

Children in China: An Atlas of Social Indicators



2014
UPDATE

NWCCW
国务院妇女儿童
工作委员会办公室

NBS
国家统计局社会科技
和文化产业统计司

unicef 
联合国儿童基金会

2 Children in China: An Atlas of Social Indicators

©
United Nations Children's Fund (UNICEF), 2014
National Working Committee on Children and Women (NWCCW), 2014
National Bureau of Statistics (NBS), Department of Social, Science,
Technology and Cultural Statistics, 2014

Contact:
UNICEF Office for China
12, Sanlitun Lu
Beijing, 100600, P.R. CHINA
Email: beijing@unicef.org
www.unicef.cn

All rights reserved. Any part of *Children in China: An Atlas of Social Indicators* may be freely reproduced with the appropriate acknowledgement and as long as credit is given.

PHOTOGRAPHY CREDIT

Cover: © UNICEF China/Jerry Liu, et al.
Page 13: © UNICEF China/2012/Hao Zhiming
Page 25: © UNICEF China/2010/Jerry Liu
Page 41: © UNICEF China/2011/Yan Lu
Page 61: © UNICEF China/2005/Zhu Xu
Page 67: © UNICEF China/2010/Jerry Liu
Page 73: © 2013/Chen Bijing
Page 79: © UNICEF China/2013/Jerry Liu
Page 91: © UNICEF China/2013/Jerry Liu
Page 107: © 2011/Tang Xiaoping
Page 111: © UNICEF China/2008/Thomas Billhardt
Page 119: © UNICEF China/2012/Zhao Heting
Page 127: © UNICEF China/2012/Jerry Liu
Page 133: © UNICEF China/2004/Zeng Huang
Page 137: © UNICEF China/2010/Jerry Liu

Note: The boundaries and the names shown and the designations used on these maps do not necessarily imply official endorsement or acceptance by the United Nations.

Children in China:

An Atlas of Social Indicators

2014

FOREWORD

This 2014 *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 updated 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.

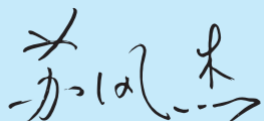
The Government of China attaches great importance to the protection and promotion of children's rights. Since signing the UN Convention on the Rights of the Child in 1990, the Government of China has been following and abiding by the mission and spirit of the Convention, fulfilling its obligations with 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.

The Government of China unequivocally integrates and synchronizes the child development in the overall planning and implementation of national economic and social development. Especially, for the first time, the *Twelfth Five-Year Plan for National Economic and Social Development* gives a special section on the programme to ensure the First Call for Children, and all provinces, autonomous regions and municipalities also integrate the main targets and contents of child development in their local plans. Since the issuance of the 2011-2020 National Programme of Action (NPA) for Children in 2011, the Government of China has adopted a number of measures in implementing the NPA for Children and achieved major milestones in the key areas.

However, social-economic, cultural 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 China, especially in terms of reducing disparities between rural and urban areas, across regions and among individuals.

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, in promoting child development and protecting 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, Technology and Cultural Statistics of the National Bureau of Statistics and Mrs. Gillian Mellsop, Representative of UNICEF China, together with her colleagues, for their unremitting efforts and hard work in compiling and publishing this Atlas.



Su Fengjie
Deputy Director, Executive Office,
National Working Committee on Children and Women
State Council, People's Republic of China

FOREWORD

UNICEF China is delighted to present this *2014 Atlas of Social Indicators on Children in China*, in collaboration with the National Working Committee on Children and Women and the National Bureau of Statistics.

Since the publication of its inaugural edition in 2010, the bilingual *Atlas* has become an authoritative source on the status of children in China for UNICEF, counterparts from the Government of China and the general public. Since the launch of the new UNICEF China website (www.unicef.cn) in 2011, all of the information and data contained in the *Atlas* have also been made available to web audiences.

The *2014 Atlas* contains a number of important updates. Many charts and graphs have been updated with the most recent data from new surveys, the *Statistical Yearbooks* published by the National Bureau of Statistics and line ministries, and China's most recent census, the Sixth National Population Census (2010). Increased focus has been given to equity in terms of the level of data disaggregation and data interpretation. The *Atlas* has also been updated with information on several new government policies with significant implications for children, including the *Twelfth Five-Year Plan (2011–2015)*, the *National Programme of Action on Children and Women (2011–2020)*, the national *Rural Poverty Reduction Strategy (2011–2020)* and the *Opinions on Further Promoting Reform of Household Registration System*.

The *Atlas* shows the remarkable achievements that China has made in improving the survival, development and protection of children. China's tremendous progress for children and women puts it well on track to achieve most of the Millennium Development Goals by 2015. 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 over 30 years of cooperation with the Government of China.

As in other developing countries, many challenges 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 cities, migration and rapid urbanization in China present additional challenges related to urban poverty and vulnerability. UNICEF looks forward to continued collaboration with all partners in helping to address these challenges.



Gillian Mellsop
UNICEF Representative in China

ACKNOWLEDGEMENTS

Yan Fang of UNICEF China prepared and developed the 2014 update of the Atlas of Social Indicators for Children in China, in close cooperation with Song Wenzhen and Hu Daohua of the National Working Committee for Children and Women (NWCCW), and Li Suoqiang and Xiao Li of the National Bureau of Statistics (NBS).

The 2014 update of the Atlas benefitted from the technical inputs, and data analysis and interpretation provided by the following UNICEF China staff: Lisa Bow, Guo Sufang, Li Tao, Jillian Popkins, Shi Weilin, and Vimommas Pam Vachatimanont.

Xu Jianlin of NBS provided relevant data to the 2014 update of the Atlas. Li Chunhua of UNICEF China and Lv Lidan of Peking University assisted in the update of maps and charts, while the UNICEF China Communications team contributed photos and enabled public access to the Atlas on UNICEF's country website (www.unicef.cn).

UNICEF China programme staff have contributed to the development of the Atlas over different years. The following are main contributors to the inaugural edition of the 2010 Atlas and 2012 Atlas update: Estelle Langlais Al-Mahdawi, Hana Brix, Frankie Chen, David Hipgrave, Yin Yin Nwe, Robert Scherpbier, Scott Whoolery, Yang Zhenbo and Zhang Lei.

Overall guidance and strategic directions for developing this publication were provided by Gillian Mellsop, Representative of UNICEF China; Su Fengjie, Deputy Director General of Executive Office of NWCCW; and Jia Nan, Director General of the Department of Social, Science, Technology and Cultural Statistics of NBS.

CONTENTS

13 1. POPULATION DEMOGRAPHICS

14 Overview

- 15 Figure 1.1 Geographic regions of China
- 16 Figure 1.2 Total population, 2013
- 16 Figure 1.3 Population density, 2013
- 17 Figure 1.4 Total population and child population, 1953–2013
- 17 Figure 1.5 Child population, 2010
- 18 Figure 1.6 Population pyramid, 2013
- 18 Figure 1.7 Percentage of ethnic minority groups, 2010
- 19 Figure 1.8 Life expectancy at birth, 1981–2010
- 19 Figure 1.9 Life expectancy at birth, 2010
- 20 Figure 1.10 Sex ratio at birth, 1982–2012
- 20 Figure 1.11 Sex ratio at birth, 2010
- 21 Figure 1.12 Sex ratio at birth, urban and rural, 1982–2010
- 21 Figure 1.13 Sex ratio at birth, by birth order, 1982–2010
- 22 Figure 1.14 Migrant population, 1982–2013
- 22 Figure 1.15 Migrant population, 2010
- 23 Figure 1.16 Urbanization, 1978–2013
- 23 Figure 1.17 Urbanization, 2013
- 24 Figure 1.18 Years in which the number of fatalities caused by natural disasters exceeded 6,000, 1976–2013
- 24 Figure 1.19 Years in which the direct economic loss caused by natural disasters exceeded RMB 150 billion (US\$ 25 billion equivalent), 1994–2013

25 2. ECONOMIC AND SOCIAL DEVELOPMENT

26 Overview

- 28 Figure 2.1 GDP per capita, 1978–2013
- 28 Figure 2.2 GNI per capita, 1978–2013
- 29 Figure 2.3 Per capita income, urban and rural, 1978–2013
- 29 Figure 2.4 Urban/rural income and rural/urban health outcome disparities, 1991–2013
- 30 Figure 2.5 Urban per capita disposable income and rural per capita net income, by quintile, 2005, 2010 and 2013
- 30 Figure 2.6 National Gini index, 2003–2013
- 31 Figure 2.7 Urban per capita disposable income, 2013
- 31 Figure 2.8 Rural per capita net income, 2013
- 32 Figure 2.9 General, health and education government expenditure as a percentage of GDP, 1978–2013
- 32 Figure 2.10 Government expenditure on social security and employment, health and education as a percentage of general government expenditure, 2002–2013
- 33 Figure 2.11 Rural poverty, 1978–2013
- 34 Figure 2.12 Consumption poverty in absolute numbers, 1981–2011
- 34 Figure 2.13 Consumption poverty rate, 1981–2011
- 35 Figure 2.14 *Dibao* recipients in absolute numbers, urban and rural, 2001–2013
- 35 Figure 2.15 Average *dibao* received by eligible households and minimum living standard in urban areas, by province, 2013

8 Children in China: An Atlas of Social Indicators

- 36 Figure 2.16 Average income, *dibao* received by eligible households and minimum living standard in urban and rural areas, 1999–2013
- 37 Figure 2.17 Age distribution of urban and rural *dibao* recipients, 2007–2013
- 38 Figure 2.18 The share of children among total urban and rural *dibao* recipients, by province, 2013
- 39 Figure 2.19 Urban and rural minimum living standards as a percentage of consumption expenditures, by province, 2013
- 39 Figure 2.20 Urban and rural minimum living standards and national poverty lines, by province, 2013

41 3. MATERNAL AND CHILD HEALTH

42 Overview

- 44 Figure 3.1 Under-five mortality rate, 1991–2013
- 44 Figure 3.2 Under-five mortality rate, 2013
- 45 Figure 3.3 Age distribution of deaths among under-five children, 1991–2013
- 45 Figure 3.4 Causes of under-five mortality, 2013
- 46 Figure 3.5 Causes of under-five mortality, by province, 2008
- 47 Figure 3.6 GDP per capita and under-five mortality rate, by province, 2013
- 47 Figure 3.7 GDP per capita and under-five mortality rate, 1990 and 2013
- 48 Figure 3.8 Infant mortality rate, 1991–2013
- 48 Figure 3.9 Infant mortality rate, 2013
- 49 Figure 3.10 Neonatal mortality rate, 1991–2013
- 49 Figure 3.11 Cause-specific neonatal mortality, by locality, 2000–2004
- 50 Figure 3.12 Maternal mortality ratio, 1990–2013
- 50 Figure 3.13 Maternal mortality ratio, 2013
- 51 Figure 3.14 Causes of maternal mortality, 1989–2013
- 51 Figure 3.15 Cause-specific maternal mortality, by locality, 2000–2004
- 52 Figure 3.16 Coverage of interventions across the continuum of care for maternal and child health, 2008 and 2011
- 52 Figure 3.17 Hospital delivery rate, urban and rural, 1990–2013
- 53 Figure 3.18 Hospital delivery rate, 2013
- 53 Figure 3.19 Hospital delivery rate and maternal mortality ratio, 1990–2013
- 54 Figure 3.20 Antenatal care coverage: at least one visit, 2013
- 54 Figure 3.21 Antenatal care coverage: at least five visits, 2003, 2008 and 2011
- 55 Figure 3.22 Skilled attendant at birth, 2013
- 55 Figure 3.23 Caesarean section rate, 2003, 2008 and 2011
- 56 Figure 3.24 Number of physicians and nurses, 1980–2013
- 56 Figure 3.25 Number of physicians, by province, 2013
- 57 Figure 3.26 Health insurance coverage, 2003, 2008 and 2011
- 57 Figure 3.27 Choice of urban health provider by income group, 2006
- 58 Figure 3.28 Percentage of households with catastrophic health expenses, 2003, 2008 and 2011
- 58 Figure 3.29 Ratios of the poorest and the richest quartile for selected indicators, 2003, 2008 and 2011
- 59 Figure 3.30 Provincial expenditure on health per capita in relation to provincial GDP per capita, by province, 2012
- 59 Figure 3.31 Government, social and out-of-pocket expenditure on health, 1978–2013

61 4. EXPANDED PROGRAMME ON IMMUNIZATION

62 Overview

- 63 Figure 4.1 Full vaccination coverage among one-year olds, 1983–2011
- 64 Figure 4.2 Full vaccination coverage among one-year olds, 2004
- 64 Figure 4.3 Hepatitis B3 vaccination coverage among one-year olds, 2004
- 65 Figure 4.4 Measles incidence and supplementary immunization activities, 2003–2011

67 5. NUTRITION

68 Overview

- 69 Figure 5.1 Prevalence of underweight among children under-five years old, 1990–2010
- 69 Figure 5.2 Prevalence of stunting among children under-five years old, 1990–2010
- 70 Figure 5.3 Prevalence of anaemia among children under-five years old, 1998–2010
- 70 Figure 5.4 Vitamin A deficiency among children under-five years old, 2000 and 2006
- 71 Figure 5.5 Infant and young child breastfeeding and complementary feeding, 2008
- 71 Figure 5.6 Infant and young child feeding practices in the first two years of life in poor rural areas of China, 2010
- 72 Figure 5.7 Household consumption of adequately iodized salt (20–50 parts per million), 1995–2011
- 72 Figure 5.8 Household consumption of adequately iodized salt, 2013

