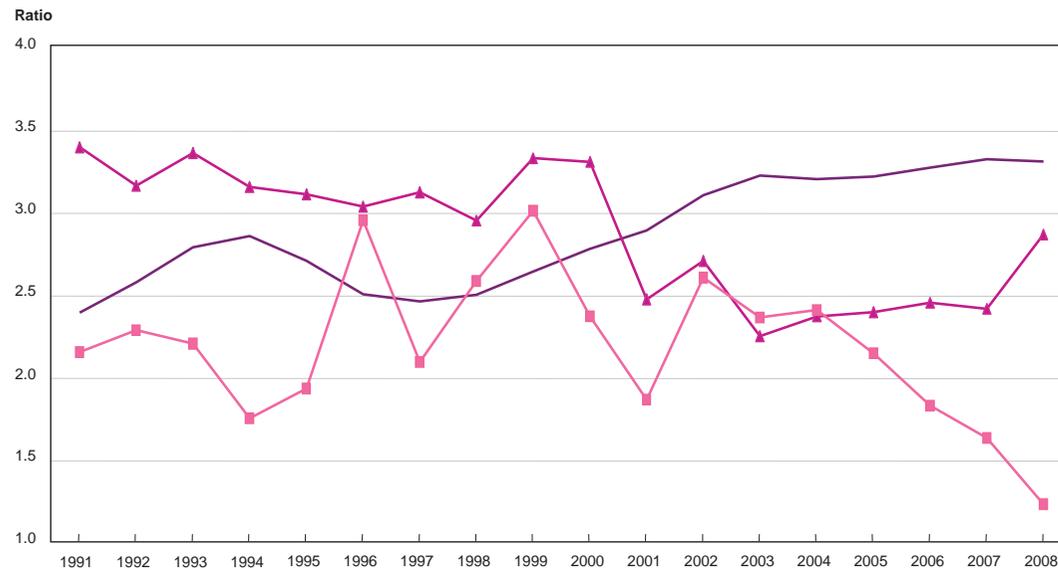
Figures 2.9 and 2.10

China's rapid economic growth, complemented by the Government's attention to poverty, has lifted hundreds of millions of people out of poverty, whether measured by consumption poverty or income poverty⁴⁸.

Figures 2.11 and 2.12

There has been a remarkable reduction in the share of the population that is poor, whether measured by consumption poverty or income poverty.

Figure 2.13
 Urban/rural income and rural/urban health outcome disparities, 1991–2008



Sources: National Bureau of Statistics, *China Statistical Yearbook, 2009 (income)*; Ministry of Health, *China Health Statistical Yearbook, 2009*

— Urban/rural income ratio
 -▲- Rural/urban under-five mortality rate
 -■- Rural/urban maternal mortality ratio

Figure 2.13
 Even as rural-urban income disparities continue to grow, rural-urban disparities in selected health indicators, namely maternal mortality ratio, have declined since the 1990s.

Figure 2.14
Dibao recipients in absolute numbers, urban and rural, 2001–2008

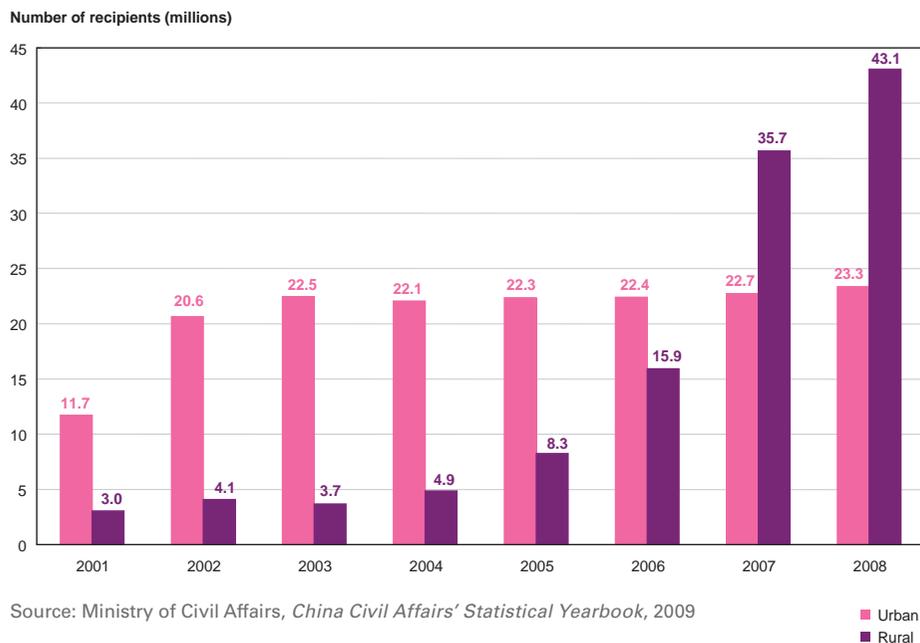
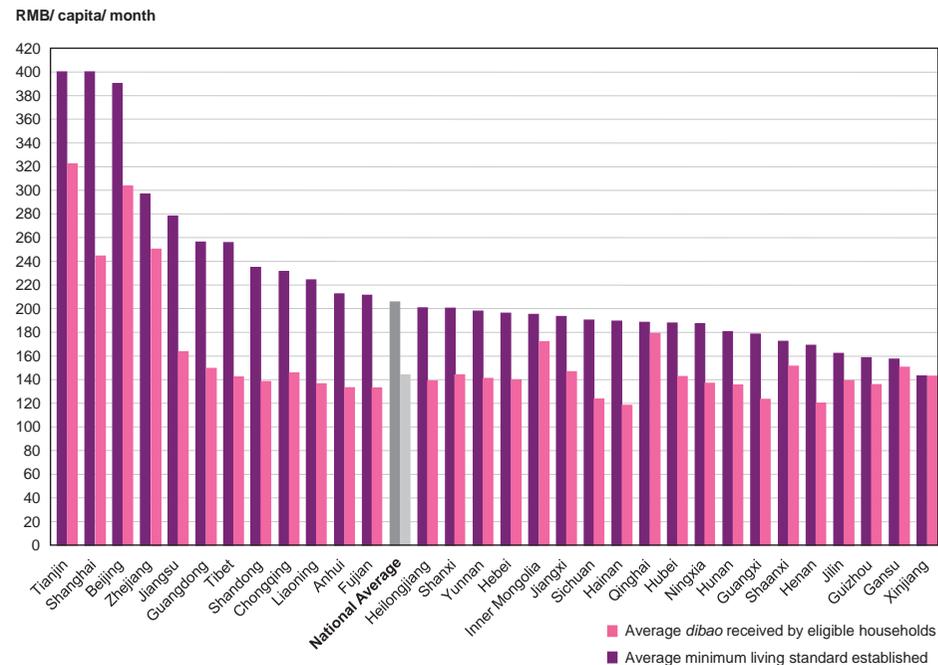


Figure 2.14
 In recent years, social assistance has become one of the Government's priorities, as it seeks to address the basic needs of poor households in both urban and rural areas through, for example, cash transfers in the form of the *dibao* programme.

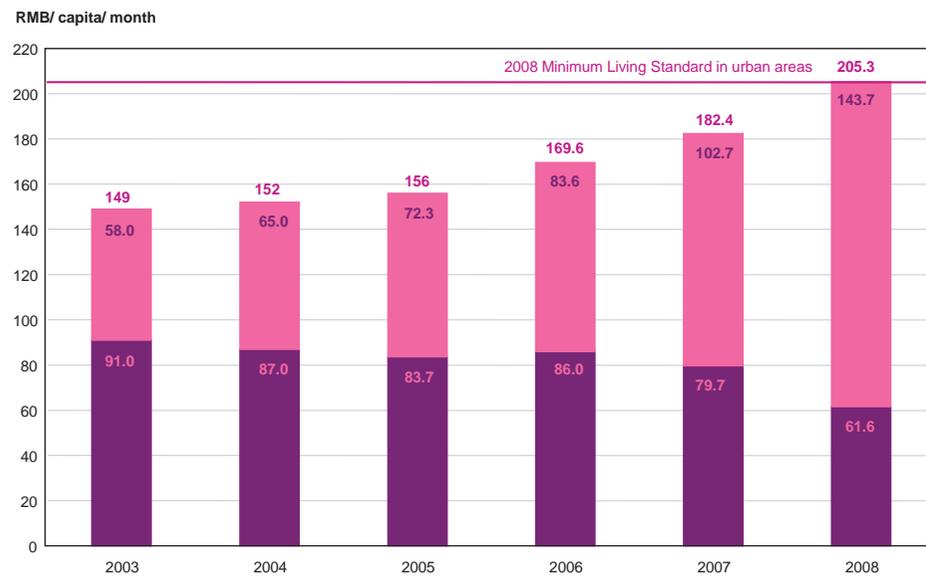
Figure 2.15
 Average *dibao* received by eligible households and minimum living standard in urban areas, by province, 2008



Source: Ministry of Civil Affairs, *China Civil Affairs' Statistical Yearbook*, 2009

Figure 2.15
 The *dibao* received by eligible households serves to “top up” household income so that it reaches the locally established minimum living standard, which varies from RMB 143 to RMB 400 across provinces.

Figure 2.16
Average *dibao* received by eligible households and minimum living standard in urban areas, 2003–2008

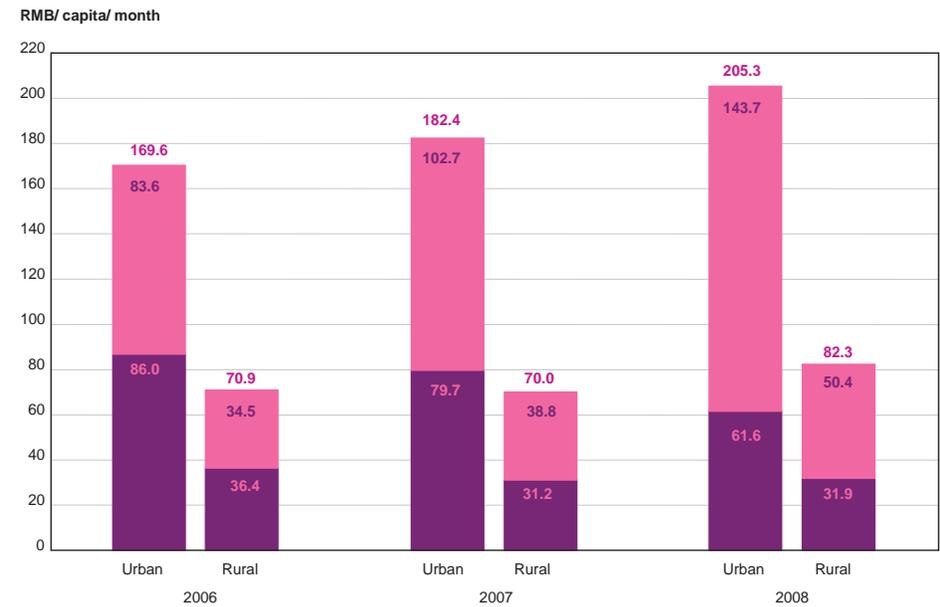


Source: Ministry of Civil Affairs, *China Civil Affairs' Statistical Yearbook*, 2009

■ Average income of urban *dibao* recipient
■ Average *dibao* received by eligible households

Figure 2.16
The minimum living standard in urban areas has increased significantly. The average urban *dibao* received by eligible households has increased accordingly.

Figure 2.17
Average *dibao* received and income, urban and rural, 2006–2008

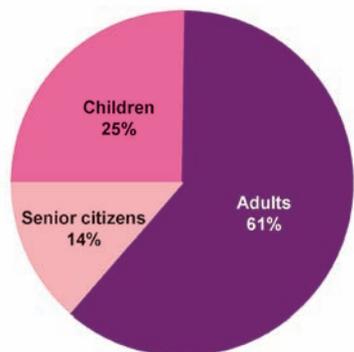


Source: Ministry of Civil Affairs, *China Civil Affairs' Statistical Yearbook*, 2009

■ Average Income
■ Average *dibao* received by eligible households

Figure 2.17
Social assistance, namely the *dibao* cash transfers in both urban and rural areas, has benefited from increasing government commitment and financing, which has not only allowed an increase in population coverage, but has also raised the level of average benefit received by poor households.

Figure 2.18
Age distribution of urban *dibao* recipients, 2008

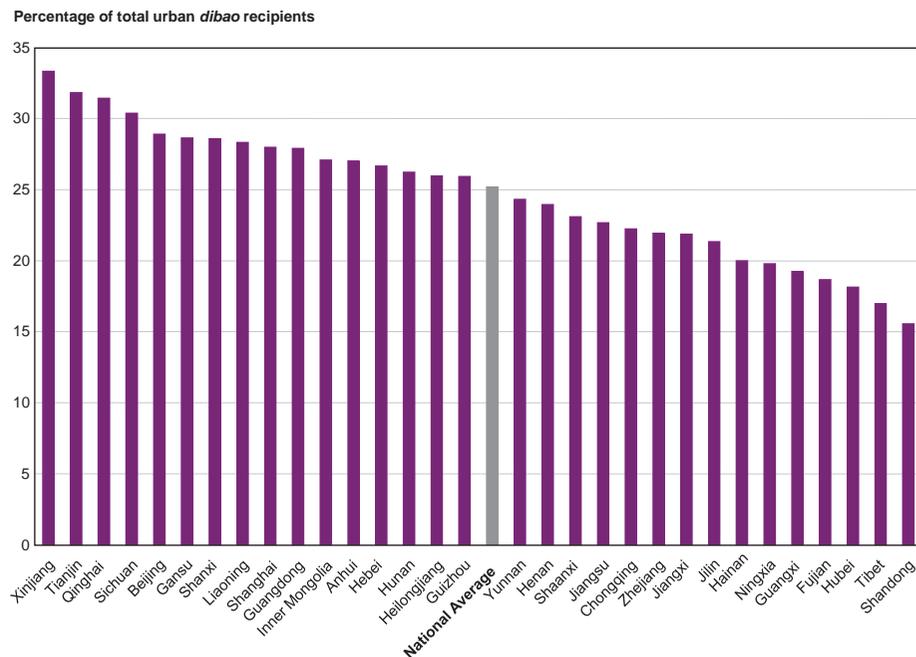


Group	Number of recipients
Children (0–17 years old)	5.9 million
Adults (18–59 years old)	14.3 million
Senior citizens (>=60 years old)	3.2 million

Source: Ministry of Civil Affairs, *China Civil Affairs' Statistical Yearbook*, 2009

Figure 2.18
Children account for a quarter of all urban *dibao* recipients.

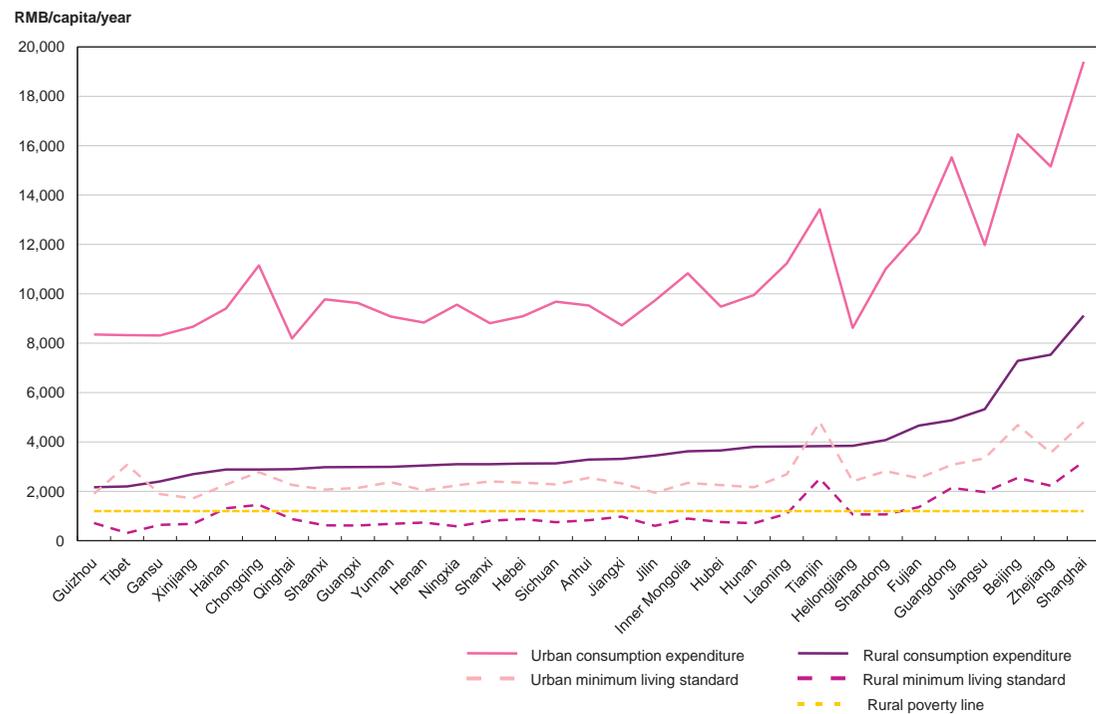
Figure 2.19
The share of children among total urban *dibao* recipients, by province, 2008



Source: Ministry of Civil Affairs, *China Civil Affairs' Statistical Yearbook*, 2009

Figure 2.19
Children in poor households have benefited from *dibao* cash transfers, which have facilitated improvements in their nutrition, education and health.

Figure 2.20
Urban and rural minimum living standards and consumption expenditures, by province, 2008



Sources: Ministry of Civil Affairs, *China Civil Affairs' Statistical Yearbook*, 2009 (urban minimum living standard); National Bureau of Statistics, *China Statistical Yearbook*, 2009 (consumption); Ministry of Civil Affairs (rural minimum living standard)

Figure 2.20
The urban and rural *dibao* cash transfer programmes have been rolled out nationally, although the minimum living standards differ widely from province to province, reflecting local development conditions and local government fiscal capacity.



3

MATERNAL AND CHILD HEALTH

OVERVIEW

China has made remarkable progress in the health sector over the last few decades, as shown by the reduction of infant and child mortality and the increase in life expectancy. China's *2008 Millennium Development Goals (MDG) Report*⁴⁹ suggests that it is on track to achieving all the health-related MDGs, as well as the more ambitious targets the nation has set for itself. China's enormous population means that this progress will greatly influence the global achievement of the MDG indicators, but also that the numbers affected by residual problems remain huge. In addition, while China may be doing well on many child indicators in aggregate national terms, this masks major inequalities and disparities, particularly between urban and rural areas and between eastern, central and western regions. In less developed areas, indicators lag far behind national averages. The size of China's disadvantaged populations, their poorer access to and lower uptake of health services, and the lower quality of these services mean that much work remains to be done to improve Maternal and Child Health (MCH) in China.

Relative to China's remarkable economic development during the last two decades, progress in the health sector has lagged behind. Out-of-pocket expenditure continues to grow rapidly, while the proportion of the population with access to healthcare has declined. These issues apply to both clinical and preventive care. In the 1970s, China's health system was held up as a model for providing universal basic healthcare at modest cost. Recently, however, it has been described as one of the least equitable health systems in the world⁵⁰. The

proportion of total health expenditure that is out-of-pocket in China is much higher than in developed countries and among the highest in low and middle-income countries⁵¹. The Government of China is aware of these problems and is making determined efforts to address them.

The Government recently initiated a series of reforms for the health sector. The reforms are directed at reducing disparities in basic public health services, improving grassroots healthcare services, supporting the establishment of a comprehensive basic medical security/insurance system, establishing a national essential medicine system, and piloting public hospital reform. Overall, these reforms aim to ensure the effective and well-regulated operation of the healthcare system, including for MCH services, with appropriate legal and policy frameworks, supervision and regulation.

According to local data, China has achieved the MDG-4 targets on infant and under-five mortality, and is on track to achieving the MDG-5 target on maternal mortality. While there has been significant progress in MCH, the absolute number of maternal and child deaths remains high and significant rural-urban gaps remain. Rural areas, where patients have a lower capacity to pay, have relatively poor access to quality MCH services. As the provision of MCH services became more market-oriented the burden of out-of-pocket payments increased, and until the recent provision of subsidies, uptake of some services remained low outside cities.

Service coverage rates may explain some urban-rural differences, with antenatal care and hospital delivery rates slightly lower in rural than in urban areas. More recently, an upward trend in proportion of maternal and child deaths occurring in hospitals rather than at home has been noted, probably due to increased hospital delivery rates brought about by improvements in transportation, income, subsidies and community knowledge on health services.

The leading causes of maternal death are postpartum haemorrhage, pregnancy-induced hypertension, indirect causes and sepsis. For under-fives, mortality is heavily concentrated in the first year of life, especially during the four weeks after delivery. The main causes of child mortality are neonatal asphyxia, prematurity, low birth weight, pneumonia, diarrhoea, accidents and injury.

Overall, coverage of MCH services is high, with 3,000 MCH institutes across China and 500,000 professionals engaged directly in MCH work, in 2006. However, there are still extensive opportunities for further reducing China's child and maternal mortality rates, by improving staff quality and financial support for poor families in rural areas. Several provinces and cities have developed local policies to increase systematic health care for migrant women. Central and local governments have also initiated services for migrant children or mechanisms to integrate them into the local immunization or child health care system.

A relatively complete policy and legal framework on MCH has been established, with the Law on Maternal and Infant Health Care (1994) and the two National Plans of Action (2001) usually mentioned as core components. Many additional regulations, recommendations and standards have been issued, including on prevention of mother-to-child transmission of HIV and others relating to financing, systems management and human resources for MCH services. However, the implementation of these relies heavily on the interest, financing and capacity of local authorities.

Public funding for MCH has grown rapidly in the last five years, increasing from RMB 1.6 billion in 2003 to RMB 2.8 billion in 2007, accounting for 4.2 per cent of total public health funding in 2007 compared to 3.5 per cent in 2003. In addition, both the Rural Cooperative Medical Scheme (RCMS) and Medical Financial Assistance Scheme (MFAS) provide further relief to rural areas. As RCMS membership has risen dramatically, more and more pregnant women in particular are benefiting. Pregnant women can also receive a further subsidy from the earmarked fund of the Maternal Mortality Reduction Project (MMRP) in supported counties – further reducing the risk of out-of-pocket expenses. Since 2009, all rural women in China are eligible to receive a government-funded subsidy for maternity care in a hospital.

Figure 3.1
Under-five mortality rate, 1991–2008

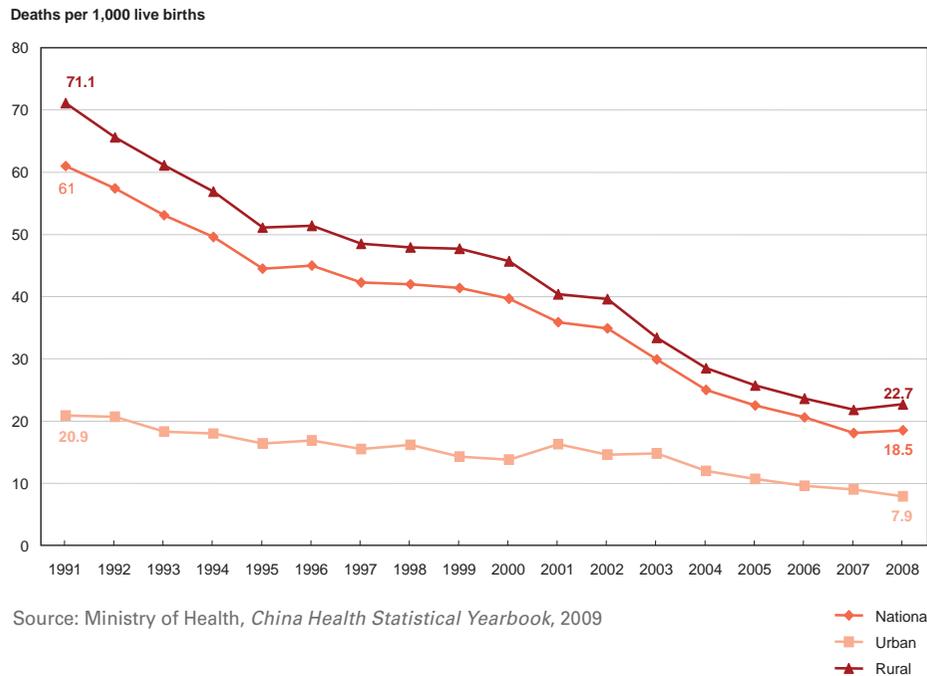


Figure 3.1
In recent years, there has been a significant decline in the national Under-Five Mortality Rate (U5MR)⁵², from 61 per thousand live births in 1991 to 18 per thousand live births in 2008. During this period, the under-five mortality rate dropped by 62 per cent in urban areas and 68 per cent in rural areas. In 1991, the under-five mortality rate was 2.4 times higher in rural than in urban areas. By 2008, this risk ratio had decreased slightly to 1.9 times higher in rural areas. However, this does not take into account the undocumented contribution of rural migrant children who die in urban areas.

Figure 3.2
Under-five mortality rate, 2008

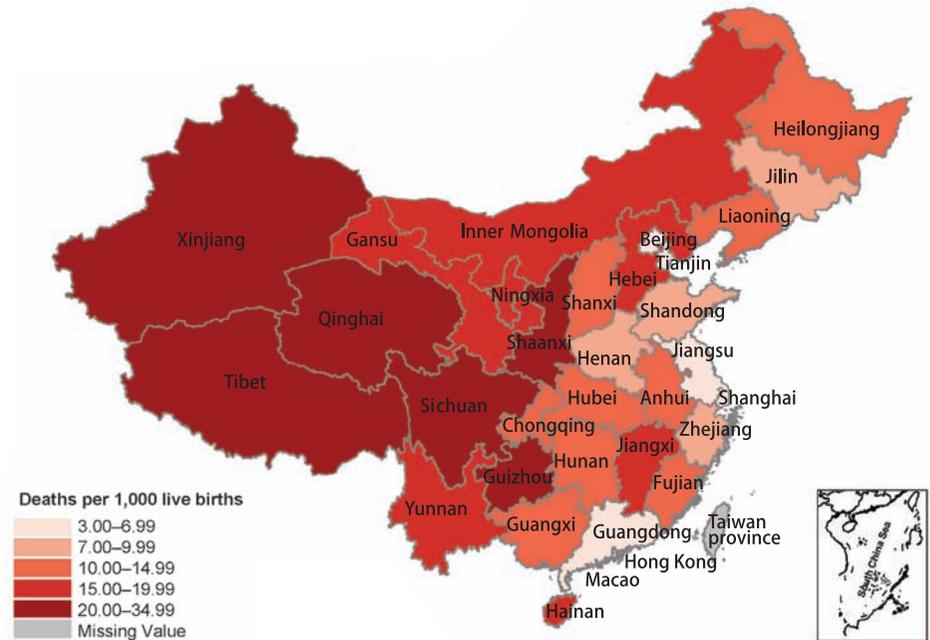
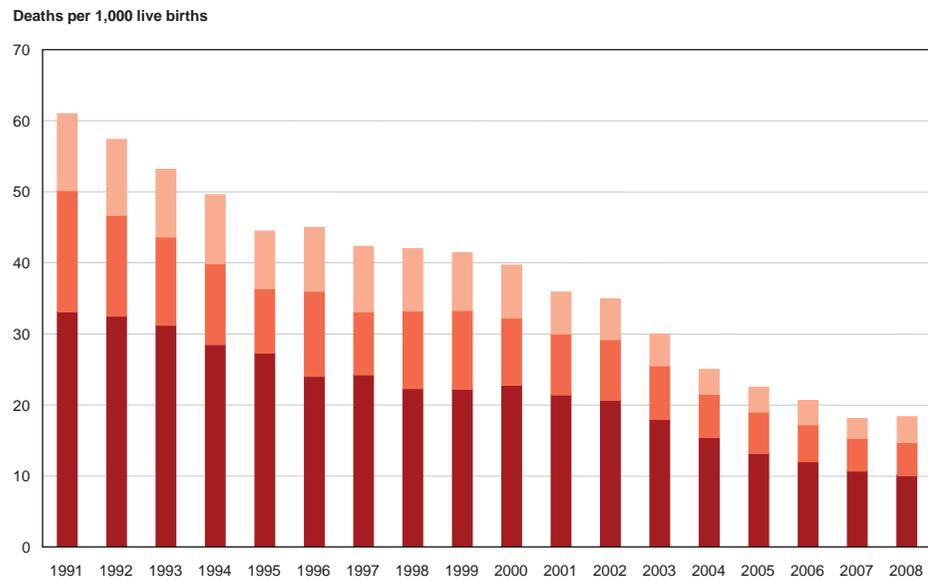


Figure 3.2
Great disparities in the under-five mortality rate exist between the different provinces. In general, the under-five mortality rate is highest in western provinces and lowest in eastern provinces. In Shanghai, it is around 4 per thousand live births, while in some western provinces, it is above 30 per thousand live births.

Figure 3.3
Age distribution of deaths among under-five children, 1991–2008

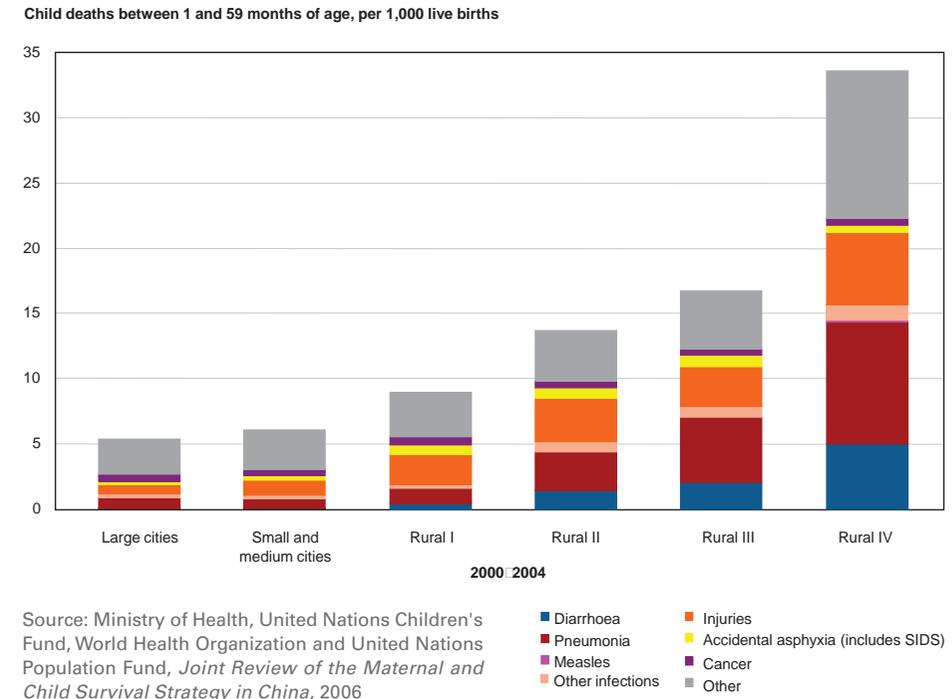


Source: Ministry of Health, *China Health Statistical Yearbook*, 2009

- Deaths between 12 and 59 months
- Deaths between 28 days and 12 months
- Deaths between 0 and 28 days

Figure 3.3
Between 1991 and 2008, the under-five mortality rate decreased steadily, according to the national MCH surveillance system. Neonatal mortality (deaths between 0 and 28 days of age) accounted for around 60 per cent of all under-five deaths in 2008.

Figure 3.4
Cause-specific child mortality between 1 and 59 months, by locality, 2000–2004



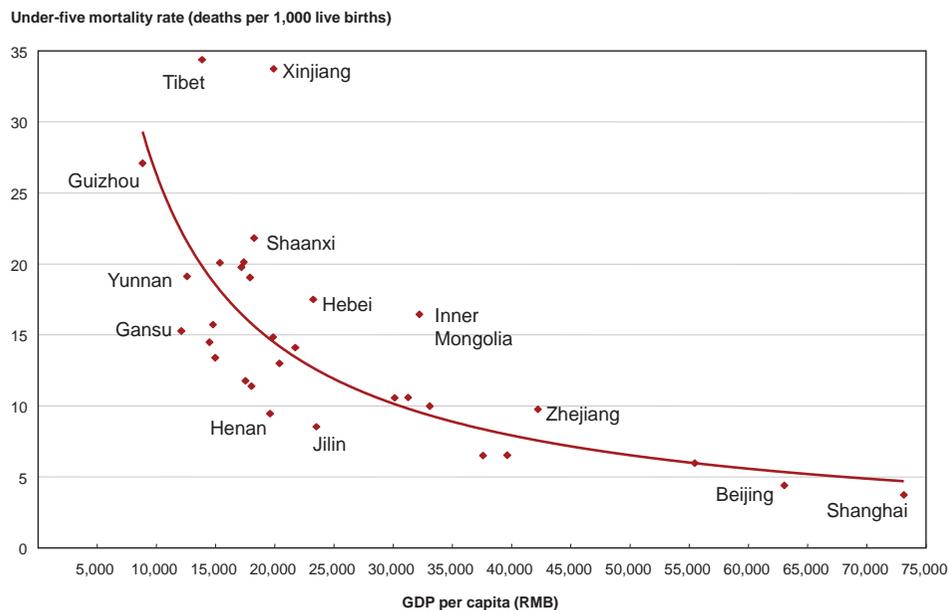
Source: Ministry of Health, United Nations Children's Fund, World Health Organization and United Nations Population Fund, *Joint Review of the Maternal and Child Survival Strategy in China*, 2006

- Diarrhoea
- Pneumonia
- Measles
- Other infections
- Injuries
- Accidental asphyxia (includes SIDS)
- Cancer
- Other

Figure 3.4
During the period 2000–2004, pneumonia was the leading cause of post-neonatal mortality in rural type III and IV counties. In all other areas, injury was the leading cause of post-neonatal under-five mortality in China. Diarrhoea, which has historically been a leading cause of death, has become less important across China and accounts for a very low proportion of post-neonatal deaths in wealthier locations (i.e. urban districts and rural type I counties). However, it is still the third leading cause of death among children aged 1–59 months in poorer areas (i.e., rural type II, III and IV), where sanitation is poorer.

Note: Figure 3.4 uses a 1993 Ministry of Health classification whereby all counties and districts in China are categorized as being within large cities or small and medium cities, or are rural areas of four types (I, II, III and IV). The classification used a development index that included the most recent values for indicators such as industrialization, education, illiteracy, infant mortality rate, GDP per capita and population demographics.

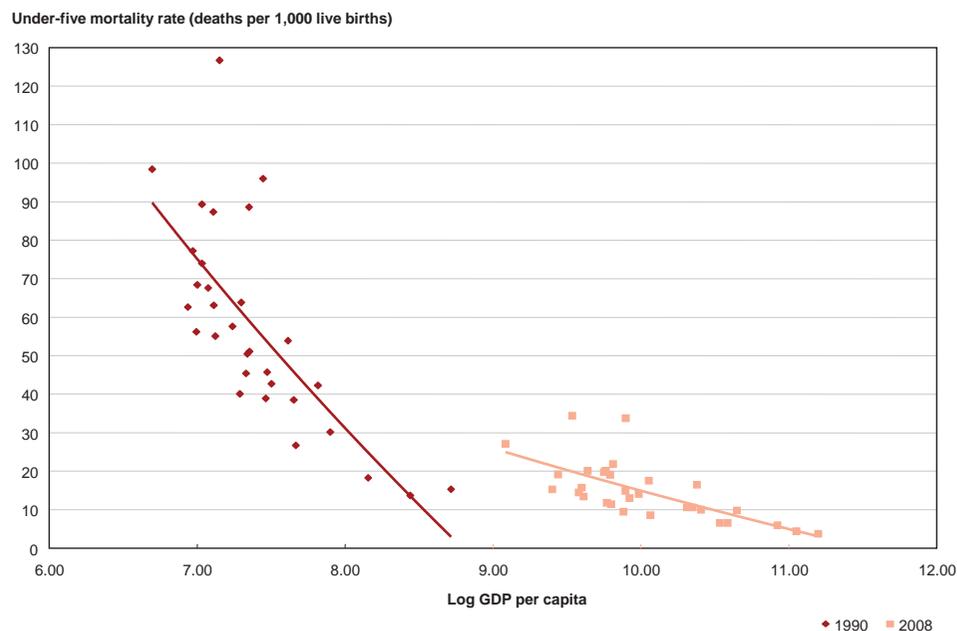
Figure 3.5
GDP per capita and under-five mortality rate, by province, 2008



Sources: National Bureau of Statistics, *China Statistical Yearbook*, 2009 (GDP); National Bureau of Statistics, *NPA Monitoring Statistics*, 2009 (U5MR)

Figure 3.5
Under-five mortality in China has an inverse relationship with economic development. In general, although there are some exceptions in the middle ranges, provinces with a low GDP per capita have a relatively high child mortality rate, and vice-versa. Shanghai and Beijing have the highest GDP per capita and the lowest under-five mortality rates.

Figure 3.6
Log GDP per capita and under-five mortality rate, 1990 and 2008



Sources: National Bureau of Statistics, *China Statistical Yearbook*, 2009 (GDP); National Bureau of Statistics, *NPA Monitoring Statistics*, 2009 (U5MR)

Figure 3.6
China made remarkable progress according to both economic and health indicators between 1990 and 2008. The per capita GDP of the poorest provinces in 2008 is close to that of the richest provinces in 1990. Similarly, under-five mortality rates of the worst-off provinces in 2008 are similar to those of the wealthiest provinces in 1990.

Figure 3.7
Infant mortality rate, 1991–2008

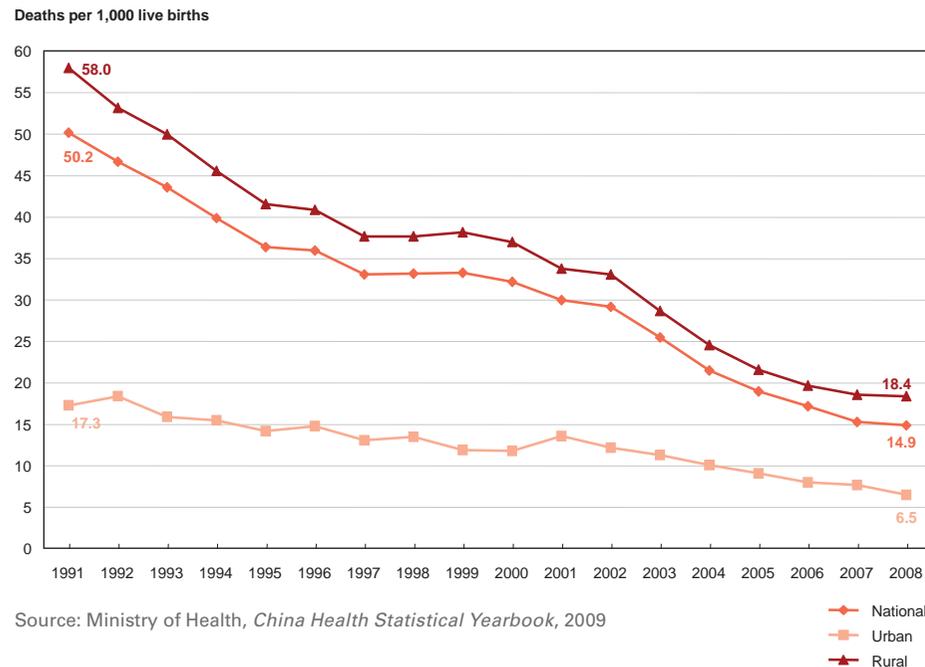


Figure 3.7
 Since 1991, there has been a significant decline in the Infant Mortality Rate (IMR)⁵³. Nationally, the infant mortality rate dropped from 50 per thousand live births in 1991 to 15 per thousand live births in 2008, according to the national MCH surveillance network. Between 1991 and 2008, the infant mortality rate dropped by 62 per cent in urban areas and 68 per cent in rural areas. Again, great disparities remain, as rural infant mortality rates in 2008 were 1.8 times higher than those in urban areas.