73 6. CHILD INJURY

74 Overview

- 75 Figure 6.1 Leading causes of death among children in China aged 0–17 years, by age group, 2004–2005
- 75 Figure 6.2 Injury-related death rate among children in China aged 0–17 years, 2010–2013
- 76 Figure 6.3 Leading causes of injury-related death among children in China aged 0–17 years, 2004–2005
- 76 Figure 6.4 Injury-related death rate among children in China aged 0–17 years, by urban/rural and sex, 2004–2005
- 77 Figure 6.5 Leading causes of injury-related death among children in China aged 0–14 years, by sex, 2004
- 77 Figure 6.6 Leading causes of injury-related death among children aged 0–17 years, by sex, Jiangxi Province, 2005
- 78 Figure 6.7 Leading causes of injury-related morbidity among children aged 0–17 years, by cause and sex, Jiangxi Province, 2005
- 78 Figure 6.8 Consequences of child injury, Beijing, 2003

79 7. WATER, SANITATION AND HYGIENE

80 Overview

- 81 Figure 7.1 Rural access to improved water sources, 1990–2013
- 81 Figure 7.2 Percentage of population using improved water sources, 1990–2012
- 82 Figure 7.3 Rural access to improved water sources, by province, 2013
- 82 Figure 7.4 Rural access to improved water sources, 2013
- 83 Figure 7.5 Rural access to improved water sources, by type, 1990–2013
- 83 Figure 7.6 Rural access to sanitary latrines, 2000–2013
- 84 Figure 7.7 Percentage of population using improved sanitation facilities, 1990–2012

10 Children in China: An Atlas of Social Indicators

- 84 Figure 7.8 Rural access to sanitary latrines, by type, 2000–2013
- 85 Figure 7.9 Rural access to sanitary latrines, by province, 2013
- 85 Figure 7.10 Rural access to sanitary latrines, 2013
- 86 Figure 7.11 Central government expenditure on rural water and sanitation, 2000–2011
- 86 Figure 7.12 Rural population affected by high arsenic in water sources, selected provinces, 2013
- 87 Figure 7.13 Population living in coal-borne arsenic-affected areas, 2013
- 87 Figure 7.14 Arsenic-affected provinces, 2013
- 88 Figure 7.15 Fluorosis-affected provinces, 2013
- 88 Figure 7.16 Rural population affected by water-borne fluorosis, selected provinces, 2013
- 89 Figure 7.17 Percentage of rural population affected by water-borne fluorosis, 2011
- 89 Figure 7.18 Schistosomiasis-affected provinces, 2013

91 8. EDUCATION AND CHILD DEVELOPMENT

92 Overview

- 93 Figure 8.1 Structure of the education system
- 93 Figure 8.2 Absolute numbers of students at all education levels, 2013
- 94 Figure 8.3 Gross enrolment ratio in three-year pre-primary education, 2000–2013
- 94 Figure 8.4 Gross enrolment ratio in three-year pre-primary education, by province, 2013
- 95 Figure 8.5 Net enrolment ratio in primary education, 1980–2013
- 95 Figure 8.6 Net enrolment ratio in primary education, 2013
- 96 Figure 8.7 Gross enrolment ratio in junior and senior secondary education, 1990–2013
- 96 Figure 8.8 Gross enrolment ratio in junior secondary education, 2013
- 97 Figure 8.9 Gross enrolment ratio in senior secondary education, 2013
- 97 Figure 8.10 Transition rates from one level to the next level of education, 1985–2013
- 98 Figure 8.11 Cohort survival rate in junior secondary education, 2013
- 98 Figure 8.12 Reasons for drop-out among children aged 7-15 years in national poverty counties, 2002 and 2010
- 99 Figure 8.13 Distribution by sex of enrolled students at different education levels, 2013
- 99 Figure 8.14 Net enrolment ratio in primary education, by sex, 1993–2013
- 100 Figure 8.15 Net enrolment ratio in primary education, by province and sex, 2013
- 100 Figure 8.16 Gross enrolment ratio in junior secondary education, by province and sex, 2013
- 101 Figure 8.17 Migrant students as a percentage of all students in primary education of receiving cities, 2013
- 101 Figure 8.18 Migrant students as a percentage of all students in junior secondary education of receiving cities, 2013
- 102 Figure 8.19 Number of left-behind children in primary and junior secondary education in rural areas, by province, 2013
- 102 Figure 8.20 Number of boarding students in primary and junior secondary education, 2013
- 103 Figure 8.21 Type of urban school attended by income group, 2006
- 103 Figure 8.22 Student to teaching staff ratio, 1993–2013
- 104 Figure 8.23 Teachers' qualification, 2013
- 104 Figure 8.24 Provincial per capita education expenditure and provincial per capita GDP, by province, 2012
- 105 Figure 8.25 Government expenditure on education and its percentage of GDP, 1992-2012
- 105 Figure 8.26 Adult (15+) illiteracy rate by sex, 2013

107 9. THE RIGHTS OF CHILDREN AND WOMEN

108 Overview

109 Figure 9.1 International and China's milestones in the rights of children and women

111 10. CHILDREN AFFECTED BY MIGRATION

112 Overview

114 Figure 10.1 Children affected by migration as a percentage of all children, 2010

114 Figure 10.2 Children affected by migration, 2000, 2005 and 2010

115 Figure 10.3 Number of migrant children, 2010

115 Figure 10.4 Number of left-behind children in rural areas, 2010

116 Figure 10.5 Age structure of migrant children and rural left-behind children, 2010

117 Figure 10.6 Sex ratio of migrant children and rural left-behind children, 2010

118 Figure 10.7 Family arrangement of migrant children and rural left-behind children, 2010

118 Figure 10.8 Proportion of children who failed to receive or complete compulsory education as required, 2010

119 11. CHILDREN WITH DISABILITIES

120 Overview

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

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

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

122 Figure 11.4 Types of disabilities among children with disabilities, 2006

122 Figure 11.5 Sex structure of children with disabilities, 2006

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

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

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

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

125 Figure 11.10 Percentage of children with disabilities aged 6–14 receiving nine-year basic education, 2007–2013

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

127 12. VIOLENCE AGAINST CHILDREN

128 Overview

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

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

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

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

131 Figure 12.5 Suicidal intentions and experience with different types of violence before age 16, 2005

133 13. TRAFFICKING

134 Overview

135 Figure 13.1 Number of trafficking cases involving young children and women, 2000–2013

135 Figure 13.2 Source and destination provinces for trafficking, 2007

137 14. HIV / AIDS

138 Overview

139 Figure 14.1 Estimated number of people living with HIV, 2011

139 Figure 14.2 Number of cumulative reported HIV cases, 1985–2011

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

140 Figure 14.4 Transmission modes of reported HIV/AIDS cases, 1985–2013

141 Figure 14.5 Percentage of reported HIV/AIDS cases attributed to mother-to-child transmission, 1998–2013

141 Figure 14.6 Prevention-of-mother-to-child-transmission services, 2007–2013

142 Figure 14.7 Syphilis incidence rate, 2010

143 Annex 1: Data sources and references

150 Annex 2: Acronyms



1

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 km).

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 multi-ethnic country comprising 56 ethnic groups. The Han ethnic group represents 92 per cent of China's population, while 55 ethnic minority groups¹ account for the remaining 8 per cent.

China's population has more than doubled during the last five decades, from 583 million inhabitants in 1953 to 1.36 billion people in 2013². 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 total fertility rate³ and birth rates⁴ since the 1970s, when China began to implement the family planning policy to limit population growth. In China, the total fertility rate (TFR) of women decreased from 5.8 to 2.4 in only 10 years from 1970 to 1980. It fell below the replacement level of 2.1 in the early 1990s and remains at low level since then. The TFR is estimated at 1.6 for 2010-2015⁵. In 2013, the birth rate was 12 per thousand, 35 per cent lower than in 1978. The rate of natural increase⁶ in 2013 dropped to 5 per thousand, half that in 1978⁷.

China's family planning policy has led to a decrease in the national fertility rate, but this policy has been relaxed over the years with variations in policy across provinces, in rural areas and among ethnic minority groups. In rural areas, it is not uncommon for couples to have two or three children. In order to promote long-term balanced development of the population, China further relaxed its family planning policy in 2013 to allow couples to have a second child if one parent is an only child.

China had the world's second largest child population⁸ (aged 0-17 years), with an estimated 274 million⁹ children in 2013, representing 20 per cent of China's total population and 14 per cent of the world's children. However, the number of children in China declined by 21 per cent between 2000 and 2013.

China's population is currently ageing. While the population aged 0-14 years represented 34 per cent of the total population in 1982, that same age group constituted 16 per cent of China's population in 2013. In contrast, people aged 65 years or over doubled between 1982 and 2013, and now represent 10 per cent of the total population¹⁰. The significantly larger proportion of people over 65 years in the future, will have implications for the nature and scope of public services needed, and the enormous pressure faced by younger generations to care and support elderly parents and grandparents.

The sex ratio at birth has been increasing gradually since the 1980s. Data for 2012 show a sex ratio at birth¹¹ of 118 males for 100 females¹², rising from 109 in 1982¹³, while the global norm for sex ratio at birth ranges between 103 and 107 male births to every 100 female births. In 2013, there were 34 million¹⁴ fewer females than males in China. This imbalance has implications for China's future social and economic development, changing societal and gender relations, and various social issues, including a growing sub-population of unmarried men and the trafficking of girls and women for marriage, and sexual exploitation.

Figure 1.1
Geographic regions of China

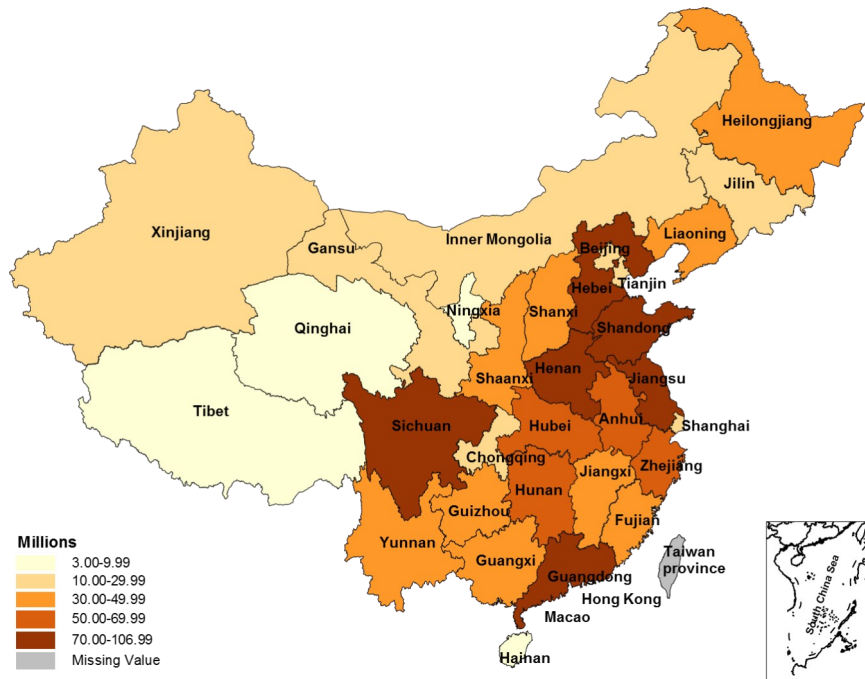


Source: (Derived from)
National Bureau of Statistics

Figure 1.1

Administratively, China is divided into provinces, Autonomous Regions (Guangxi, Inner Mongolia, Ningxia, Tibet, Xinjiang), municipalities (Beijing, Chongqing, Shanghai, Tianjin) and Special Administrative Regions (Hong Kong, Macao). China is also classified into different geographic areas, specifically eastern, central and western regions. Many economic and human development indicators are highest in the eastern regions and lowest in the western regions.

Figure 1.2
Total population, 2013



Source: National Bureau of Statistics, *China Statistical Yearbook*, 2014

Figure 1.3
Population density, 2013



Source: (Derived from) National Bureau of Statistics, *China Statistical Yearbook*, 2014

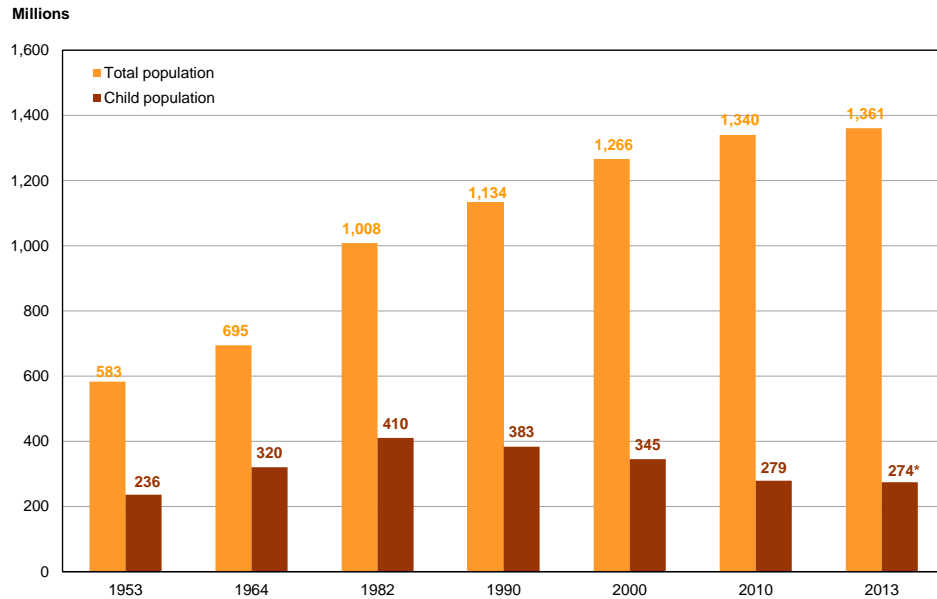
Figure 1.2

With a total population of 1.36 billion, China is the world's most populous country. China's population distribution is uneven, with 60 per cent of the population living on one-fifth of the country's land area. In 2013, Guangdong (106 million) was the most populous province while Tibet (3 million) was the least populous.

Figure 1.3

The average population density is 142 people per sq km in China, but varies greatly across the country. While Shanghai has an average of more than 3,800 persons per sq km, Xinjiang, Qinghai and Tibet have fewer than 15 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.

Figure 1.4
Total population and child population, 1953–2013



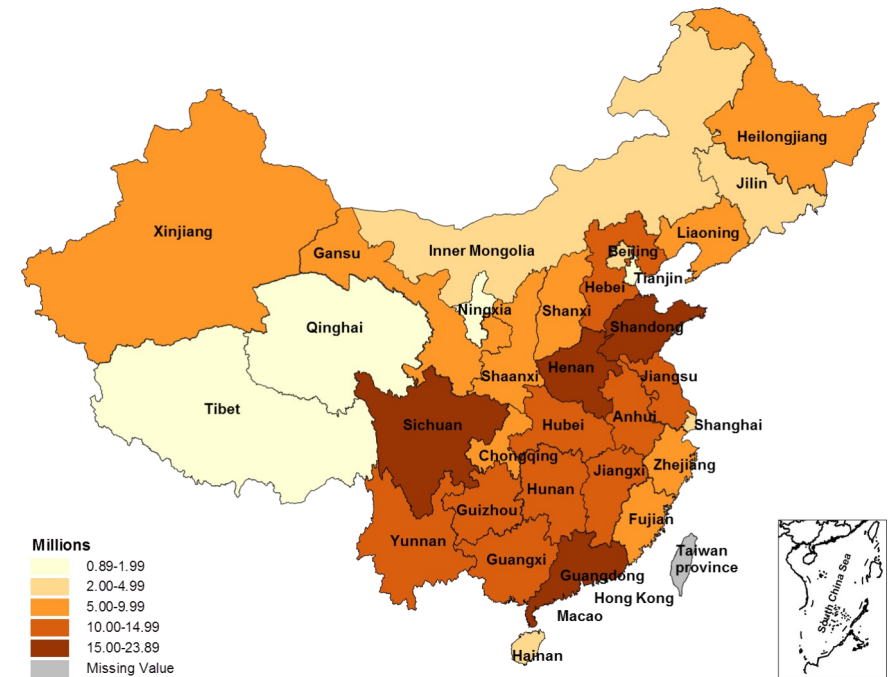
Sources: National Bureau of Statistics, 1953, 1964, 1982, 1990, 2000 and 2010 *Population Censuses* (respectively published in 1955, 1966, 1985, 1993, 2002 and 2012); National Bureau of Statistics, *China Statistical Yearbook*, 2014 (2013 data)

Figure 1.4

According to the national population census, the number and percentage of children increased between 1953 and the 1980s, and then began to fall after this, despite the continuous increase of the total population. China conducts a national population census every ten years. In total six censuses were conducted in the years indicated in this chart between 1953 and 2010.

* Number of children in 2013 is estimated by UNICEF China Office using age-specific population structure in percentages based on the 2013 National Sample Survey on Population Changes conducted by the National Bureau of Statistics of China. Results of this survey are published in *China Population and Employment Statistics Yearbook 2014*.

Figure 1.5
Child population, 2010

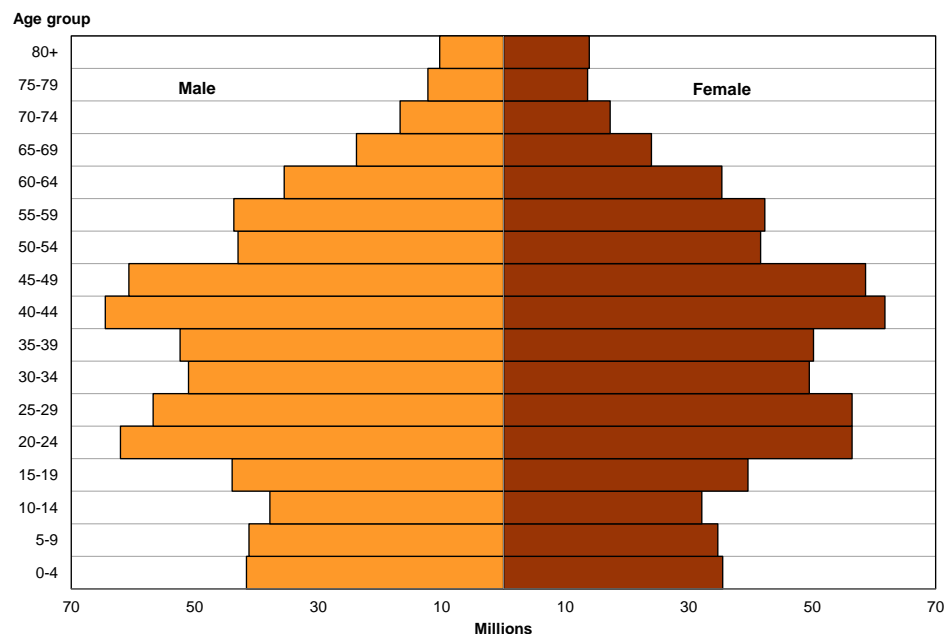


Source: (Derived from) National Bureau of Statistics, 2010 Population Census

Figure 1.5

According to 2010 Census, China has 279 million children aged 0–17 years, comprising 21 per cent of its total population. Child population is concentrated in the southeastern regions of the country.

Figure 1.6
Population pyramid, 2013



Source: National Bureau of Statistics, *China Statistical Yearbook*, 2014

Figure 1.7
Percentage of ethnic minority groups, 2010



Source: National Bureau of Statistics, *Tabulation on the 2010 Population Census of the people's Republic of China*, 2012

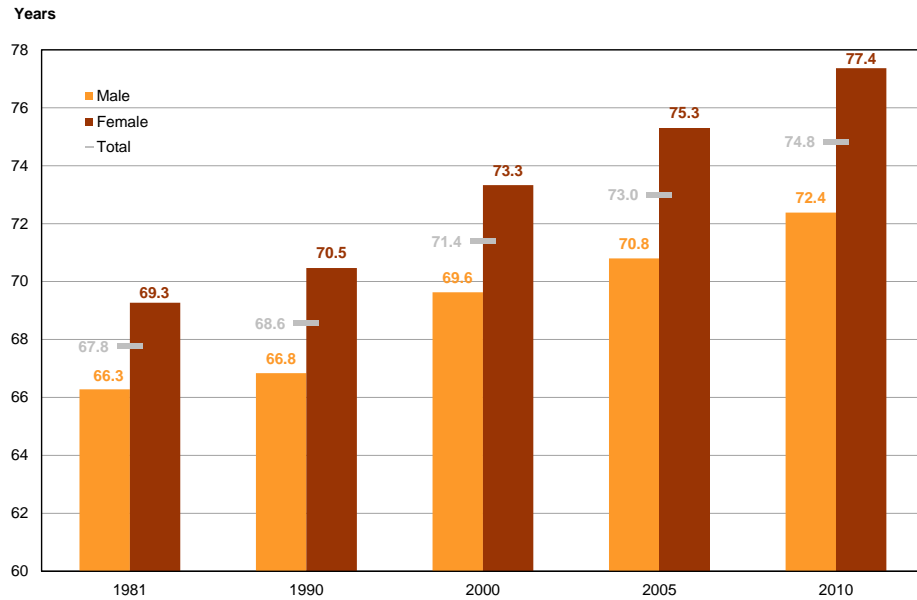
Figure 1.6

China's population is ageing due to the low total fertility rate and the increase in life expectancy. This is reflected in the shape of the population pyramid where the bottom bars are smaller and the top bars are wider than a standard pyramid. Globally, a population is defined as "aged" if people aged 60 years or over account for more than 10 per cent, or people aged 65 years or over account for more than 7 per cent of the total population. According to either of these two criteria, China has stepped into an ageing society since 2000. In 2013, 14.9 per cent of the total population was over 60 years of age, and 9.7 per cent was over 65 years of age.

Figure 1.7

China is comprised of 56 different ethnic groups, including Han and 55 ethnic minority groups. In 2010, the total population of the 55 ethnic minority groups was 112 million, accounting for 8.4 per cent of the total population and mostly concentrated in western China. Four ethnic minority groups in China had a population over 10 million, namely Zhuang, Manchu, Hui and Uyghur. Among all provinces in 2010, Tibet had the highest proportion of the population who were ethnic minorities (92 per cent), while Guangxi was home to 17 million people of ethnic minority status, who were mainly Zhuang. This is the largest population of a single ethnic minority group within a province.

Figure 1.8
Life expectancy at birth, 1981–2010



Sources: National Bureau of Statistics, *1982, 1990, 2000, and 2010 Population Censuses*, (respectively published in 1985, 1993, 2002 and 2012); *2005 One Per cent Population Sample Survey, 2007*

Figure 1.8

According to the National Health and Family Planning Commission (formerly the Ministry of Health), the average life expectancy at birth¹⁵ was only 35 years in 1949¹⁶, when the People's Republic of China was founded. By 2010, this had risen to 75 years. Between 1981 and 2010, life expectancy increased by eight years and six years for women and men, respectively. Average life expectancy at birth in China is now higher than many other countries with a similar GNI per capita¹⁷.

Figure 1.9
Life expectancy at birth, 2010

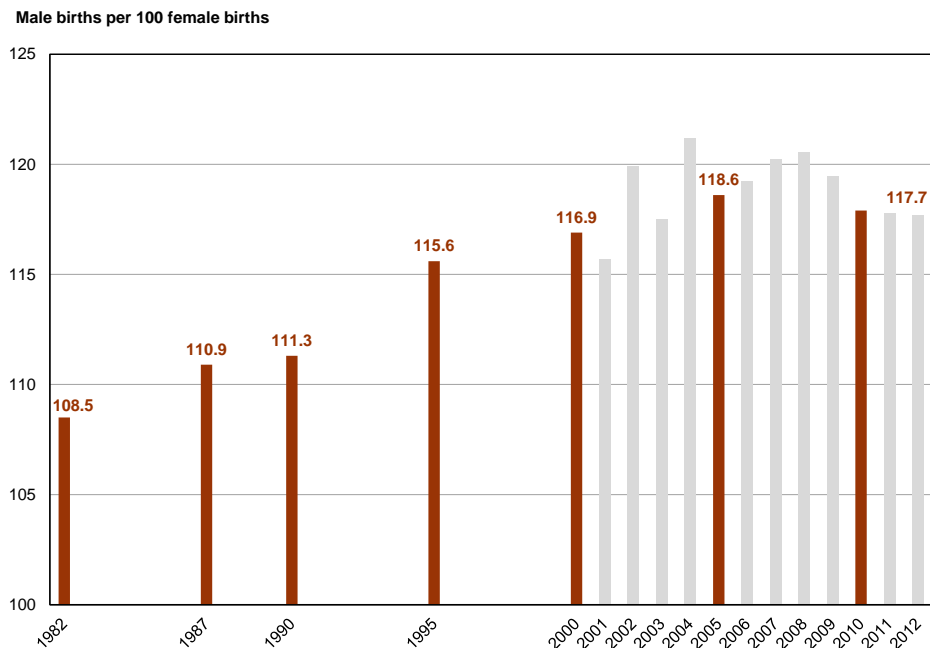


Source: National Bureau of Statistics, *China Statistical Yearbook, 2012*

Figure 1.9

There are significant disparities in life expectancy between western and eastern provinces. Life expectancy in western provinces such as Tibet, Yunnan and Qinghai increased by four to five years between 2000 and 2010, but still lags about 10 years behind Beijing and Shanghai, which record average life expectancy of 80 years.