Figure 3.8
Infant mortality rate, 2008

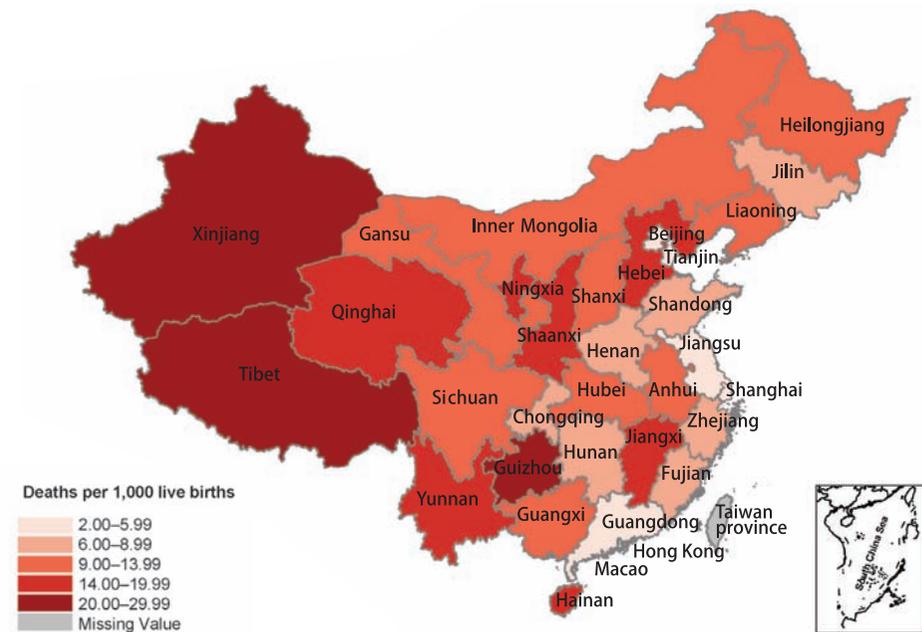


Figure 3.8
 Great disparities exist in the infant mortality rates of different provinces. The infant mortality rate is generally highest in western provinces and lowest in eastern provinces, while central provinces mainly fall in between. The infant mortality rate ranges from 3 per thousand live births in Shanghai to more than 20 per thousand live births in Guizhou, Xinjiang and Tibet.

Figure 3.9
Neonatal mortality rate, 1991–2008

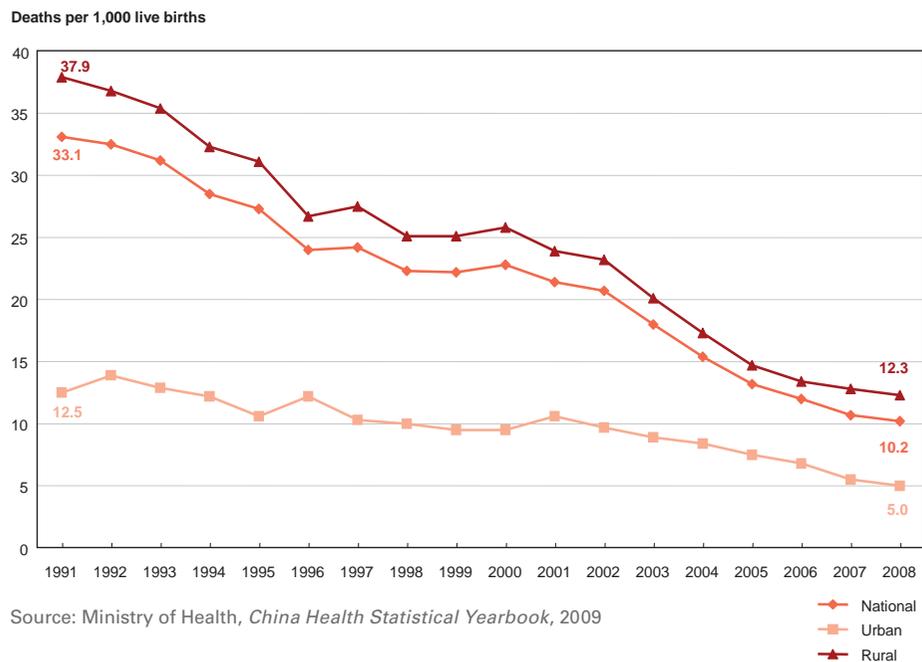


Figure 3.9 Since 1991, there has been a significant decline in the Neonatal Mortality Rate (NMR)⁵⁴. China's neonatal mortality rate dropped from 33 per thousand live births in 1991 to 10 per thousand live births in 2008. In 1991, the neonatal mortality rate was two times higher in rural areas than in urban areas, and remained 1.4 times higher in 2008.

Figure 3.10
Cause-specific neonatal mortality, by locality, 2000–2004

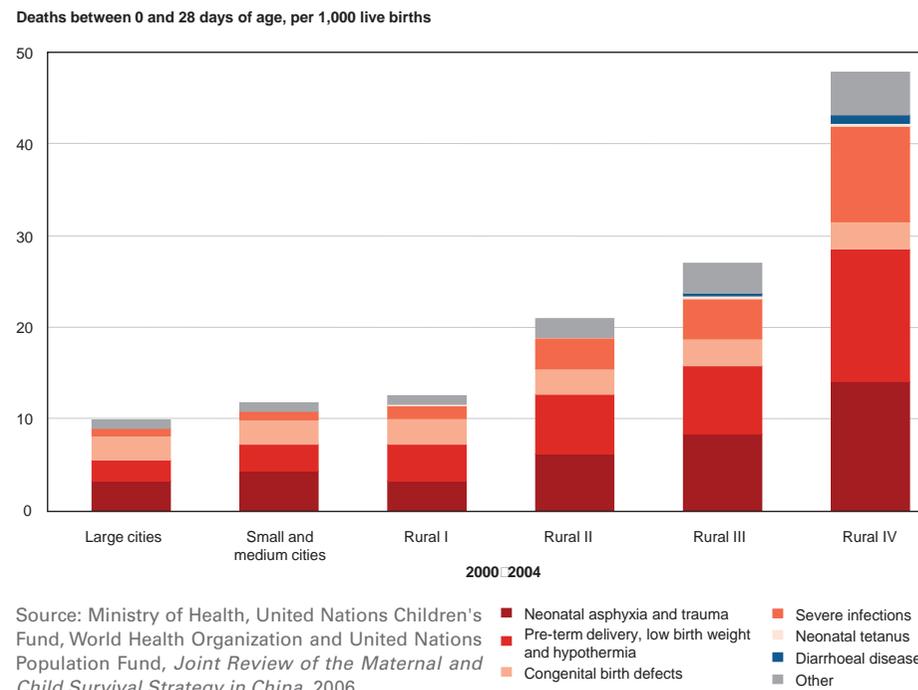


Figure 3.10 During the period of 2000–2004, the four leading causes of neonatal mortality were (a) neonatal asphyxia and trauma; (b) pre-term delivery, low birth weight and hypothermia; (c) severe infection; and (d) congenital birth defects. Collectively, these four causes accounted for 89 per cent of all neonatal deaths nationally and thus over 50 per cent of under-five deaths.

Figure 3.11
Maternal mortality ratio, 1991–2008

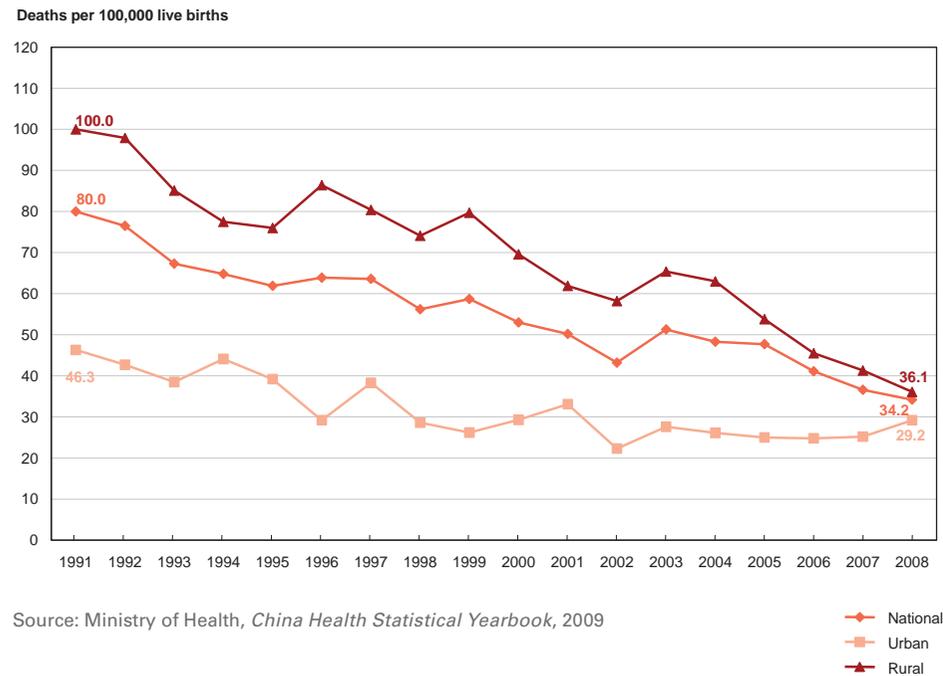


Figure 3.11
Since 1991, the Maternal Mortality Ratio (MMR)⁵⁵ has decreased significantly. The disparity between urban and rural areas has also decreased; the maternal mortality ratio was 1.2 times higher in rural than urban areas in 1991, but only 24 per cent higher in 2008. The influence of maternal deaths amongst urban migrant women can be observed in the roughly static urban maternal mortality ratio since 1998.

Figure 3.12
Maternal mortality ratio, 2008



Figure 3.12
Significant disparities again exist in the maternal mortality ratios of China's provinces, with the same pattern as observed for child mortality. The maternal mortality ratios range from less than 10 in some coastal provinces, to around 30 in central provinces, and above 50 in western provinces.

Figure 3.13
Cause-specific maternal mortality, 1989, 1995 and 2008

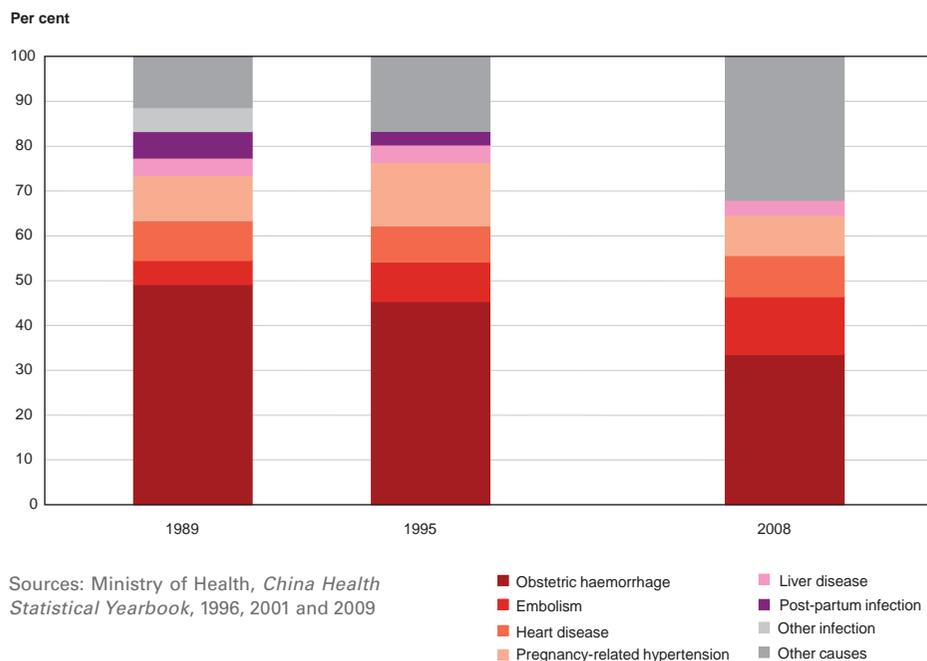


Figure 3.13
Obstetric haemorrhage is the leading cause of maternal mortality across all years, but the percentages of maternal deaths caused by obstetric haemorrhage decreased from 49 per cent in 1989 to 34 per cent in 2008. Post-partum infection is no longer a major cause of maternal death in China.

Figure 3.14
Cause-specific maternal mortality, by locality, 2000–2004

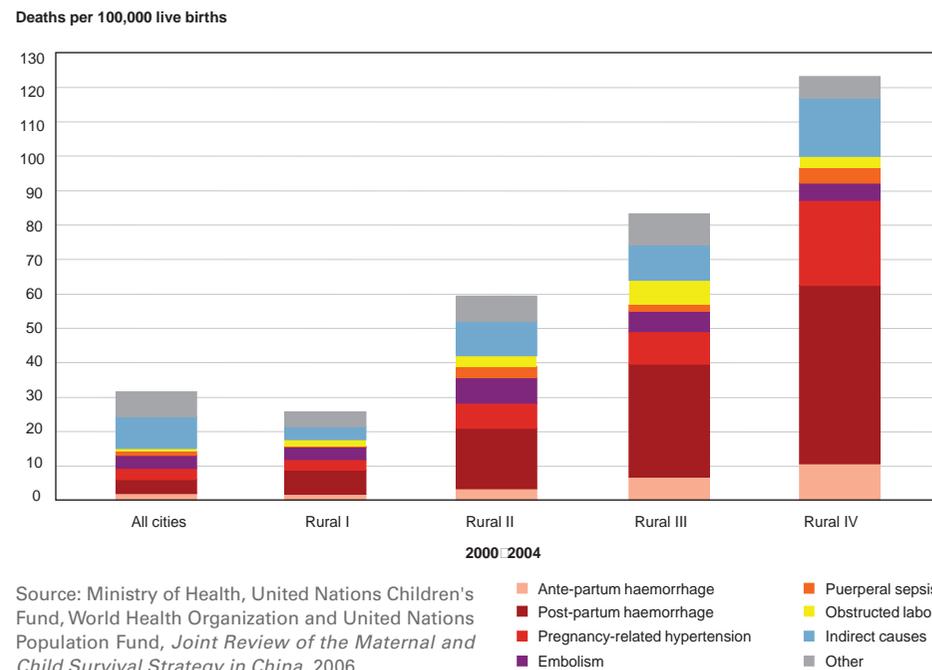


Figure 3.14
Post-partum haemorrhage is the leading cause of maternal death in China, followed by indirect causes, pregnancy-related hypertension, obstructed labour, ante-partum haemorrhage, embolism and puerperal sepsis according to national MCH surveillance data. The maternal mortality data show that over 75 per cent of all maternal deaths in China are caused by factors that can either be prevented or treated through the provision of essential obstetrical care.

Figure 3.15
Hospital delivery rate, urban and rural, 1990–2008

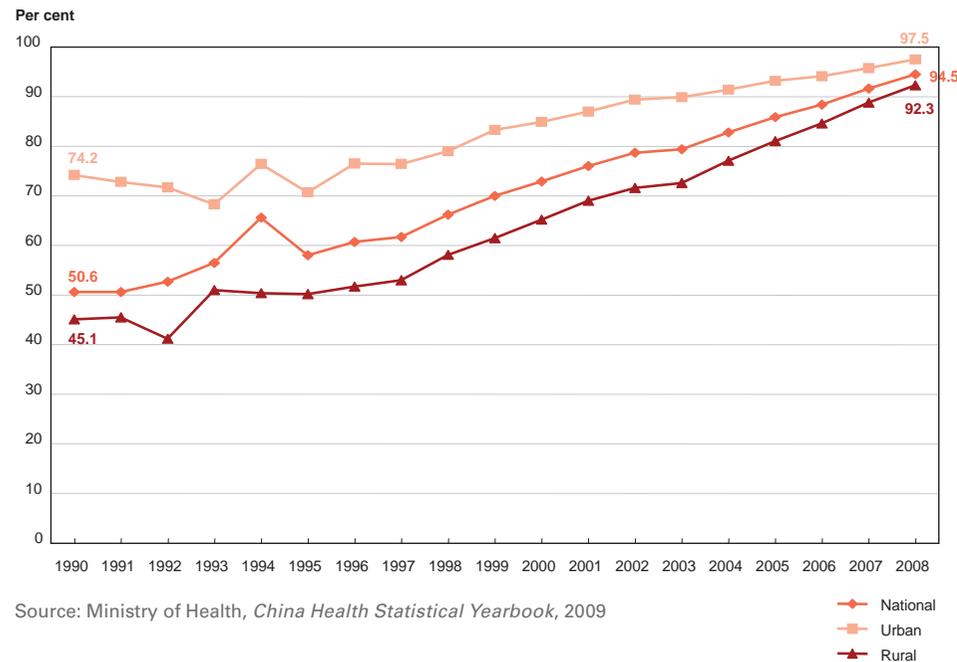


Figure 3.15
China's hospital delivery rate has increased steadily over the last two decades. While an urban-rural disparity continues to exist, the gap is much smaller now than in the 1990s. The remarkable increase in hospital delivery over the last two decades in rural and urban areas has played a significant role in making pregnancy safer and reducing maternal mortality.

Figure 3.16
Hospital delivery rate, 2008

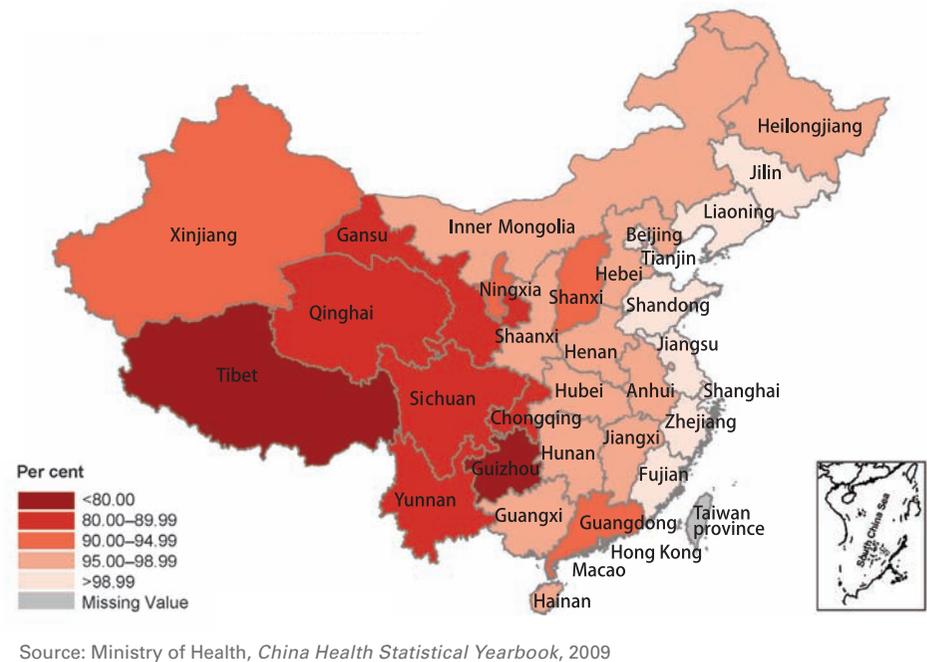
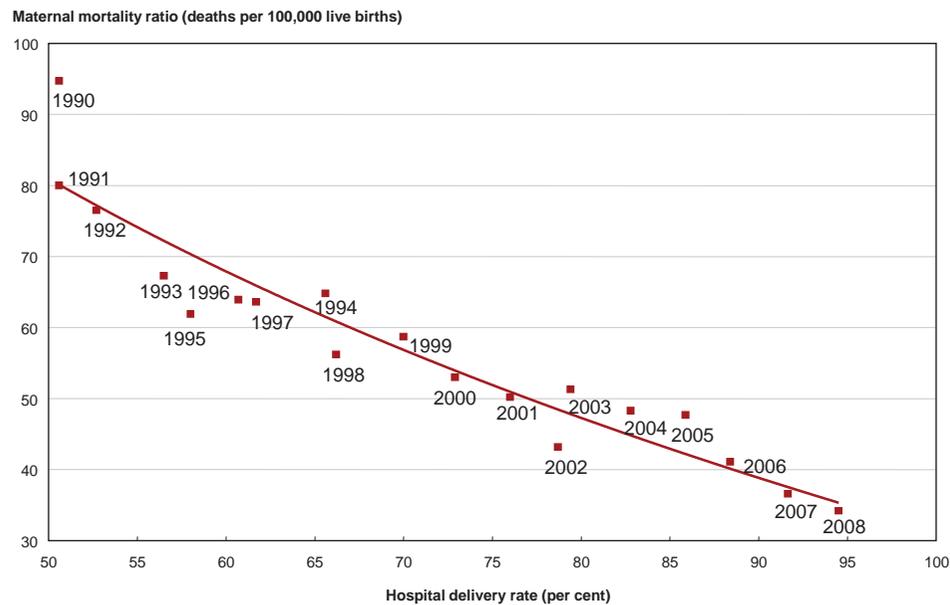


Figure 3.16
Overall, the hospital delivery rate is high across all provinces, but relatively low rates persist in some western provinces. In Guizhou and Tibet, the hospital delivery rate is still below 80 per cent.

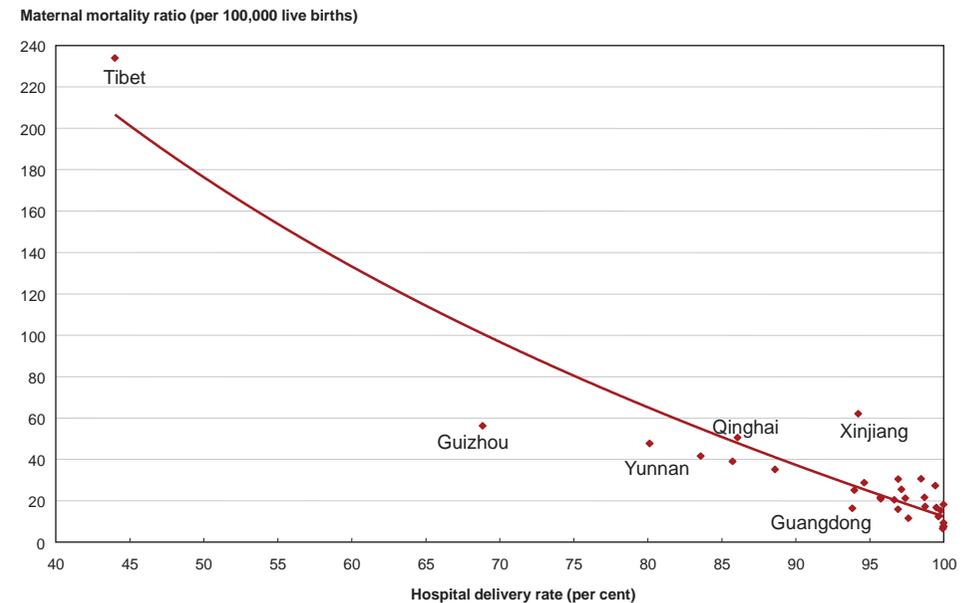
Figure 3.17
Hospital delivery rate and maternal mortality ratio, 1990–2008



Source: Ministry of Health, *China Health Statistical Yearbook*, 2009

Figure 3.17
There is a clear inverse relationship between China's maternal mortality ratio and hospital delivery rate. From 1990 to 2008, the hospital delivery rate increased from 51 per cent to 94 per cent. Over the same period, the maternal mortality ratio decreased from 95 per 100,000 live births to 34 per 100,000 live births.

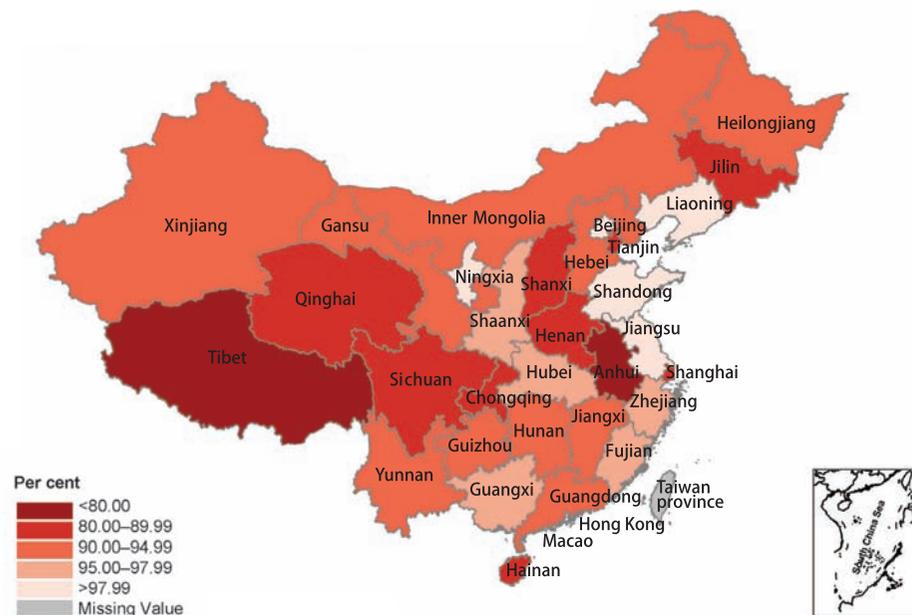
Figure 3.18
Hospital delivery rate and maternal mortality ratio, by province, 2008



Source: Ministry of Health, *China Health Statistical Yearbook*, 2009

Figure 3.18
Provincial-level data from 2008 also show that the maternal mortality ratio has a clear inverse relationship with the hospital delivery rate.

Figure 3.19
Antenatal care coverage: at least one visit, 2008



Source: Ministry of Health, *China Health Statistical Yearbook*, 2009

Figure 3.19
Antenatal care coverage⁵⁶ is defined in China as the percentage of women who attend a skilled health provider (doctor, nurse or midwife) at least once during pregnancy. UNICEF and WHO recommend a minimum of four antenatal care visits during pregnancy.

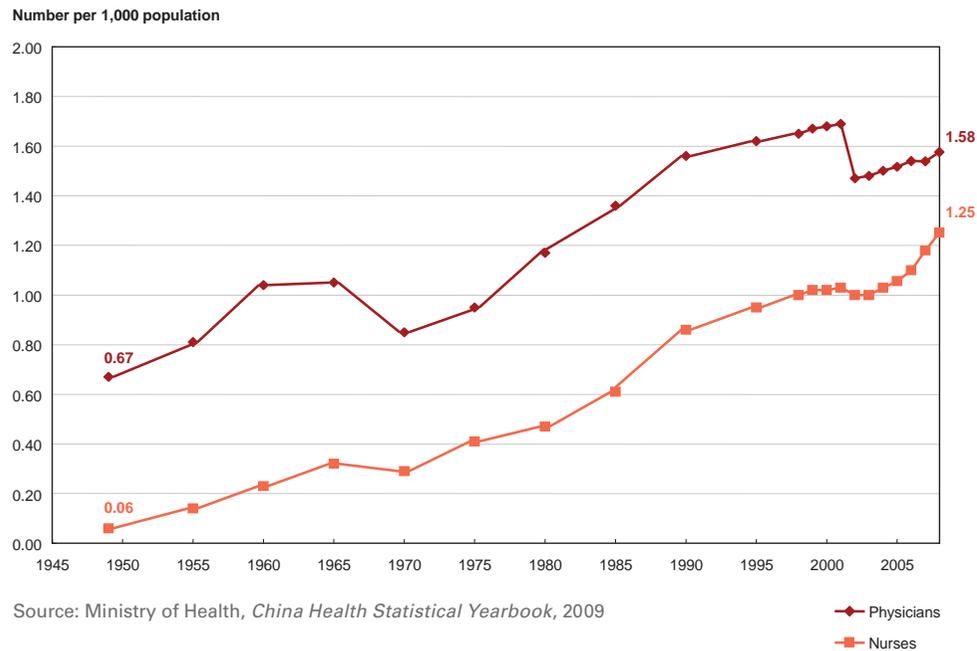
Figure 3.20
Skilled attendant at birth, 2008



Source: Ministry of Health, *China Health Statistical Yearbook*, 2009

Figure 3.20
Overall, the per cent of births attended by skilled health personnel⁵⁷ is high across all provinces, but is notably lower in Qinghai and Tibet.

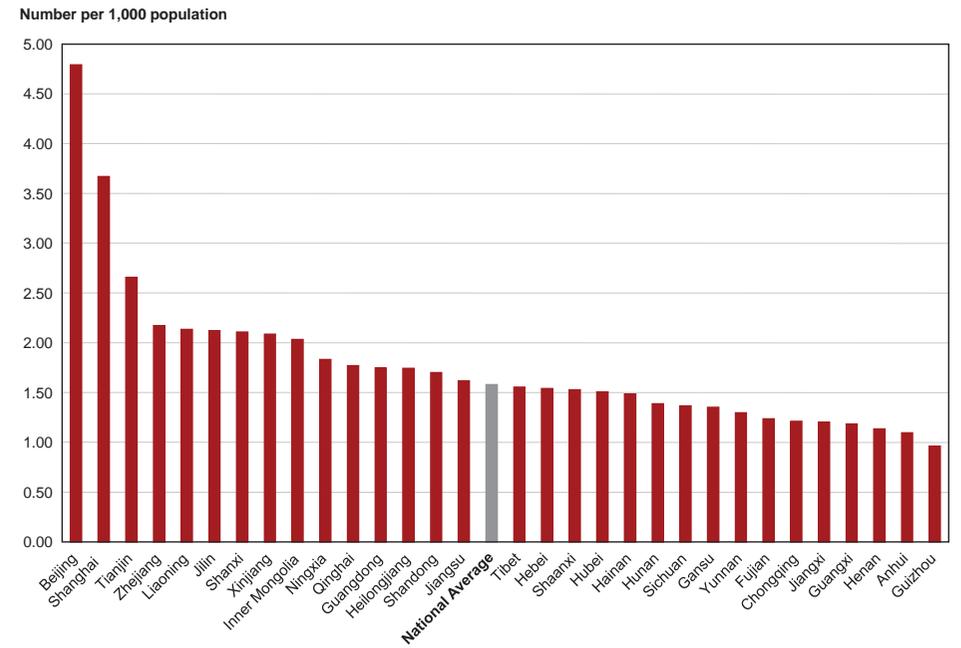
Figure 3.21
Number of physicians and nurses, 1949–2008



Source: Ministry of Health, *China Health Statistical Yearbook*, 2009

Figure 3.21
Over the last 50 years, the number of physicians has increased from around 1.0 to 1.6 per thousand population. The drop observed between 2001 and 2002 reflects a more restrictive definition of the competencies and qualifications required for a health worker to be considered a physician.

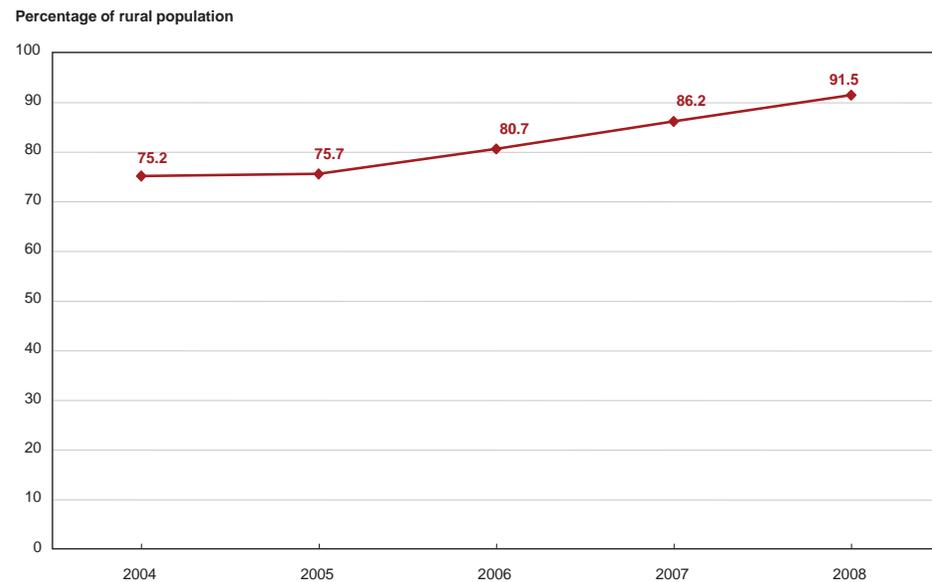
Figure 3.22
Number of physicians, by province, 2008



Source: Ministry of Health, *China Health Statistical Yearbook*, 2009

Figure 3.22
The number of physicians per thousand⁵⁸ population varies among provinces from 5 in Beijing to less than 2 in two-thirds of China's provinces, including many eastern provinces.

Figure 3.23
Enrolment in rural cooperative medical scheme, 2004–2008

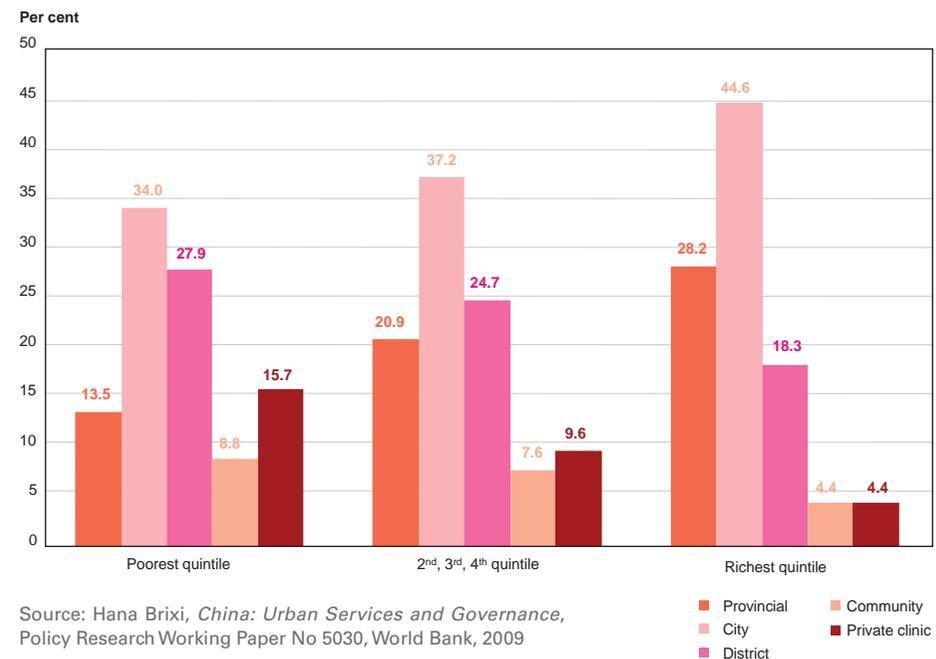


Source: Ministry of Health, *China Health Statistical Yearbook*, 2009

Figure 3.23

Since the Rural Cooperative Medical Scheme (RCMS)⁵⁹ was introduced in early 2000, the enrolment rate has increased steadily, and the Scheme now covers more than 90 per cent of all the country's rural residents, improving their access to health services.

Figure 3.24
Choice of health provider by income group, 2006

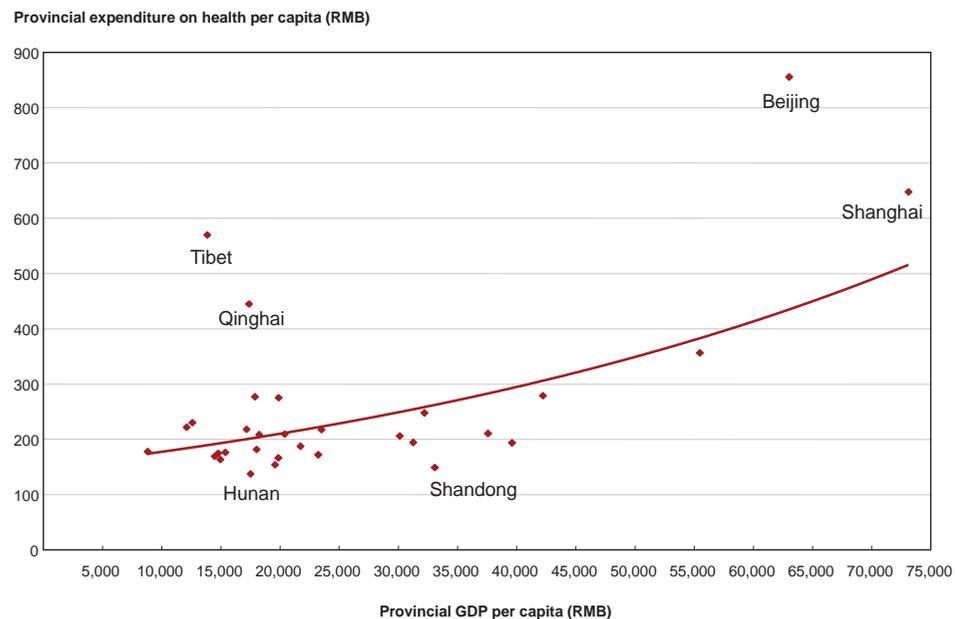


Source: Hana Brix, *China: Urban Services and Governance*, Policy Research Working Paper No 5030, World Bank, 2009

Figure 3.24

There are clear differences in the choice of healthcare provider among the richest, poorest and middle quintiles of the population. The richest quintile tends to favour provincial and city-level health facilities, which offer the most comprehensive care. In China, community-level clinics tend to offer cheaper and lower-quality healthcare. As such, the poorest quintile is more likely than the middle or upper quintiles to use healthcare providers at the local level.

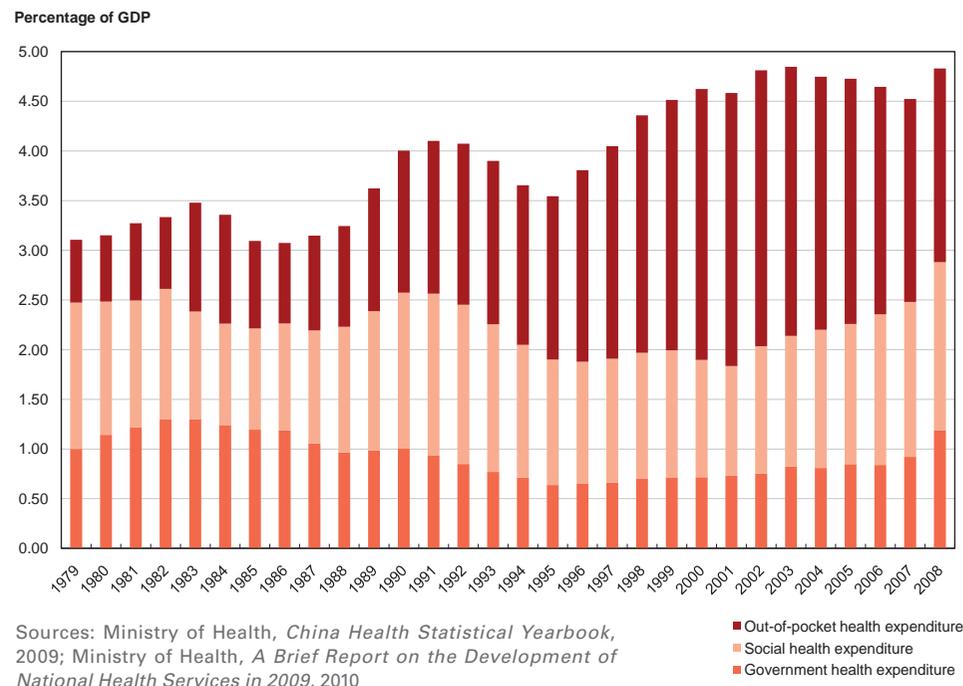
Figure 3.25
 Provincial expenditure on health per capita in relation to provincial GDP per capita, by province, 2008



Source: National Bureau of Statistics, *China Statistical Yearbook*, 2009

Figure 3.25
 Per capita spending on healthcare is correlated with provincial GDP per capita. Generally, those provinces with a low GDP per capita also spend less per capita on healthcare than the wealthier provinces.

Figure 3.26
 Government, social and out-of-pocket expenditure on health, 1979–2008



Sources: Ministry of Health, *China Health Statistical Yearbook*, 2009; Ministry of Health, *A Brief Report on the Development of National Health Services in 2009, 2010*

Figure 3.26
 Over the past three decades, China has seen its total health spending increase from about 3 to 4.8 per cent of its GDP. This increase is driven almost entirely by out-of-pocket payments.





4

EXPANDED PROGRAMME ON IMMUNIZATION

OVERVIEW

Since its introduction in 1978, the Expanded Programme on Immunization (EPI) in China has been an extremely successful and cost-effective public health intervention. Between 1978 and 1995, there was a 98 per cent reduction in the incidence of mortality and morbidity caused by several diseases targeted by the EPI (poliomyelitis, measles, tetanus, pertussis and diphtheria). Since the addition of the hepatitis B vaccine to the EPI in 2002, there has been a dramatic fall in hepatitis B infection rates among young children, further testament to the success of China's EPI.

In 1990, China achieved Universal Childhood Immunization, defined as immunization coverage above 80 per cent, and in 2000, it achieved polio-free status.

In 2005, the State Council adopted the Law on Infectious Disease Control and Prevention, making routine immunization for children free of charge. In 2008, China increased the number of vaccines included in the routine EPI schedule, to protect children against 12 infectious diseases. The Government of China has

also made a strong commitment to eliminate maternal and newborn tetanus by 2010, and measles by 2012. Overall, China is protecting millions of children from vaccine-preventable diseases.

A number of challenges remain. Insufficient operational funds to administer the increased number of vaccines, despite greater funding from the central Government, the limited capacity in numbers and expertise of health personnel, and logistical and geographical factors in some areas all pose hurdles. The persistent circulation of the measles virus poses a major challenge.

National and provincial disease reporting systems have also shown that migrant children living in urban areas have relatively low rates of vaccination coverage.

Province-level implementation of the recently expanded routine immunization programme is still variable. Certain western provinces and poor areas have been slow to introduce the new vaccines.

Figure 4.1
Full vaccination coverage among one-year olds, 1983–2007

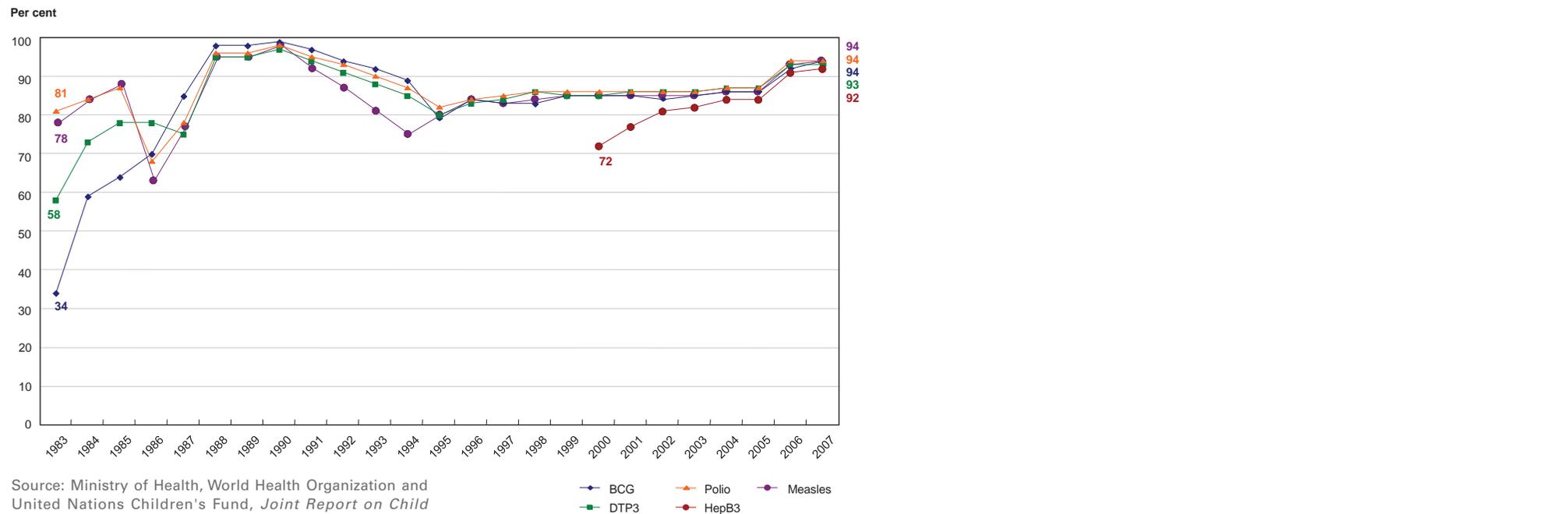
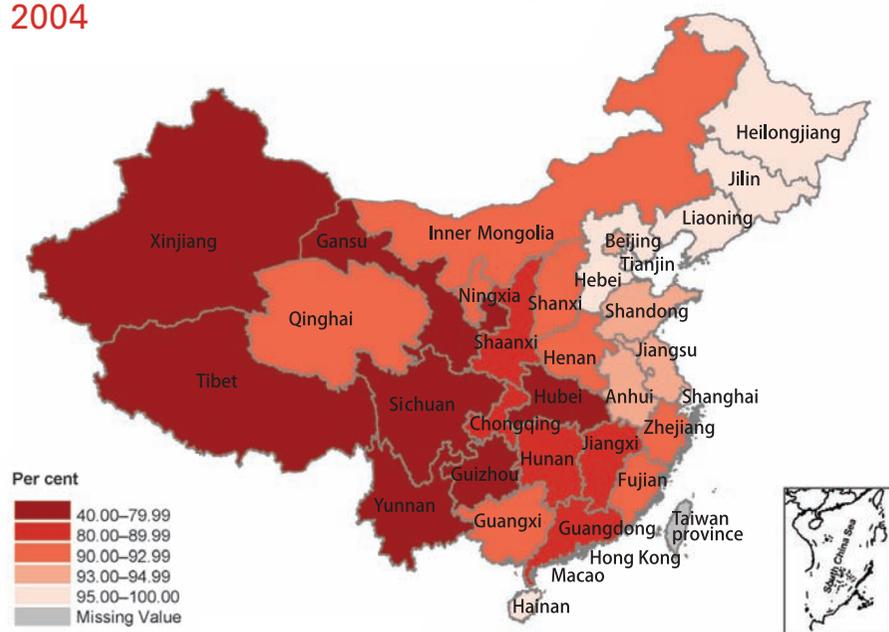


Figure 4.1

In the early 1980s, coverage of some vaccinations was as low as 35 per cent. Through the EPI, national vaccination coverage reached levels of above 90 per cent by the early 1990s. A slight drop in vaccination coverage was noted between 1991 and 1996 – a result of reduced financial investment in the programme at the beginning of the economic reforms and an increasing reliance on out-of-pocket contributions to cover some of the costs related to immunization services. In 2002, hepatitis B was introduced into the National Immunization Schedule. In 2006, the Government implemented a new policy that made routine immunization services free of charge. Vaccination coverage has since risen accordingly.

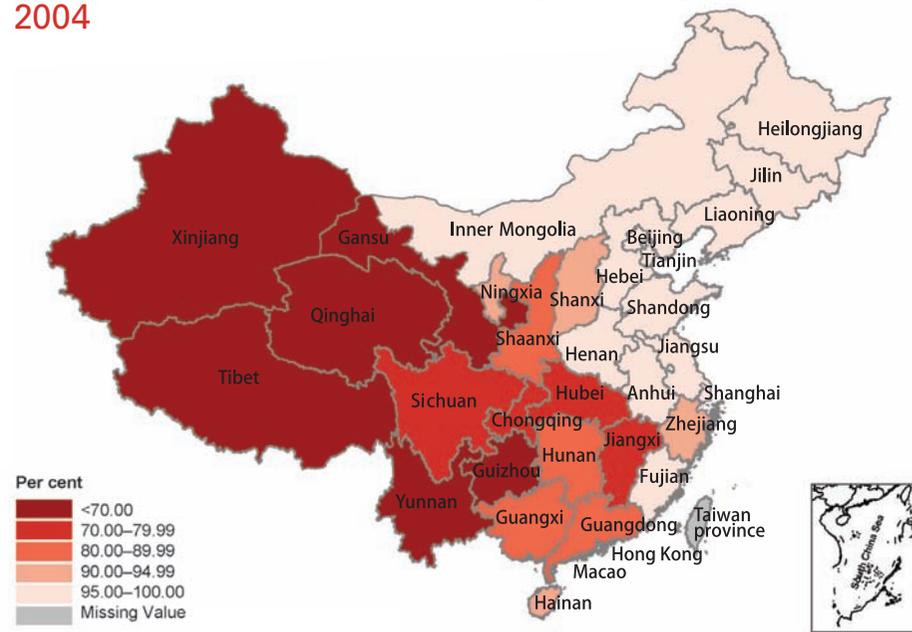
Figure 4.2
Full vaccination coverage among one-year olds, 2004



Source: Ministry of Health, *National Immunization Survey Report, 2004*

Figure 4.2
Full vaccination coverage⁶⁰ refers to the receipt of Bacille Calmette-Guérin (BCG), Oral Polio Vaccine (OPV) and Diphtheria Tetanus and Pertussis (DTP) vaccines, and the measles vaccine. While China's national goal in 2004 was to achieve 85 per cent coverage in every township, coverage was significantly lower in western and central regions, falling below 80 per cent in many provinces.

Figure 4.3
Hepatitis B3 vaccination coverage among one-year olds, 2004

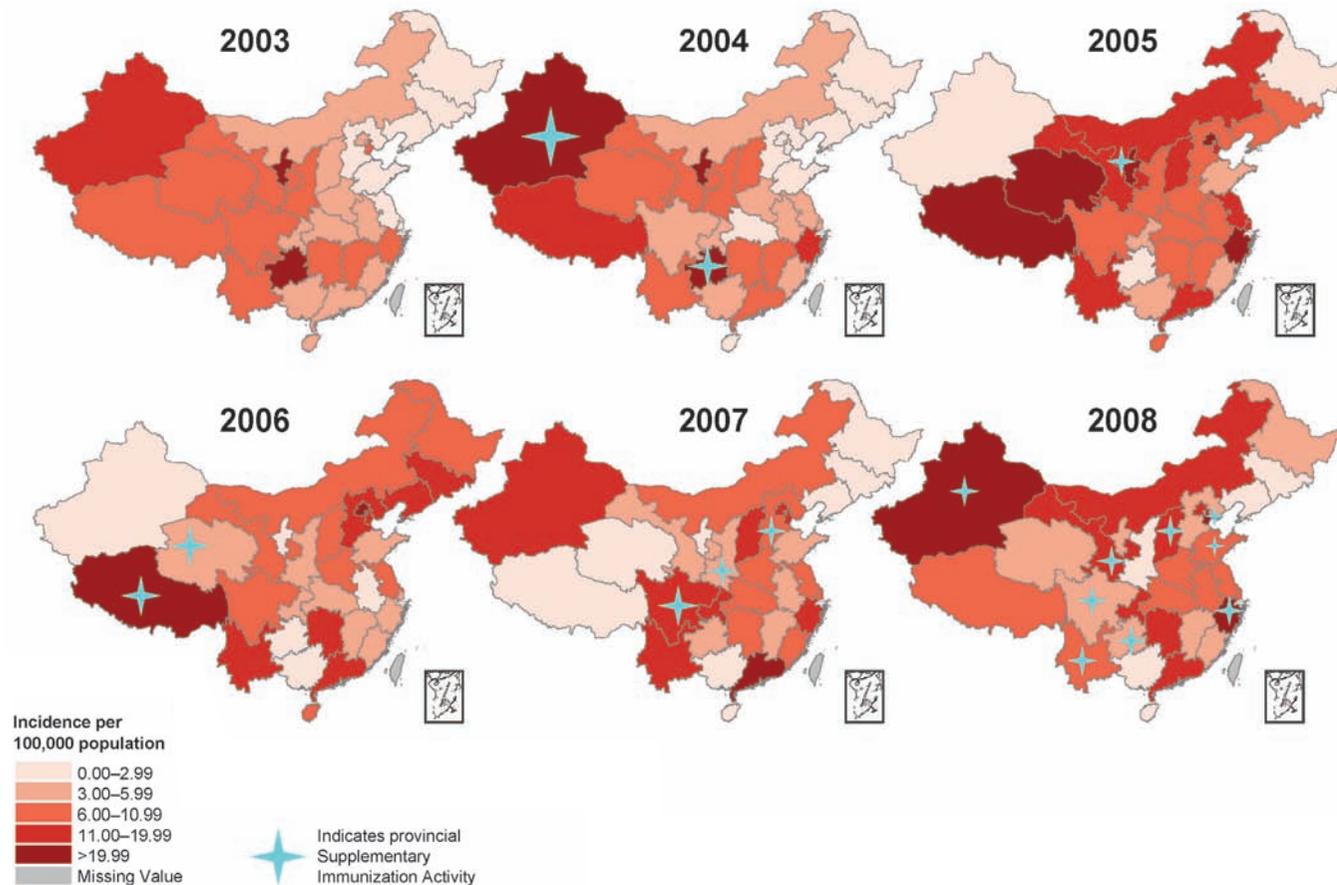


Source: Ministry of Health, *National Immunization Survey Report, 2004*

Figure 4.3
In 2002, the Government and the Global Alliance for Vaccines and Immunization (GAVI) introduced the hepatitis B vaccine to the country's National Immunization Schedule. Like many other countries in East Asia, China has a high prevalence of hepatitis B. Medical treatment of hepatitis B and related chronic complications, such as cirrhosis and liver carcinoma, puts a great economic burden on communities.

The 2004 national survey is the most recent source of non-administrative reporting on EPI coverage. More recently, a national serology survey conducted by the Chinese Centre for Disease Control and Prevention in 2006 found a major reduction in hepatitis B infections among children. Between 1992 and 2006, the prevalence of the hepatitis B surface antigen among children aged 0-4 decreased from 9 per cent to 1 per cent, an enormous achievement. With the increase in rates of hospital delivery, birth-dose vaccination against hepatitis B has increased dramatically, almost eliminating the risk of perinatal infection. However, hepatitis B vaccination coverage is still low in China's western provinces, and the disease burden (hepatitis B infection rate) remains high in certain western provinces and ethnic minority groups.

Figure 4.4
Measles incidence and supplementary immunization activities, 2003–2008



Source: Chinese Centre for Disease Control and Prevention, *National Measles Surveillance Reporting System*, 2008

Figure 4.4

The map shows provincial-level measles incidence and Supplementary Immunization Activities (SIA) between 2003 and 2008. While many SIAs have been conducted in western provinces during the past several years, the sustainability of the impact of SIAs is low in these areas, because of the inadequate level of follow-up routine vaccination. This is due to insufficient financial support and low operational capacity. In 2008, a number of SIAs took place in eastern coastal provinces such as Zhejiang, Guangdong and Beijing, in response to a higher incidence of measles in these areas, largely linked to the inflow of migrant populations.



5

NUTRITION

OVERVIEW

General nutrition

The nutrition status in a population is indicated by the prevalence of stunting (low height-for-age), underweight (low weight-for-age), and wasting (low weight-for-height). In China, rapid economic development has helped to significantly reduce the prevalence of underweight and wasting, but stunting remains a problem. Stunting is caused by poor feeding over a prolonged period and by the inadequate prevention and treatment of disease and infection. Studies have shown that stunted children have a higher risk of mortality and that undernutrition is an underlying cause of about one-third of global under-five deaths⁶¹.

Essential micronutrients

Micronutrients, particularly iron, vitamin A, zinc, iodine and folate, play a vital role in a child's development and health. Vitamin and mineral deficiencies, notably in iron and vitamin A, remain common in China. Anaemia is caused by limited amounts of iron and other vitamins in the diet, as well as by factors that inhibit iron absorption. In 2009, China approved standards for micronutrient-fortified complementary food supplements, which may help to reduce iron and other micronutrient deficiencies.

Sustainable elimination of iodine deficiency

Iodine plays an important role in the proper functioning of the thyroid gland, which regulates growth and metabolism. Globally, iodine deficiency is the primary cause of preventable learning disabilities and brain damage, because it has the most devastating impact on the brain of the developing foetus. In China, more than 60 per cent of the population lives on land that is low in iodine content. In line with World Health Organization (WHO) recommendations, China has adopted Universal Salt Iodization (USI) as the national strategy for improving iodine intake and preventing iodine deficiency. In 1995, China promulgated the Regulation on Adding Iodine to Salt to Eliminate Iodine Deficiency. The global Universal Salt Iodization target is for 90 per cent of households to consume adequately iodized salt. China has established a more rigorous target on iodized salt consumption. The national goal is for at least 90 per cent of households to be consuming adequately iodized salt in at least 95 per cent of counties by 2010. By 2008, about 88 per cent of counties had reached this goal.

Breastfeeding

Breastfeeding has a profound impact on a child's survival, health, nutrition and development. Breastmilk provides all of the nutrients, vitamins and minerals an infant needs for growth for the first six months. In addition, breastmilk carries antibodies from the mother that help combat disease. UNICEF and WHO recommend that during the first six months of life, infants should be given only breastmilk, and no other fluids or food. After six months, other foods and fluids should be introduced, but breastfeeding should continue for at least two years.

Despite the benefits, many mothers do not exclusively breastfeed their babies, and instead replace breastmilk with substitutes. Formula feeding is expensive, and is not nutritionally equivalent to breastmilk. Formula feeding exposes children to dangers, such as infections and contamination, and increases the risk of certain chronic diseases later in life. The rate of exclusive breastfeeding in China is 28 per cent nationally, 16 per cent in urban areas and 30 per cent in rural areas⁶².

Breastfeeding in China is undermined by the aggressive marketing of infant formula. National policies issued by the Ministry of Health and other relevant government departments recommend and support exclusive breastfeeding during the first six months of life. These include national policies on infant and young child feeding and the Regulation on the Marketing of Breastmilk Substitutes. The Regulation, which was promulgated in 1995, stipulates that the marketing of breastmilk substitutes should be done in a way that respects, supports and promotes breastfeeding. However, surveys conducted by the China Consumers Association in 2008 and 2009 found that marketing practices were not in compliance with the Regulation, and many mothers were being deliberately misinformed by infant formula marketing representatives.

Another reason why mothers do not exclusively breastfeed is that they are not adequately supported to do so in health facilities at the time of delivery, or after they return home. Promotion or availability of infant formula in health facilities is not uncommon in China. Some mothers erroneously believe they cannot produce enough milk or that their busy work schedules will not allow for breastfeeding. In fact, the majority of mothers produce enough milk to support the normal growth and development of their baby. Busy mothers can express milk for the baby and breastfeed after work.

Figure 5.1
Prevalence of underweight among children under-five years old, 1990–2005

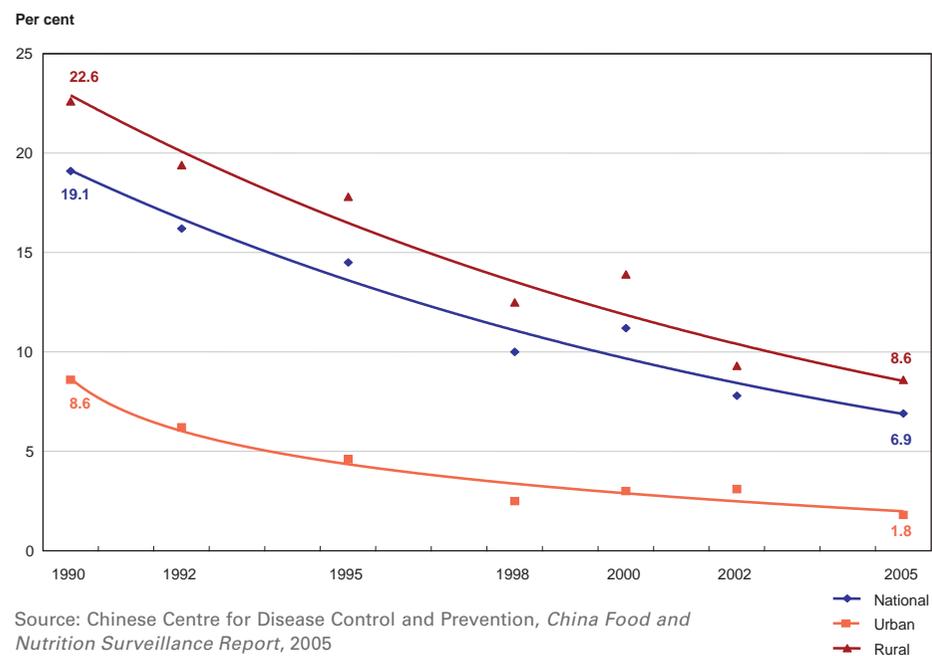


Figure 5.1

In 1990, the national prevalence of underweight⁶³ (low weight-for-age) among under-five children was 19 per cent (9 per cent in urban areas and 23 per cent in rural areas). Between 1990 and 2005, the prevalence of underweight among under-five children decreased significantly to 7 per cent nationally, to less than 2 per cent in urban areas and to 9 per cent in rural areas.

Figure 5.2
Prevalence of stunting among children under-five years old, 1990–2005

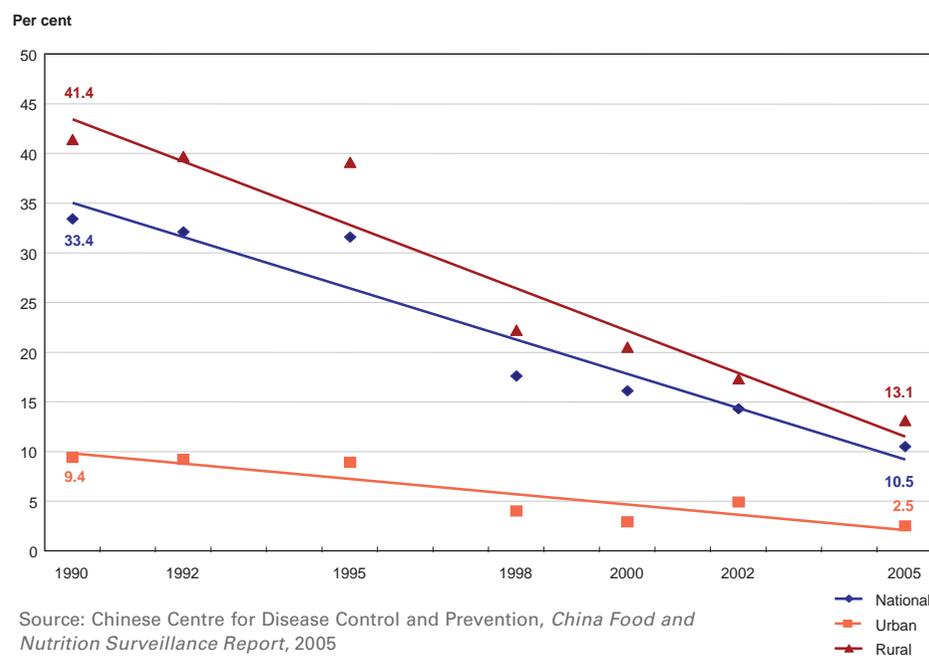


Figure 5.2

The prevalence of stunting⁶⁴ (low height-for-age) decreased from 33 per cent in 1990 to 11 per cent in 2005. Stunting among urban children decreased from 9 per cent in 1990 to 3 per cent in 2005 and from 41 per cent to 13 per cent among rural children. In poor rural areas, the prevalence of stunting still remains high, at about 18 per cent.

Figure 5.3
Prevalence of anaemia among children under-five years old, 1998–2005

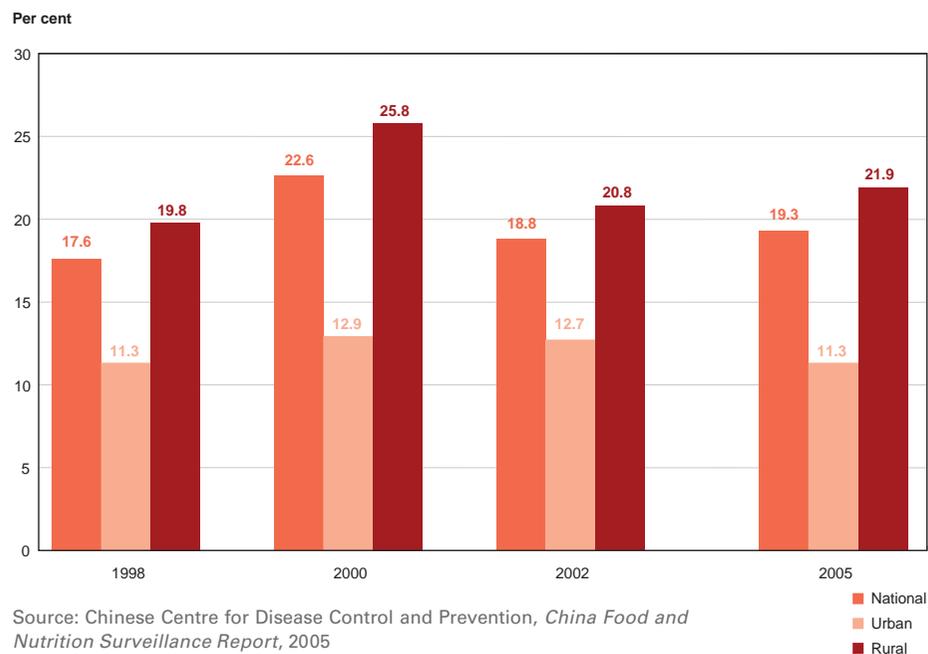


Figure 5.3
Anaemia⁶⁵ remains a persistent problem among children in China. Around one in five children is anaemic, a figure that has changed little between 1998 and 2005. The prevalence of anaemia varies with age and is highest among 6–12 month-olds.

Figure 5.4
Vitamin A deficiency among children under-five years old, 2000 and 2006

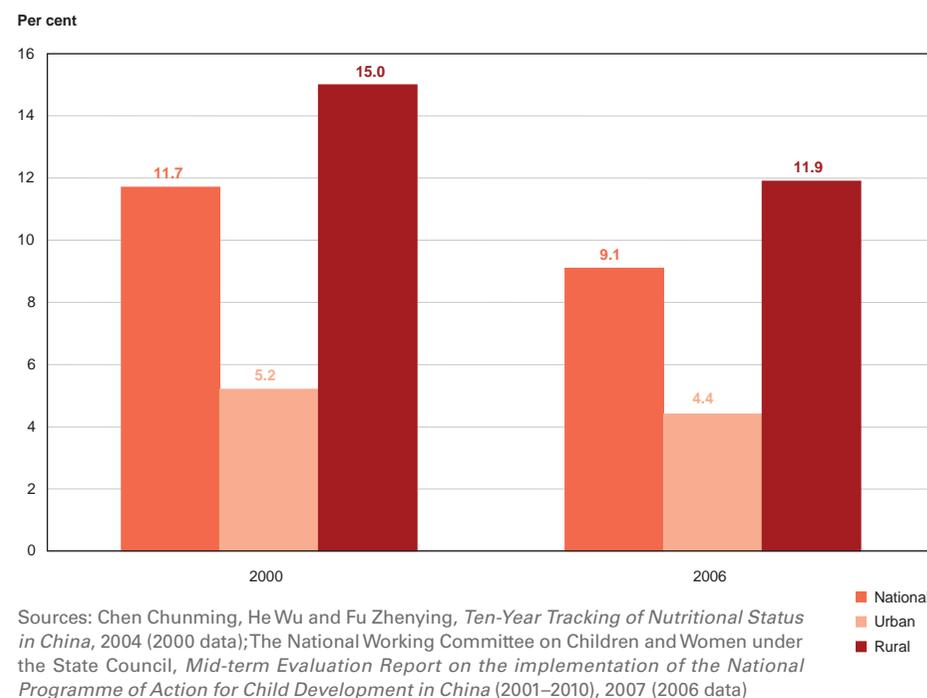


Figure 5.4
A nationwide survey conducted in 2000 among children below the age of five years found Vitamin A deficiency prevalence (serum concentrations of retinol less than 20 µg/dL) to be 12 per cent nationally, 5 per cent in urban areas and 15 per cent in rural areas. A 2006 survey found slightly decreased prevalence levels: 9 per cent nationally, 4 per cent in urban areas and 12 per cent in rural areas.

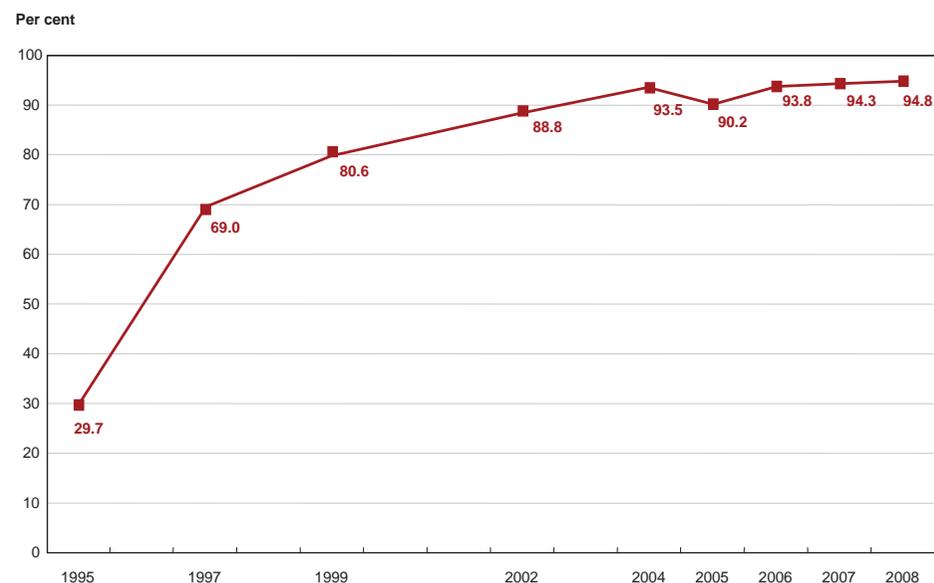
Figure 5.5
Household consumption of adequately iodized salt (20–50 parts per million), 2008



Source: Ministry of Health, *National Iodized Salt Monitoring Report*, 2008

Figure 5.5
In China, adequately iodized salt is defined as that in which the level of iodine is in the 20–50 parts per million (ppm) range. National iodized salt monitoring data from 2008 indicate that in almost all provinces, with the exception of Hainan, Tibet, and Xinjiang, coverage of adequately iodized salt⁶⁶ has reached more than 90 per cent of households.

Figure 5.6
Household consumption of adequately iodized salt (20–50 parts per million), 1995–2008



Sources: Ministry of Health, *National IDD Surveillance*, 1995, 1997, 1999, 2002 and 2005; Ministry of Health, *National Iodized Salt Monitoring Report*, 2004, 2006, 2007 and 2008

Figure 5.6
National iodized salt monitoring data indicate that household consumption of adequately iodized salt has risen dramatically from around 30 per cent in 1995 to more than 90 per cent in 2004.



Jb
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6

CHILD INJURY

OVERVIEW

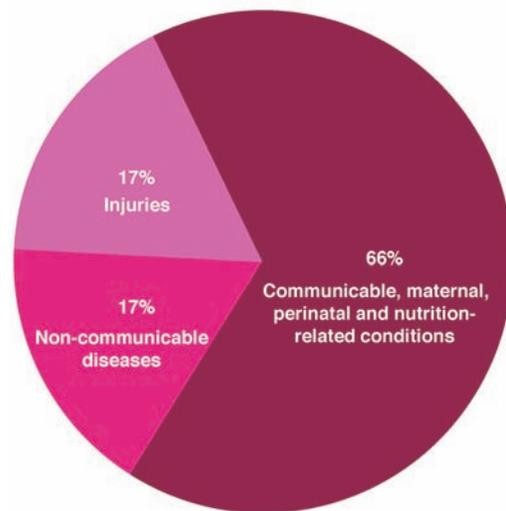
Child injury is increasingly recognized as a major public health problem. Globally, injury and violence are responsible for about 950,000 deaths per year among children and young people under the age of 18, with unintentional injuries accounting for almost 90 per cent of these deaths⁶⁷.

In China, it is estimated that over 10 million children under 15 years of age are injured each year, and more than 100,000 children die from drowning, traffic accidents, accidental suffocation, falls, poisoning and other accidents. Annually, 80 per cent of injured children require hospitalization or medical attention, and for every child fatality caused by injury, another three children are permanently disabled⁶⁸. Children from rural areas or low-income families are at the highest risk of injury. UNICEF China surveys also indicate that the risk of accidental death is significantly higher among children who are left behind in rural areas while both parents migrate to cities for work.

As China has made progress in reducing infectious diseases and improving maternal and child health care, child injury has risen to become the leading cause of death and disability among children beyond the newborn period, exacting a heavy toll on families and society as a whole.

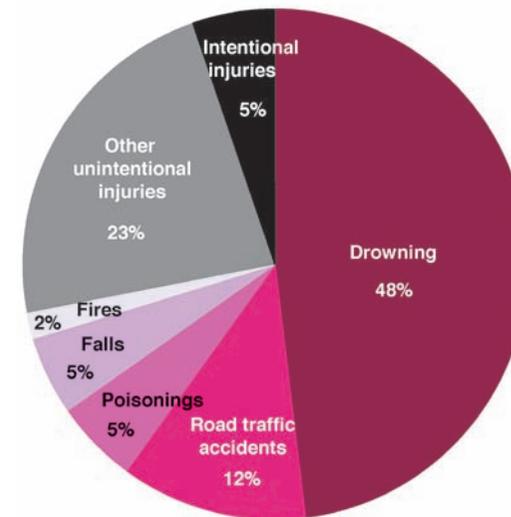
In developed countries, deaths due to injury have been reduced substantially from earlier levels. However, this reduction is not simply a natural outcome of economic development, as reductions have also been observed in some developing countries. As China's development advances, much greater attention should be paid to reducing injuries, including efforts to reduce the risk of injuries in the setting of natural disasters.

Figure 6.1
Leading causes of death among children in China aged 0–14 years, 2004



Source: World Health Organization, Department of Measurement and Health Information Systems, 2009

Figure 6.2
Leading causes of injury death among children in China aged 0–14 years, 2004



Source: World Health Organization, Department of Measurement and Health Information Systems, 2009

Figures 6.1 and 6.2

Injury is one of the leading causes of death among children in China. In 2004, drowning accounted for 48 per cent of all injury deaths.

Figure 6.3
 Leading causes of injury death among children in China aged 0–14 years, by sex, 2004

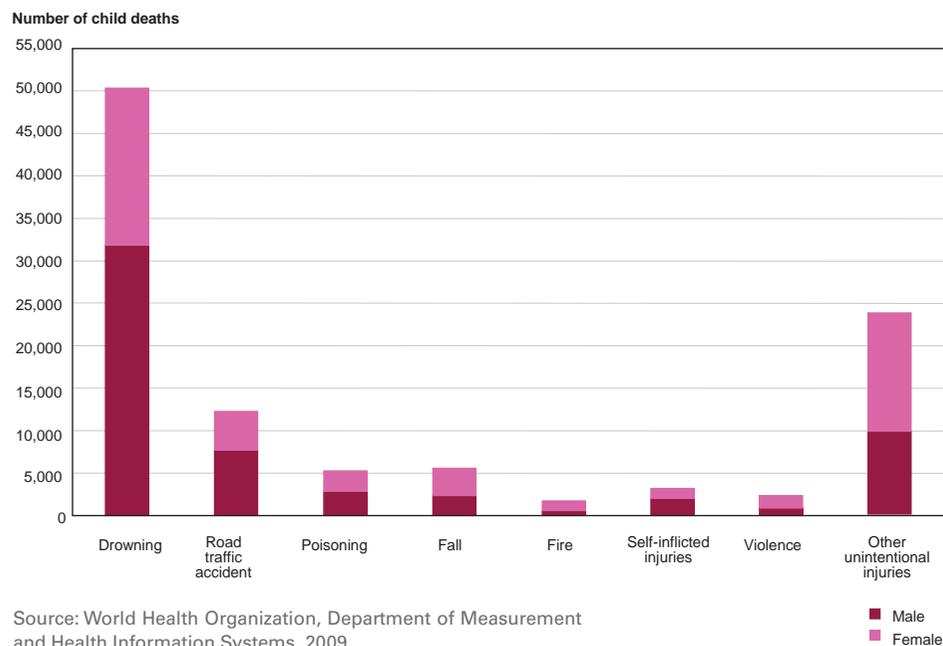
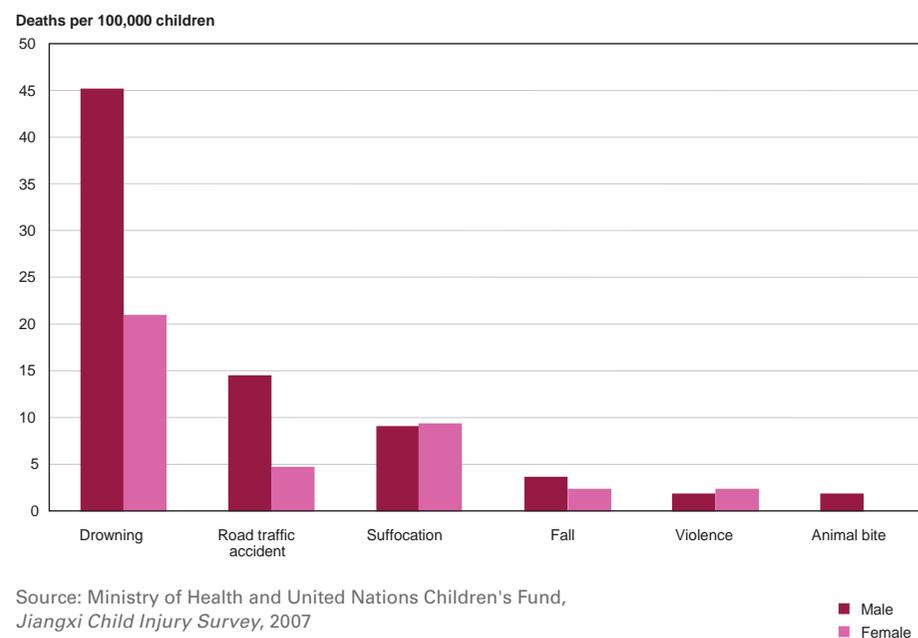


Figure 6.4
 Leading causes of injury death among children aged 0–17 years, by sex, Jiangxi province, 2005



Figures 6.3 and 6.4

Drowning and road traffic accidents were the most common causes of injury death in China and were significantly more common among males than females. Both WHO estimates and the UNICEF *Jiangxi Child Injury Survey* have shown the same result.