Figure 1.10
Sex ratio at birth, 1982–2012

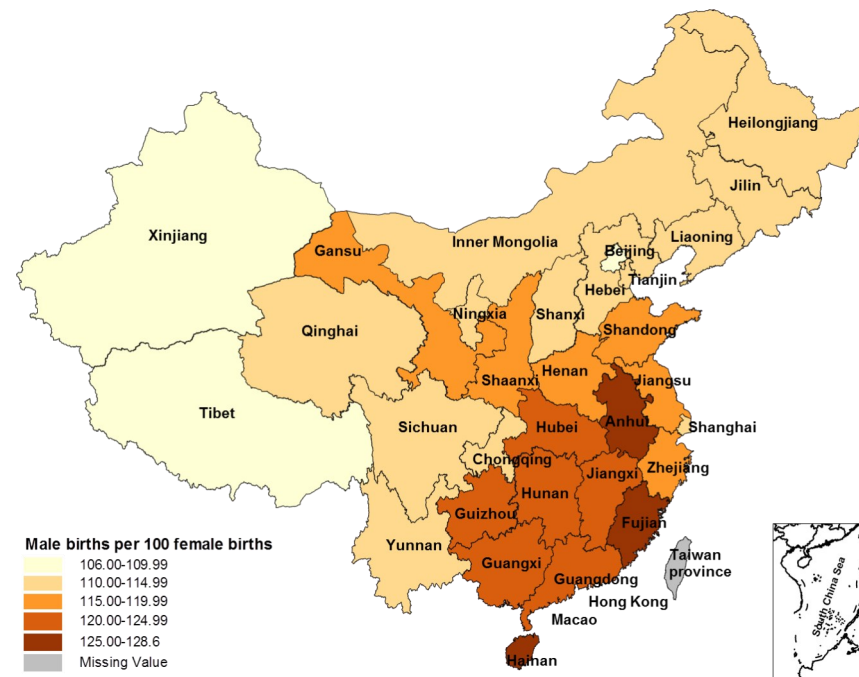


Sources: National Bureau of Statistics, *1982, 1990, 2000, and 2010 Population Censuses*, (respectively published in 1985, 1993, 2002 and 2012); *1987, 1995 and 2005 One Per cent Population Sample Surveys* (respectively published in 1988, 1997 and 2007); *Annual National Sample Survey on Population Changes*, other years (published via annual *Statistical Communiqué on the National Economic and Social Development*)

Figure 1.10

In the absence of intervention, the human sex ratio at birth lies between 103 and 107 male births per 100 female births¹⁶. As men have a higher mortality rate than women, the sex ratio at birth is higher than the sex ratio observed later in life, such as at reproductive age. In China, the sex ratio at birth has become increasingly skewed in general, growing from 109 males per 100 females in 1982 to 118 males per 100 females in recent years. The abnormally high SRB and the associated number of "missing women" in China highlights the extent to which girls are denied the right to life and reflects deep-seated sex discrimination that adversely affects girls' development.

Figure 1.11
Sex ratio at birth, 2010

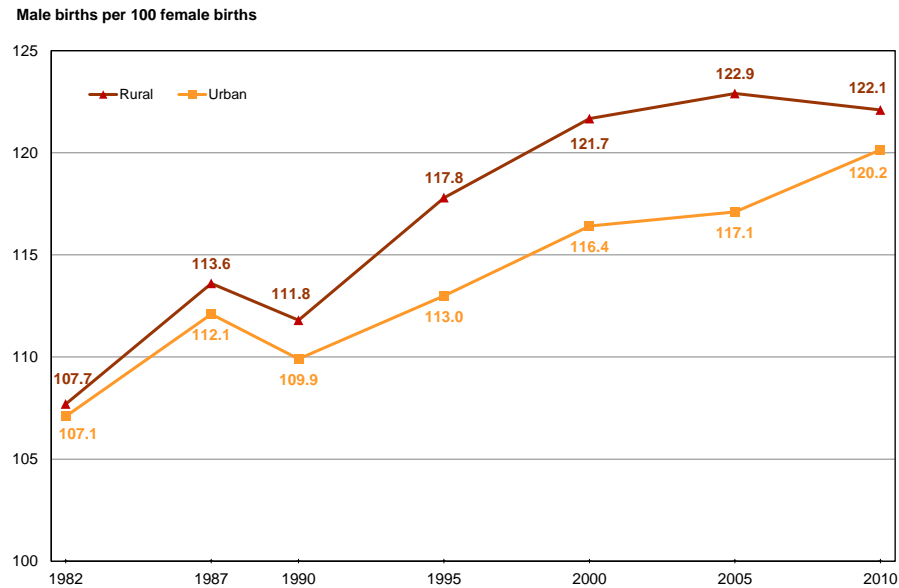


Source: National Bureau of Statistics, *Tabulation on the 2010 Population Census of the people's Republic of China, 2012*

Figure 1.11

The sex ratio at birth (SRB) in 2010 was above 110 in all but three provinces (Xinjiang, Tibet and Beijing). In Anhui, Fujian and Hainan provinces, the sex ratio exceeded 125 males per 100 females. Both direct and indirect factors including son preference and corresponding sex selection practices, the influence of the family-planning policy, unequal social and family status of females, and incomplete social security system may have contributed to the high SRB, particularly in rural areas and certain provinces.

Figure 1.12
Sex ratio at birth, urban and rural, 1982–2010

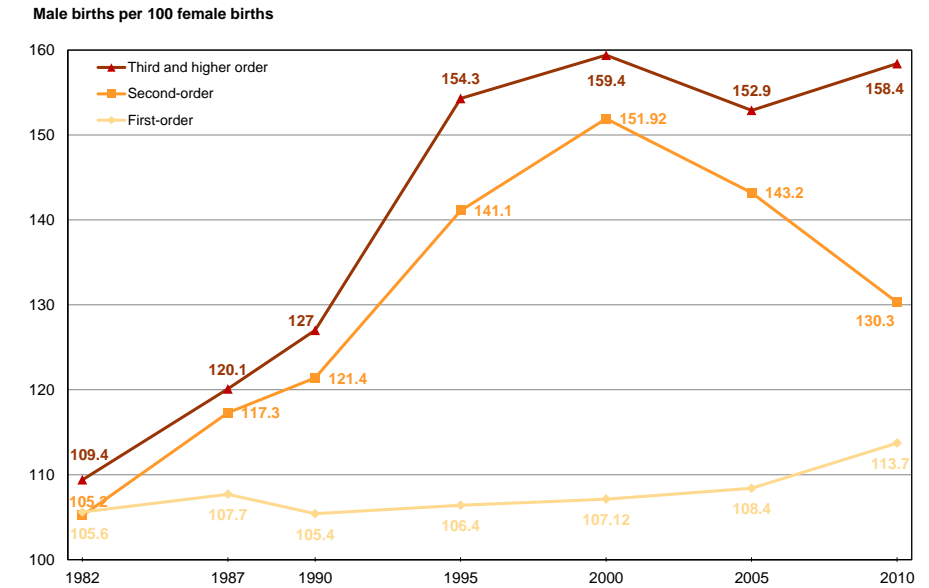


Sources: National Bureau of Statistics, *1982, 1990, 2000, and 2010 Population Censuses*, (respectively published in 1985, 1993, 2002 and 2012); *1987, 1995 and 2005 One Per cent Population Sample Surveys* (respectively published in 1988, 1997 and 2007)

Figure 1.12

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 until 2005. Data from 2010 Population Census indicates a decrease of sex ratio at birth in rural area. Accordingly, the urban-rural disparity reached its highest in 2005, and then decreased in 2010.

Figure 1.13
Sex ratio at birth, by birth order, 1982–2010

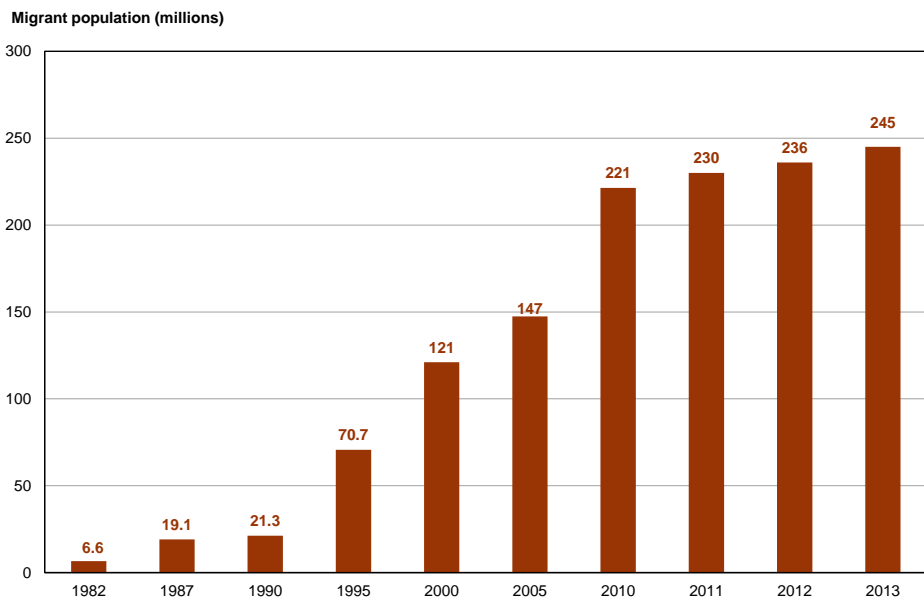


Sources: National Bureau of Statistics, *1982, 1990, 2000, and 2010 Population Censuses*, (respectively published in 1985, 1993, 2002 and 2012); *1987, 1995 and 2005 One Per cent Population Sample Surveys* (respectively published in 1988, 1997 and 2007)

Figure 1.13

Disaggregated data indicate that the sex ratio at birth increases with birth order in China. For example, in the year 2010, the sex ratio at birth was around 114 for first-order births, but rose to 130 for second-order births and reached 158 for third and higher-order births. The sex ratio at birth was within the normal range for first-order and second-order births in 1982 and for the first order from 1982 until 2000, followed by an overall increase in all orders. A decrease in second order births is observed from 2000 to 2010.

Figure 1.14
Migrant population, 1982–2013



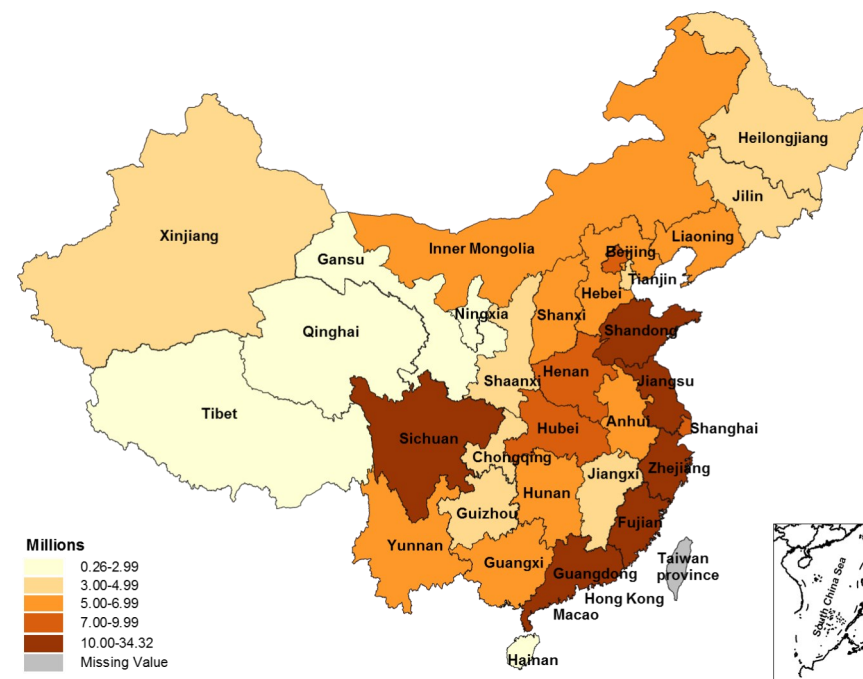
Sources: National Bureau of Statistics, *1982, 1990, 2000, and 2010 Population Censuses*, (respectively published in 1985, 1993, 2002 and 2012); *1987, 1995 and 2005 One Per cent Population Sample Surveys* (respectively published in 1988, 1997 and 2007); *Annual Statistical Communiqué on the National Economic and Social Development* (2011-2013 data)

Figure 1.14

China has been experiencing enormous domestic mass migration since the 1990s. In 1982, the migrant population totalled only 6.6 million, and has increased substantially, reaching 221 million in 2010 according to the census data. The migrant population continued to rise to 245 million in 2013, accounting for 18 per cent of the total population. The general increase in the number of migrants over the last three decades is related to other processes such as industrialization and urbanization, and brings both opportunities and challenges to the social and economic development of China.

*Specific data on children affected by migration can be found in chapter 10 of this ATLAS.

Figure 1.15
Migrant population, 2010

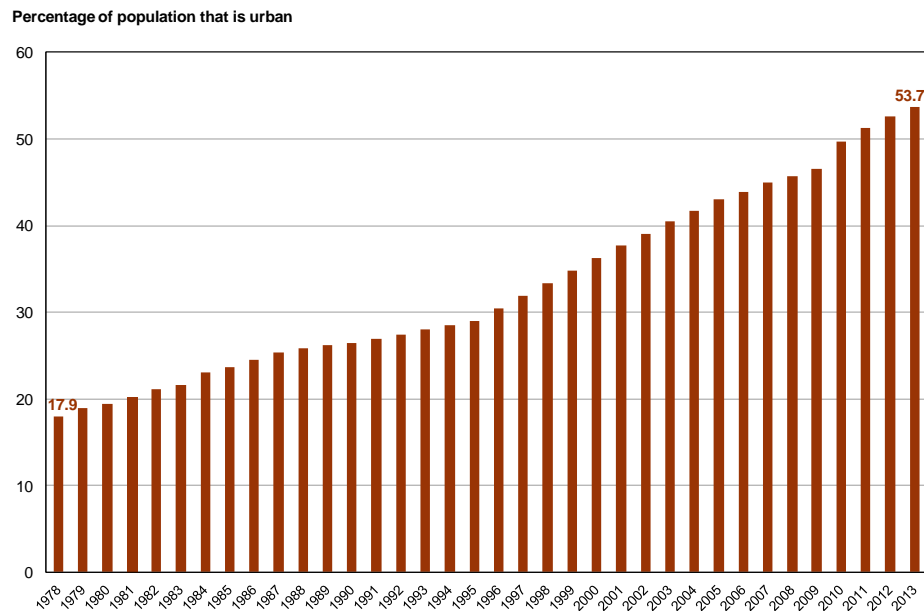


Source: National Bureau of Statistics, *Tabulation on the 2010 Population Census of the people's Republic of China, 2012*

Figure 1.15

In 2010, the migrant population was generally concentrated in the economically developed eastern coastal provinces and the densely populated inland provinces. There were six major provinces to which a total of 100 million people had migrated (more than 10 million to each province), namely Guangdong, Zhejiang, Jiangsu, Shandong, Sichuan and Fujian. The number of migrant population in these provinces accounted for 45.5 per cent of all migrant population nationwide. Beijing and Shanghai followed closely behind the six provinces in terms of the absolute number of migrant people, while with the highest percentage of migrant population among the 31 provinces, accounting for 41.8 per cent and 39.6 per cent respectively and over 90 per cent of the migrant population were from other provinces. In 2010, inter-provincial migrants accounted for 38.9 per cent of the total of the 221 million migrant population nationwide.