Figure 6.5
Leading causes of injury morbidity among children aged 0–17 years, by cause and sex, Jiangxi province, 2005

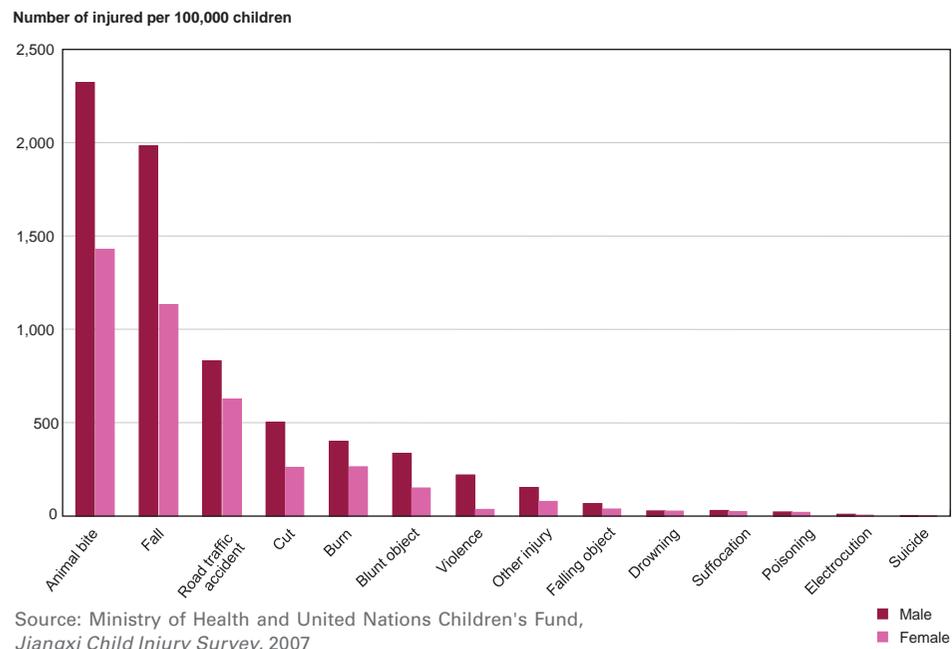
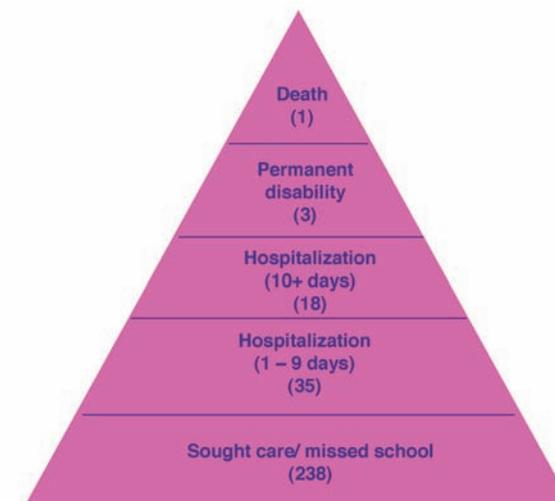


Figure 6.5
Animal bites, falls and road traffic accidents were the most common non-fatal injuries among children. Poor supervision of children is a common theme in injury morbidity.

Figure 6.6
Consequences of child injury, Beijing, 2003



Source: National Working Committee on Children and Women and United Nations Children's Fund, *Beijing Child Injury Survey, 2005*

Figure 6.6
UNICEF-funded surveys in Beijing show that injury, even when non-fatal, has many other impacts, leading to permanent disability, hospitalization and missed schooling. For every death due to injury, there were three cases of permanent disability, 18 cases requiring hospitalization for ten days or more, 35 cases requiring hospitalization for one to nine days and 238 cases requiring medical care or at least one day of absence from school.

"Injuries account for **more than 10 per cent of all deaths and more than 30 per cent of all potentially productive years of life lost in China**. Traffic-related injuries (mainly among cyclists and pedestrians), suicide, drowning, and falls account for 79 per cent of all injury deaths. Rural injury death rates are double those of urban rates and male rates are double those of female rates."⁶⁹



7

WATER, SANITATION AND HYGIENE

OVERVIEW

In recent years, China has undergone rapid economic development and has also seen remarkable improvements in providing access to improved drinking water sources⁷⁰ and access to improved sanitation facilities⁷¹.

For nearly three decades, beginning with its participation in the First International Decade on Safe Drinking Water and Environmental Sanitation (1981–1990), China has worked with the international community to improve rural water supply and sanitation by building water supply plants, introducing appropriate water and sanitation technologies, and building the institutional capacity of the Government. These efforts laid the foundation for rapid development in rural water supply and environmental sanitation.

From 2000, the central Government allocated funds for rural water supply. Monitoring activities between 2003 and 2005 found elevated levels of arsenic in the rural water supply of many provinces, which led to the integration of rural water supply into the Eleventh Five-Year National Development Plan (2006–2010). Beginning in 2006, there was a sharp increase in central Government expenditure on rural water supply, rising to more than RMB 11 billion in 2008.

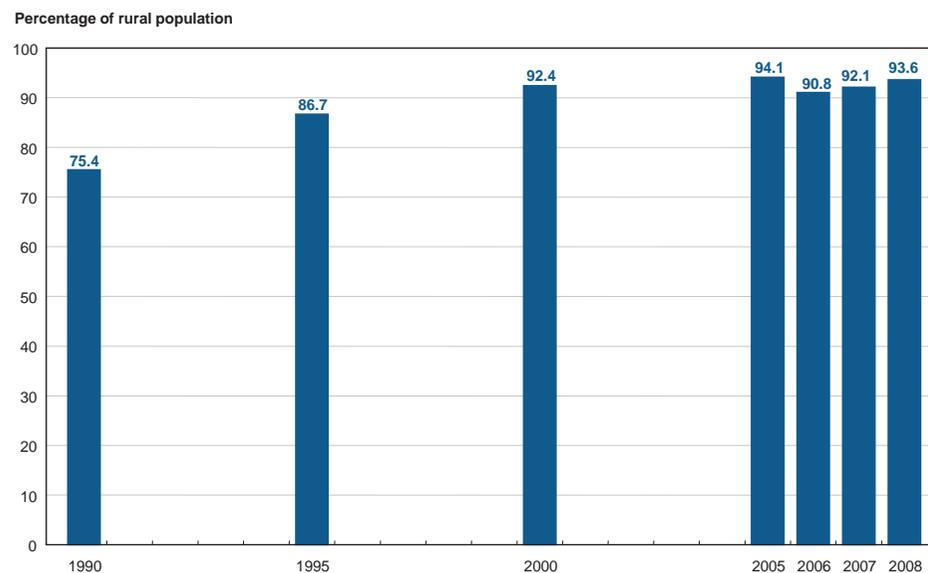
Unlike rural water supply, rural sanitation has not been included in the Eleventh Five-Year National Development Plan. Instead, improvements in rural sanitation are supported by general fund transfers from the central Government to local budgets, and by some designated programmes, such as the eradication of schistosomiasis (an endemic disease which can be spread by improper management of livestock and human waste) and the agriculture sector's biogas programme. Most recently, rural sanitation was promoted through its inclusion in the three-year Health System Reform Programme, which led to a central Government allocation of RMB 1.6 billion every year for three years to support improvements in rural household sanitation.

Challenges

Much progress has been made in the water and sanitation sector, but there continue to be disparities in the provision of water supply and sanitary facilities, with the western and central provinces lagging behind the eastern coastal provinces. The poorer areas of the western and central provinces need particular attention, as they are often unable to allocate matching funds to implement programmes funded in part by the central Government. This may lead to even greater disparities, as the most vulnerable groups in these poorer regions cannot benefit from the programmes.

- Particular efforts are needed to improve water, sanitation and hygiene in schools. A recent survey⁷² found that 17 per cent of schools in the country had no water supply, and that even among those schools equipped with a water supply, less than 38 per cent met the national drinking water quality standard. The survey also found that sanitation remains a problem, with only 32 per cent of schools equipped with sanitary latrines, and most schools lacking handwashing facilities.
- Water quality continues to be a challenge. Drinking water sources are becoming scarcer, and the treatment of water is increasingly more costly. Arsenic and fluoride poisoning and schistosomiasis pose particular problems. Both surface water and groundwater are contaminated in many areas by industrial and human activities.
- UNICEF and WHO (2008) estimates show that more than 462 million people in China did not use improved sanitation facilities in 2006. In rural areas, 41 per cent of people did not use improved sanitation facilities. To achieve the MDG sanitation target by 2015, special efforts are needed.
- China is a country prone to natural disaster. Extreme climatic conditions, caused by global climate change, occur more and more frequently and pose risks to the security of water supply. Environmental degradation often makes safe water supply and sanitation solutions more costly.

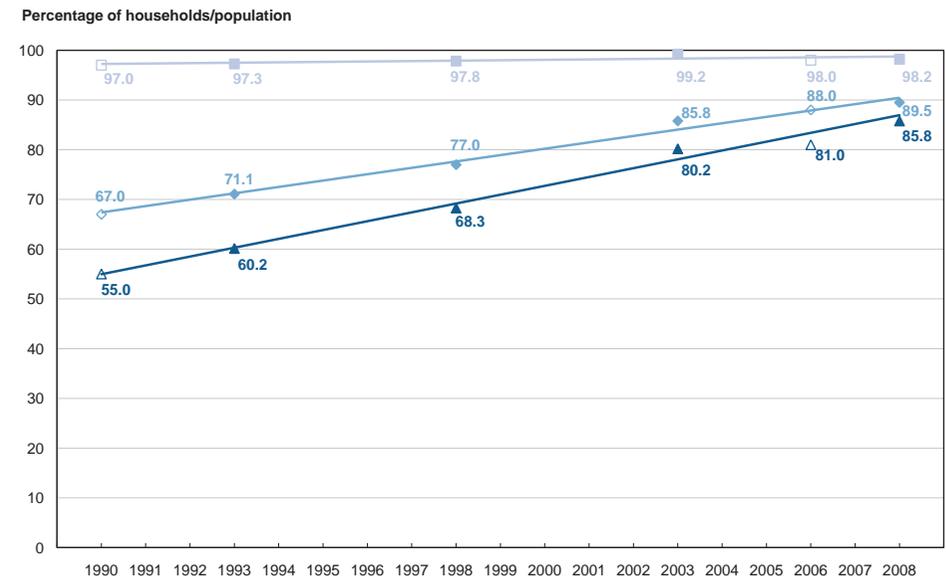
Figure 7.1
Rural access to improved water sources, 1990–2008



Sources: Ministry of Health, *China Health Statistical Yearbook*, 2008 and 2009

Figure 7.1
Access to improved water sources⁷³ has generally increased in rural China over the past two decades⁷⁴.

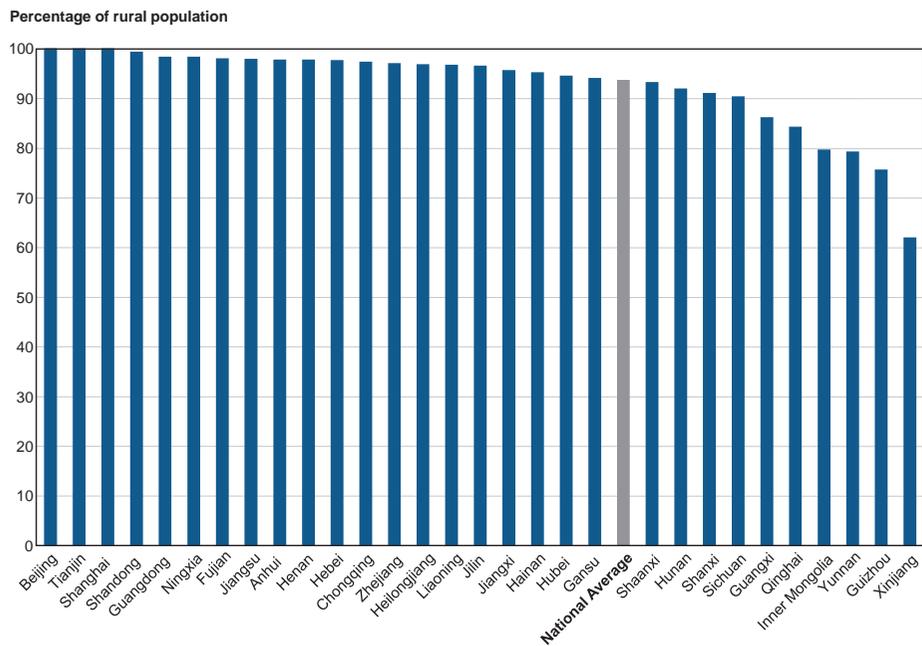
Figure 7.2
Percentage of households using improved water sources, 1990–2008



Sources: Ministry of Health, Reports of the 1st, 2nd, 3rd and 4th *National Health Services Surveys* (Household survey data); United Nations Children’s Fund and World Health Organization, *Progress on drinking water and sanitation, special focus on sanitation*, 2008 (1990 and 2006 data)

Figure 7.2
National Health Services Surveys (NHSS) are conducted every five years and assess the status of household use of improved water sources⁷⁵. Between 1993 and 2008, the use of improved water sources has increased 42 per cent in rural areas and 26 per cent nationally. The NHSS data on access to improved water sources are slightly different from the corresponding figures reported by MOH/NPHCCO (Figure 7.1) and published in the *China Health Statistical Yearbook*⁷⁶.

Figure 7.3
Rural access to improved water sources, by province, 2008



Source: Ministry of Health, *China Health Statistical Yearbook*, 2009

Figure 7.4
Rural access to improved water sources, 2008



Source: Ministry of Health, *China Health Statistical Yearbook*, 2009

Figures 7.3 and 7.4

There is a great disparity among provinces in access to improved water sources. Provinces with limited access to improved water sources also tend to be less economically developed.

Figure 7.5
Rural access to improved water sources, by type, 1990–2008

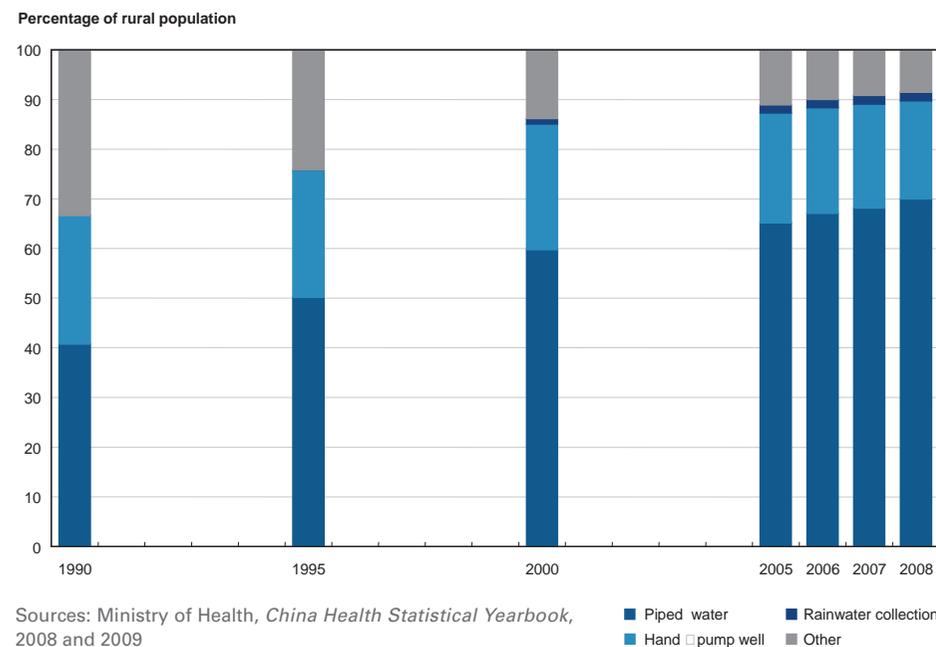


Figure 7.5
Among the major types of improved water sources, piped water is the preferred option, and its coverage has been expanding steadily since 1990. Hand-pumped wells, which were promoted in China during the first International Decade for Water and Sanitation (1981–1990), continue to be used in many rural households.

Figure 7.6
Rural access to sanitary latrines, 2000–2008

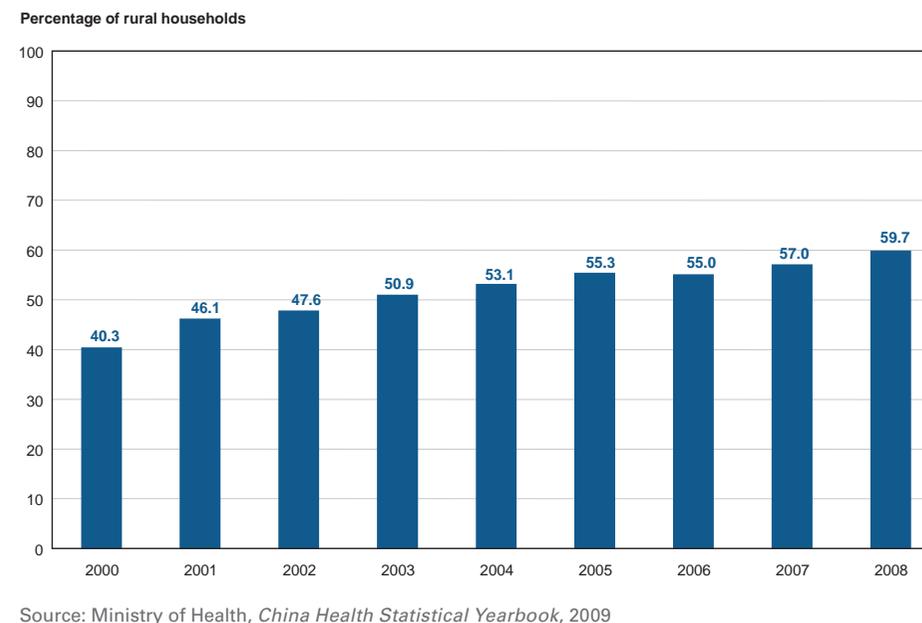
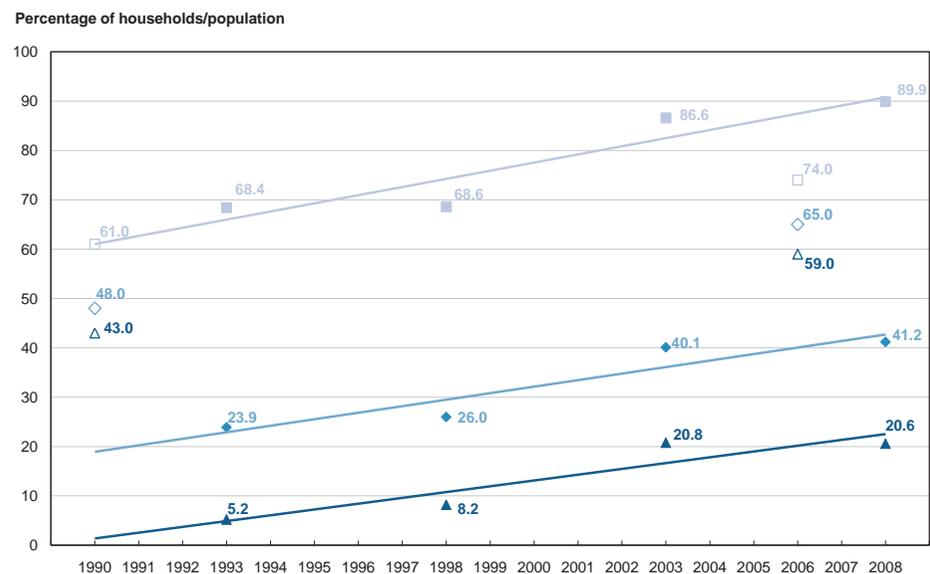


Figure 7.6
Between 2000 and 2008, the proportion of rural households with access to sanitary latrines⁷⁷ increased dramatically, from around 40 to 60 per cent, according to data from MOH/NPHCCO.

Figure 7.7
Percentage of households using improved sanitation facilities⁷⁸, 1990–2008



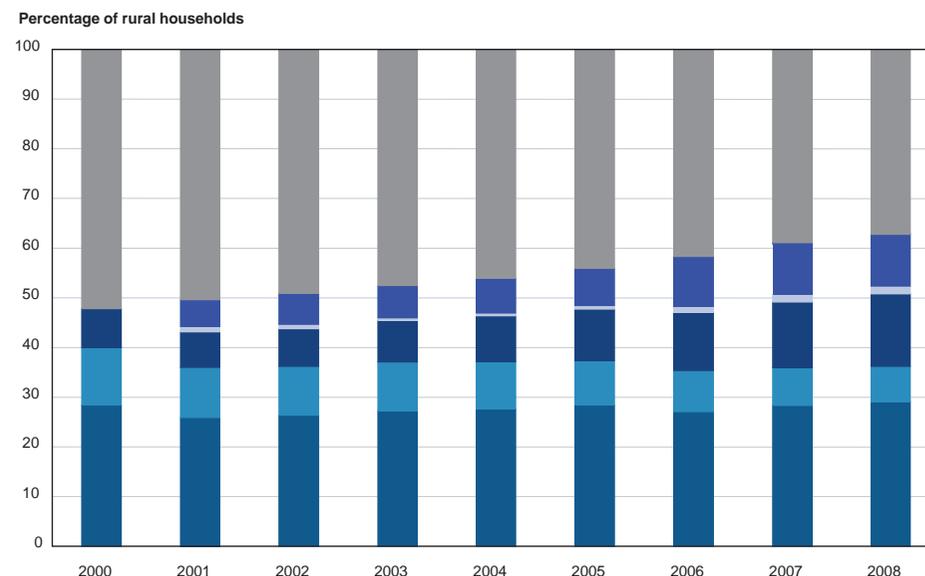
Sources: Ministry of Health, Reports of the 1st, 2nd, 3rd and 4th *National Health Services Surveys* (Household survey data); United Nations Children's Fund and World Health Organization, *Progress on drinking water and sanitation, special focus on sanitation*, 2008 (1990 and 2006 data)

◆ National
□ Urban
▲ Rural

Figure 7.7

The *National Health Services Survey* assesses the status of household use of sanitary latrines. In 2008, the use of harmless sanitary latrines was almost three times higher in rural areas than in 1993. During the same period, the use of harmless sanitary latrines increased 72 per cent nationally. NHSS data on household access to sanitary latrines are quite different from the data published by MOH/NPHCCO (Figure 7.6)⁷⁹.

Figure 7.8
Rural access to sanitary latrines, by type, 2000–2008



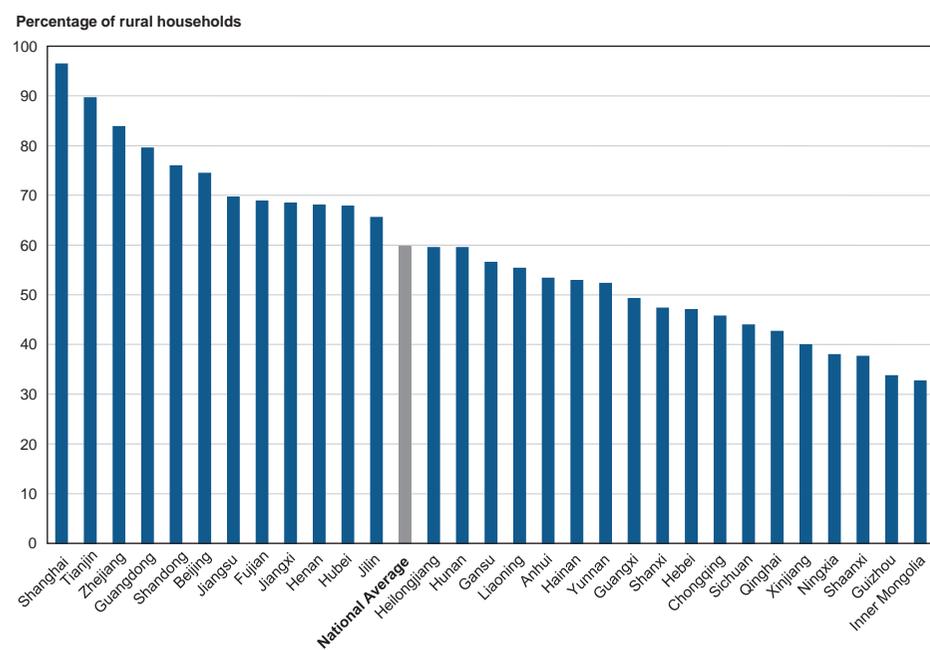
Source: Ministry of Health, *China Health Statistical Yearbook*, 2009

■ Three compartment septic tank latrine
■ Double-urn septic tank latrine
■ Three-in-one biogas latrine
■ Urine-diverting latrine
■ Water flush latrine
■ Other

Figure 7.8

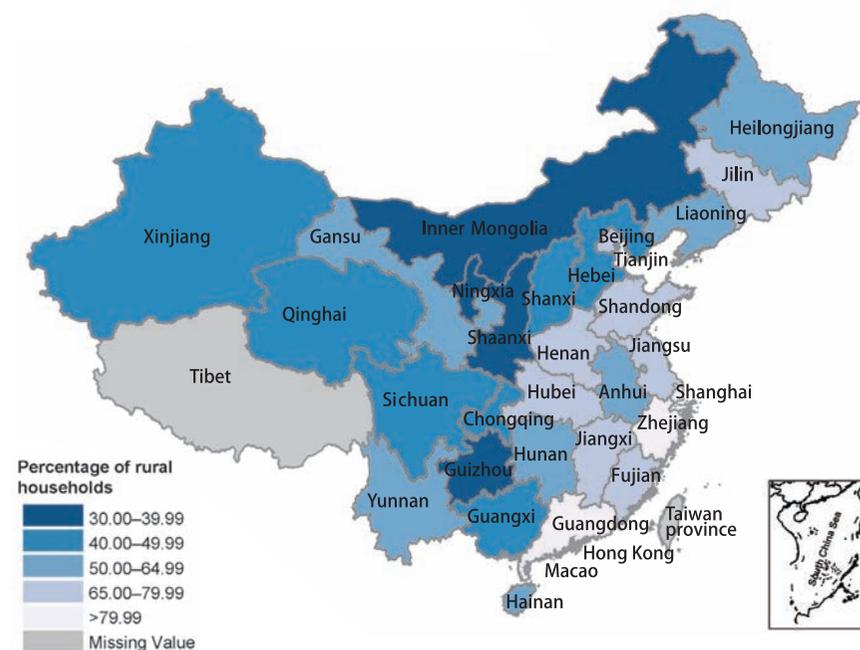
The Government has approved hygienic standards for rural household latrines. While households and regions may choose different types of latrines, depending on local conditions and preferences, the Government promotes the three-compartment septic tank latrine most intensively and this is now the most common type of latrine. Three-in-one biogas septic tank latrines and water-flush latrines are also becoming increasingly common.

Figure 7.9
Rural access to sanitary latrines, by province, 2008



Source: Ministry of Health, *China Health Statistical Yearbook, 2009*

Figure 7.10
Rural access to sanitary latrines, 2008



Source: Ministry of Health, *China Health Statistical Yearbook, 2009*

Figures 7.9 and 7.10

The percentage of the rural population with access to sanitary latrines varies widely across provinces. For example, 96 per cent of the rural population in Shanghai has access to sanitary latrines, compared to 33 per cent of the rural population in Inner Mongolia.

Figure 7.11
Central government expenditure on rural water and sanitation, 2000–2008

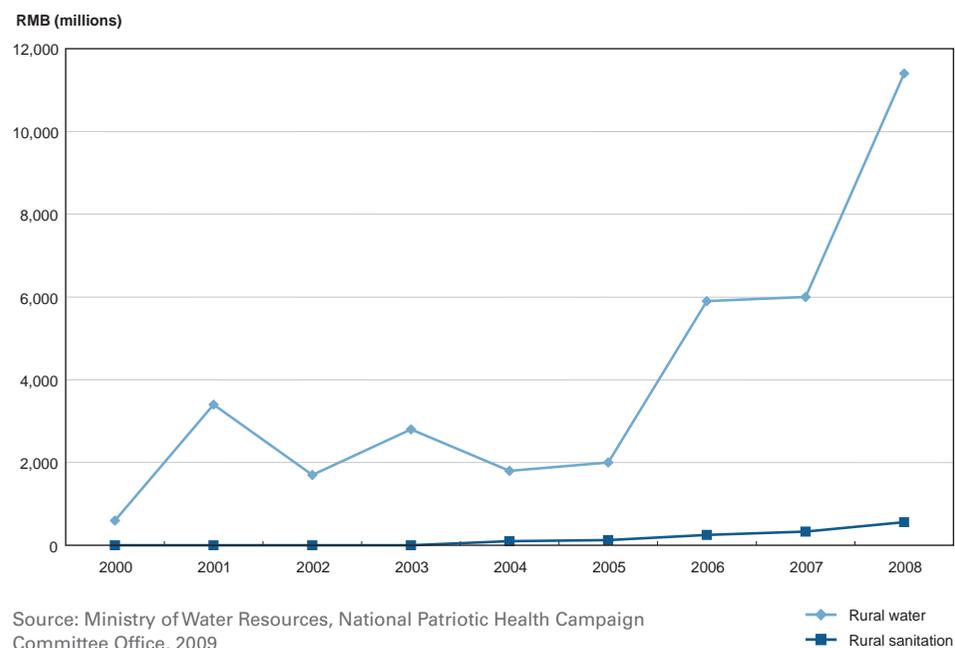


Figure 7.11
The central Government began to allocate funding for rural water supply in 2000 and for household sanitation in 2004. Water supply is regarded as a public service and has therefore received more attention. In contrast, allocations for sanitation have lagged behind.

Figure 7.12
Rural population affected by high arsenic in water sources, selected provinces, 2008

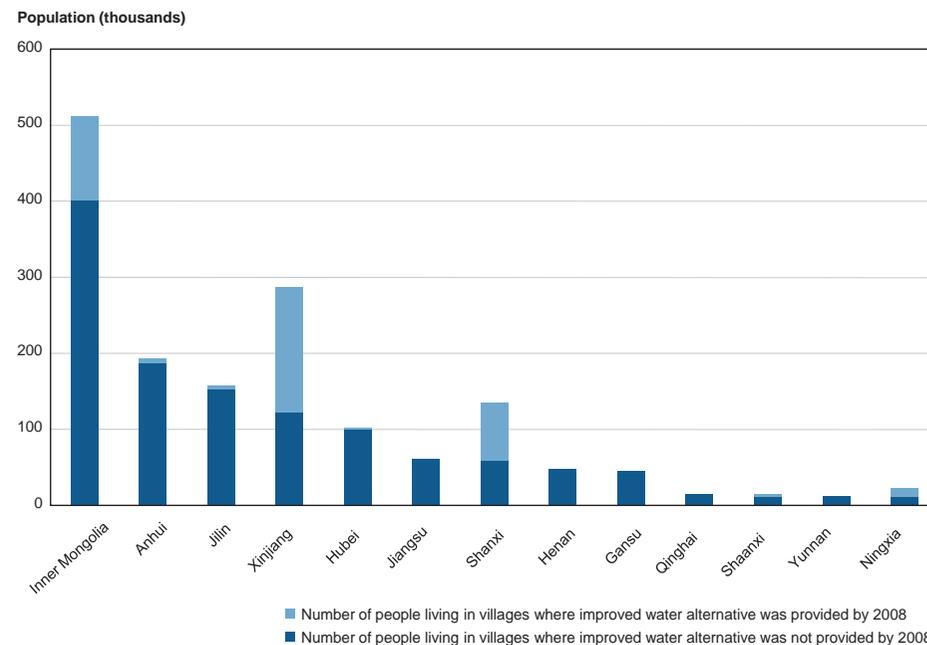


Figure 7.12
Arsenic is found in groundwater in about half the country's provinces. So far, it is known to affect 1.68 million people, mainly living in northern China, but full screening may reveal many more affected people. Arsenic is present in geological formations and enters the groundwater naturally. In most areas known to have high arsenic in the water supply, alternative safe water sources have yet to be provided.

Figure 7.13
Population living in coal-borne arsenicosis-affected areas, 2008

Province	Number of people living in villages affected by coal-borne arsenicosis	Number of people living in villages with improved stoves
Guizhou	39,000	38,000
Shaanxi	1,179,000	1,214,000

Source: Ministry of Health, *China Health Statistical Yearbook*, 2009

Figure 7.13
In Guizhou and Shaanxi Provinces, the inhalation of smoke from coal-burning is another source of arsenic poisoning. In most areas, such coal-borne arsenicosis⁸⁰ can be avoided by providing improved stoves or by channelling the smoke outdoors.

Figure 7.14
Arsenicosis-affected provinces, 2008



Source: Ministry of Health, *China Health Statistical Yearbook*, 2009

Figure 7.14
Water-borne arsenicosis is common throughout northern China, where the groundwater has high levels of arsenic. Coal-borne arsenicosis is more limited in distribution, primarily affecting Guizhou and Shaanxi Provinces. Shaanxi Province has both water-borne and coal-borne arsenic poisoning. Poorer families are often disproportionately affected by arsenic and fluoride poisoning, as they cannot afford alternative safe water sources or improved cooking and heating stoves.

Figure 7.15
Fluorosis-affected provinces, 2008

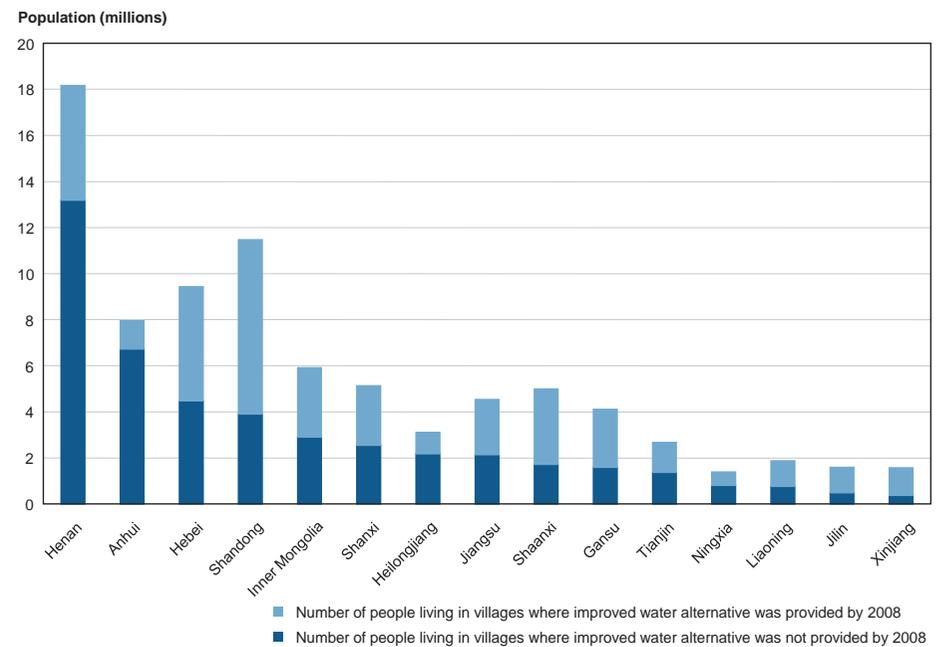


Source: Ministry of Health, *China Health Statistical Yearbook*, 2009

Figure 7.15

Almost all provinces are affected by high levels of fluoride in groundwater. Many central and southwestern provinces are also affected by high levels of fluoride in coal. Twelve central and southern provinces have both types of fluorosis⁸¹. Again, poorer families are disproportionately affected by fluoride poisoning, as alternative safe water sources and improved stoves are out of their reach.

Figure 7.16
Rural population affected by water-borne fluorosis, selected provinces, 2008

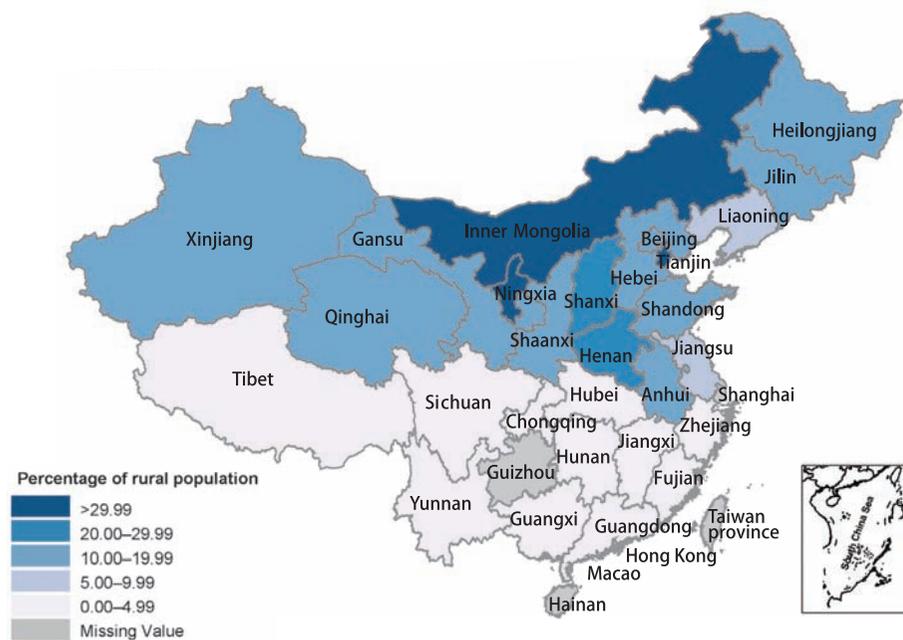


Source: Ministry of Health, *China Health Statistical Yearbook*, 2009

Figure 7.16

In 2008, some 87 million people lived in villages with high levels of fluoride in the water. Approximately half of these people have been provided with alternative safe water sources.

Figure 7.17
 Percentage of rural population affected by water-borne fluorosis, 2008



Sources: Ministry of Health, *China Health Statistical Yearbook*, 2009 (fluorosis); National Bureau of Statistics, Department of Rural Surveys, 2009 (rural population 2008)

Figure 7.17
 Water-borne fluorosis is more common among the rural population in northern China than in other parts of the country.