Figure 1.16
Urbanization, 1978–2013



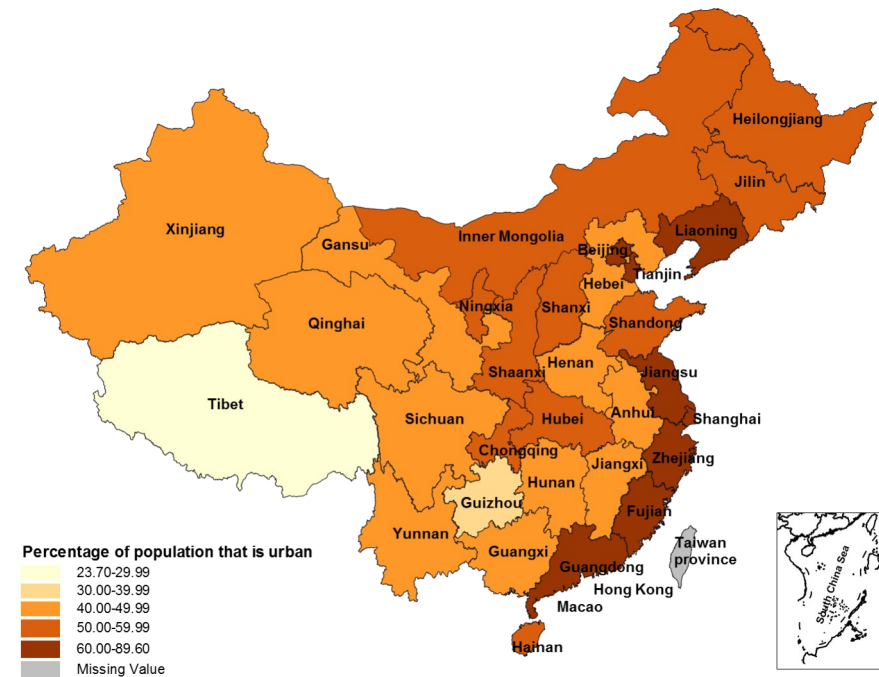
Source: National Bureau of Statistics, *China Statistical Yearbook*, 2014

Figure 1.16

Urbanization rate (the urban share of population¹⁹) increased from 18 per cent in 1978 to over 50 per cent in 2011 for the first time, and rose further to 54 per cent in 2013. Beginning in the early 1980s, this increase was fuelled by the migration of large numbers of surplus agricultural workers and rural populations seeking better economic opportunities in cities.

* Since 1987, China has been implementing a strategy to manage urbanization by supporting the growth of small cities, developing medium-sized cities and limiting the size of big cities. In order to promote the urbanization steadily at this stage, help the migrant population to settle in the cities and ensure they are gradually covered by the basic urban public services, the Government issued the *Opinions on Further Promoting Reform of Household Registration System* in 2014, and as one of the measures, to adjust the household registration policy for migrants. The government will completely lift restrictions on household registration in towns and small cities (which are officially classified as cities with less than 500,000 people), gradually relax the restrictions in medium-sized cities (500,000-1,000,000 people), properly set qualifications for registration in big cities (1-5 million people), and strictly control the population scale in mega cities (over 5 million people).

Figure 1.17
Urbanization, 2013



Source: National Bureau of Statistics, *China Statistical Yearbook*, 2014

Figure 1.17

China's eastern regions account for the highest rates of urbanization. Municipalities including Shanghai, Beijing and Tianjin have urbanization rates between 80 and 90 per cent, while other eastern provinces such as Guangdong, Liaoning, Jiangsu, Zhejiang and Fujian have urbanization rates between 60 and 70 per cent.

Figure 1.18
Years in which the number of fatalities caused by natural disasters exceeded 6,000, 1976–2013

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
2010	7,844

Sources: Ministry of Civil Affairs, *China National Civil Affairs Statistical Yearbook*, 2014; China Earthquake Data Centre (1976 data)

Figure 1.18 and 1.19

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 terms of the number of fatalities and in the economic costs from damage²⁰.

* Data reflect fatalities from the 1976 Tangshan earthquake only.

Figure 1.19
Years in which the direct economic loss caused by natural disasters exceeded RMB 150 billion (US\$ 25 billion equivalent), 1994–2013

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	1,355
2009	252
2010	534
2011	310
2012	419
2013	581

Source: Ministry of Civil Affairs, *China National Civil Affairs Statistical Yearbook*, 2014



2

ECONOMIC AND SOCIAL DEVELOPMENT

OVERVIEW

China has a long tradition of providing women and children with access to essential public services. During the past 30 plus years, however, improvements in access and quality of essential public services have progressed more slowly compared to the preceding 30 years and have not been commensurate with China's spectacular economic development. Furthermore, there are increasing disparities among different population groups in terms of public service delivery performance and improvements in some aspects of human/social development outcomes. *China's Twelfth Five-Year Plan (2011-2015)* prioritizes equitable access to essential public services and recognizes challenges faced by disadvantaged children. This was reiterated in 2013 at the *Third Plenum of the 18th Central Committee* which called for reforms to improve income distribution and to narrow public service delivery gaps. As such, the Government has been working to improve access to equitable public services for poor, disadvantaged children and women.

In recent years, the Government has adopted a series of policy measures to enhance equity and quality in the delivery of essential public services.

- With the objective of achieving free compulsory 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. The *National Plan for Medium and Long-Term Education Reform and Development (2010–2020)* was launched in 2011 and seeks to ensure adequate financing for education development and to promote equal access and improved education quality. The area of early childhood development has witnessed some breakthroughs: starting from autumn 2011, special subsidies from both local and central governments have been provided to poor households' children, orphans, and children with disabilities to enable access to pre-primary education. At the same time, compulsory school age students located in poverty stricken areas began to receive central government subsidies for nutritious meals at school, which has been expanded to 300 counties in 14 clustered and contiguous poverty stricken areas by 2013.
- The Government has increased per capita spending on an essential package of public health services several times, from RMB 15 before 2011 to RMB 35 in 2014. The new Rural Cooperative Medical Scheme (RCMS), has received substantially increased government subsidies, and has reached 98.7 per cent of the rural population, i.e., 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 the basic medical insurance scheme for urban residents launched in 2007. Since 2011, rural children aged 0-14 who have joined the new

RCMS are eligible to receive more than 70 per cent reimbursement of the costs involved in treating six types of congenital heart disease and leukaemia. Immunization against 15 diseases and treatment for selected communicable diseases, including AIDS, tuberculosis and schistosomiasis, are now provided free of charge.

- Social protection and assistance has improved as the urban and rural minimum subsistence allowance schemes (*dibao*²¹) have received greater funding and increased their population coverage and benefit levels. A special protection scheme for orphans was established in 2010, benefiting about 600,000 orphans nationwide.
- In 2014, the Government endorsed *the Child Development Plan in National Poverty Areas*, to improve education and health of children in "poverty blocks" (as defined in the 2011-2020 national *Rural Poverty Reduction Strategy*), in particular covering a life-cycle period from children's birth to compulsory education stage.
- In 2014, the Government issued the *Opinions on Further Promoting Reform of the Household Registration System*, aiming to promote the orderly urbanization of China's population with stable employment and life, and to steadily increase the coverage of essential urban public services to the migrant population in urban areas. The Government aims to do this through integrating household registration systems by desegregating the agricultural and non-agricultural *Hukou*, establishing an urban-rural integrated residence permit system, expanding the coverage of basic urban public services such as compulsory education, employment services, basic pension, basic health services and housing, providing the migrant population with the same services and equal rights as locally registered populations, and improving public financing for equalized basic public services.

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 which facilitated rapid economic growth, 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. From 2010, China became the second largest economy in the world after the United States whether measured in terms of currency exchange rate or purchasing power parity²². The GDP

per capita has grown at an average annual rate of 9 per cent over the last three decades, and stood at US\$ 6,807 in 2013²³. Based on its GNI per capita, China became an upper-middle-income country group by World Bank standards²⁴ in 2010.

Income disparities

Economic growth has been uneven across China. Consequently, the income disparities between rural and urban residents and among residents living in the eastern, 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 3.03 in 2013. 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's income grew by only 3 per cent²⁵.

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 0.29 in 1981 to 0.42 in 2010 according to World Bank estimates. The measured level of inequality by the World Bank in China was, in fact, comparable to that of many middle-income economies globally, including Thailand and Malaysia, and was still lower than in many Latin American countries²⁶. In 2013, China for the first time released its official estimates of national Gini index which are higher than the World Bank estimation and stand around 0.48 in recent years.

Poverty reduction performance

Along with the progress in other human development indicators, China's progress in poverty reduction over the past three decades is enviable and impressive²⁷. 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 lines and the internationally-used World Bank poverty lines²⁸. The strong poverty alleviation performance reflects the spectacular economic growth performance and the success of the series of market-oriented reform 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.

In 2011 when the new ten-year *Rural Poverty Reduction Strategy* (2011–2020) was launched, the Government increased its official rural poverty line by nearly doubling it to RMB 2,300 to benefit more eligible households in rural areas. Geographic coverage was also expanded from originally 592 national designated poverty counties to also include 11 block areas and three special areas which are to be key "battlefields" for poverty alleviation efforts under the current *Rural Poverty Reduction Strategy*.

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.

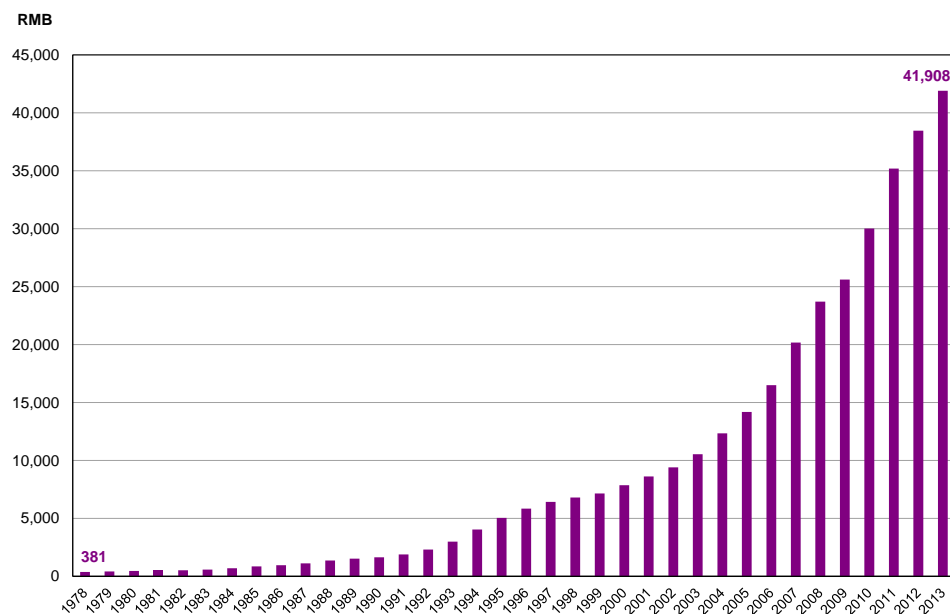
Social assistance

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 performance²⁹. Surveys indicate that the beneficiaries of the *dibao* cash benefits are highly concentrated among the poorest urban groups.