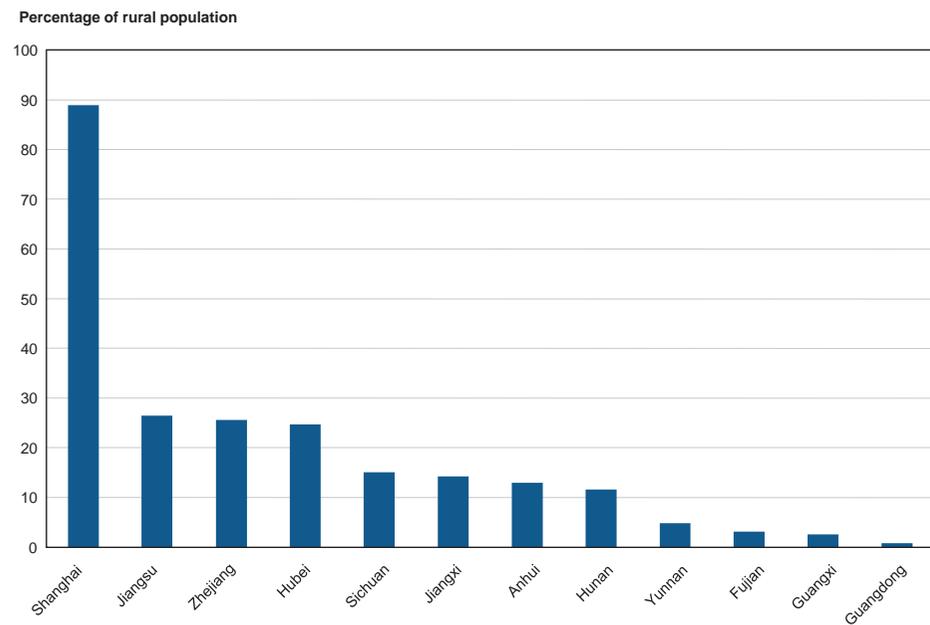
Figure 7.18
 Schistosomiasis-affected provinces, 2008



Source: Ministry of Health, *China Health Statistical Yearbook*, 2009

Figure 7.18
 Schistosomiasis is a disease that is endemic in southern China, where the parasitic *Schistosoma* micro-organism and its host snail live. Schistosomiasis⁸² can be prevented with proper management of livestock and human waste. The Government has been making efforts to treat schistosomiasis, but continued interventions are needed.

Figure 7.19
 Percentage of rural population affected by schistosomiasis, selected provinces, 2008



Sources: Ministry of Health, *China Health Statistical Yearbook*, 2009 (schistosomiasis); National Bureau of Statistics, Department of Rural Surveys, 2009 (rural population 2008)

Figure 7.19
 Schistosomiasis affects many southern provinces.





马林正好看到尼莫
死了，史古叫了史古
来，尼莫被捞了上来。



**EDUCATION AND
CHILD DEVELOPMENT**

OVERVIEW

The objective of providing free nine-year education has been achieved in all but 42 of the country's 2,862 counties and covers 95 per cent of the national primary-school-aged population. After achieving the goal of universal basic education, the Government of China revised the Compulsory Education Law in 2006 and put a new emphasis on balanced and equitable development to reduce disparities among regions and between rural and urban areas. The Government also aimed to boost balanced development by establishing national standards for government spending per student, providing special funds to accelerate the construction of rural schools, developing systems to share education resources among schools in a teaching district, and supporting efforts to recruit teachers for special education in rural schools of western regions.

By 2008, the primary net enrolment ratios⁸³ for females and males showed that the gender disparity in primary education had been eliminated. The Millennium Development Goal to eliminate gender disparity at all levels of education by 2015 is likely to be met on time.

The Government doubled its investment in schooling over the five-year period from 2003 to 2007. The increased allocations were used to support reform in educational expenditure and improve school infrastructure. The increased budgets have allowed two ambitious schemes to be implemented: the abolition of tuition fees, and the policy of "Two Exemptions and One Subsidy" (exemption of textbook fees, exemption of miscellaneous fees and increased subsidy for rural boarding school students). The Two Exemptions and One Subsidy policy has benefited nearly 150 million rural students. The exemption of textbook and miscellaneous fees is also currently being expanded to urban areas. School infrastructure and facilities in rural areas were improved through two schemes: construction of junior secondary schools with dormitory facilities, and provision of distance education facilities.

In spite of the increased allocations, China has yet to meet its target of allocating 4 per cent of its GDP to education. Consequently, funds for improving education quality are still inadequate, and the bulk of funding goes into infrastructure, teachers' salaries and textbooks, while teacher training, curriculum reform and monitoring and evaluation remain under-funded. The policy for pre-primary education, including kindergartens and pre-school classes, is yet to be backed by law or commensurate budget allocations, making it difficult for the poorest communities to gain access to pre-primary education services.

In recent years, with the growing numbers of migrant workers, the issue of education for the children of migrant workers has become prominent. The revised Compulsory Education Law of 2006 makes special provisions to ensure that children of migrant workers receive equal access to nine-year basic education. Measures to address the education and care of children left behind by migrant parents were also implemented, such as the establishment of boarding schools and custodial and support mechanisms. Despite progressive government policies and regulations, which prohibit discrimination against children of migrants, many are unable to attend local public schools due to entrance costs, special regulations, and their high rates of mobility. Instead, many children of migrants are enrolled in private, low-quality schools set up to cater to the migrant community. High fees, as well as the entry of older migrant children into the labour market, result in higher dropout rates among migrant children than among urban resident children.

Figure 8.1
Structure of the education system

Ending age of nine-year basic education schooling →

Age (Years)	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21						
School year				1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
	Pre-primary			Primary									General Junior secondary			General Senior secondary			University			Master's degree		Doctorate degree	
													Vocational junior secondary			Vocational senior secondary			Vocational post-secondary						

Figure 8.1
China's Compulsory Education Law of 2006 ensures nine-year free basic education for all children aged 6–14 years: six years of primary education and three years of junior secondary education.

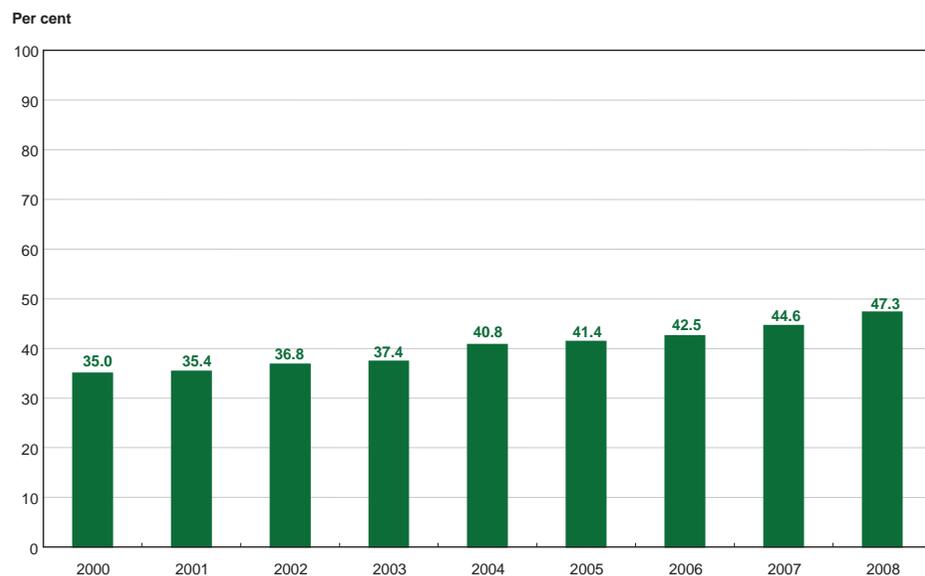
Figure 8.2
Absolute numbers of students at all education levels, 2008

	Students (in school)	Teachers (full-time)	Schools
Pre-Primary	24,749,600	898,552	133,722
Primary	103,315,122	5,621,938	300,854
General Junior Secondary	55,741,542	3,468,957	57,701
General Senior Secondary	24,762,842	1,475,533	15,206
TOTAL	208,569,106	11,464,980	507,483

Figure 8.2
China's general education system has a total of approximately 209 million students taught by 11.5 million full-time teachers in over half a million schools.

Source: Ministry of Education, *China Education Development Essential Statistical Analysis*, 2009

Figure 8.3
Gross enrolment ratio in pre-primary education, 2000–2008



Source: Ministry of Education, *China Education Development Essential Statistical Analysis*, 2009

Figure 8.3
The gross enrolment ratio in pre-primary education⁸⁴ has been steadily growing, but was still under 50 per cent in 2008.

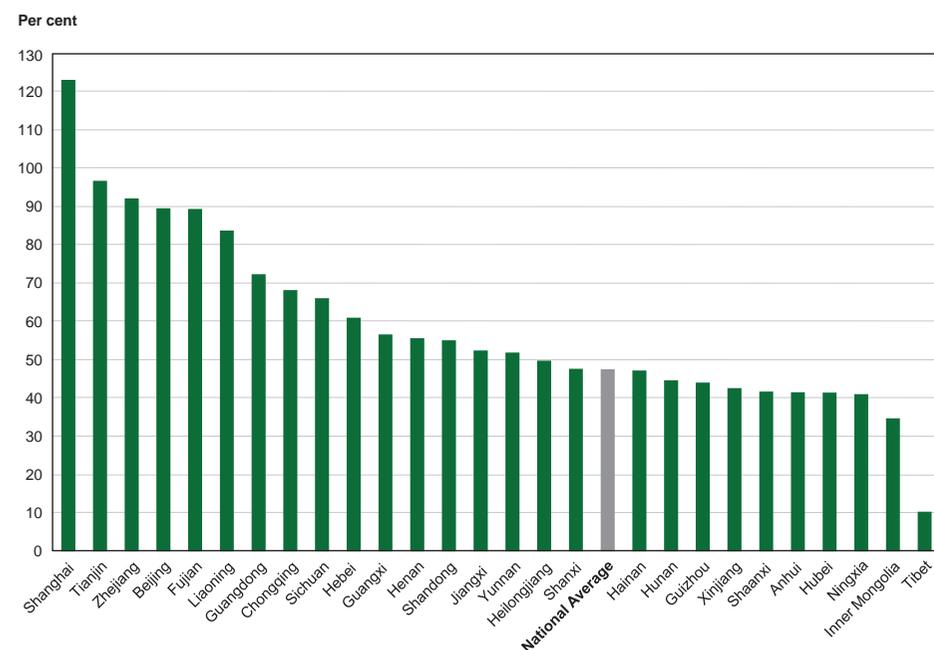
Figure 8.4
Gross enrolment ratio in pre-primary education, 2008



Source: National Bureau of Statistics, *NPA Monitoring Statistics*, 2009

Figure 8.4
Pre-primary gross enrolment ratio varies significantly across provinces from 10 per cent to over 100 per cent. Service provision varies greatly from province to province.

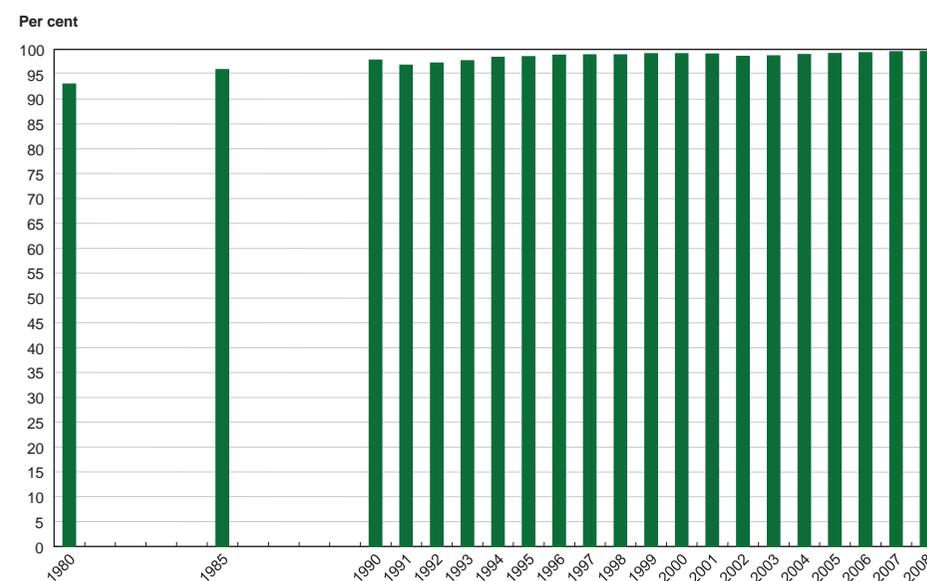
Figure 8.5
Gross enrolment ratio in pre-primary education, by province, 2008



Source: National Bureau of Statistics, *NPA Monitoring Statistics*, 2009

Figure 8.5
Provinces in the western region record the lowest rates of access to pre-primary education. The gross enrolment ratio for pre-primary education is only 10 per cent in Tibet and 34 per cent in Inner Mongolia, in contrast to the average national gross enrolment ratio of 47 per cent.

Figure 8.6
Net enrolment ratio in primary education, 1980–2008



Source: Ministry of Education, *China Education Development Essential Statistical Analysis*, 2009

Figure 8.6
The primary net enrolment ratio has increased over the past two decades to reach 99.5 per cent in 2008, achieving the Millennium Development Goal on universal primary education well in advance of 2015. However, significant numbers of primary-school-aged children remain out of school, most of them concentrated in poor rural areas of western and central China.

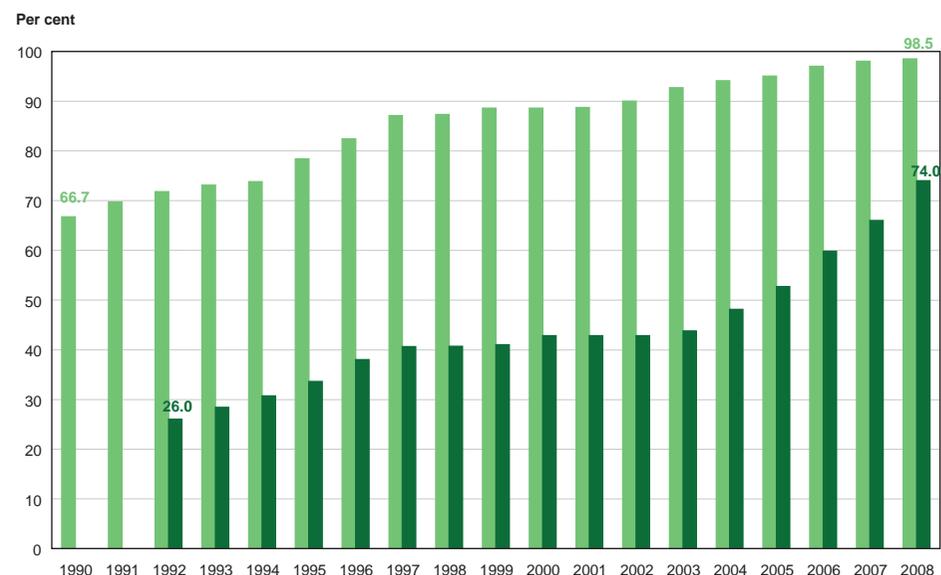
Figure 8.7
Net enrolment ratio in primary education, 2008



Source: Ministry of Education, *China Education Development Essential Statistical Analysis*, 2009

Figure 8.7
Within the high levels of primary school enrolment, provinces in the west lag behind those in the east.

Figure 8.8
Gross enrolment ratio in junior and senior secondary education, 1990-2008



Source: Ministry of Education, *Essential Statistics of Education in China*, 2009

Figure 8.8
Gross enrolment levels in both junior and senior secondary education⁸⁵ have increased steadily over the last decade. Enrolment in junior secondary education, which is covered under the Compulsory Education Law, increased from 67 per cent in 1991 to 98.5 per cent in 2008 and is much higher than enrolment in senior secondary education. Yet, over a million children of junior secondary school age are out of school, mainly in the poorer regions of western and central China.

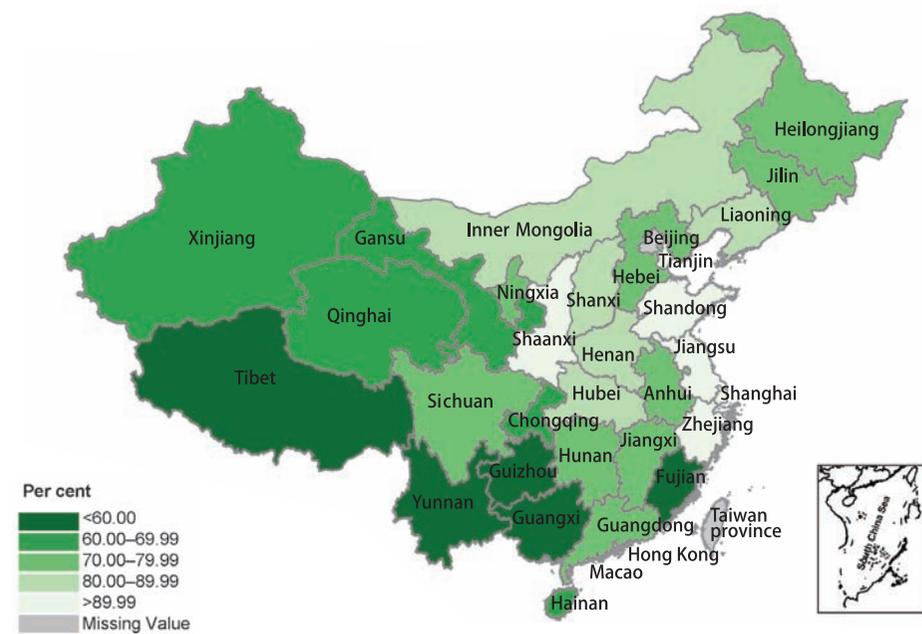
Figure 8.9
Gross enrolment ratio in junior secondary education, 2008



Source: National Bureau of Statistics, *NPA Monitoring Statistics*, 2009

Figure 8.9
Gross enrolment ratios in junior secondary school vary among provinces, with five of the lowest enrolment ratios reported in the western region. Provinces such as Tibet, Qinghai and Gansu have the lowest enrolment levels. It is worth noting that many of these provinces are heavily populated by ethnic minorities.

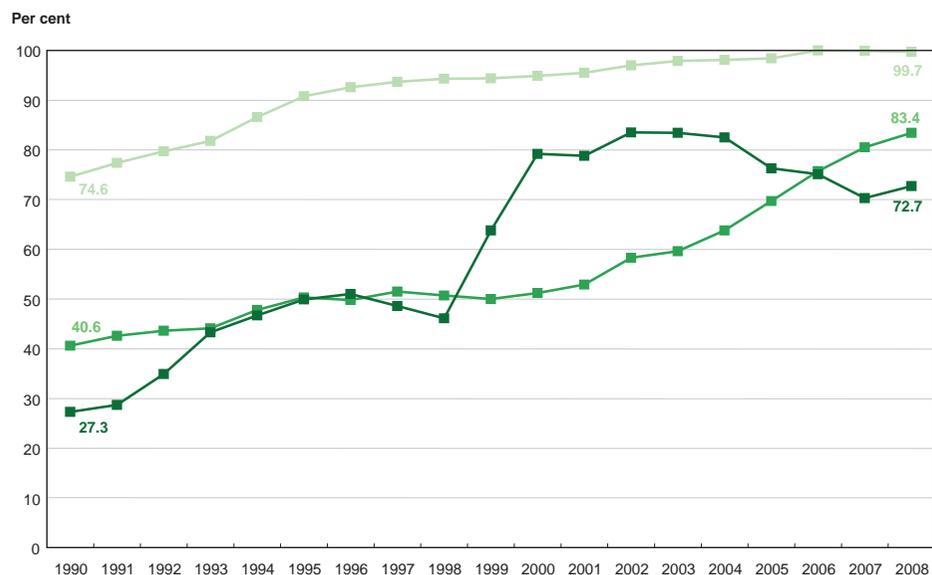
Figure 8.10
Gross enrolment ratio in senior secondary education, 2008



Source: National Bureau of Statistics, *NPA Monitoring Statistics*, 2009

Figure 8.10
Large disparities among provinces are evident in senior secondary education enrolment, with some provinces recording over 100 per cent gross enrolment and a few falling short of the 60 per cent mark.

Figure 8.11
Transition rates from one level to the next level of education, 1990–2008

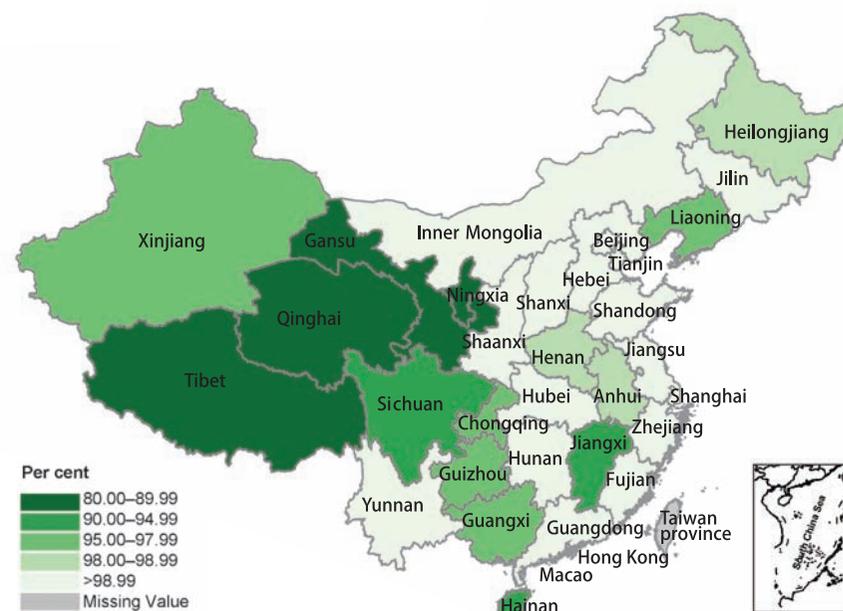


Source: Ministry of Education, *Essential Statistics of Education in China*, 2009

■ Transition from primary to junior secondary
■ Transition from junior secondary to senior secondary
■ Transition from senior secondary to tertiary education

Figure 8.11
Transition rates⁸⁶ from one level of schooling to the next have increased impressively at primary level but still need attention at the junior secondary and senior secondary levels. Around four million children failed to transfer from junior secondary school to senior secondary school in 2008.

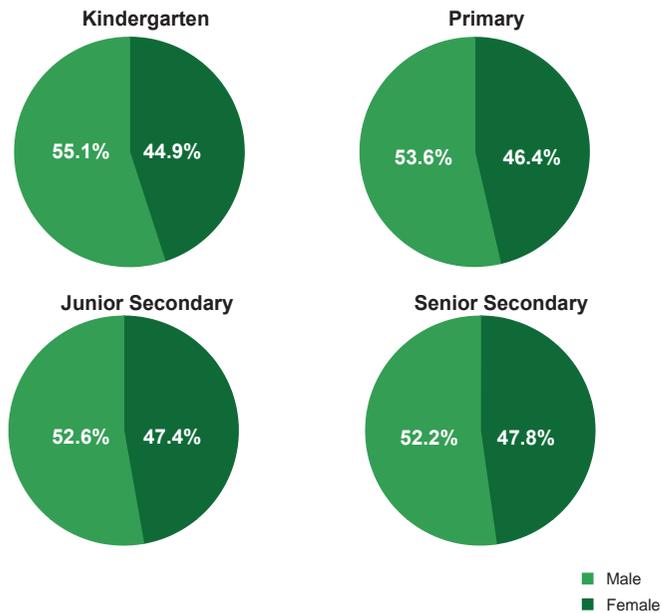
Figure 8.12
Primary-level cohort survival rate, 2008



Source: Ministry of Education, *China Education Development Essential Statistical Analysis*, 2009

Figure 8.12
The eastern provinces continue to do better on primary school survival rates⁸⁷ compared to the rest of the country in 2008. In contrast, the survival rates in Qinghai, Ningxia, Gansu and Tibet were below 90 per cent, with Qinghai having the lowest survival rate of 81 per cent.

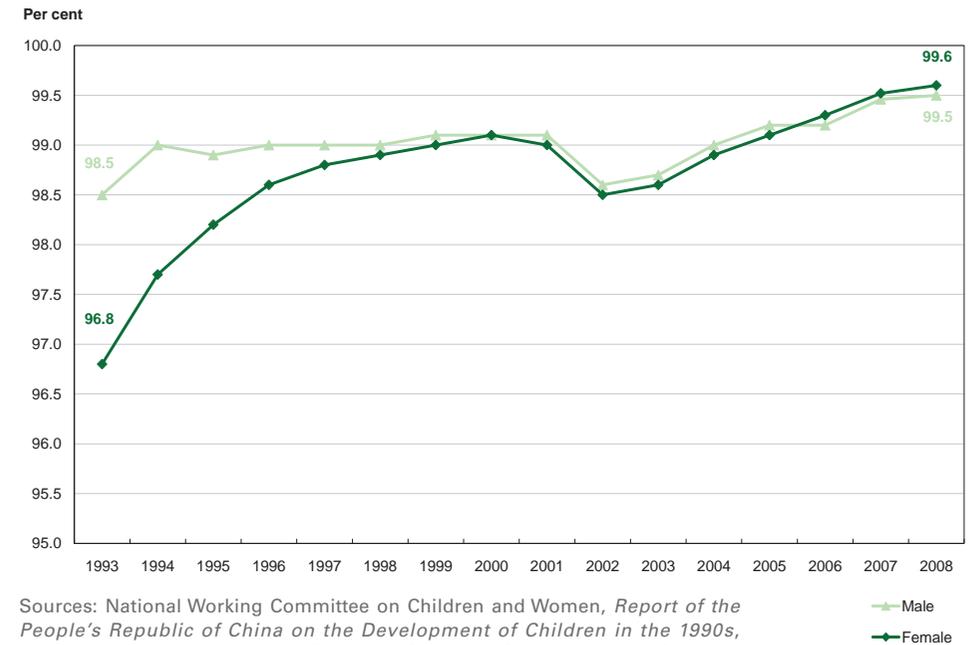
Figure 8.13
Distribution by sex of enrolled students at different education levels, 2008



Source: Ministry of Education, *China Education Statistical Yearbook*, 2009

Figure 8.13
The distribution of students by sex shows a higher ratio of males to females at all levels of schooling. This, however, may also be influenced by the sex ratio of the school-age population, which has shown a steady increase in favour of males over the last decades.

Figure 8.14
Net enrolment ratio in primary education, 1993–2008



Sources: National Working Committee on Children and Women, *Report of the People's Republic of China on the Development of Children in the 1990s*, 2001 (1993–1999 data); National Bureau of Statistics, *Statistics on the Status of Women and Children in China*, 2009 (2000–2008 data)

Figure 8.14
China has achieved gender parity at the primary school level. Female enrolment has increased at a faster rate than male enrolment, actually surpassing that of males since 2006.

Figure 8.15
Net enrolment ratio in primary education, by province, 2008

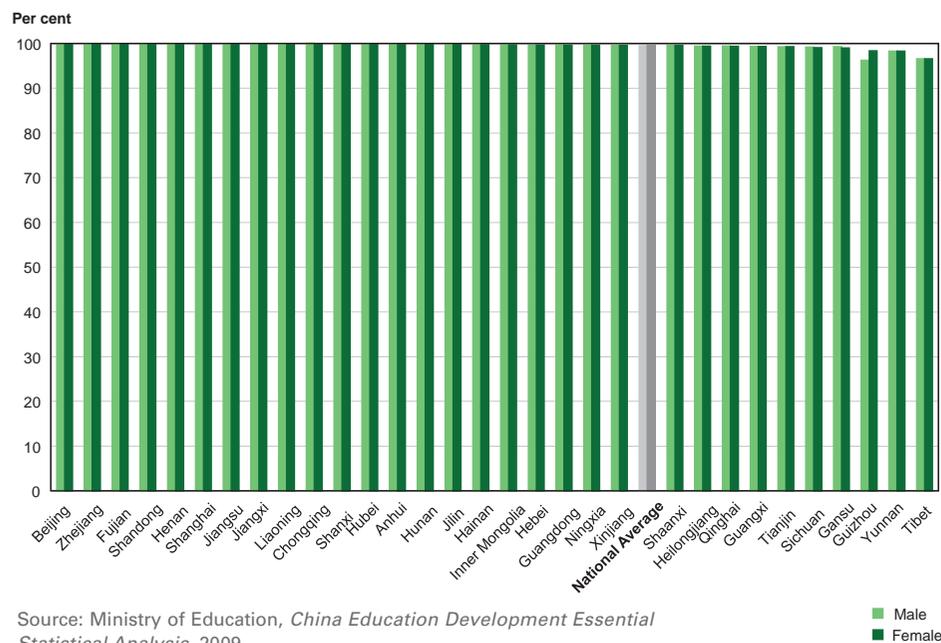
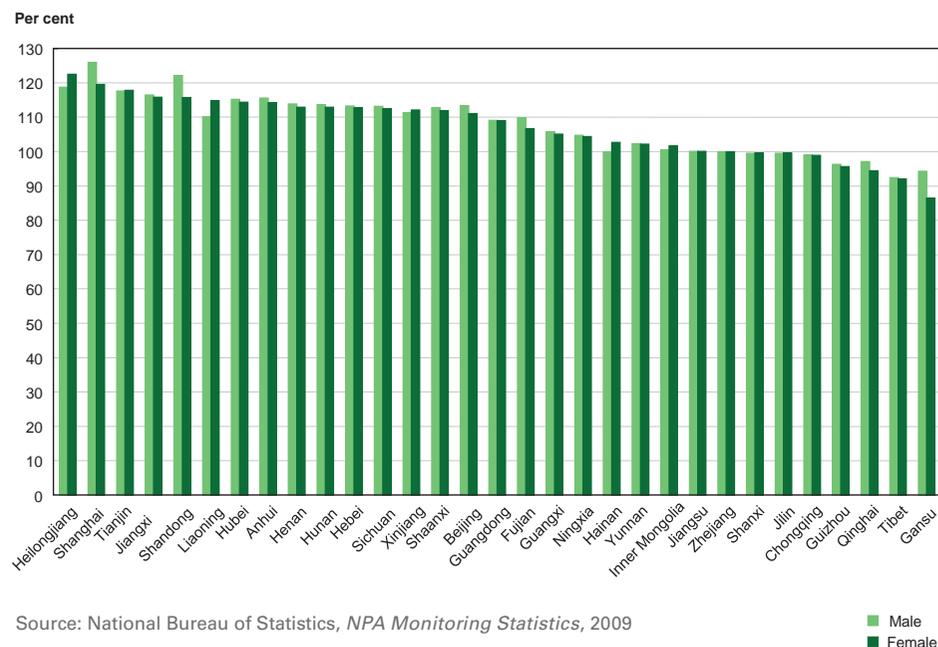


Figure 8.16
Gross enrolment ratio in junior secondary education, by province, 2008



Figures 8.15 and 8.16

There are no significant differences between male and female primary net enrolment ratios. At junior secondary level, the male and female enrolment ratios show a slight difference in some provinces.

Figure 8.17
Teachers' qualification, 2008

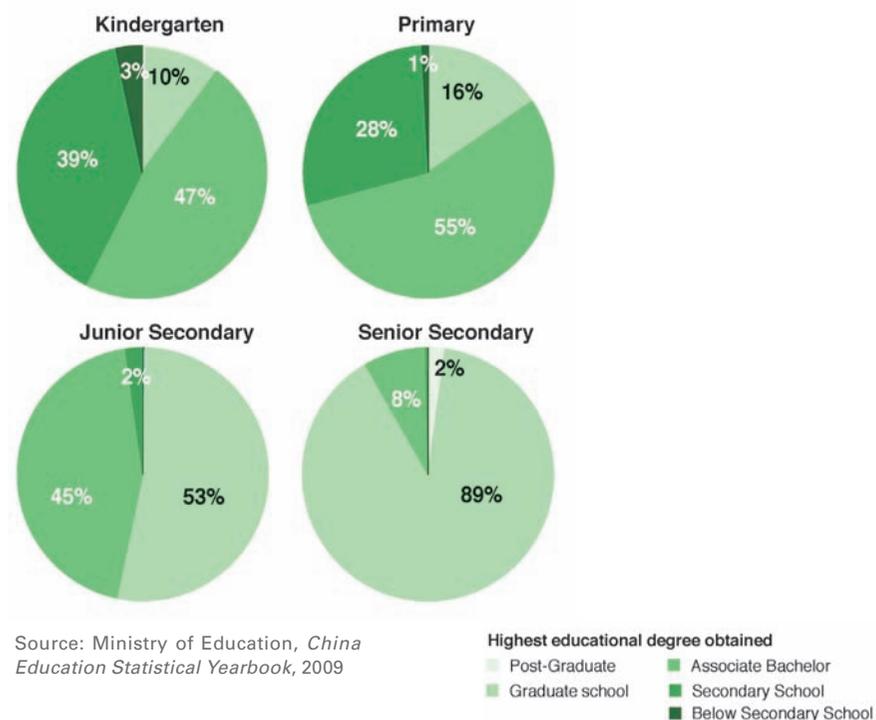


Figure 8.17
The majority of teachers have the necessary educational qualifications according to China's Law on Teachers. In 2008, 97 per cent of teachers at kindergarten level, 99 per cent at primary level, 98 per cent at junior secondary level, and 92 per cent at senior secondary level had the required educational qualifications.

Figure 8.18
Type of school attended by income group, 2006

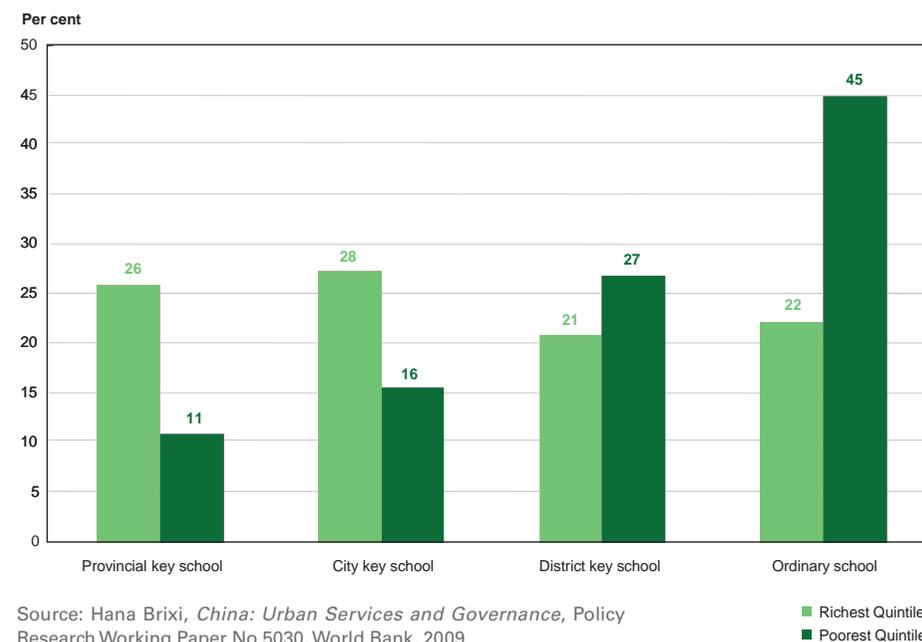
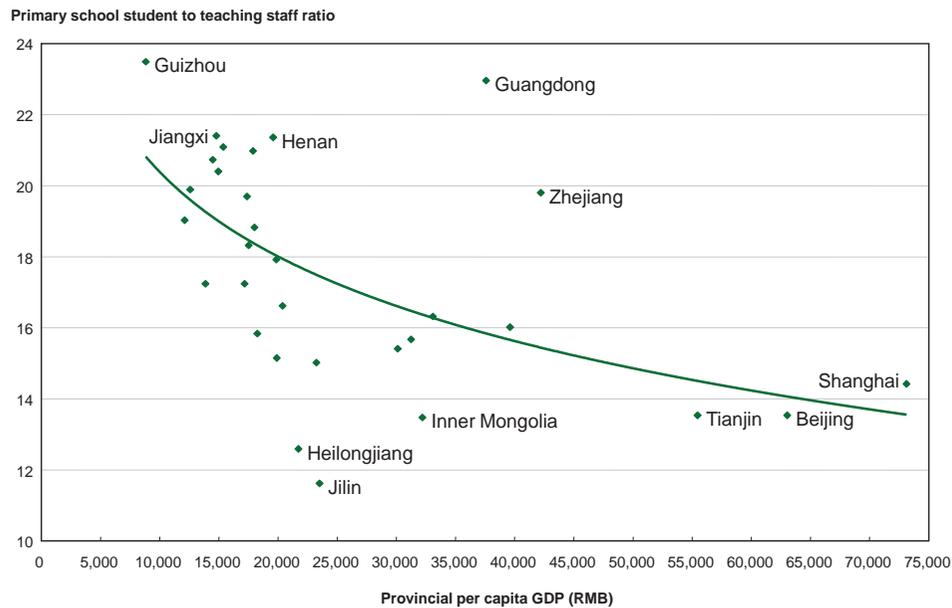


Figure 8.18
Better quality schools in China's cities tend to disproportionately benefit children from higher-income households, while ordinary schools are left to cater to children from lower-income households. Children from the richest quintile are disproportionately represented in the better-equipped and better-staffed key schools at the province, city and district levels.

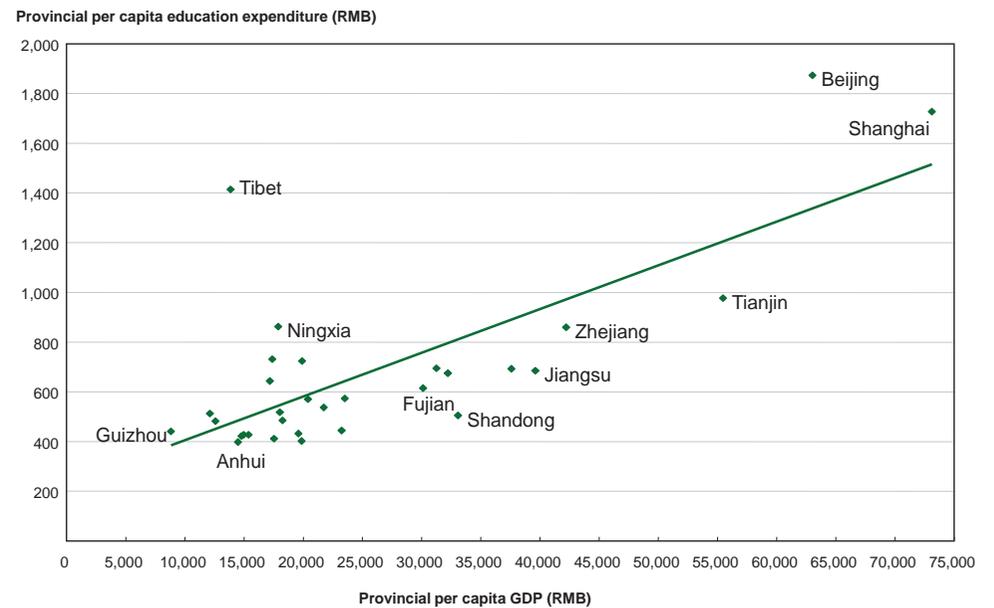
Figure 8.19
 Student to teaching staff ratio in primary education and provincial per capita GDP, by province, 2008



Source: Ministry of Education, *China Education Development Essential Statistical Analysis*, 2009

Figure 8.19
 In general, the ratio of students to teaching staff in primary education improves with increasing per capita GDP.

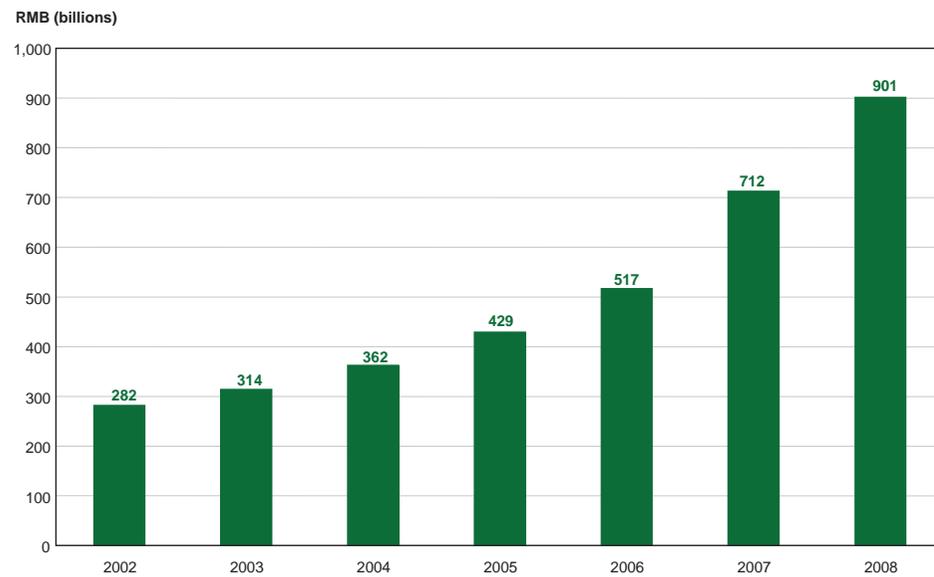
Figure 8.20
 Provincial per capita education expenditure and provincial per capita GDP, by province, 2008



Source: National Bureau of Statistics, *China Statistical Yearbook*, 2009

Figure 8.20
 Per capita spending on education in China's provinces correlates with provincial per capita GDP. Expenditure on education averages around RMB 700 per capita for provinces with a per capita GDP of around RMB 25,000. A notable exception is Tibet, where education expenditure levels exceed RMB 1,400 per capita. Among provinces with a higher per capita GDP, the highest expenditures per capita are found in Beijing (approximately RMB 1,800) and Shanghai (approximately RMB 1,700).

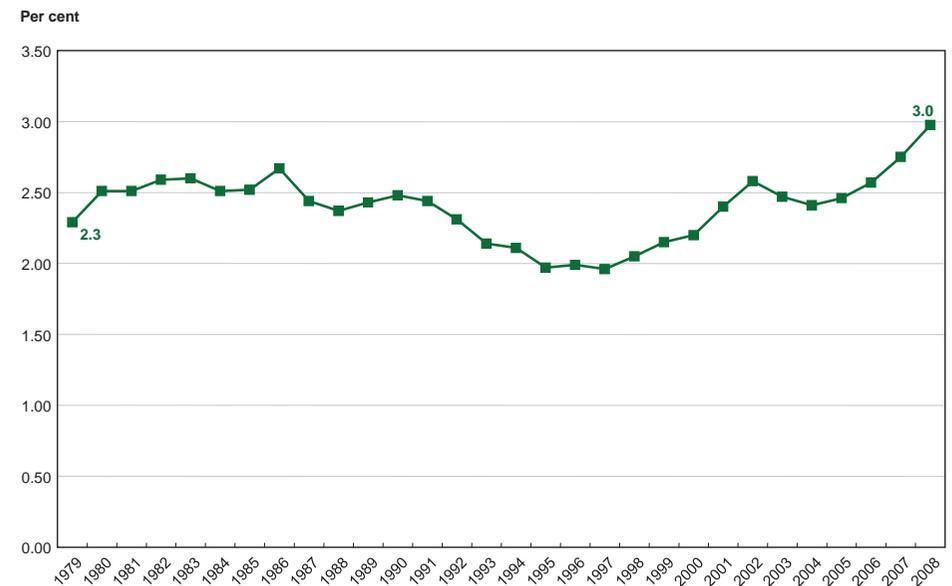
Figure 8.21
Government expenditure on education, 2002–2008



Source: National Bureau of Statistics, *China Statistical Yearbook*, 2009

Figure 8.21
Government expenditure on education has increased substantially from 2002, to reach RMB 901 billion in 2008.

Figure 8.22
Government expenditure on education as a percentage of GDP, 1979–2008



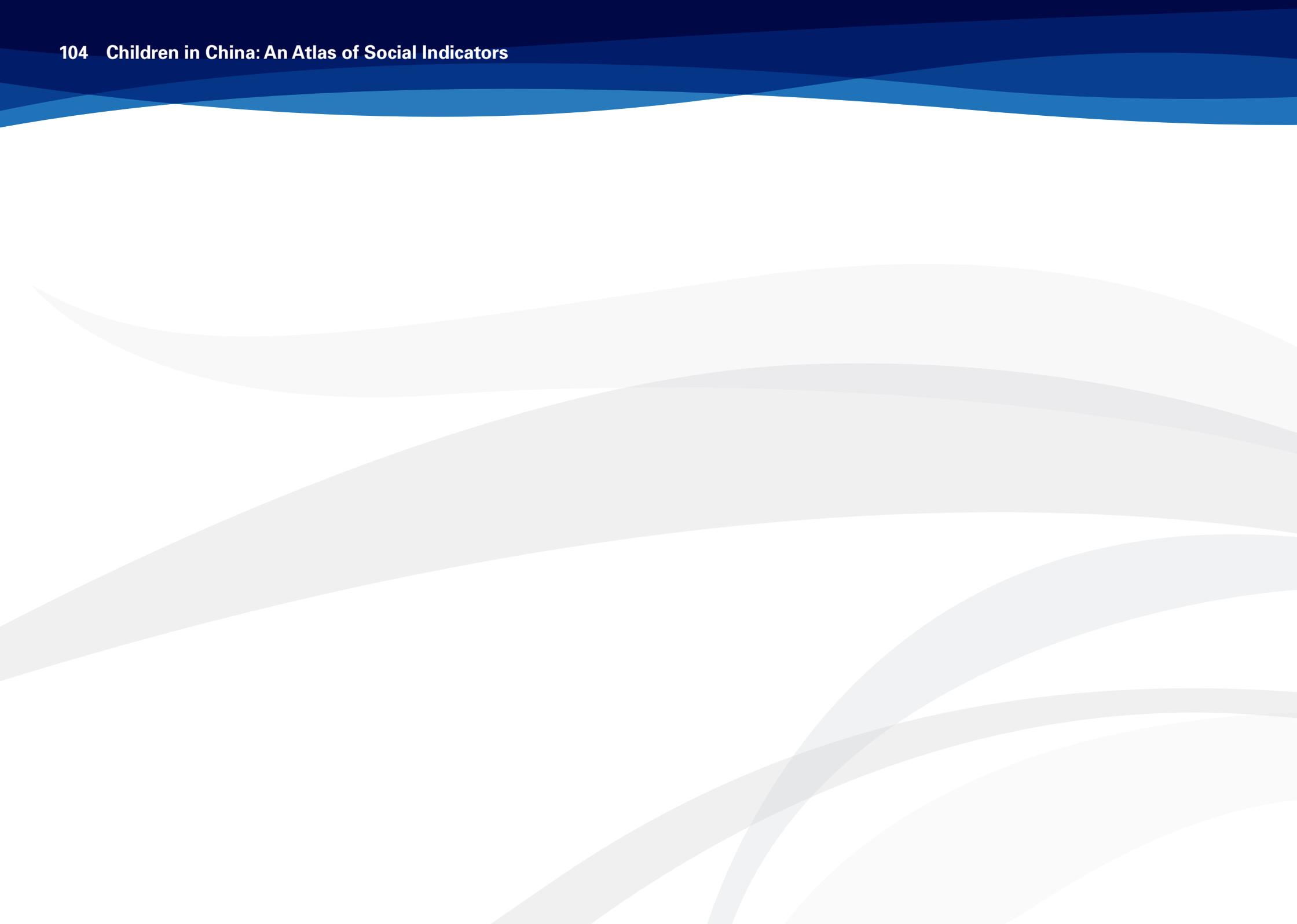
Source: National Bureau of Statistics, *China Statistical Yearbook*, 2009

Figure 8.22
Government expenditure on education as a percentage of China's GDP has yet to meet the national target of 4 per cent.



9

THE RIGHTS OF CHILDREN AND WOMEN



OVERVIEW

National Programme of Action for Children (NPA)

In 1992, in support of the international commitment made at the 1990 World Summit for Children, the Government of China adopted a first National Programme of Action (NPA) for Children for the period 1992–2000. This NPA was in line with the country's National Plan for Economic and Social Development and also took into account the global goals set at the 1990 World Summit for Children⁸⁸.

A second NPA for Children was adopted by the Government in May 2001 for the period 2001–2010.

The NPA targets serve both as China's national plan to promote children's rights, as well as the country's plan to achieve the Millennium Development Goals (MDGs), since most of the MDGs are related to children and women.

Convention on the Rights of the Child (CRC)

China ratified the Convention on the Rights of the Child (CRC) in 1992. The Government of China submitted its Initial State Party Report on the implementation of the Convention on the Rights of the Child in March 1995 through the Ministry of Foreign Affairs. In June 2003, the Government submitted its Second State Party Report to the Committee on the Rights of the Child.

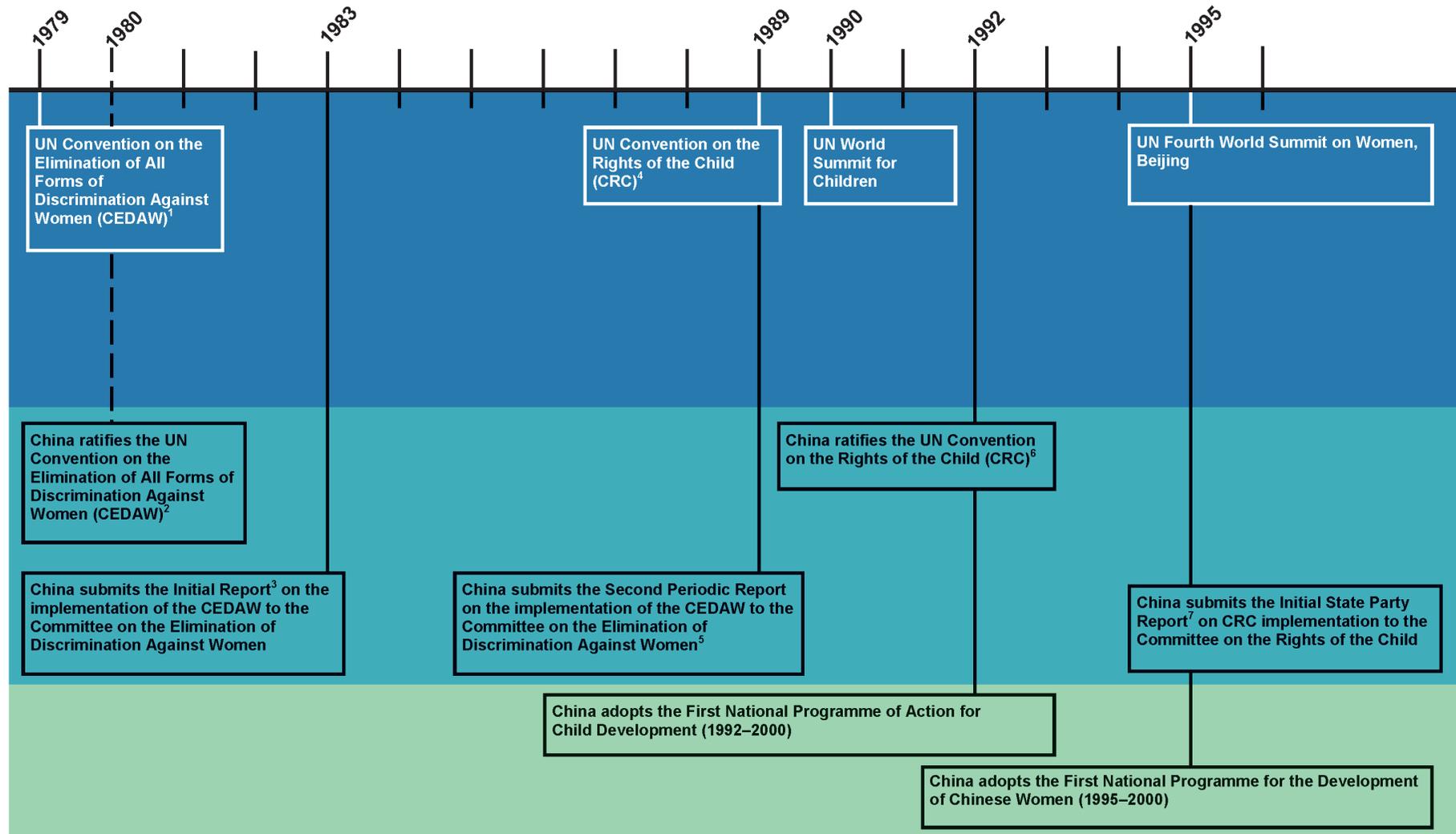
China's combined Third and Fourth State Party Report on the implementation of the Convention on the Rights of the Child and its two Optional Protocols was due in March 2009. No Report has been submitted so far.

Law on the Protection of Minors

In 2006, the National People's Congress approved revisions of the Law on the Protection of Minors which came into force in June 2007. Compared with the 1991 version, the revised law explicitly stipulates that minors shall have the right to survival, development, protection and participation in line with the core principles of the Convention on the Rights of the Child.

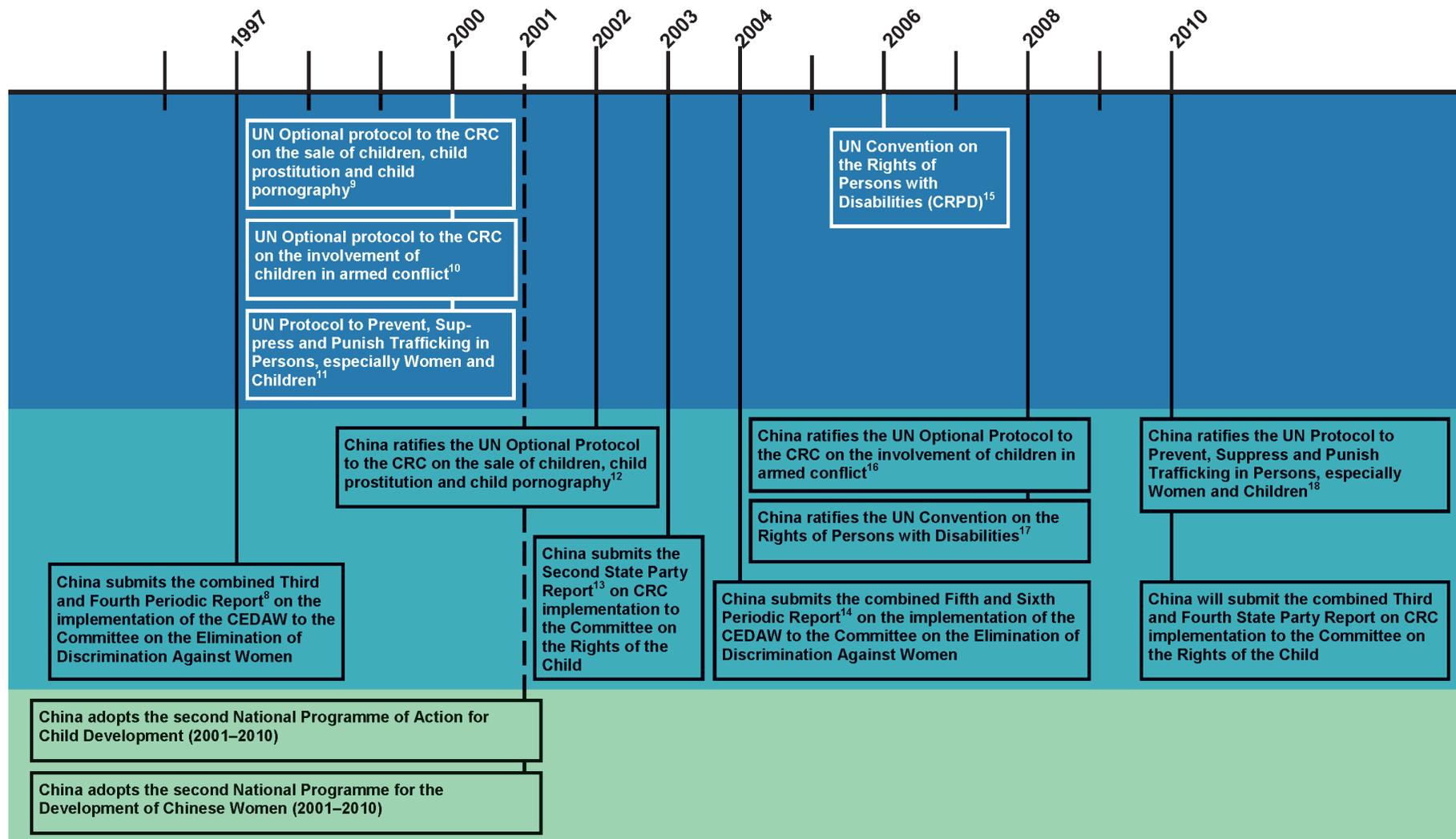
Figure 9.1

International and China's milestones in the rights of children and women



- International milestones in children's and women's rights
- China's ratification of International Conventions
- China's Programmes of Action for the Development of Children and Women

¹ General Assembly Resolution of 18 Dec 1979 entered into force on 3 Sept 1981
² China ratified the UN CEDAW on 4 Nov 1980* and it entered into force on 3 Dec 1981
³ The Initial Report on the implementation of the CEDAW was submitted on 25 May 1983
⁴ General Assembly Resolution of 20 Nov 1989 entered into force on 2 Sept 1990
⁵ The Second Periodic Report on the implementation of the CEDAW was submitted on 22 June 1989
⁶ China ratified the UN CRC on 2 March 1992* and it entered into force on 1 April 1992
⁷ The Initial State Party Report on CRC was submitted on 27 March 1995



⁸ The combined Third and Fourth Periodic Report on the implementation of the CEDAW was submitted on 25 May 1997
⁹ General Assembly Resolution of 25 May 2000 entered into force on 18 Jan 2002
¹⁰ General Assembly Resolution of 25 May 2000 entered into force on 12 Feb 2002
¹¹ General Assembly Resolution of 15 Nov 2000 entered into force on 25 Dec 2003
¹² China ratified the UN Optional Protocol to the CRC on 3 Dec 2002* and it entered into force on 3 Jan 2003
¹³ The Second State Party Report on CRC was submitted on 27 June 2003
¹⁴ The combined Fifth and Sixth Periodic Report on the implementation of the CEDAW was submitted on 4 Feb 2004

¹⁵ General Assembly Resolution of 13 Dec 2006 entered into force on 3 May 2008
¹⁶ China ratified the UN Optional Protocol to the CRC on 20 Feb 2008* and it entered into force on 20 March 2008
¹⁷ China ratified the UN Convention on the Rights of Persons with Disabilities on 1 Aug 2008* and it entered into force on 31 August 2008
¹⁸ China ratified the UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children on 8 Feb 2010*

* The date indicated reflects the formal date of ratification recorded by the United Nations; this date may differ from the official date of ratification recorded by the Government of China.



yáng guāng zài
阳光钻进了
暖炕?

吃过了
鞋，穿进了
拖鞋舒服地

奶奶睡着了
鞋里也有棉花
奶奶的拖鞋

10

**CHILDREN AFFECTED
BY MIGRATION**

OVERVIEW

Massive internal migration

China's migrant population of 200 million represents the largest movement of people in modern history. In the Eleventh Five-Year Plan for Social and Economic Development (2006–2010), the Government has embraced internal migration as essential to the national development strategy. If framed with the right measures, migration can drive urbanization, increase rural incomes, restructure the economy, and level urban-rural and regional disparities. However, maximizing the benefits of internal migration, while mitigating its adverse effects, is a difficult balancing act.

While the migrant population contributes significantly to the overall development of the country, their working and living conditions remain markedly inferior to those of the resident population in receiving cities. The planning, financing and delivery of public services by local authorities is based on one's residential *hukou* status; those with an urban *hukou* are able to benefit from social security coverage and access to public social services. The lack of permanent residence status in cities (an urban *hukou*) has become the main constraint for migrant populations.

Ensuring that migrant workers and their families have access to the social security system and receive basic, guaranteed public services has become a key challenge for the Government.

The impact of migration on children

Most migrant workers are young or middle-aged and have school-aged children. Many will choose to leave their children behind in villages to be brought up by their grandparents or relatives, but others will migrate with their children to the cities.

Children of migrants

The figures from the *2000 Population Census* put the number of children who have migrated with their parents at 23.6 million. The number has since increased to 27.3 million⁸⁹, according to the *2008 Sample Survey on Population Changes*. As they move, children of migrants lose their traditional support structures and face hardship and discrimination. Many are not registered in their new place of residence and remain "invisible" to the local authorities, as there is no requirement to register children under 16 years of age.

Despite government policies and regulations barring discrimination against children of migrants, many of them are unable to attend public schools. Instead, they have to enrol in private, low-quality schools. High fees, as well as the entry of some older migrant children into the labour market, result in higher dropout rates for migrant children than urban resident children. The inadequate coverage of migrants and their families by health insurance, partly due to the completely separate nature of the schemes set up in urban and rural areas and the non-transferability of benefits, results in high medical expenses and inhibits access to health services. Discrimination and the lack of referral mechanisms present additional barriers. Maternal and child mortality is reported to be significantly higher among migrants than among urban residents.

Left-behind children

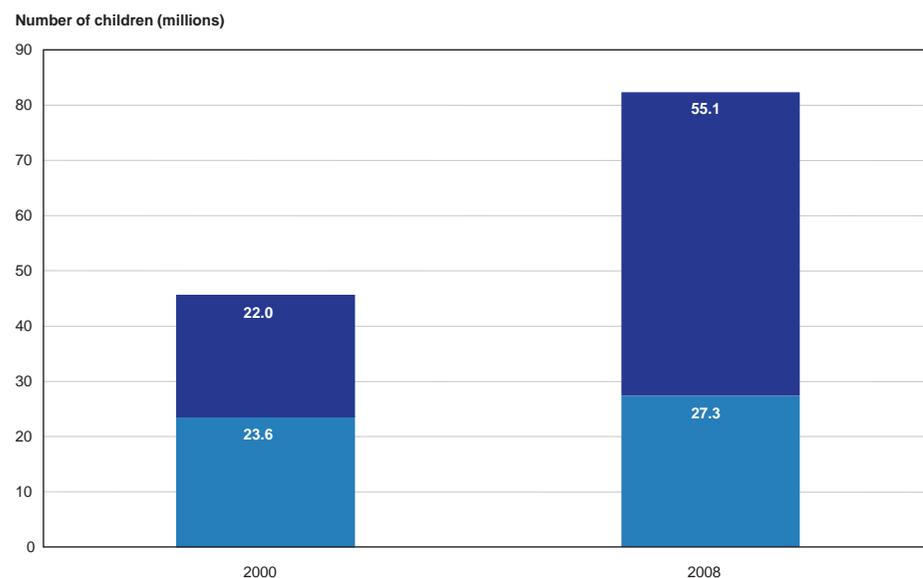
The number of children left-behind by migrating parents has almost tripled in recent years from 22.0 million in 2000 to an estimated 55.1 million in 2008⁹⁰. The situation of left-behind children, deprived of either one or both parents, is a matter of serious concern.

Left-behind children are generally concentrated in the densely populated or economically less-developed towns and townships of the provinces of Sichuan, Guangdong, Jiangxi, Jiangsu, Anhui, Hunan and Hainan.

Surveys suggest that most left-behind children maintain irregular and limited contact with their parents and feel lonely, isolated and deprived of support. Some only see their parents once a year during the Spring Festival. Their caregivers, especially grandparents, are often unable to provide them with adequate care, including emotional support, adequate hygiene and nutrition, and homework supervision. School retention rates are lower for left-behind children, especially in junior high school, and their relationships with their peers are often affected. This has a profound impact on their physical, educational and psychosocial development and well-being.

The Government's vision of a Harmonious *Xiaokang* Society places a high priority on addressing the inequalities among the urban, rural and migrant populations, and therefore on ensuring that the benefits of development reach the most vulnerable. In recent years, policy reforms and new legislation have been introduced specifically to improve migrants' access to equal labour rights, civil rights and rights to basic services and social security. However, the sheer scale and complexity of the challenge means that progress remains gradual.

Figure 10.1
Children affected by migration, 2000 and 2008



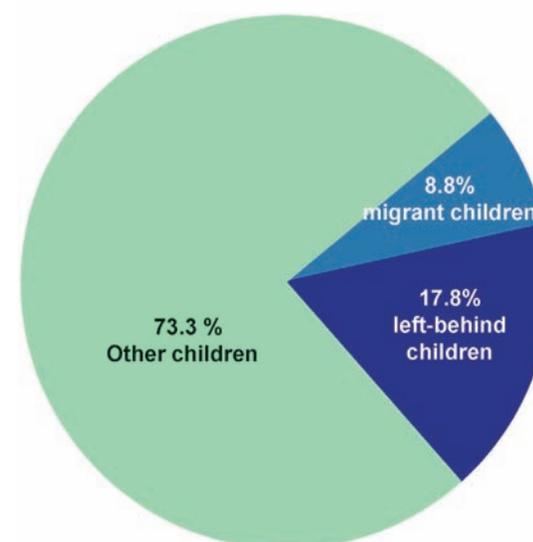
Sources: National Bureau of Statistics, *2000 Population Census*, 2002;
National Bureau of Statistics *2008 China Population*, 2009

■ Left-behind children
■ Migrant children

Figure 10.1

The number of migrant children increased from 23.6 million to 27.3 million between 2000 and 2008. In 2008, migrant children represented approximately nine per cent of China's child population. According to the national *Population Census*, 22.0 million children were left-behind in 2000. Between 2000 and 2008, that number more than doubled to reach 55.1 million in 2008, with left-behind children representing approximately 18 per cent of China's child population in 2008.

Figure 10.2
Children affected by migration as a percentage of all children, 2008



Source: National Bureau of Statistics, *2008 China Population*, 2009

Figure 10.2

In 2000, 45.6 million children were affected by migration. In 2008, the number of children affected by migration reached 82.4 million, representing a quarter (27 per cent) of China's child population.



11

**CHILDREN WITH
DISABILITIES**

OVERVIEW

The UN Convention on the Rights of Persons with Disabilities, which entered into force in China in 2008, is aimed at promoting, protecting and ensuring the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and promoting respect for their inherent dignity.

As defined in the UN Convention on the Rights of Persons with Disabilities, *“Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others.”*

China played an active role as advocate and participant during the negotiation process and the drafting of the UN Convention on the Rights of Persons with Disabilities. The Government of China signed the Convention in 2007 and officially ratified it on 1 August 2008.

In order to align China’s national legislation with international standards on disability, the Government started a parallel process in 2006 to revise the *Law of the People’s Republic of China on the Protection of Persons with Disabilities*, which had originally been formulated in 1990. New provisions for children with disabilities were included in the revised Law, which entered into force on 1 July 2008.

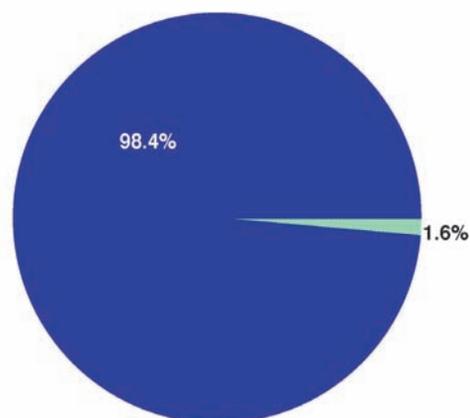
These efforts demonstrate how, over the past few years, the Government has taken significant action in pursuing policy and legislative reform to promote the rights and well-being of people with disabilities, and with a special attention to the protection and rights of children with disabilities.

This policymaking process was informed by data and research on disability, notably the *Second National Sample Survey on Disability*, conducted in 2006, nearly 20 years after the *1987 First National Sample Survey on Disability*. The 2006 survey, which was conducted in the 31 provinces, autonomous regions and municipalities of mainland China, sampled 771,797 households and 2,526,145 people, including 616,940 children below the age of 18 years.

The survey used the *“Criteria of Disabilities for the Second National Sample Survey on Disability,”* which were designed on the basis of the World Health Organization’s International Classification of Diseases (ICD) and the International Criteria of Functions, Disabilities and Health (ICFDH). Disabilities were accordingly divided into seven categories: visual, hearing, speech, physical, intellectual, mental and multiple.

The 2006 survey found that 1.6 per cent of the children surveyed live with some kind of disability and that children accounted for 6 per cent of all people living with disabilities. According to that survey, this translates to approximately five million children in China living with some kind of disability.

Figure 11.1
Children with disabilities
as a percentage of all
children in China, 2006



Source: China Disabled Persons' Federation, *The Status Analysis and Strategies Study of Children With Disability in China, 2008*

Figure 11.2
Children with disabilities
as a percentage of all
people with disabilities in
China, 2006

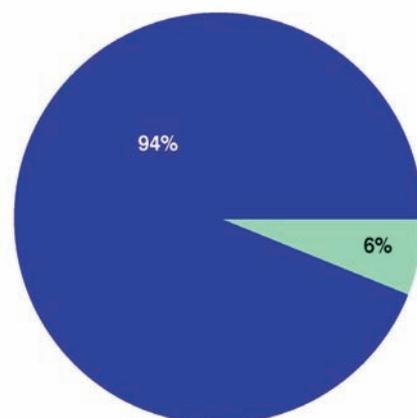
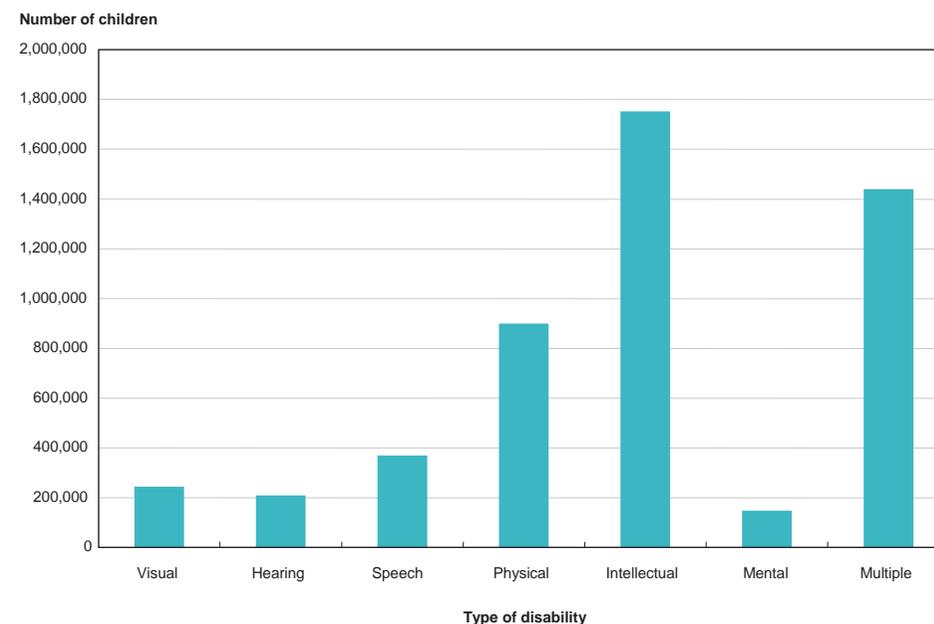


Figure 11.3
Children with disabilities, by type of disability, 2006



Source: China Disabled Persons' Federation, *The Status Analysis and Strategies Study of Children With Disability in China, 2008*

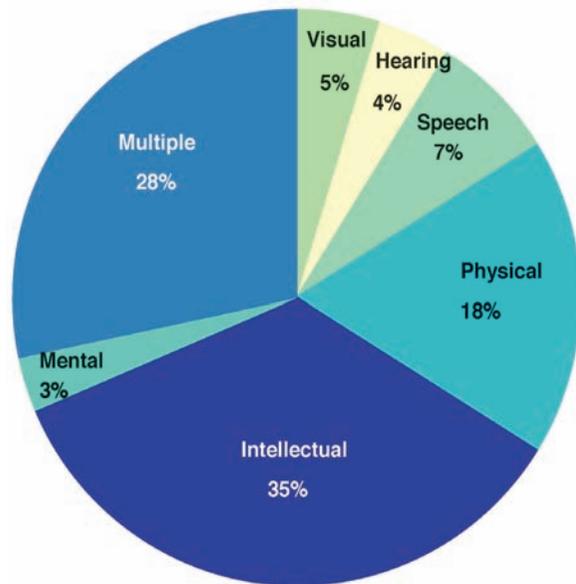
Figures 11.1 and 11.2

According to the survey, China has an estimated five million children with disabilities who represent 1.6 per cent of all children in the country and 6 per cent of all people with disabilities.

Figure 11.3

The estimated number of children with specific types of disabilities⁹¹ has been extrapolated from data from the *Second National Sample Survey on Disability*.

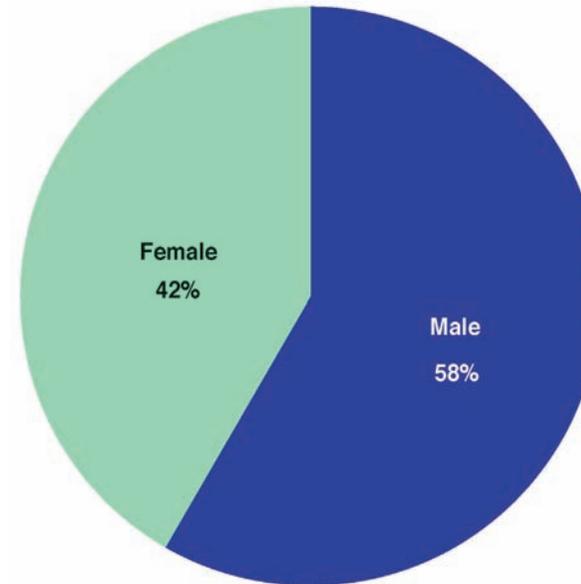
Figure 11.4
Types of disabilities among children with disabilities, 2006



Source: China Disabled Persons' Federation, *The Status Analysis and Strategies Study of Children With Disability in China*, 2008

Figure 11.4
The survey found that the three most common types of disability in China among children between 0 and 17 years of age were intellectual impairment, multiple impairments and physical impairment.

Figure 11.5
Sex ratio of children with disabilities, 2006

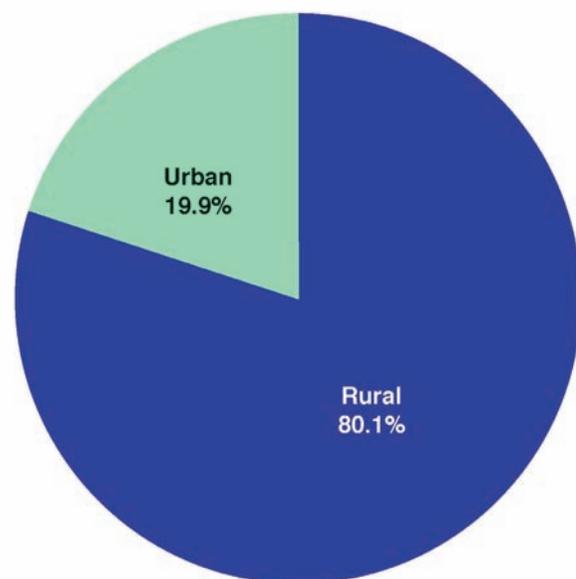


Source: China Disabled Persons' Federation, *The Status Analysis and Strategies Study of Children With Disability in China*, 2008

Figure 11.5
Of the number of children aged 0–17 identified with a disability during the Second National Sample Survey on Disability, 58 per cent were male and 42 per cent female, resulting in a sex ratio of 141 males to 100 females.

According to the *First National Sample Survey on Disability*, conducted in 1987, out of the total number of children identified with a disability, 56 per cent were male and 44 per cent were female. In 1987, the sex ratio of children with disabilities was 126 males to 100 females.

Figure 11.6
Percentage of children with disabilities, urban and rural, 2006

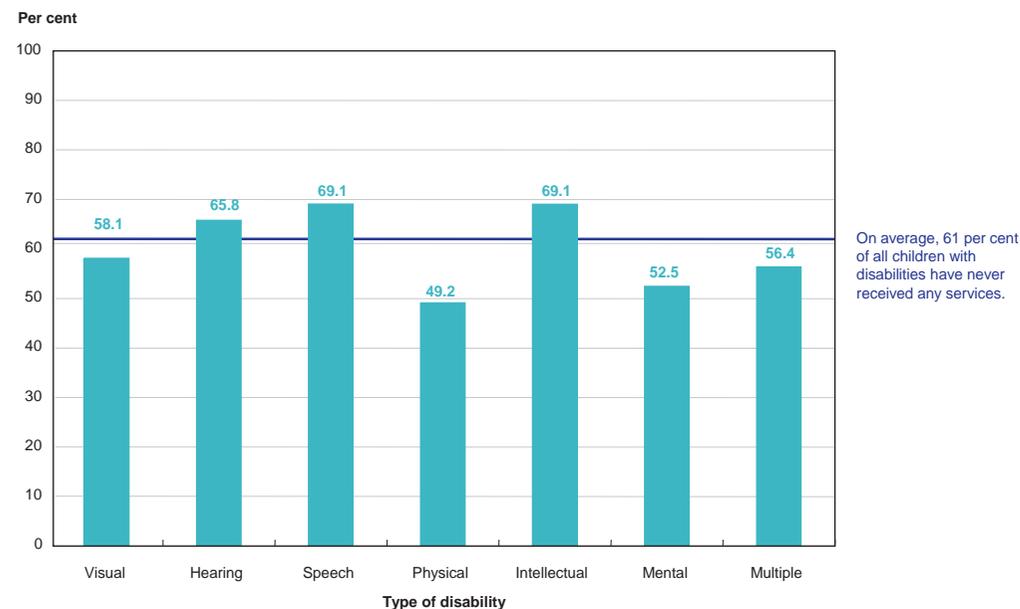


Source: China Disabled Persons' Federation, *The Status Analysis and Strategies Study of Children With Disability in China*, 2008

Figure 11.6

The percentage of children with disabilities living in urban and rural areas did not vary significantly between 1987 and 2006. The *2006 National Sample Survey on Disability* found that 20 per cent of children with disabilities aged 0–17 lived in urban areas, while 80 per cent of them lived in rural areas.

Figure 11.7
Percentage of children with disabilities who have never received any of the listed services, 2006



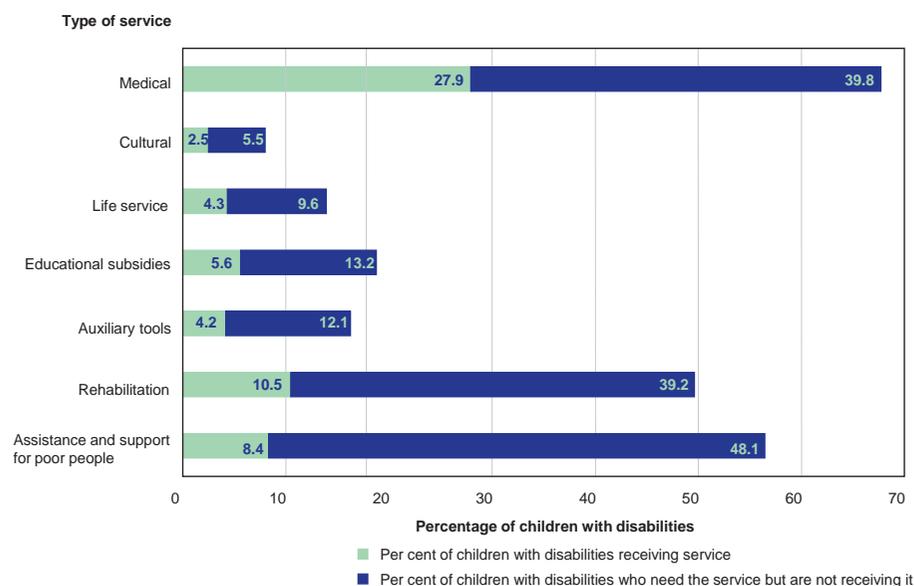
Source: (Derived from) China Disabled Persons' Federation, *The Status Analysis and Strategies Study of Children With Disability in China*, 2008

Figure 11.7

In the *2006 National Sample Survey on Disability*, children with disabilities aged 0–17 and/or their caretakers were asked to identify the types of services/assistance they received to address the child's disability.