Remaining challenges include the following:

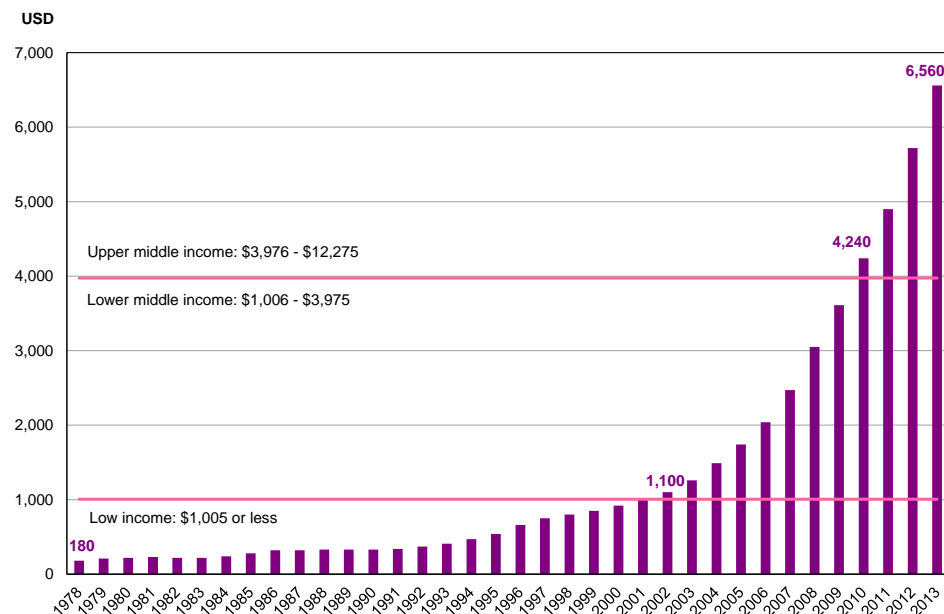
- The coverage and benefit levels of social assistance to the poor need to be further increased, with financial support from central and provincial governments in both rural and urban areas.
- The benefit level needs to reflect the basic needs of children.
- Building on the successful implementation 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, 1978–2013



Source: National Bureau of Statistics, *China Statistical Yearbook*, 2014

Figure 2.2
GNI per capita, 1978–2013



Source: World Bank data, data.worldbank.org, accessed 2014

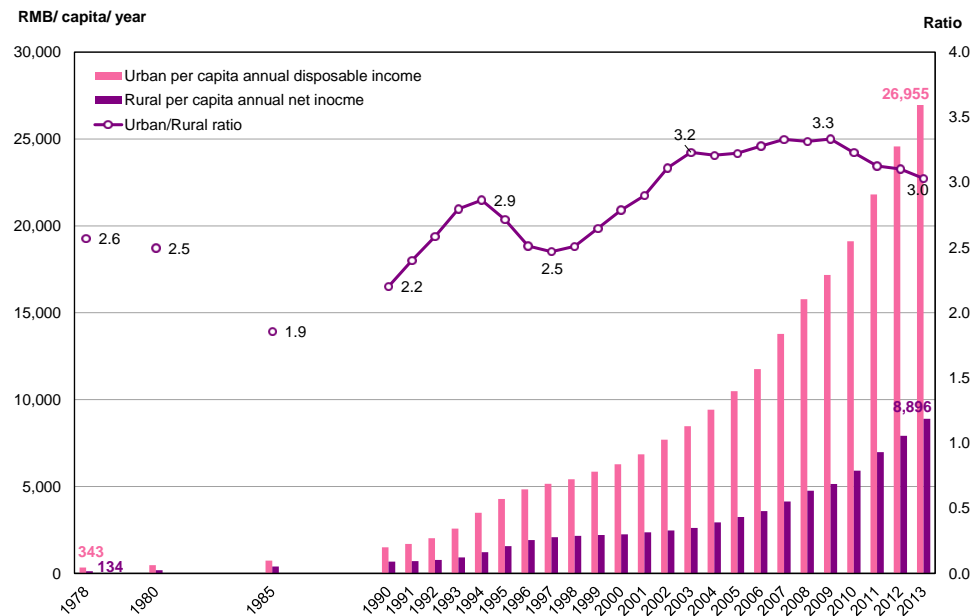
Figure 2.1

China, one of the poorest countries in the world three decades ago, with a GDP per capita³⁰ of only US\$165 (constant 2000 US\$) in 1978, is now the world's second largest economy, with annual growth rates averaging 9 per cent over the past 30 years, and GDP per capita of RMB 41,908 in 2013 (current US\$ 6,807). Rapid economic growth is projected to continue though at a lower rate, but disparities among regions and population groups are large and widening.

Figure 2.2

China's per capita GNI reached US\$ 6,560 in 2013. In 2011, the World Bank reclassified China from a "lower middle income country" to an "upper middle income country" since 2010, calculated using the World Bank Atlas method.

Figure 2.3
Per capita income, urban and rural, 1978–2013

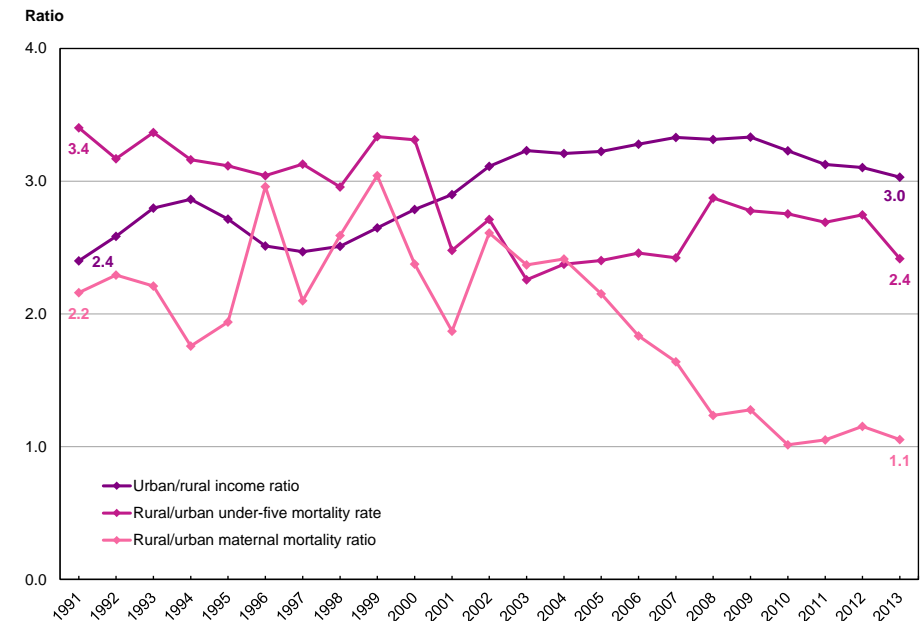


Source: National Bureau of Statistics, *China Statistical Yearbook*, 2014

Figure 2.3

Per capita income has grown in both urban³¹ and rural areas³², but urban-rural income inequities have intensified, exceeding the ratio of 3.3 to 1 in 2009. Though the urban-rural income ratio likely decreased in 2010-2013 due to more rapid rural income growth, it still stood at 3:1³³.

Figure 2.4
Urban/rural income and urban/rural health outcome disparities, 1991–2013

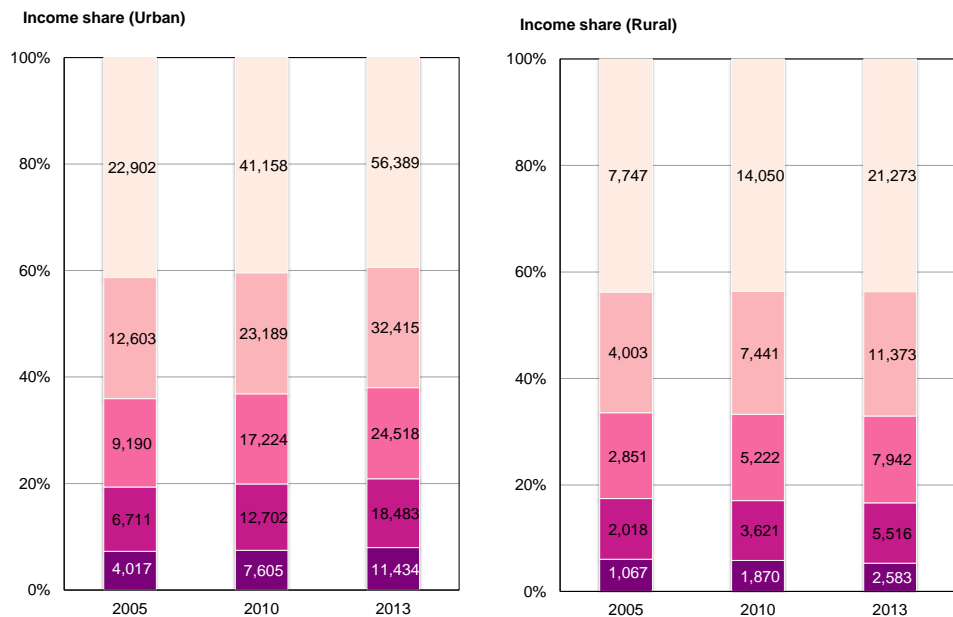


Sources: National Bureau of Statistics, *China Statistical Yearbook*, 2014 (income); National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook*, 2014

Figure 2.4

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

Figure 2.5
Urban per capita disposable income and rural per capita net income, by quintile, 2005, 2010 and 2013



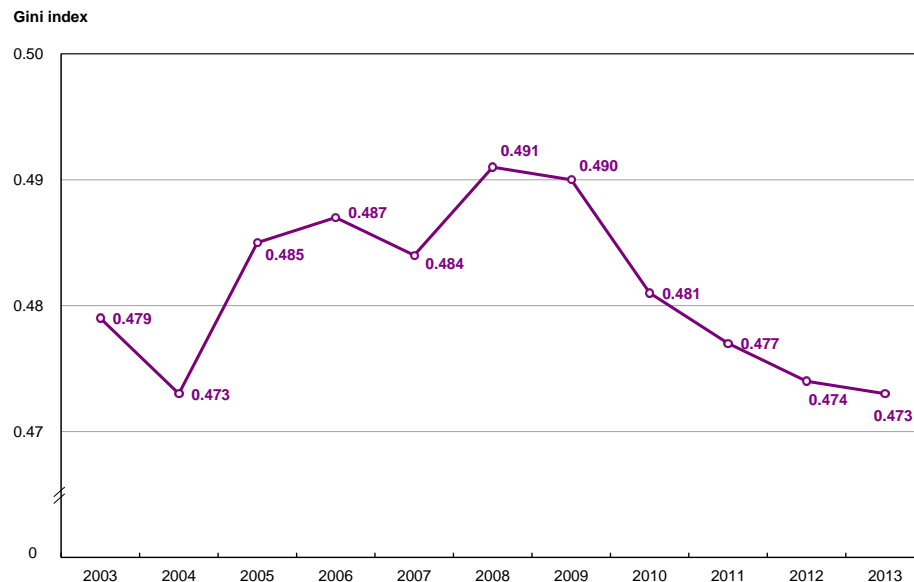
Source: National Bureau of Statistics, *China Statistical Yearbook*, 2014

Figure 2.5

There is significant inequality across income quintiles within both urban and rural China, where the highest quintile has an income share of more than 40 per cent. Income share by quintile remained relatively unchanged between 2005 and 2013.

* Data label in the charts indicate the average annual per capita income in RMB for each quintile.

Figure 2.6
National Gini index, 2003-2013



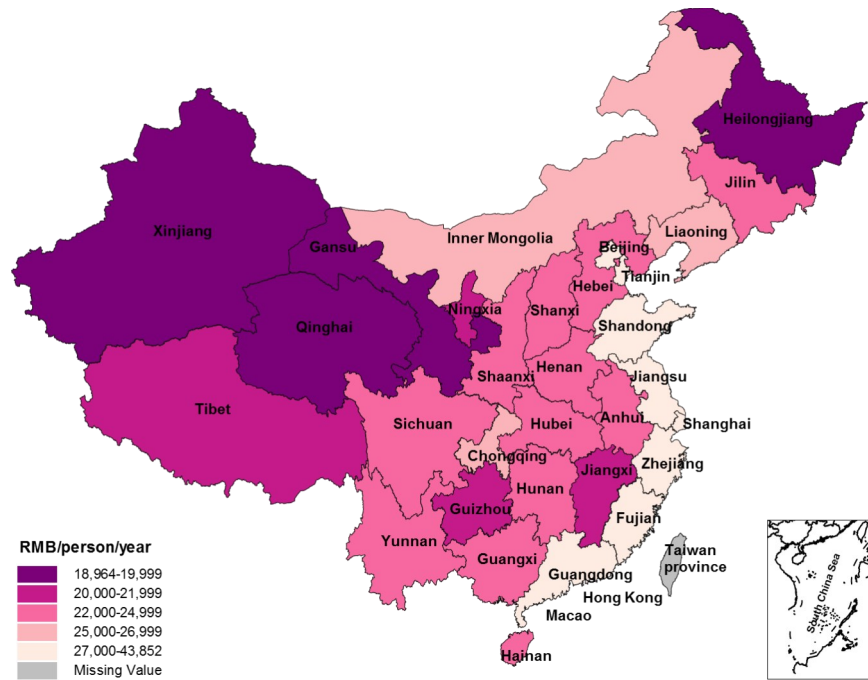
Source: Estimated by National Bureau of Statistics based on Urban/Rural Household Surveys, www.stats.gov.cn, accessed 2014

Figure 2.6

In 2013, China for the first time released its official estimation of national Gini index. The estimates range from 0.473 to 0.491 across China during 2003 and 2013, indicating a high level of income inequality though the trend towards rising inequality has been basically curbed in recent years. Rural-urban dual economy and unequal access to public services may contribute, together with other factors, to the high level of income inequality.

* (1) Although there are no internationally defined standard cut-off values, it's commonly recognized that Gini index < 0.2 corresponds perfect income equality, 0.2-0.3 corresponds relative equality, 0.3-0.4 corresponds relatively reasonable income gap, 0.4-0.5 corresponds high income disparity, above 0.5 corresponds severe income disparity. (2) China's official estimates are higher than that of the World Bank, which is 0.42 for 2010 (the latest available estimation from the World Bank) and increased from around 0.29 in 1981.

Figure 2.7
Urban per capita disposable income, 2013

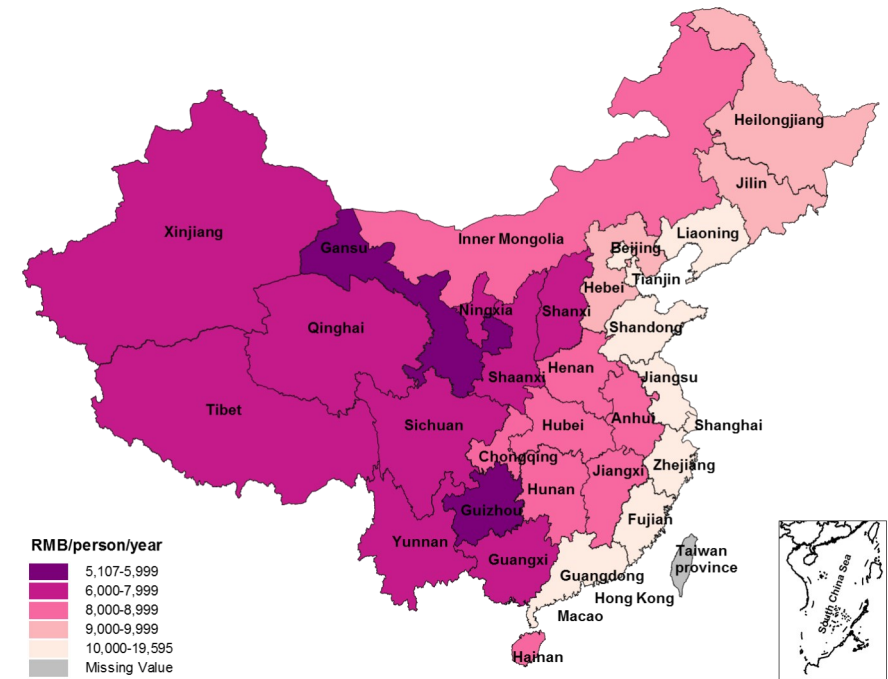


Source: National Bureau of Statistics, *China Statistical Yearbook*, 2014

Figure 2.7

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

Figure 2.8
Rural per capita net income, 2013

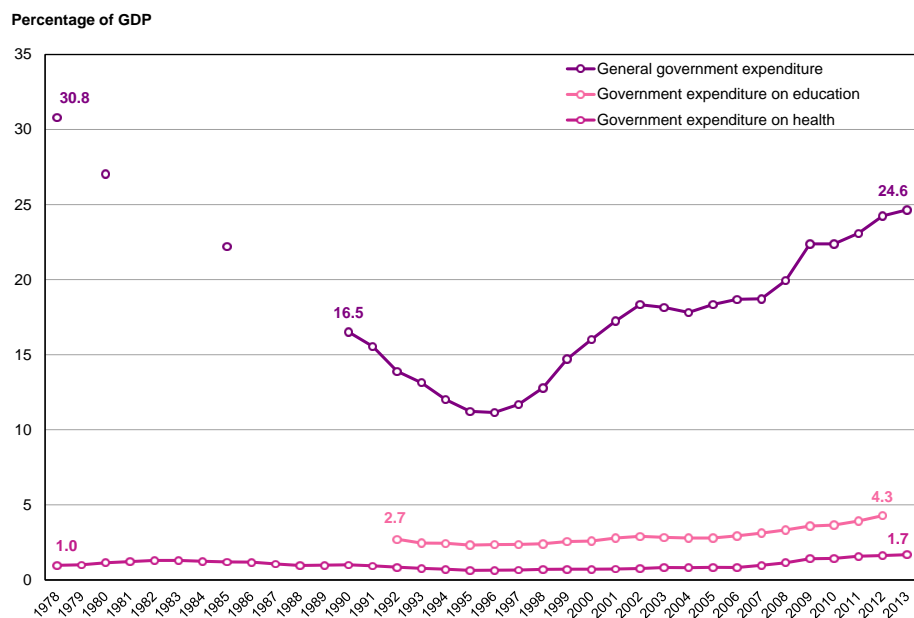


Source: National Bureau of Statistics, *China Statistical Yearbook*, 2014

Figure 2.8

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

Figure 2.9
General, health and education government expenditure
as a percentage of GDP, 1978–2013

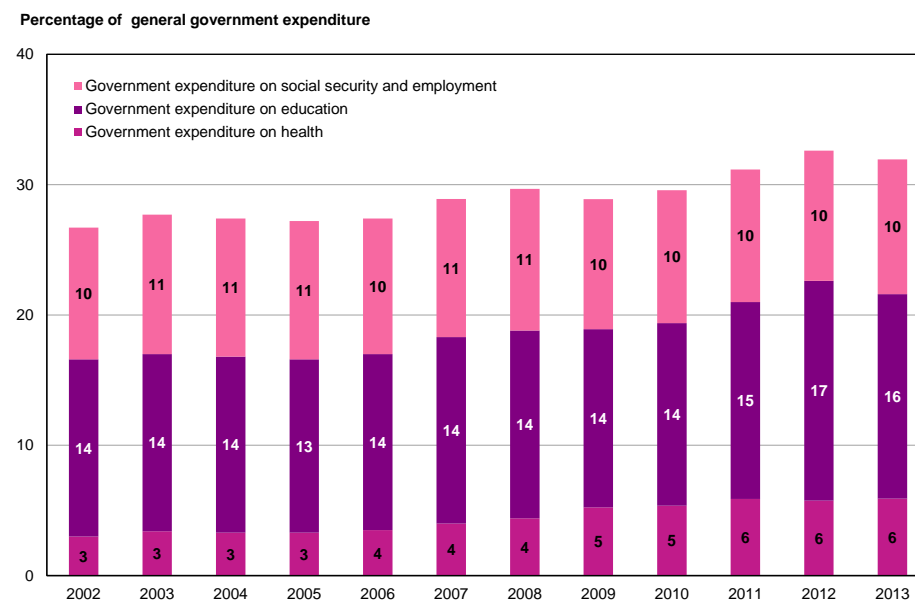


Source: National Bureau of Statistics, *China Statistical Yearbook*, 2014

Figure 2.9

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 2.10
Government expenditure on social security and employment,
health and education as a percentage of general government
expenditure, 2002–2013



Source: National Bureau of Statistics, *China Statistical Yearbook*, 2014 (2008–2013 data); Ministry of Finance, *Finance Yearbook of China*, 2008 (2002–2007 data)

Figure 2.10

Government spending in social sectors has increased steadily as a share of total government spending.

Figure 2.11
Rural poverty,
1978–2013

Sources:

National Bureau of Statistics,
China Rural Household Survey
Statistical Yearbook, 2011 (1978-
1999 data);

National Bureau of Statistics,
Poverty Monitoring Report of
Rural China, 2011 (2000-2010
data);

National Bureau of Statistics,
annual *Statistical Communiqué of*
the People's Republic of China on
the National Economic and Social
Development (2011-2013 data)

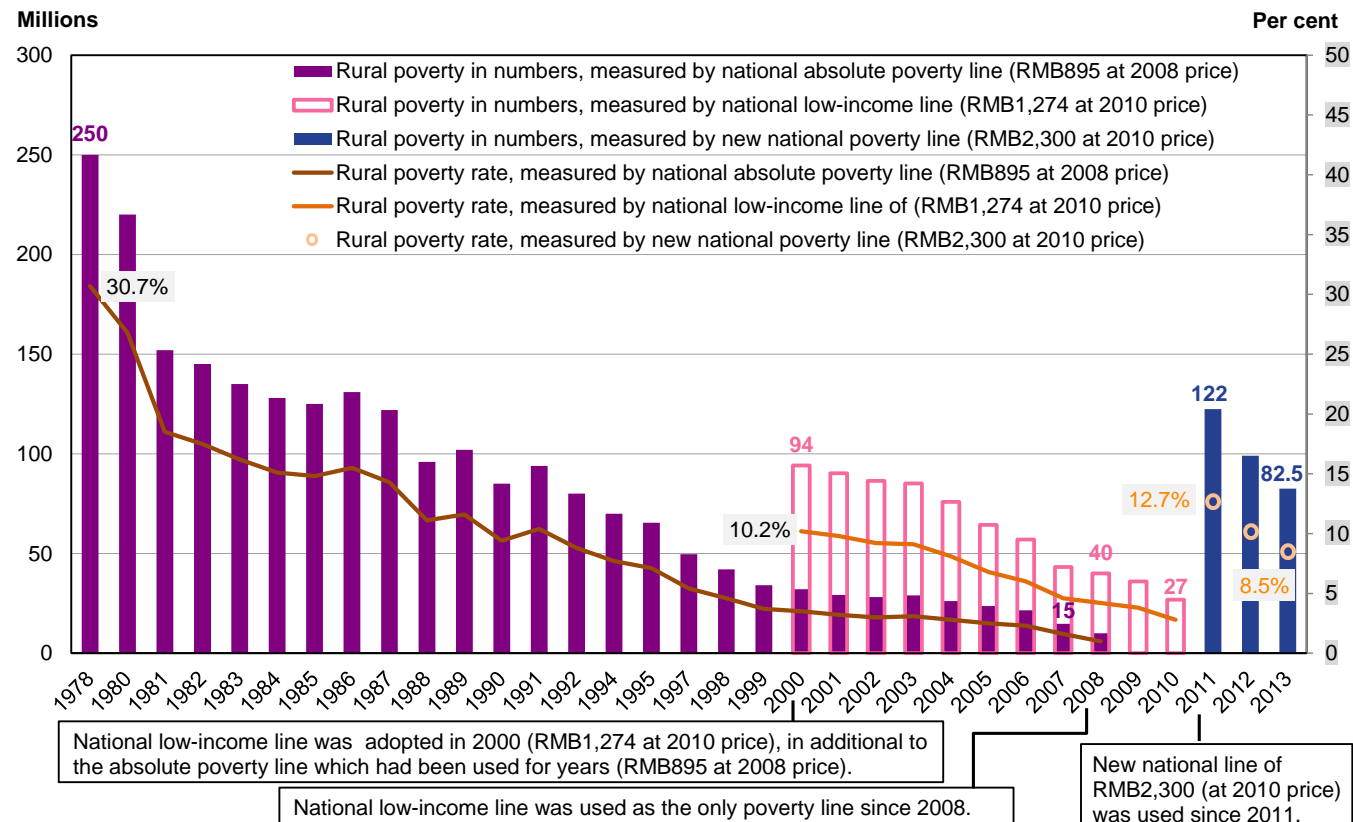
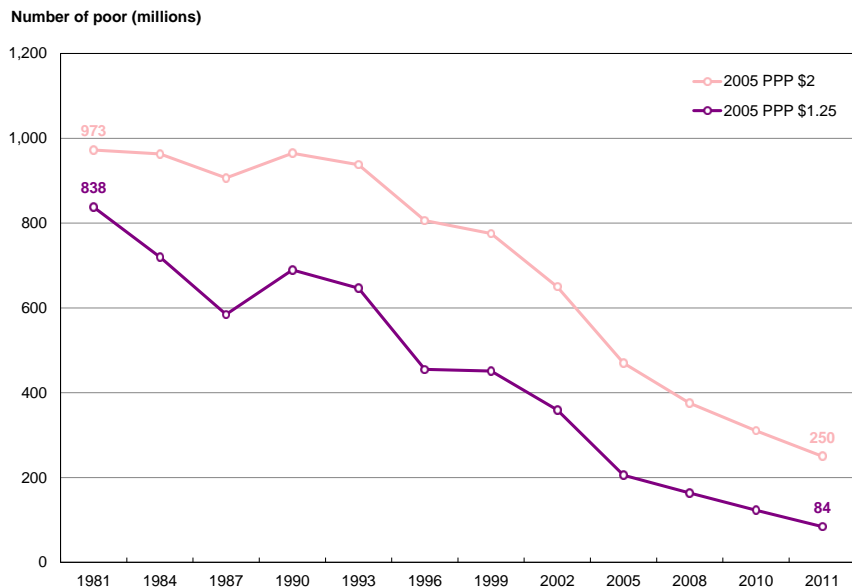


Figure 2.11

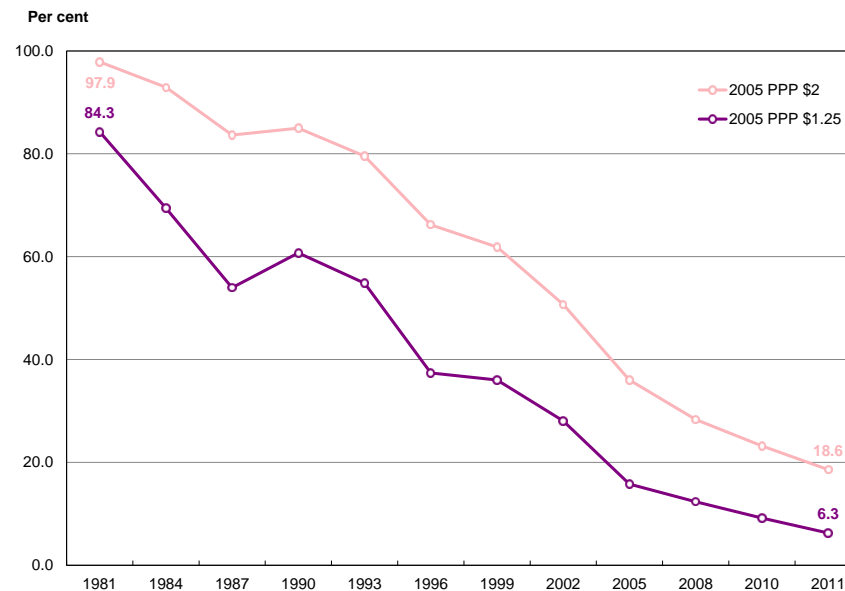
Over the past three decades, progress in rural poverty reduction has been tremendous, as measured by any of China's official poverty lines. The Government has increased official rural poverty lines twice since 2000. It adopted a national low-income line of RMB 1,274 (at 2010 prices) in 2000, in addition to the absolute poverty line which had been used for years, and then the low-income line was used as the only poverty line since 2008. In 2011 when the Government launched the new ten-year Rural Poverty Reduction Strategy (2011–2020), the official poverty line was increased to RMB 2,300 (at 2010 prices, equivalent to 2005 PPP US\$1.6 per person per day). The near-doubling of the poverty line means that more people are now eligible for government assistance, reflecting both the Government's increased fiscal capacity and its greater attention to poverty alleviation. In 2013, there were 82.5 million or 8.5 per cent of rural residents living below the new poverty line of RMB 2,300.