The survey found that, on average, 61 per cent of children with disabilities had never received any of the services mentioned in the questionnaire – namely medical service and assistance; auxiliary tools for people with disabilities; rehabilitation training and services; subsidy, reduction or exemption of education fees; vocational education and training; employment placement and support; assistance and support for poor people with disabilities; legal assistance and services; barrier-free facilities; and barrier-free access to information, life services and cultural services⁹².

Figure 11.8
Percentage of children with disabilities receiving needed services, 2006

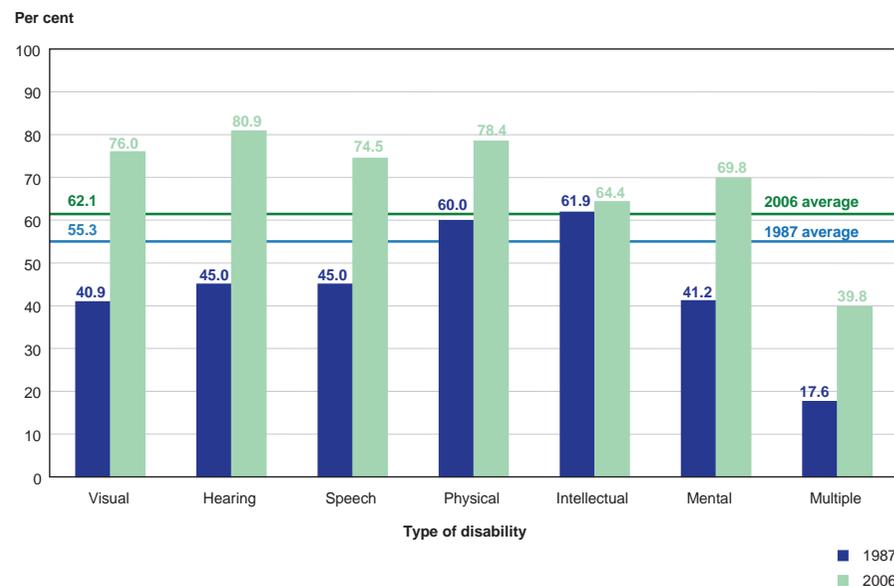


Source: (Derived from) China Disabled Persons' Federation, *The Status Analysis and Strategies Study of Children With Disability in China*, 2008

Figure 11.8
In the 2006 Sample Survey on Disability, children with disabilities and their guardians were asked to identify the three main types of services/assistance needed to address the child's disability.

- Medical services and assistance were received by 28 per cent of respondents, but reported as needed by an additional 40 per cent.
- Assistance and support for poor people with disabilities were received by 8 per cent of respondents, but needed by an additional 48 per cent.
- Rehabilitation training and services were received by 10 per cent of respondents, but needed by an additional 39 per cent.
- Subsidy, reduction or exemption of education fees were received by 6 per cent of respondents, but needed by an additional 13 per cent.

Figure 11.9
Percentage of children with disabilities aged 6–14 receiving nine-year basic education, 1987 and 2006



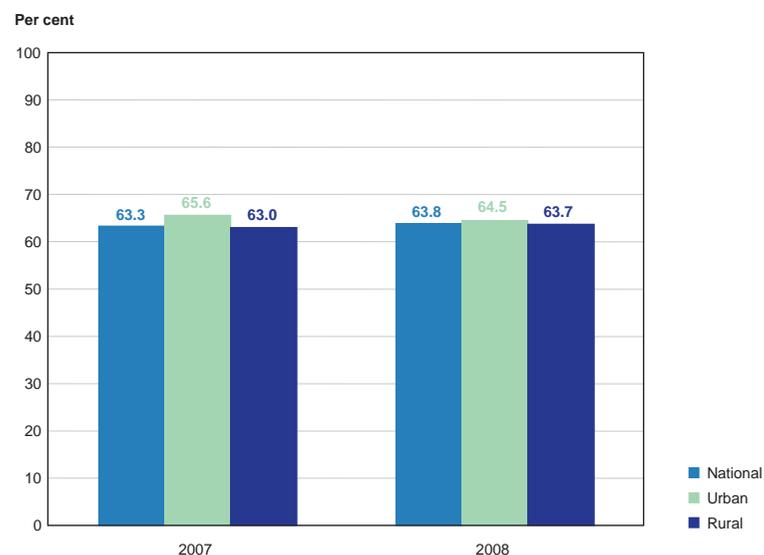
Source: China Disabled Persons' Federation, *The Status Analysis and Strategies Study of Children With Disability in China*, 2008

Figure 11.9
In 2006, 62 per cent of children with disabilities aged 6–14 were receiving nine-year basic education, an increase from 55 per cent in 1987. Nine-year basic education for children with disabilities is provided through normal schools, special education schools and other channels (e.g. community-based schooling, home schooling).

The 2006 data show that among children with disabilities, the proportion of children receiving nine-year basic education is highest among children with hearing impairment and lowest among children with multiple disabilities.

In China, males with disabilities are more likely to be educated than females with disabilities. According to the *First National Sample Survey on Disability*, this ratio was 157:100 in 1987. According to the *Second National Sample Survey on Disability*, the sex ratio of children with disabilities aged 6–14 receiving nine-year basic education in 2006 was 144 males to 100 females.

Figure 11.10
Percentage of children with disabilities aged 6–14 receiving nine-year basic education, 2007–2008



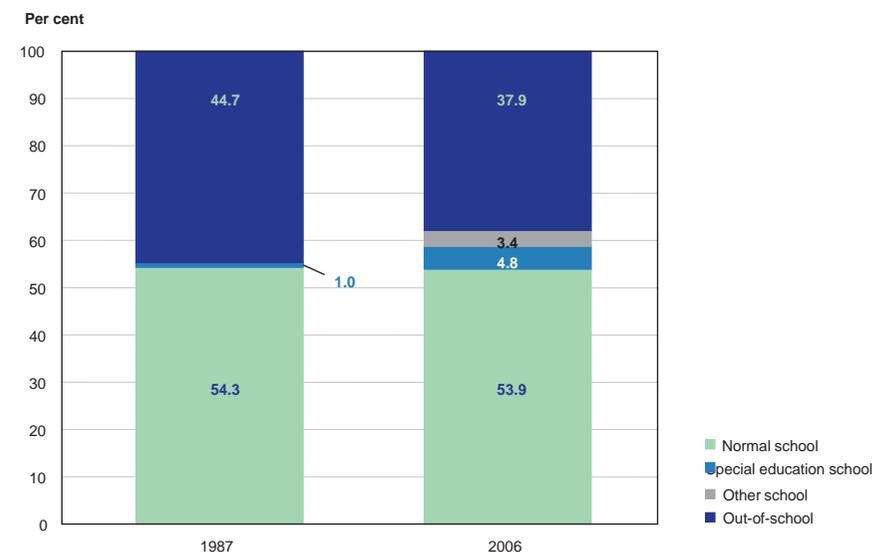
Sources: (Derived from) China Disabled Persons' Federation, *National Monitoring Report on the Situation of People with Disabilities, 2007*; China Disabled Persons' Federation, *National Monitoring Report on the Situation of People with Disabilities, 2008*

Figure 11.10

To better monitor the situation of people with disabilities after the *2006 National Sample Survey on Disability*, the China Disabled Persons' Federation (CDPF) conducted three national follow-up monitoring surveys on the situation of people with disabilities in 2007, 2008 and 2009. These monitoring surveys selected 734 communities, one from each of the counties sampled during the *Second National Sample Survey on Disability* in 2006. According to the *2007 National Monitoring Survey Report*, the proportion of school-aged children with disabilities aged 6–14 receiving nine-year basic education was 63 per cent nationwide (65.6 per cent in urban areas and 63.0 per cent in rural areas).

In 2008, the proportion of school-aged children with disabilities receiving nine-year basic education increased to 64 per cent (64.5 per cent in urban areas and 63.7 per cent in rural areas).

Figure 11.11
Type of school attended by children with disabilities, 1987 and 2006



Source: (Derived from) China Disabled Persons' Federation, *The Status Analysis and Strategies Study of Children With Disability in China, 2008*

Figure 11.11

The majority of surveyed children with disabilities aged 6–14 who were receiving nine-year basic education in China in 2006 attended normal schools (54 per cent), while 5 per cent were enrolled in special education schools and 3 per cent were reported to be receiving education through other channels (e.g. community-based schooling, home schooling).

The percentage of children receiving nine-year basic education in special education schools has increased by 4 per cent in the past 19 years.

In 1987, 45 per cent of children with disabilities aged 6–14 were out of school. This percentage dropped to 38 per cent in 2006.



12

**VIOLENCE AGAINST
CHILDREN**

OVERVIEW

WHO defines violence⁹³ as “*the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation.*”

Violence is therefore not restricted to acts of severe physical violence; but includes emotional/mental violence, sexual violence and neglect as well. This definition of violence has been accepted by the international community and is reflected in Article 19 of the UN Convention on the Rights of the Child (CRC):

Article 19.1 of the CRC: States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

In 2004, the former UN Secretary General, Kofi Annan, launched the *UN Study on Violence against Children*. This represented the first comprehensive global attempt to document the scale of all forms of violence against children and its

impact. The Government of China was among the 130 States that took part in this important study and submitted an official response to the UN questionnaire.

As part of this global initiative, UNICEF supported a *Retrospective Survey on Childhood Violence Experiences Among Young People in China* in 2005. This study, developed using the international definition of violence against children, provides the most comprehensive data available to date on violence against children in China.

Conducted by a research team led by Professor Chen Jingqi from Peking University, the survey sampled students enrolled in colleges and technical secondary schools in five provinces (Guangdong, Zhejiang, Hubei, Shaanxi and Heilongjiang) and Beijing. The questionnaire was given to 4,327 students and completed by approximately 83 per cent of these participants. Of the respondents, 54 per cent were female and 46 per cent were male. The percentages of respondents who grew up in urban and rural areas were almost equal.

Figure 12.1
Reported prevalence of physical violence before age 16, 2005

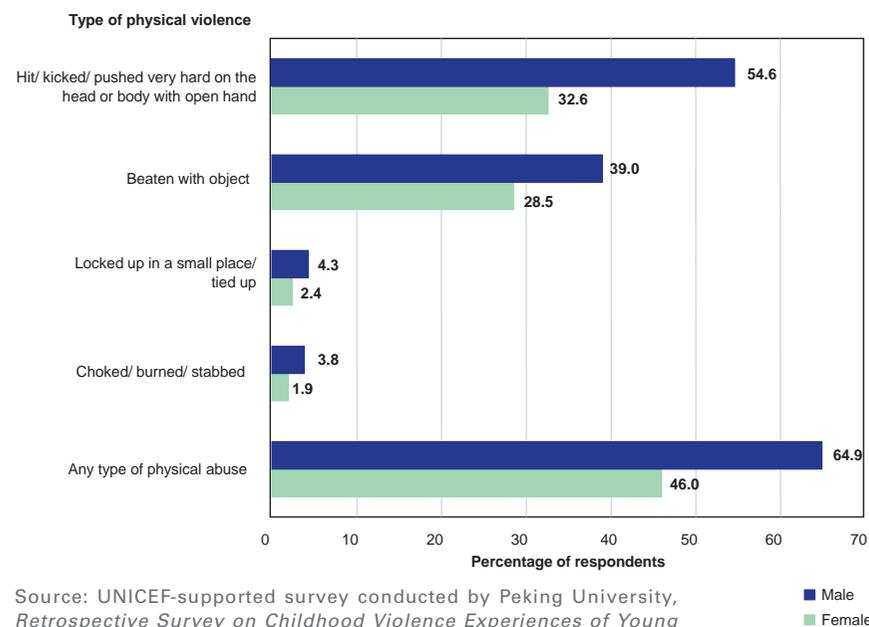


Figure 12.1
Based on a questionnaire referring to four types of physical violence, as listed in the chart above, more than half (55 per cent) of all respondents reported having experienced one or more types of physical violence before the age of 16.

Additional information on physical violence:

- According to respondents, the three main perpetrators of physical violence against children were parents, teachers and classmates.
- Respondents reported being beaten most frequently between the ages of 10 and 12.
- 65 per cent of all male respondents experienced physical violence, compared to 46 per cent of all female respondents.
- 3 per cent of respondents experienced three or four types of physical violence.

Figure 12.2
Reported prevalence of psychological violence before age 16, 2005

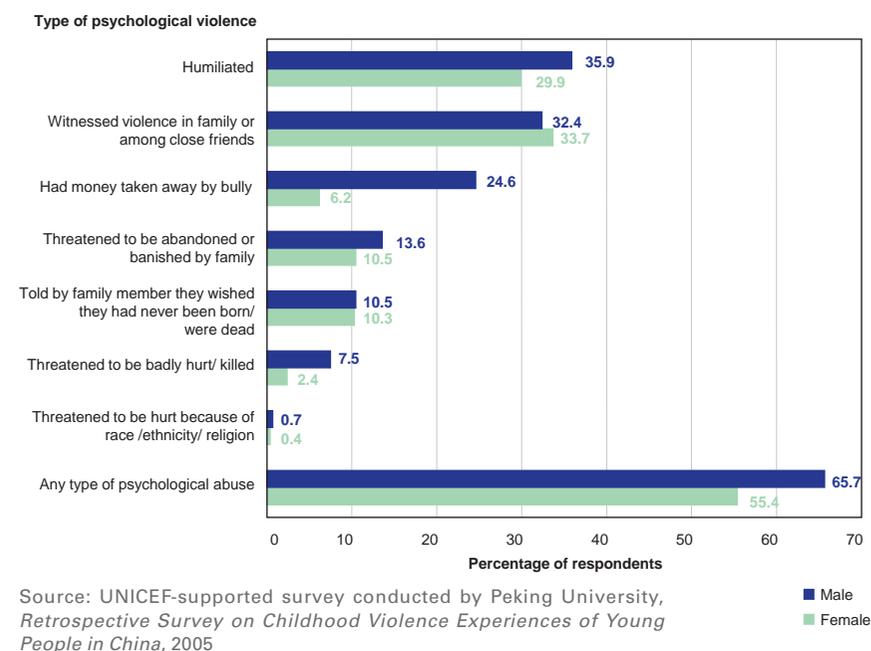


Figure 12.2
Based on a questionnaire referring to seven types of psychological violence, as listed in the chart above, 60 per cent of all respondents reported having experienced one or more types of psychological violence before the age of 16.

Additional information on psychological violence:

- Humiliation is one form of psychological violence. The main perpetrators of humiliation against children were classmates, teachers and parents.
- Psychological violence was generally reported to be most frequent between the ages of 13 and 15.
- 66 per cent of all male respondents experienced psychological violence, compared to 55 per cent of all female respondents.
- 3 per cent of respondents experienced four forms of psychological violence, and 1.5 per cent experienced five or more forms of psychological abuse.

Figure 12.3
Reported prevalence of sexual violence before age 16, 2005

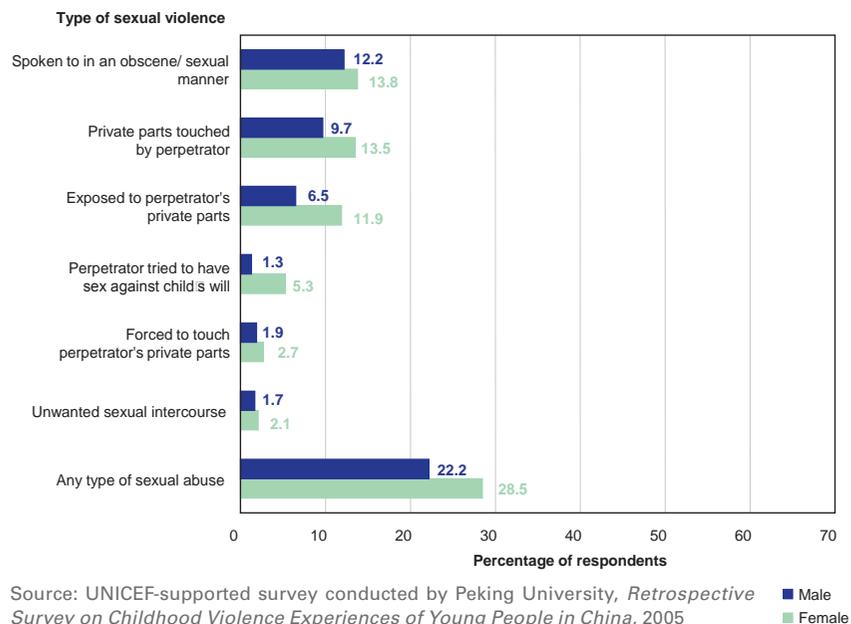


Figure 12.3
Based on a questionnaire referring to six types of sexual violence, as listed in the chart above, 26 per cent of all respondents reported having experienced one or more types of sexual violence before the age of 16.

Additional information on sexual violence:

- 2 per cent of respondents said they were forced to have sexual intercourse against their will, while another 3 per cent of respondents said someone had tried to have sexual intercourse with them against their will.
- The three main perpetrators of unwanted sexual intercourse were dating partners, classmates and relatives.
- Among respondents who experienced sexual violence, the first incidence of sexual violence was most likely to occur between the ages of 13 and 15.
- Overall, females were more likely to report having experienced sexual violence than males (28 per cent, versus 22 per cent).

Figure 12.4
Experience with different types of violence before age 16, 2005

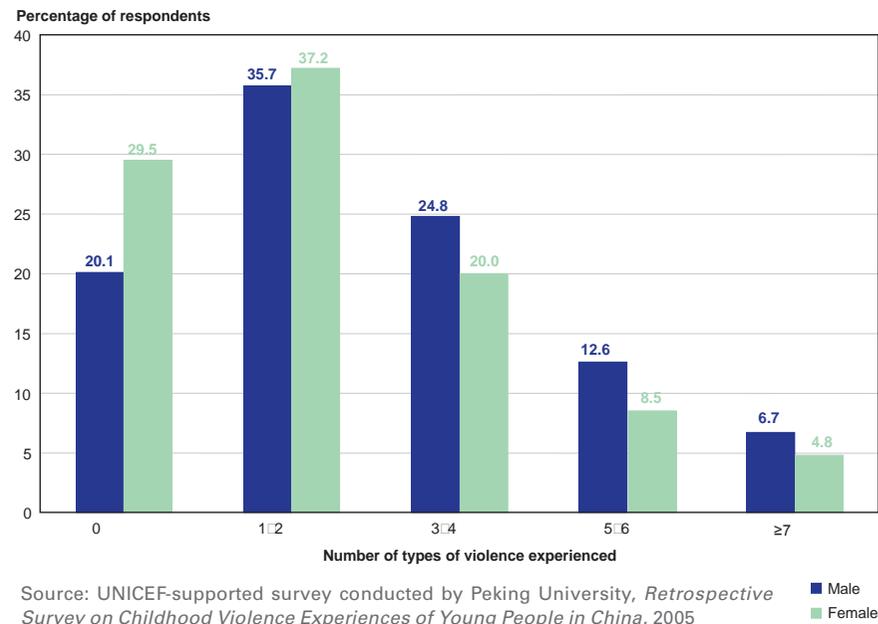


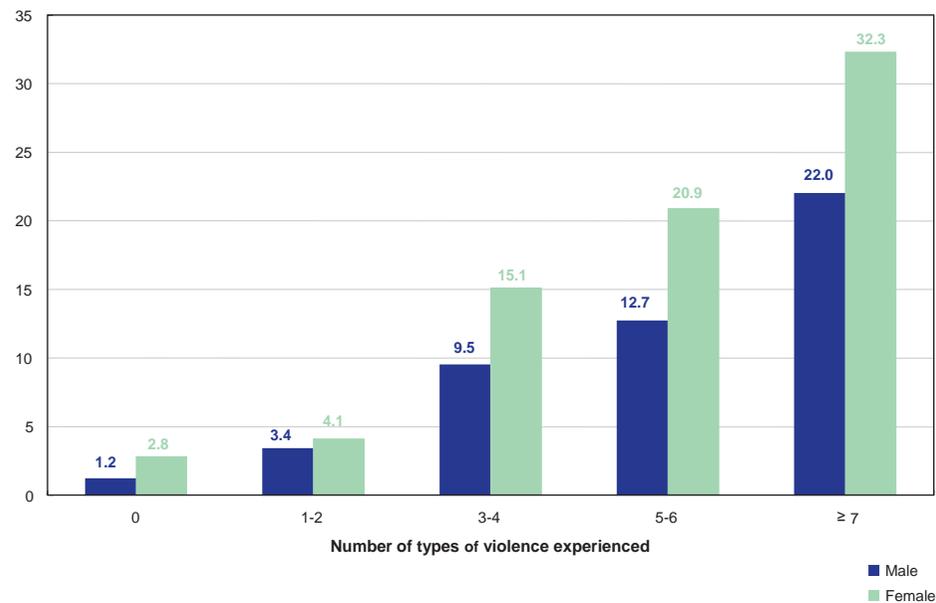
Figure 12.4
The figure listed a total of 17 types of violence: four types of physical violence, seven types of psychological violence, and six types of sexual violence.

- The majority of respondents (62 per cent) reported that they had experienced none or less than two types of violence.
- Six per cent of respondents reported that they had experienced seven or more types of violence before the age of 16.
- No significant difference was detected in the rates of violence among respondents of different backgrounds, whether from urban or rural areas, or single-child or multiple-child families. Neither was any significant difference in rates of violence detected among children raised by junior-high-school-educated or senior-high-school-educated parents.

Figure 12.5

Suicidal intentions and experience with different types of violence before age 16, 2005

Percentage of respondents in each group who seriously considered attempting suicide during the past year



Source: UNICEF-supported survey conducted by Peking University, *Retrospective Survey on Childhood Violence Experiences of Young People in China, 2005*

Figure 12.5

Compared with their peers who experienced no violence in childhood, respondents who experienced multiple types of violence had significantly higher levels of suicidal intention. This was especially true for females.

拐卖妇女儿童犯



13

TRAFFICKING

OVERVIEW

Children are trafficked for the purposes of illegal adoption, sexual exploitation and labour exploitation. There is a greater risk of trafficking among migrant and left-behind children.

Between 2000 and 2007, the Ministry of Public Security (MPS) detected 44,507 cases of trafficking in women and children, with cases generally involving several victims. During that period, 132,899 women and children were rescued. Between April and October 2009, over 6,000 women and children were rescued in a National Campaign to Combat Trafficking of Women and Children.

The Government of China issued its first National Plan of Action to Combat Trafficking in Women and Children (2008–2012) in December 2007. The Plan detailed the anti-trafficking responsibilities of 32 ministries and appointed the Ministry of Public Security as the coordinator of the Government's anti-trafficking efforts.

In addition, as host to the Second Coordinated Mekong Ministerial Initiative Against Trafficking (COMMIT) Summit in December 2007, China joined other countries in signing a Joint Declaration to work together to implement the Sub-Regional Plan of Action.

The Government of China is a signatory to the United Nations Convention against Transnational Organized Crime (2000), and ratified in February 2010 its supplementary Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children.

Much work remains to be done to prevent trafficking by raising community awareness. Further work is also needed to raise the knowledge and skills of law enforcement officials, social workers, health workers and communities on the need to recognize and respect the rights of trafficking victims in the rescue and rehabilitation process.

Figure 13.1
 Number of trafficking cases involving young children and women, 2000–2007

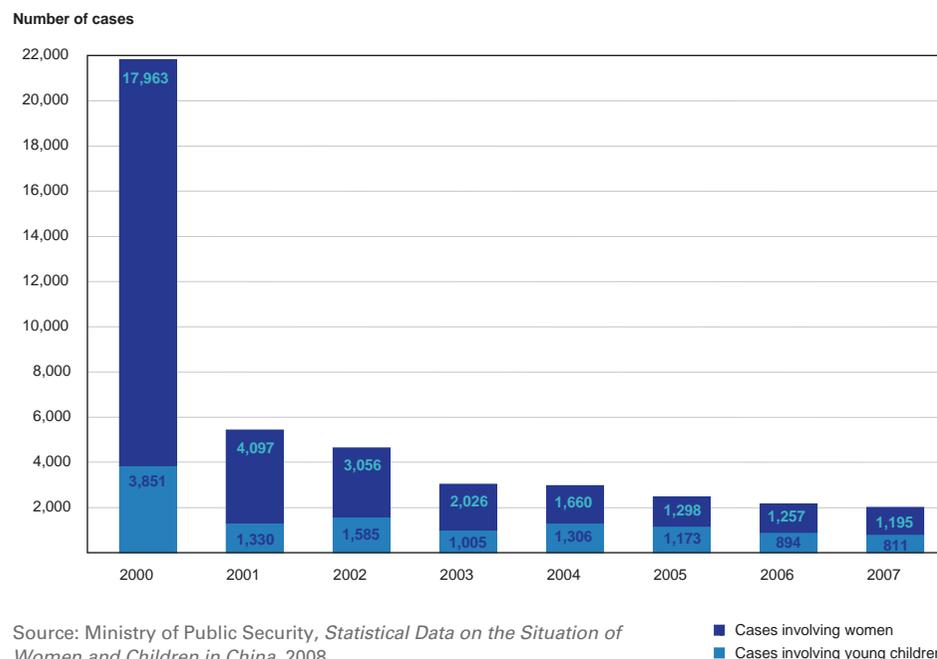


Figure 13.1
 The total number of trafficking cases detected in China from 2000–2007 was 44,507. In 2000 alone, 21,814 cases were registered during a national campaign to combat children and women’s trafficking. In the years after the campaign, there has been a decline in the number of trafficking cases detected by the police, with some 2,000–3,000 cases detected each year between 2003 and 2007. However, the actual number of cases is believed to be much greater than the officially registered number, and each trafficking case may involve several victims.

Figure 13.2
 Source and destination provinces for trafficking, 2007



Figure 13.2
 Generally speaking, women and children are likely to be trafficked from poorer inland areas to more affluent coastal areas or central provinces. Guangdong, Henan, Yunnan, Sichuan, Guizhou, Guangxi, Shaanxi and Fujian have been identified as the main “source provinces” from where women and children are trafficked, while Guangdong, Shanxi, Fujian, Henan, Sichuan, Guangxi and Jiangsu have been identified as key “destination provinces” to where they are trafficked.

China is both a source and destination country for trafficking. Women and children from poorer areas in China are trafficked to richer destinations such as Hong Kong, Japan, Malaysia, Singapore, Taiwan Province and Thailand; while women and children from Laos, Myanmar and Vietnam are trafficked into China, for forced marriage as well as for labour and sexual exploitation.



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14

HIV / AIDS

OVERVIEW

In 2009, 740,000 people in China were estimated to be living with HIV⁹⁴, with around 50,000 new infections per year. In 2007, cumulative reported cases showed that 70 per cent of HIV infections were concentrated in young adults between the ages of 20 to 39 years⁹⁵.

Currently, China's HIV epidemic, at 0.05 per cent of the total population, remains one of low prevalence overall, but with pockets of high infection rates among specific sub-populations. Some 80 per cent of the total cumulative reported cases of HIV occur in just six provinces; namely Yunnan, Henan, Guangxi, Xinjiang, Guangdong and Sichuan.

In 2007, sexual transmission replaced injecting drug use as the main mode of HIV transmission⁹⁶. Consequently, some epidemiologists in China have begun to observe syphilis incidence rates with a view to predicting the future spread of HIV. Some of the highest syphilis incidence rates are in the eastern coastal provinces, suggesting that HIV could spread quickly in these regions.

Between 1993 and October 2007, the percentage of females among reported cases of HIV infection has increased significantly from 15 to 29 per cent. Consequently, the percentage of mother-to-child transmission of HIV has risen steadily, from 0.1 per cent of all cases in 1998 to 1.6 per cent of all cases in 2007⁹⁷.

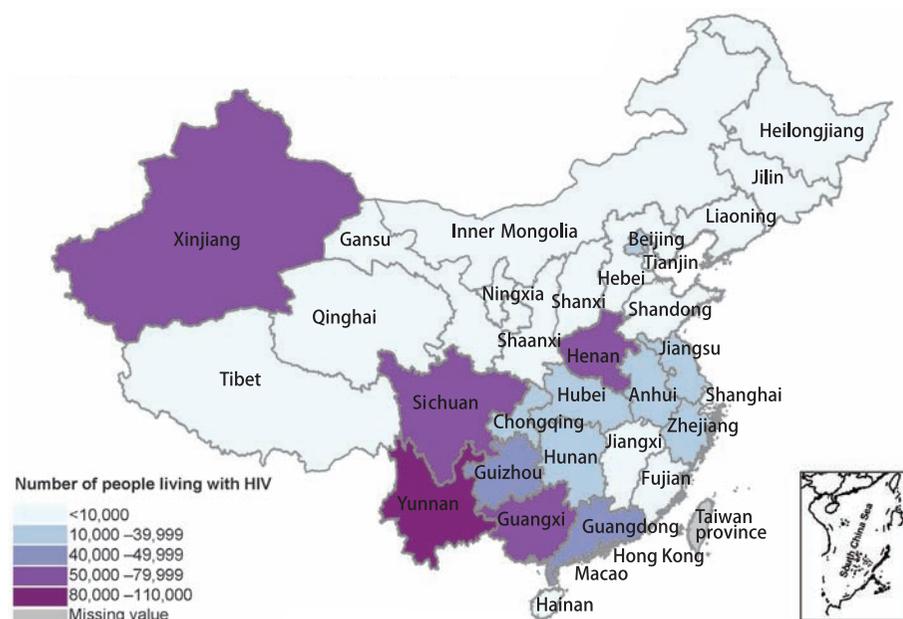
Between the launch in June 2005 of the National Paediatric AIDS Programme and September 2007, 3,531 paediatric HIV/AIDS cases were reported⁹⁸, 80 per cent of which occurred in just six provinces: Henan, Yunnan, Guangxi, Xinjiang, Anhui and Shanxi.

Knowledge and awareness about HIV transmission are still low among young people. The percentage of young women and men aged 15–24 who correctly identified ways of preventing the sexual transmission of HIV and also rejected major misconceptions about HIV transmission was about 41 per cent at the end of 2007⁹⁹.

Stigma and discrimination remain a barrier to seeking government services. In a 2006 UNICEF - Ministry of Education survey¹⁰⁰ of 34,599 students across 18 provinces, 49 per cent reported that they were not willing to eat at the same table as a person living with HIV.

The economic impact on families affected by AIDS can be significant as fewer family members are able to work and finances have to be diverted to the treatment and care of AIDS patients. A study¹⁰¹ found that the average per capita income in households affected by AIDS was 44 to 47 per cent of those not affected by AIDS. Additional costs of treating opportunistic infections add to the burden.

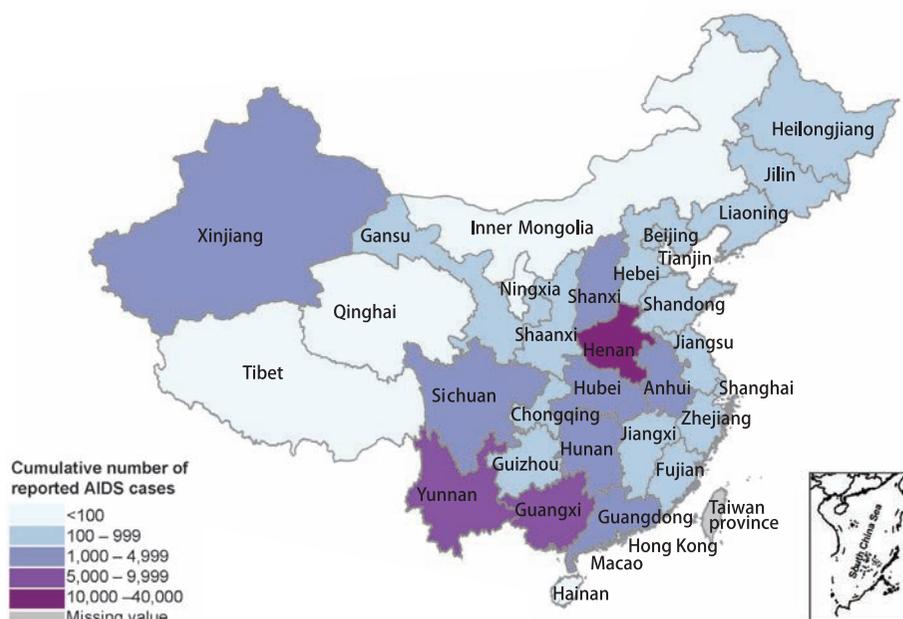
Figure 14.1
Estimated number of people living with HIV, 2007



Source: State Council AIDS Working Committee Office, United Nations Theme Group on AIDS in China, *A Joint Assessment of HIV/AIDS Prevention, Treatment and Care in China (2007)*, 2007

Figure 14.1
In 2007, 700,000 people in China were estimated to be living with HIV. Five provinces, namely Yunnan, Xinjiang, Sichuan, Guangxi and Henan, account for 53 per cent of the country's estimated number of people living with HIV¹⁰².

Figure 14.2
Number of cumulative reported AIDS cases, 1985–2007 (as of October 2007)



Source: State Council AIDS Working Committee Office, United Nations Theme Group on AIDS in China, *A Joint Assessment of HIV/AIDS Prevention, Treatment and Care in China (2007)*, 2007

Figure 14.2
Between 1985 and October 2007, the cumulative number of reported AIDS cases was approximately 63,000. Henan, Yunnan, Guangxi, Anhui, Guangdong and Hubei Provinces accounted for 83 per cent of the cumulative number of reported AIDS cases.

Figure 14.3
Age distribution of cumulative HIV infections, AIDS cases and AIDS-related deaths, 1985–2007 (as of October 2007)

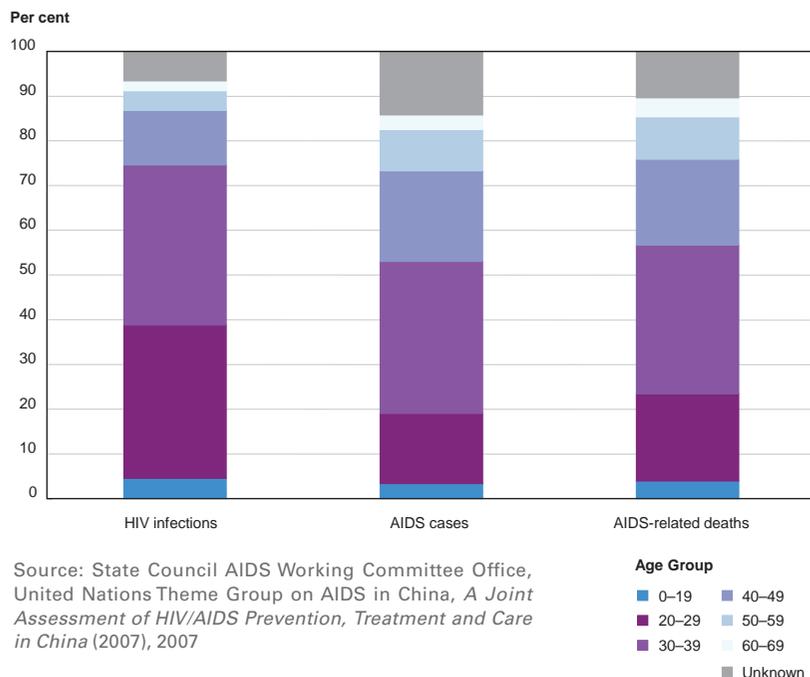


Figure 14.3
Reported cases show that HIV infections are concentrated in the 20–29 and 30–39 age groups, which together account for 70 per cent of all infections.

Figure 14.4
Transmission modes of reported HIV/AIDS cases, 1985–2007 (as of October 2007)

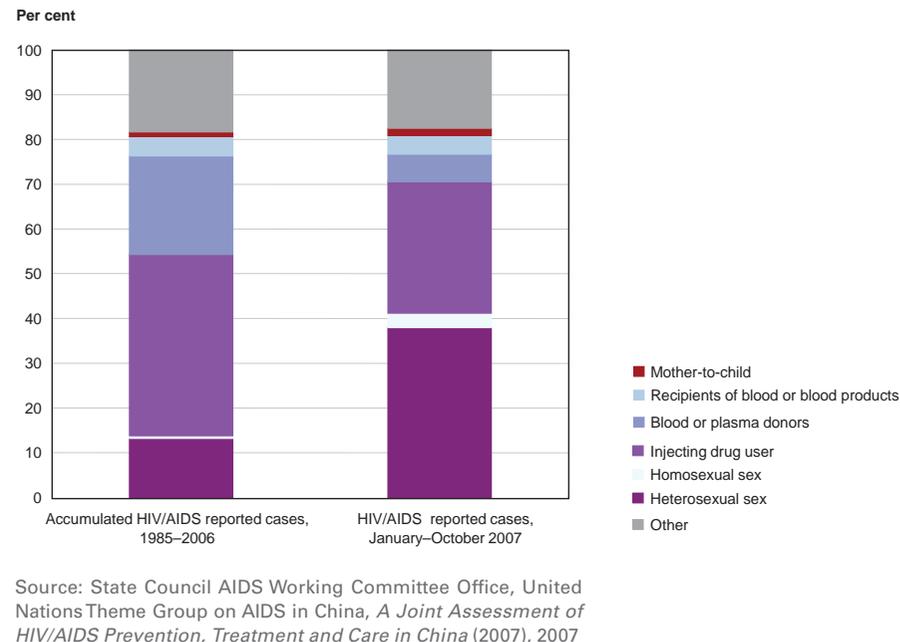
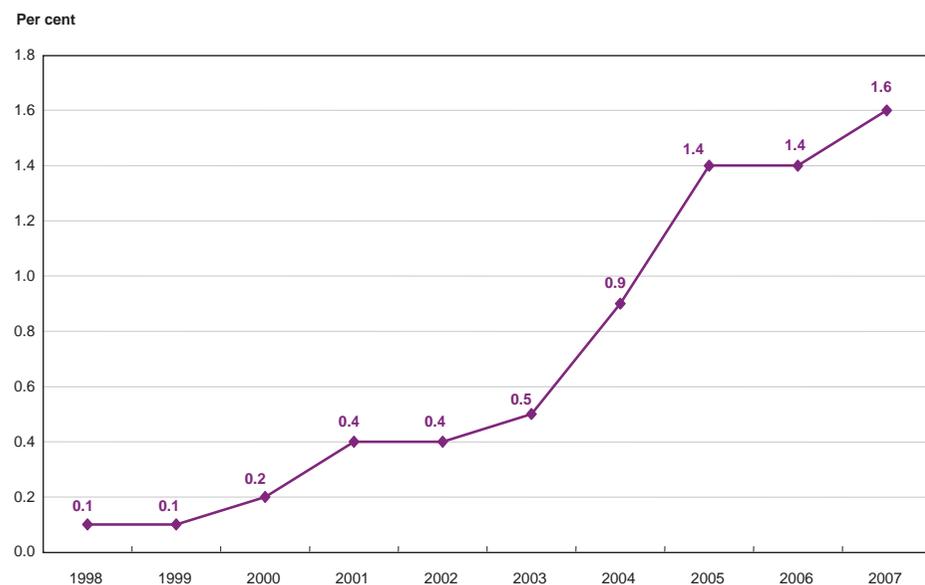


Figure 14.4
In 2007, sex became the main mode of HIV transmission for the first time. Mother-to-child transmission of HIV accounted for a higher percentage of reported HIV/AIDS cases in 2007. Throughout, injecting drug use accounted for roughly one-third of all HIV infections. Yunnan, Xinjiang, Guangxi, Guangdong, Guizhou, Sichuan and Hunan account for 88 per cent of all people estimated to be infected through IDU.

Figure 14.5
Percentage of reported HIV/AIDS cases attributed to mother-to-child transmission, 1998–2007

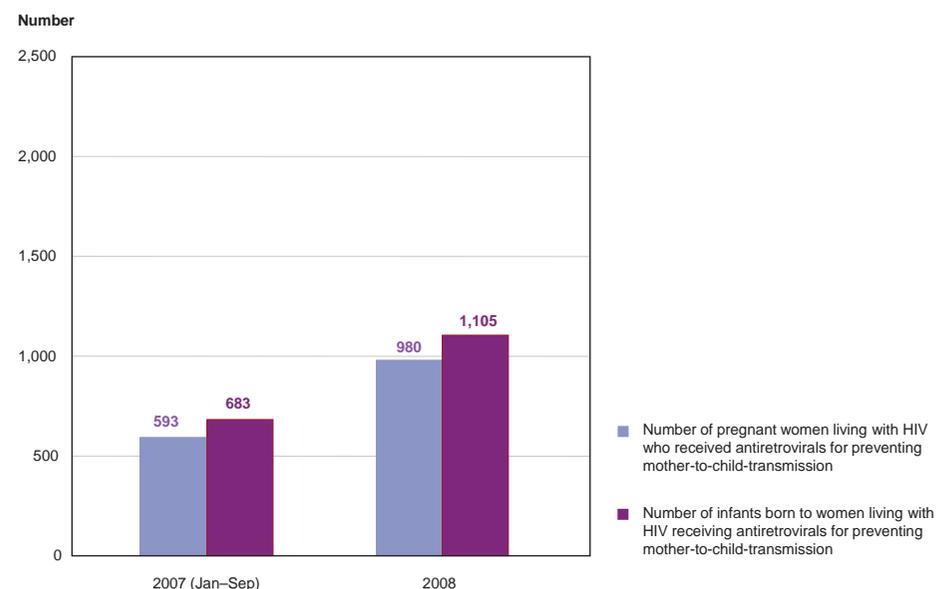


Source: China Ministry of Health, United Nations Children's Fund, World Health Organization, United Nations Population Fund, Joint United Nations Programme on HIV/AIDS, Clinton Foundation, United States Centers for Disease Control and Prevention, Family Health International, Chinese PMTCT and Paediatric AIDS Experts, *PMTCT and paediatrics inter-agency task team joint mission report*, 21–30 April 2008.

Figure 14.5

Between 1998 and 2007, mother-to-child transmission as a proportion of all new HIV cases has increased steadily, from less than 0.2 per cent to around 1.6 per cent of all reported HIV/AIDS cases. This highlights the urgent need for measures to expand paediatric care and treatment and contain the vertical transmission of HIV.

Figure 14.6
Prevention-of-mother-to-child-transmission services, 2007–2008

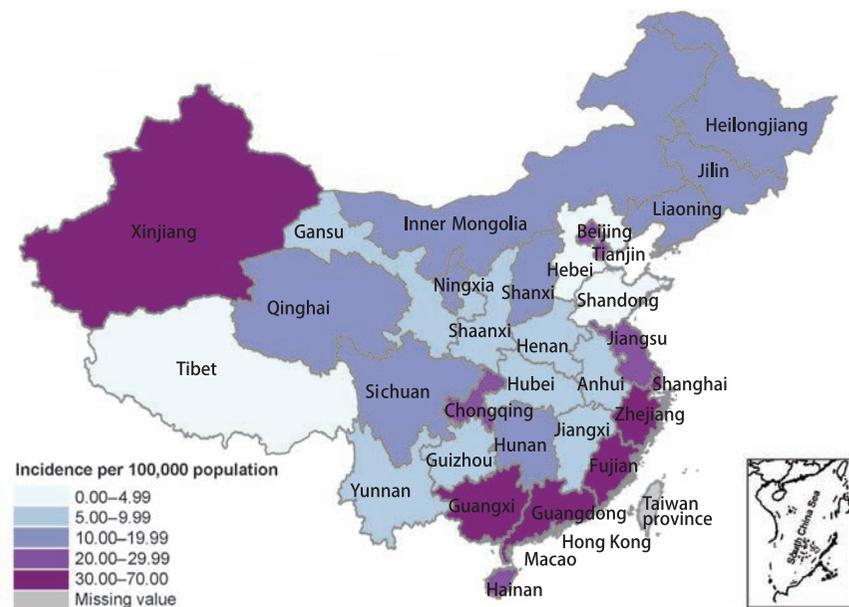


Sources: World Health Organization, United Nations Joint Programme on HIV/AIDS and United Nations Children's Fund, *Towards Universal Access, Scaling up priority HIV/AIDS interventions in the health sector, progress reports, 2008 and 2009*¹⁰³

Figure 14.6

Approximately 1.8 million pregnant women were tested for HIV in 2008¹⁰⁴ which represents an estimated coverage of 10 per cent. About 1,000 pregnant women living with HIV and 1,100 infants born to women living with HIV are currently receiving antiretroviral drugs for prevention of mother-to-child-transmission.

Figure 14.7
Syphilis incidence rate, 2007



Source: National Centre for AIDS/STD Prevention and Control, 2008

Figure 14.7

As sexual transmission is now the main mode of HIV transmission in China, data on sexually transmitted infections, such as syphilis incidence rate, provide an indication of where the rate of HIV infections might accelerate. Concurrent syphilis infection among HIV-positive pregnant women is also significantly associated with vertical perinatal HIV transmission.



ANNEXES

ANNEX 1: Data sources and references

1. Population demographics

- ¹ China National Bureau of Statistics, *China Statistical Yearbook*, NBS, 2009
- ² China's ethnic minority groups are, by population size: Zhuang, Manchu, Hui, Miao, Uygur, Tujia, Yi, Mongolian, Tibetan, Bouyei, Dong, Yao, Korean, Bai, Hani, Kazak, Li, Dai, She, Lisu, Gelao, Dongxiang, Lahu, Shui, Va, Naxi, Qiang, Tu, Mulam, Xibe, Kirgiz, Daur, Jingpo, Maonan, Salar, Blang, Tajik, Achang, Pumi, Ewenki, Nu, Jing, Jino, De'ang, Bonan, Russian, Yugur, Uzbek, Moinba, Oroqen, Drung, Tatar, Hezhen, Gaoshan and Lhoba. (China National Bureau of Statistics, *China Statistical Yearbook*, NBS, 2009)
- ³ China National Bureau of Statistics, *China Population and Employment Statistics Yearbook*, NBS, 2009
- ⁴ **Total fertility rate** – Number of children who would be born per woman if she lived to the end of her childbearing years and bore children at each age in accordance with prevailing age-specific fertility rates. (United Nations Children's Fund, *The State Of the World's Children 2009*, UNICEF, 2009)

Crude birth rate – Annual number of births per 1,000 population. (United Nations Children's Fund, *The State Of the World's Children 2009*, UNICEF, 2009)
- ⁵ **Rate of natural increase (decrease)** – Crude birth rate minus the crude death rate. Represents the portion of population growth (or decline) determined exclusively by births and deaths. (UNPD)
- ⁶ China National Bureau of Statistics, *China Population and Employment Statistics Yearbook*, NBS, 2009
- ⁷ China National Bureau of Statistics, *Women and Men in China, Facts and Figures*, NBS, 2007
- ⁸ United Nations Children's Fund, *The State Of the World's Children 2009*, UNICEF, 2009
- ⁹ China National Bureau of Statistics, *2008 China Population*, NBS, 2009
- ¹⁰ China National Bureau of Statistics, *China Population and Employment Statistics Yearbook*, NBS, 2009
- ¹¹ China National Bureau of Statistics, *2008 China Population*, NBS, 2009
- ¹² China National Bureau of Statistics, *2008 China Population*, NBS, 2009
- ¹³ China National Bureau of Statistics, *China Population and Employment Statistics Yearbook*, NBS, 2009
- ¹⁴ China National Bureau of Statistics, *China Statistical Yearbook*, NBS, 2009
- ¹⁵ China National Bureau of Statistics, *China Statistical Yearbook*, NBS, 2009
- ¹⁶ Derived from China National Bureau of Statistics, *China Statistical Yearbook*, NBS, 2009
- ¹⁷ China National Bureau of Statistics, *China Statistical Yearbook*, NBS, 2009
- ¹⁸ China National Bureau of Statistics, *Women and Men in China, Facts and Figures*, NBS, 2007
- ¹⁹ China National Bureau of Statistics, *China Statistical Yearbook*, NBS, 2009
- ²⁰ China National Bureau of Statistics, *China Statistical Yearbook*, NBS, 2009
- ²¹ **Life expectancy at birth** – Number of years newborn children would live if subject to the mortality risks prevailing for the cross section of population at the time of their birth. (United Nations Children's Fund, *The State Of the World's Children 2009*, UNICEF, 2009)
- ²² China Ministry of Health, *China Health Statistical Yearbook*, MOH, 2009
- ²³ China Ministry of Health, *China Health Statistical Yearbook*, MOH, 2009

²⁴ China Ministry of Health, *China Health Statistical Yearbook*, MOH, 2009

²⁵ World Bank Development Indicators database, World Bank, 2009

GNI per capita – Gross national income (GNI) is the sum of value added by all resident producers, plus any product taxes (less subsidies) not included in the valuation of output, plus net receipts of primary income (compensation of employees and property income) from abroad. GNI per capita is gross national income divided by midyear population. GNI per capita in US dollars is converted using the World Bank Atlas method. (United Nations Children's Fund, *The State Of the World's Children 2009*, UNICEF, 2009)

²⁶ China National Bureau of Statistics, *China Statistical Yearbook*, NBS, 2009

²⁷ **Sex ratio at birth** – Number of male births per one female birth. (UNSD)

²⁸ James WH, 'The human sex ratio. Part 1: a review of the literature', *Human Biology*, 1987, 59:721-5

²⁹ China National Bureau of Statistics. *2008 China Population*, NBS, 2009

³⁰ China National Bureau of Statistics, *2005 One Per Cent Population Sample Survey*, NBS, 2007

³¹ China National Bureau of Statistics, *1982, 1990 and 2000 Population Censuses*, NBS, published in 1985, 1993 and 2002 respectively; China National Bureau of Statistics, *1987 and 2005 One Per Cent Population Sample Surveys*, NBS, published in 1988 and 2007 respectively

³² China National Bureau of Statistics, *1982, 1990 and 2000 Population Censuses*, NBS, published in 1985, 1993 and 2002 respectively; China National Bureau of Statistics, *1987 and 2005 One Per Cent Population Sample Surveys*, NBS, published in 1988 and 2007 respectively

³³ **Urban share of population** – Percentage of population living in urban areas as defined according to the national definition used in the most recent National Population Census. (United Nations Children's Fund, *The State Of the World's Children 2009*, UNICEF, 2009)

³⁴ China National Bureau of Statistics, *China Statistical Yearbook*, NBS, 2009

³⁵ China National Bureau of Statistics, *China Statistical Yearbook*, NBS, 2009

³⁶ **Fatalities** (Disaster casualties) – Number of deaths caused directly by natural disasters (includes deaths of non-permanent residents).

Direct Economic Loss – Economic loss caused by damage or a decrease in the value of certain objects subject to natural disaster(s). It is calculated by multiplying the pre-disaster value of objects by the damage factor of the disaster. (China Ministry of Civil Affairs)

2. Economic and social development

³⁷ **Dibao** – *Dibao* is the Chinese term for Minimum Subsistence Allowance, which constitutes an integral part of a social assistance system within the social security framework. Households with income per capita below a defined minimum level, uncovered or inadequately covered by any other social security system, are eligible to obtain subsidies under *Dibao* to cover some basic living costs. (China Ministry of Civil Affairs)

³⁸ World Bank, *World Development Indicators*, World Bank, 2008

³⁹ World Bank, Development Indicators database, World Bank, 2009

⁴⁰ According to World Bank 2008 Classification Standards, countries with Gross National Income (GNI) per capita from US\$976 to US\$3,855 are classified as lower-middle-income countries.

⁴¹ World Bank, *From Poor Areas to Poor People: China's Evolving Poverty Reduction Agenda*, World Bank, 2009

⁴² World Bank, *From Poor Areas to Poor People: China's Evolving Poverty Reduction Agenda*, World Bank, 2009

⁴³ According to the 2008 Report on *China's Progress Towards the Millennium Development Goals* prepared by the Government of China and the UN System, China has already met three of the eight Millennium Development Goals: halving poverty, achieving universal access to primary education and reducing child mortality. Other MDGs are likely to be met on time.

⁴⁴ **GDP per capita** – Gross domestic product (GDP) is the sum of value added by all resident producers plus any product taxes (less subsidies) not included in the valuation of output. GDP per capita is gross domestic product divided by midyear population. Growth is calculated from constant price GDP data in local currency. (United Nations Children’s Fund, *The State Of the World’s Children 2009*, UNICEF, 2009)

⁴⁵ **Urban per capita disposable income** – Disposable income of urban households as defined by China National Bureau of Statistics refers to the income urban households have available for final consumption, non-compulsory expenditures, and savings. Disposable income equals to the total income, less income tax, employees’ social insurance contributions, and survey subsidies received by the sampled households. Per capita disposable income equals to household disposable income divided by the number of household members. (China National Bureau of Statistics)

⁴⁶ **Rural per capita net income** – Net income of rural households as defined by China National Bureau of Statistics refers to the income of rural households received in the current year and after deduction of expenses. Net income is used mainly for its input in production and consumption expenditure, and also for non-compulsory expenditures and savings. Net income equals to the total income, less expenses incurred in the operation of household business, taxes and fees, depreciation of fixed assets, and transfer to relatives and friends living outside rural areas. Per capita net income equals to net income of rural households divided by the number of permanent household members. (China National Bureau of Statistics)

⁴⁷ **Poverty line** – Poverty line is a level of income (or spending) required to purchase a minimum amount of essential goods such as food, clothing, shelter, water, electricity, schooling and reliable healthcare. (UNSD)

⁴⁸ **Consumption (income) poverty** – Individuals and households are poor if their consumption (income) falls below a certain threshold, usually defined as a minimum, socially acceptable level of wellbeing by a population group. (UNSD)

3. Maternal and child health

⁴⁹ Prepared jointly by the Government of China and the UN system.

⁵⁰ World Health Organization, 2000

⁵¹ World Health Organization, *World Health Report*, WHO, 2008

⁵² **Under-five mortality rate** – Probability of dying between birth and exactly five years of

age, expressed per 1,000 live births. (United Nations Children’s Fund, *The State Of the World’s Children 2009*, UNICEF, 2009)

⁵³ **Infant mortality rate** – Probability of dying between birth and exactly one year of age, expressed per 1,000 live births. (United Nations Children’s Fund, *The State Of the World’s Children 2009*, UNICEF, 2009)

⁵⁴ **Neonatal mortality rate** – Probability of dying during the first 28 completed days of life, expressed per 1,000 live births. (United Nations Children’s Fund, *The State Of the World’s Children 2009*, UNICEF, 2009)

⁵⁵ **Maternal mortality ratio** – Annual number of deaths of women from pregnancy-related causes per 100,000 live births. (United Nations Children’s Fund, *The State Of the World’s Children 2009*, UNICEF, 2009)

⁵⁶ **Antenatal care coverage** – Percentage of women 15–49 years old attended at least once during pregnancy by skilled health personnel (doctors, nurses or midwives) and the percentage attended by any provider at least four times. (United Nations Children’s Fund, *The State Of the World’s Children 2009*, UNICEF, 2009)

⁵⁷ **Skilled attendant at birth** – Percentage of births attended by skilled health personnel (doctors, nurses or midwives). (United Nations Children’s Fund, *The State Of the World’s Children 2009*, UNICEF, 2009)

⁵⁸ **Number of physicians per 1,000 population** – Ratio of total number of physicians working in the country to the total population, expressed per 1,000 population.

⁵⁹ **The New Rural Cooperative Medical Scheme (RCMS)**, initiated under the principle of fundraising from multiple sources (with contributions from individuals, collective units and government at various levels) and voluntary participation of farmers, aims to improve rural health insurance through major support for farmers’ in-patient hospital costs and assistance for certain out-patient medical expenses. Pilot trials of RCMS began in selected areas in 2003 before it was progressively scaled up in China. Currently, the proportion of contributions between government and individuals for RCMS is 4:1. (China Ministry of Health, *Suggestion on Establishing Rural Cooperative Medical Scheme*, 2003)

4. Expanded programme on immunization

⁶⁰ **BCG** – Percentage of infants under one year of age who received Bacille Calmette-Guérin (vaccine against tuberculosis). (United Nations Children's Fund, *The State Of the World's Children 2009*, UNICEF, 2009)

DPT3 – Percentage of infants under one year of age who received three doses of Diphtheria, Pertussis and Tetanus vaccine. (United Nations Children's Fund, *The State Of the World's Children 2009*, UNICEF, 2009)

OPV3 – Percentage of infants under one year of age who received three doses of Oral Polio Vaccine.

HepB3 – Percentage of infants under one year of age who received three doses of hepatitis B vaccine. (United Nations Children's Fund, *The State Of the World's Children 2009*, UNICEF, 2009)

Measles – Percentage of infants under one year of age who received the dose of measles vaccine.

5. Nutrition

⁶¹ Black et al, '2007 Maternal and child undernutrition: global and regional exposures and health consequences', *The Lancet*, Volume 371, January 19, 2008.

⁶² China Ministry of Health, *An Analysis Report of National Health Services Survey in China*, 2008

⁶³ **Underweight (NCHS/WHO)** – Moderate and severe: Percentage of children aged 0–59 months who are below minus two standard deviations from median weight for age of the National Center for Health Statistics (NCHS)/WHO reference population; Severe: Percentage of children aged 0–59 months who are below minus three standard deviations from median weight for age of the NCHS/WHO reference population. (United Nations Children's Fund, *The State Of the World's Children 2009*, UNICEF, 2009)

⁶⁴ **Stunting (NCHS/WHO)** – Moderate and severe: Percentage of children aged 0–59 months who are below minus two standard deviations from median height for age of the NCHS/WHO reference population. (United Nations Children's Fund, *The State Of the World's Children 2009*, UNICEF, 2009)

⁶⁵ **Anaemia** – Condition that occurs when the red blood cells do not carry enough oxygen to the tissues of the body. Its main cause, iron deficiency, is the most prevalent

nutritional deficiency in the world. Several infections related to hygiene, sanitation, safe water and water management are significant contributors to anaemia in addition to iron deficiency. (WHO) The threshold for anaemia in children aged 6-59 months is 110 g/l.

⁶⁶ **Iodized salt consumption** – Percentage of households consuming adequately iodized salt (15 parts per million or more). (United Nations Children's Fund, *The State Of the World's Children 2009*, UNICEF, 2009)

6. Child injury

⁶⁷ United Nations Children's Fund and World Health Organization, *World Report on Child Injury Prevention*, UNICEF and WHO, 2008

⁶⁸ Yang Gonghuan, Zhou Lingni, Ma Jiemin, Liu Na from Institute of Basic Medical Sciences, Peking Union Medical College and Think Tank Development Centre of Health, *Child injury in China: A literature review on current status of child injury in China*, UNICEF, 2003

⁶⁹ Prof SY Wang, Prof YH Li MPH, GB Chi MS, Prof SY Xiao MD, J Ozanne-Smith, Prof M Stevenson PhD and Prof MR Phillips MD, 'Injury-related fatalities in China: an under-recognized public-health problem', *The Lancet*, 15 November 2008, Volume 372, Issue 9651, Pages 1765–1773

7. Water, sanitation and hygiene

⁷⁰ **Improved drinking water sources** – Improved drinking water sources include piped water (including piped into dwelling, yard or plot), public tap/standpipe, tube well/borehole, protected dug well, protected spring water and rainwater. (UNICEF/WHO Joint Monitoring Programme)

⁷¹ **Improved sanitation facilities** – Improved sanitation facilities include the use, in home/compound of flush/pour-flush to piped sewer system, septic tank and pit latrine, pit latrine with slab, composting toilet and Ventilated Improved Pit (VIP) latrine. (UNICEF/WHO Joint Monitoring Programme)

⁷² China National Centre for Rural Water Supply Technical Guidance

⁷³ China Ministry of Health/National Patriotic Health Campaign Committee Office defines access to improved water sources as the percentage of population having access to piped water (including piped into dwelling, piped into yard or plot and public tap/standpipe), hand-pumped well, protected dug well, protected spring water and rainwater collection. Access is determined by the cumulative number of facilities.

⁷⁴ China Ministry of Water Resources (MWR) and other ministries, such as China Ministry of Health (MOH), are working jointly to establish standards for drinking water supply in rural areas. The MWR is in charge of planning the construction of water supply systems to meet these standards. The National Patriotic Health Campaign Committee Office (NPHCCO) is in charge of planning the construction of sanitation facilities and also responsible for collecting administrative data on access to improved water sources and improved sanitation facilities through local Patriotic Health Campaign Committee Offices (PHCCO) at county level. Once collected at county level, the local PHCCOs data are submitted to the provincial PHCCOs and afterwards to the MOH for publication in *China Health Statistical Yearbook*.

⁷⁵ Data from China Ministry of Health/National Health Services Survey define use of improved water sources as the percentage of households using piped water (including piped into dwelling, piped into yard or plot and public tap/standpipe) and water extracted from a hand-pumped well, protected dug well, protected spring water and rainwater collection. UNICEF/WHO Joint Monitoring Programme considers as improved drinking water sources a drinking water source or delivery point that, by nature of its construction and design, is likely to protect the water source from outside contamination, in particular from faecal matter. Data from UNICEF/WHO Joint Monitoring Programme measure the use of improved drinking water sources as the proportion of the population which uses piped water (into dwelling, plot or yard), public tap/standpipe, tube well/borehole, protected dug well, protected spring and rainwater collection.

⁷⁶ UNICEF/WHO Joint Monitoring Programme (JMP) estimates the percentage of population using improved water sources through national statistics offices and nationally representative household surveys and National Population Censuses.

⁷⁷ China Ministry of Health/National Patriotic Health Campaign Committee Office consider access to sanitary latrines as the percentage of households having access to harmless sanitary latrines (flush and non-flush) and the other types of sanitary latrines. Flush latrine types include three-compartment septic tank latrine, double-urn septic tank latrine, three-in-one biogas septic tank latrine and water-saving flush latrine by high pressure. Non-flush latrine types include urine-diverting latrine and double-pit alternating latrine. The other types of sanitary latrines include anti-freezing deep pit latrine, attic latrine and Ventilated Improved Pit latrine. Access is determined by the cumulative number of facilities.

⁷⁸ Data from China Ministry of Health/National Health Services Survey report on both use of sanitary latrines and harmless sanitary latrines. In this chart, NHSS refers to the use of sanitary latrines as the percentage of households using harmless sanitary latrines (flush and non-flush). Flush latrine types include three-compartment septic tank latrine, double-urn septic tank latrine, three-in-one biogas septic tank latrine and water-saving flush latrine by high pressure. Non-flush latrine types include urine-diverting latrine and double-pit alternating latrine. UNICEF/WHO Joint Monitoring Programme defines improved sanitation facility as any facility that hygienically separates human excreta from human contact. Data from the Joint Monitoring Programme measure the use of improved sanitation facility as the proportion of population which uses sanitation facilities such as flush/pour-flush to piped sewer system, septic tank and pit latrine; pit latrine with slab, composting toilet and Ventilated Improved Pit (VIP) latrine. However, sanitation facilities are not considered improved when shared with other households, or open for public use.

⁷⁹ The differences between the three sets of data from NPHCCO, NHSS and UNICEF/WHO Joint Monitoring Programme lie in the definition, methodology and the different types of data used to report on the use of/access to sanitation facilities.

⁸⁰ **Arsenicosis** – Arsenicosis is the effect of arsenic poisoning, usually over a long period such as from 5 to 20 years. Drinking arsenic-rich water over a long period results in various health effects including skin problems, skin cancer, cancers of the bladder, kidney and lung, and diseases of the blood vessels of the legs and feet, and possibly also diabetes, high blood pressure and reproductive disorders. (WHO)

⁸¹ **Fluorosis** – Fluorosis is an excess of fluorine in the body, which may result in changes in the skeleton and ossification of tendons and ligaments. Exposure results from outdoor pollution (in air and water) and indoor pollution (in insecticide, aluminium-mining and phosphate-fertilizer industries). (UNSD)

⁸² **Schistosomiasis** – Schistosomiasis is a disease contracted through exposure to water containing a species of water snail that acts as host to flukes of the genus *Schistosoma* at their first larval stage. The disease leads to malfunctioning and deterioration of the liver, heart, spleen, bladder and kidneys. It is also known as bilharzia. (UNSD)

8. Education and child development

⁸³ **Primary school net enrolment ratio** – Number of children enrolled in or attending primary school, expressed as a percentage of the total number of children of primary school age. (United Nations Children's Fund, *The State Of the World's Children 2009*, UNICEF, 2009)

⁸⁴ **Pre-primary school gross enrolment ratio** – The pre-primary school gross enrolment ratio is the number of children enrolled in pre-primary school, regardless of age, expressed as a percentage of the total number of children of official pre-primary school age.

⁸⁵ **Secondary school gross enrolment ratio** – Number of children enrolled in secondary school, regardless of age, expressed as a percentage of the total number of children of official secondary school age. (United Nations Children's Fund, *The State Of the World's Children 2009*, UNICEF, 2009)

Junior (senior) gross enrolment ratio – The junior (or senior) secondary school gross enrolment ratio is the number of children enrolled in junior (or senior) secondary school, regardless of age, expressed as a percentage of the total number of children of official junior (or senior) secondary school age.

⁸⁶ **Transition rate** – The transition rate is the number of pupils (or students) admitted to the first grade of a higher level of education in a given year, expressed as a percentage of the number of pupils (or students) enrolled in the final grade of the lower level of education in the previous year. (UNESCO)

⁸⁷ **Survival rate to the last grade of primary school** – Percentage of children entering the first grade of primary school who eventually reach the last grade of primary school. (United Nations Children's Fund, *The State Of the World's Children 2009*, UNICEF, 2009)

9. The rights of children and women

⁸⁸ *Goals for Children and Development in the 1990s* adopted at the World Summit for Children on 30 September 1990 along with the *World Declaration on the Survival, Protection and Development of Children* and *Plan of Action for Implementing the World Declaration on the Survival, Protection and Development of Children in the 1990s* under Resolution 45/217 of the General Assembly of the United Nations.

10. Children affected by migration

⁸⁹ China National Bureau of Statistics, *2008 China Population*, NBS, 2009

⁹⁰ China National Bureau of Statistics, *2008 China Population*, NBS, 2009

11. Children with disabilities

⁹¹ **Visual disability (1)** refers to a low vision of both eyes caused by various reasons that cannot be corrected, or the failure or constriction of vision that affects the daily life and social participation of the person. Visual disability includes both blindness and poor sight. Note: Blindness or low vision applies to both eyes. If one eye has better vision than the other, the better eye shall be the reference eye. If only one eye is blind or has low vision, while the other eye has a vision of or better than 0.3 on the Chinese eye chart (with 2 as the maximal value), it shall not be defined as a visual disability.

Hearing disability (2) refers to the different extents of permanent hearing impairment in the ears caused by various reasons, so as to prevent the person from hearing or hearing clearly ambient sounds or speech sounds around him/her and affect the daily life and social participation of the person.

Speech disability (3) refers to the speech impairment of different extents caused by various reasons, which is not cured after treatment of more than one year, or persists for over two years without treatment, so as to prevent or make it difficult for the person to conduct regular conversations and affect his/her daily life and social participation. (A person with speech impairment below three years old will not be considered as having a speech disability). It includes: (I) Aphasia (a disorder that results from damage to portions of the brain that are responsible for language), (II) Motor Dysarthria (Loss of the motor ability that enables speech), (III) Deformity Dysarthria (speech disorder caused by deformed speech organs), (IV) Articulation impediment, (V) Delayed speech development of children, (VI) Speech impairment caused by hearing impairment, (VII) Stammering and stuttering.

Physical disability (4) refers to the loss of the physical motor functions and limited mobility or social participation to different extents caused by missing and injured limbs, paralysis and deformity of the torso due to structural and functional damage in the motor system of the person. It includes: (I) Missing and deformed upper and lower limbs and functional disorder of the upper and lower limbs due to injury, illness or abnormal development of the limbs, (II) Deformity or functional disorder of spinal cord due to injury, illness or abnormal development of the spinal cord, (III) Functional disorder of the torso or limbs caused by injury, illness or abnormal development of the central and peripheral nervous systems.

The intelligence of people with intellectual disability (5) is markedly lower than that of the general population, and may be accompanied by a behavioural adaptability disorder. Such disability is caused by structural and functional disorders of the nervous system that limit one's mobility and social participation. Intellectual disability includes retardation caused by different factors during intellectual development (before 18 years old) or damage/deterioration caused by different factors after intellectual maturity.

Mental disability (6) refers to the mental disorder that has lasted more than one year and has not been cured. A person with mental disorder has cognitive, emotional and behavioural disorders that affect his/her daily life and social participation.

Multiple disability (7) refers to a person having two or more disabilities.

(China Disabled Persons' Federation, *Situation Analysis and Strategic Study of Children With Disabilities in China*, CDPF, 2008)

⁹² **Medical service and assistance (1)** Medical service: services provided by hospitals or specialized medical agencies to help people with disabilities restore or compensate for their lost functions, improve their self-caring ability and their social adaptability through surgery or other diagnosis.

Medical assistance refers to the specialized medical support and assistance provided by the Government or society to poor people with disabilities who cannot afford the treatment for the disease. In rural areas where the New Rural Cooperative Medical Scheme (RCMS) is developed, people with disabilities should receive subsidies to cover partially or entirely the premium that is typically borne by individuals in the local cooperative medical scheme. People with disabilities affected by severe disease will also receive financial support for any exceedingly high medical fees not covered by the subsidy from the Cooperative Medical Scheme (CMS). For those areas where the New Rural Cooperative Medical Scheme has not yet been developed, people with disabilities who cannot afford the related fees for treatment will be properly funded. People with disabilities who contract any of the special communicable diseases, as stipulated by the Government, will receive subsidies as per the regulation for his/her treatment. In urban areas, medical assistance should be provided to poor people with disabilities who cannot afford the treatment through a variety of channels such as funding by private sector, proper subsidy given by urban medical assistance foundations, voluntary reduction or exemption of related fees by medical agencies.

Auxiliary tools for persons with disabilities (2) refer to the products and devices that are used by the people with disabilities to compensate for, mitigate or replace lost physical functions or physical difficulty caused by disability. The auxiliary tools for people with physical disabilities include: artificial limbs, wheelchair, hand tricycle, electric wheelchair, motorized wheelchair, walking frame, auxiliary clutch, elbow clutch, tripod cane, quadricane, single cane, pen holder, retriever, clothing aid, dining aid, tooth brushing aid, combing aid. Auxiliary tools for people with hearing impairment include: hearing aid, speech training device, bone conduction telephone, flashing doorbell, etc. Auxiliary tools for people with visual impairment include visual aid, electronic human voice time teller, Braille writing board, Braille typewriter, Braille reader and walking stick, etc.

Rehabilitation training and services (3) refer to the training functions of people with physical disabilities, the abilities of people with intellectual impairment, the orientation and mobility skills for people with visual impairment, hearing and speech training for children with hearing impairment, the provision of visual aid and prevention, treatment and rehabilitation for mental illnesses, training guidance, rehabilitation care, psychological counselling, raising public awareness on disability prevention, health education, publicity of science and safety awareness, and related consultancy and referral provided by China Disabled Persons' Federation (CDPF), health or other departments to people with disabilities and their family members.

Subsidy, reduction or exemption of education fees (4) refer to reductions and exemptions of schooling fees, arranged by the Government, education department, China Disabled Persons' Federation or other departments; or subsidies provided by these agencies to people with disabilities or their children.

Vocational education and training (5) refers to formal schooling (including primary, secondary and post-secondary vocational education) or short-term vocational training received by people with disabilities or their children in various types of vocational schools or training agencies of different levels.

Employment placement and support (6) refers to employment guidance, employment placement, assistance or support provided by employment service agencies or other social agencies for people with disabilities.

Assistance and support for poor people with disabilities (7) refers to the assistance means, including local minimal living allowance for eligible poor people with disabilities or entitlements to institutional care, five-guarantees care (subsidies to cover food, clothing, medical care, housing and funeral costs), temporary relief, regular subsidy and dedicated subsidy by China Disabled Persons' Federation etc. Support for poor people refers to poverty reduction activities for people with disabilities developed by agencies at different levels of the Government such as Leading Group Office of Poverty Alleviation and Development, Women's Federation, Youth League of China, and China Disabled Persons' Federation (CDPF), and social groups, or by credit cooperatives and Funding the Poor Cooperatives to help raise funds for poor people with disabilities, implement preferential policies, choose income generation projects and learn skills.

Legal assistance and service (8) refers to free legal services, reduction/exemption/delayed payment of legal fees for poor people with disabilities, legal counselling, referral and legal assistance provided by legal assistance agencies at different levels of the Government, judicial administration departments at different levels, rights protection agencies for people with disabilities at different levels, notary agencies and grassroot legal service agencies, lawyers, legal assistance NGOs, specialized legal websites and volunteers.

Barrier-free facilities (disability-friendly facilities) (9) refer to the service facilities built along with roads, public buildings, residential buildings and residential areas for the safe access and the convenience of people with disabilities, the senior, the injured, the sick, the children and other members of society.

Barrier-free (disability-friendly) access to information (10) refers to public media that ensure that people have barrier-free (disability-friendly) access to information and communication, such as subtitles and voiceover of films, TV dramas and TV programmes, sign language with TV programmes, audio books for people with hearing impairment and Information and Communication Technology (ICT) and ICT products developed specifically to meet the needs of people with different impairments.

Life services (11) refers to services provided by community organizations and volunteers from time to time to assist people with disabilities with house chores.

Cultural services (12) refers to cultural and artistic activities and related services provided or organized by cultural authorities, cultural organizations, grassroots organizations, social groups and volunteers to people with disabilities in order to address their cultural needs, such as home delivery of books, donation of books, Braille and audio books, and favourable services when people with disabilities participate in social and cultural activities.

Other services (13) refers to the other types of services or support which are not listed above.

(China Disabled Persons' Federation, *Working Manual for the Second National Sample Survey on Disability*, CDPF, 2006)

12. Violence against children

⁹³ World Health Organization, *World Report on Violence and Health*, WHO, 2002

14. HIV/AIDS

⁹⁴ China Ministry of Health and Joint United Nations Programme on HIV/AIDS, *Global AIDS Epidemic Report*, 2010

⁹⁵ State Council AIDS Working Committee Office, United Nations Theme Group on AIDS in China, *A Joint Assessment of HIV/AIDS Prevention, Treatment and Care in China (2007)*, 2007

⁹⁶ State Council AIDS Working Committee Office, United Nations Theme Group on AIDS in China, *A Joint Assessment of HIV/AIDS Prevention, Treatment and Care in China (2007)*, 2007

⁹⁷ State Council AIDS Working Committee Office, United Nations Theme Group on AIDS in China, *A Joint Assessment of HIV/AIDS Prevention, Treatment and Care in China (2007)*, 2007

⁹⁸ China Ministry of Health, United Nations Children's Fund, World Health Organization, United Nations Population Fund, Joint United Nations Programme on HIV/AIDS, Clinton Foundation, United States Centers for Disease Control and Prevention, Family Health International, Chinese PMTCT and Paediatric AIDS Experts, *PMTCT and paediatrics inter-agency task team joint mission report*, 21–30 April 2008.

⁹⁹ *China United Nations General Assembly Special Session Country Progress Report*, 2008

¹⁰⁰ China Ministry of Education and United Nations Children's Fund, baseline survey, 2006

¹⁰¹ State Council AIDS Working Committee Office, United Nations Theme Group on AIDS in China, *A Joint Assessment of HIV/AIDS Prevention, Treatment and Care in China (2007)*, 2007

¹⁰² State Council AIDS Working Committee Office, United Nations Theme Group on AIDS in China, *A Joint Assessment of HIV/AIDS Prevention, Treatment and Care in China (2007)*, 2007

¹⁰³ Data for 2007 (January-September) are collected from 271 programme counties out of a total of 2,860. Data for 2008 are collected from 33 priority counties.

¹⁰⁴ World Health Organization, United Nations Joint Programme on HIV/AIDS and United Nations Children's Fund, *Towards Universal Access, Scaling up priority HIV/AIDS interventions in the health sector, progress report*, WHO, UNAIDS and UNICEF, 2009

ANNEX 2: Acronyms

AIDS	Acquired Immune Deficiency Syndrome	HepB	Hepatitis B
BCG	Bacille Calmette-Guérin	HIV	Human Immunodeficiency Virus
CDPF	China Disabled Persons' Federation	ICD	International Classification of Diseases
CEDAW	UN Convention on the Elimination of All Forms of Discrimination Against Women	ICFDH	International Criteria of Functions, Disabilities and Health
CMS	Cooperative Medical Scheme	IDD	Iodine Deficiency Disorders
COMMIT	Coordinated Mekong Ministerial Initiative Against Trafficking	IMR	Infant Mortality Rate
CRC	Convention on the Rights of the Child	JMP	Joint Monitoring Programme
CRPD	UN Convention on the Rights of Persons with Disabilities	MCH	Maternal and Child Health
DTP	Diphtheria Tetanus and Pertussis	MDG	Millennium Development Goals
EPI	Expanded Programme on Immunization	MFAS	Medical Financial Assistance Scheme
GAVI	Global Alliance for Vaccines and Immunization	MMR	Maternal Mortality Ratio
GDP	Gross Domestic Product	MMRP	Maternal Mortality Reduction Project
GNI	Gross National Income	MOH	Ministry of Health
		MPS	Ministry of Public Security

MWR	Ministry of Water Resources	SIA	Supplementary Immunization Activities
NBS	National Bureau of Statistics	STD	Sexually Transmitted Disease
NCHS	(USA) National Center for Health Statistics	U5MR	Under-Five Mortality Rate
NHSS	National Health Services Survey	UN	United Nations
NMR	Neonatal Mortality Rate	UNAIDS	Joint United Nations Programme on HIV/AIDS
NPA	National Programme of Action for Children	UNESCO	United Nations Educational, Scientific and Cultural Organization
NPHCCO	National Patriotic Health Campaign Committee Office	UNICEF	United Nations Children's Fund
NWCCW	National Working Committee on Children and Women	UNPD	United Nations Population Division
OPV	Oral Polio Vaccine	UNSD	United Nations Statistics Division
PHCCO	Patriotic Health Campaign Committee Offices	USI	Universal Salt Iodization
PMTCT	Prevention of Mother-To-Child Transmission	WHO	World Health Organization
PPM	Parts Per Million		
PPP	Purchasing Power Parity		
RCMS	New Rural Cooperative Medical Scheme		
RMB	Renminbi (China's currency)		