Figure 2.12
Consumption poverty in absolute numbers, 1981–2011



Source: World Bank data, data.worldbank.org, accessed 2014

Figure 2.13
Consumption poverty rate, 1981–2011

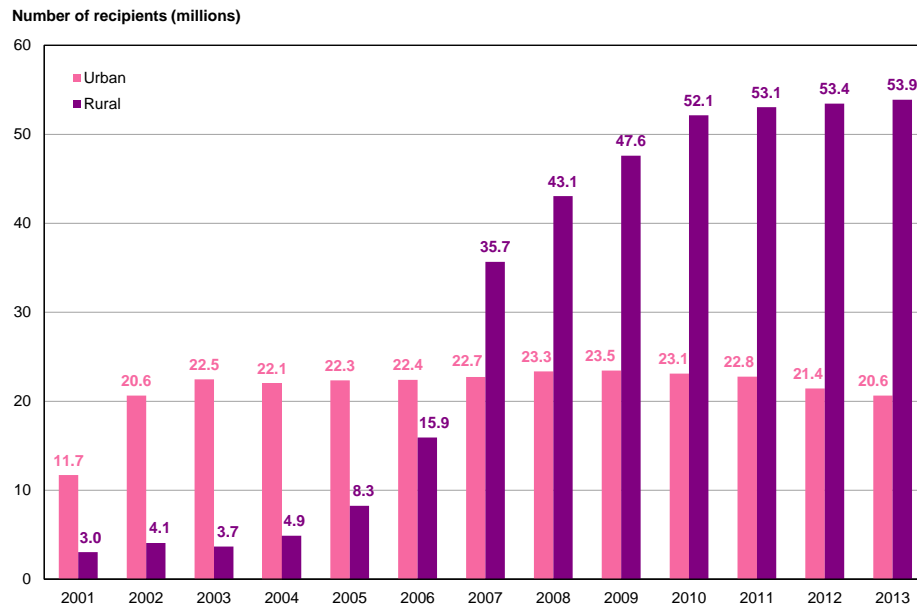


Source: World Bank data, data.worldbank.org, accessed 2014

Figure 2.12 and 2.13

The World Bank estimates and publishes international estimation of consumption poverty³⁴. Data indicate that during the period 1981-2011, 753 million people in China were lifted from poverty as defined by the US\$1.25 standard, exceeding the total number of people lifted from poverty in the rest of the developing world during the same period. The progress of poverty reduction in China has been similarly dramatic when measured by the US\$2 standard. However, to gain a complete assessment, these poverty measures must be complemented by non-economic dimensions, including access to health care and education.

Figure 2.14
Dibao recipients in absolute numbers,
urban and rural, 2001–2013

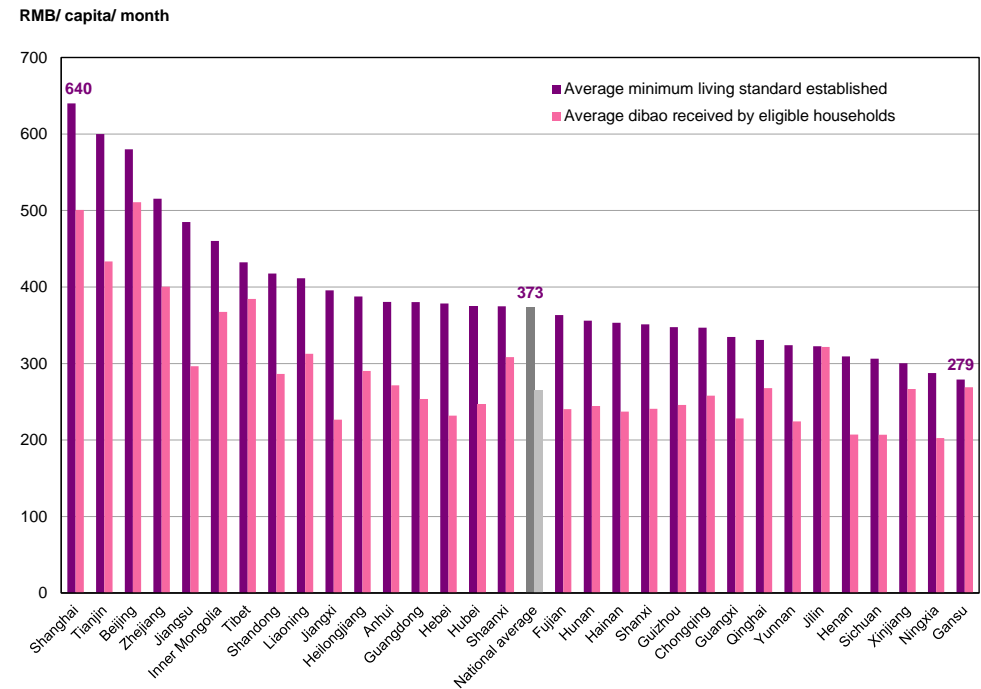


Source: Ministry of Civil Affairs, *China Civil Affairs' Statistical Yearbook*, 2014

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. By 2013, *dibao* covered 21 million people in urban areas and 54 million people in rural areas.

Figure 2.15
Average *dibao* received by eligible households and minimum
living standard in urban areas, by province, 2013

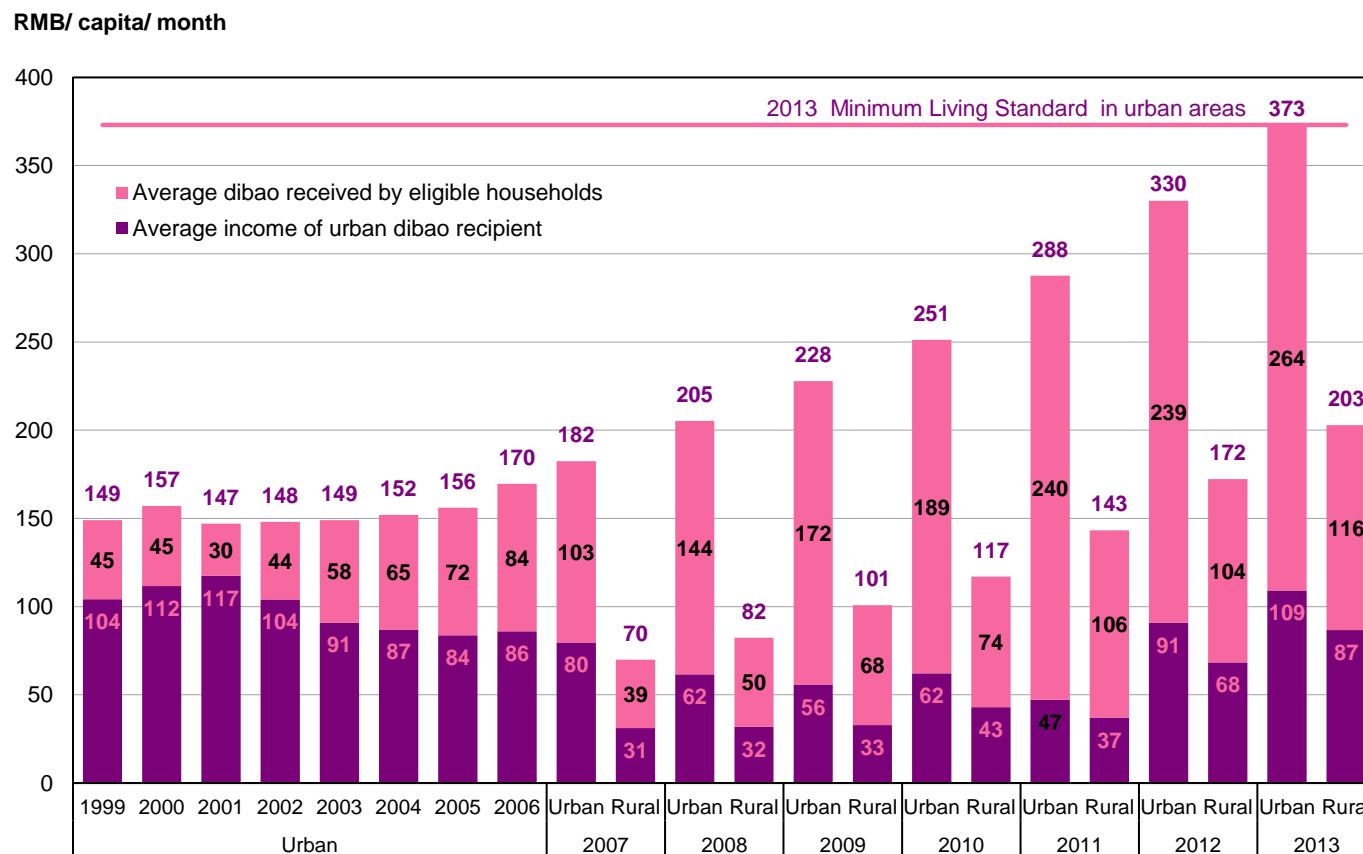


Source: Ministry of Civil Affairs, *China Civil Affairs' Statistical Yearbook*, 2014

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 279 to RMB 640 across provinces in urban areas.

Figure 2.16
Average income, *dibao* received by eligible households and minimum living standard in urban and rural areas, 1999–2013



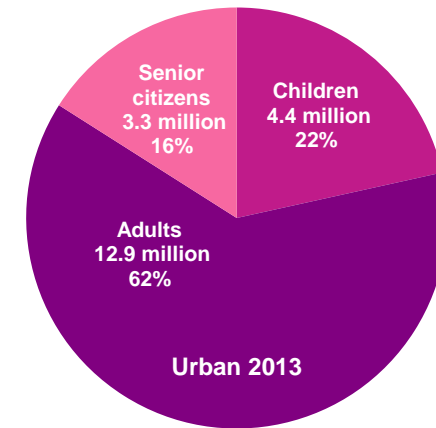
Source: Ministry of Civil Affairs, *China Civil Affairs' Statistical Yearbook*, 2014

Figure 2.16

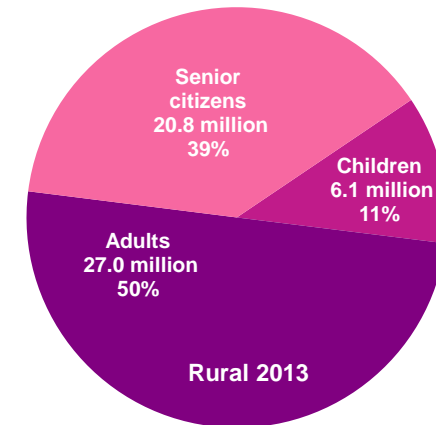
Social assistance, namely the *dibao* cash transfers in both urban and rural areas, has benefited from increasing government commitment and financing, which has not only allowed an increase in population coverage, but has also raised the level of average benefit received by poor households. *Dibao* was adopted in all urban areas in 1999 and in rural areas in 2007.

Figure 2.17
Age distribution of urban and rural *dibao* recipients, 2007-2013

Year	Number of urban <i>dibao</i> recipients (million persons)				Percentage (per cent)		
	Urban total	Children (0–17 years old)	Adults (18–59 years old)	Senior citizens (≥60 years old)	Children (0–17 years old)	Adults (18–59 years old)	Senior citizens (≥60 years old)
2007	22.72	5.45	14.29	2.98	24%	63%	13%
2008	23.35	5.88	14.30	3.17	25%	61%	14%
2009	23.46	5.80	14.32	3.34	25%	61%	14%
2010	23.11	5.59	14.13	3.39	24%	61%	15%
2011	22.77	5.40	13.90	3.47	24%	61%	15%
2012	21.44	4.73	13.31	3.39	22%	62%	16%
2013	20.64	4.45	12.89	3.30	22%	62%	16%



Year	Number of rural <i>dibao</i> recipients (million persons)				Percentage (per cent)		
	Rural total	Children (0–17 years old)	Adults (18–59 years old)	Senior citizens (≥60 years old)	Children (0–17 years old)	Adults (18–59 years old)	Senior citizens (≥60 years old)
2007	35.66	4.03	21.45	10.18	11%	60%	29%
2008	43.06	5.34	24.46	13.25	12%	57%	31%
2009	47.60	6.09	24.90	16.61	13%	52%	35%
2010	52.14	6.87	26.69	18.57	13%	51%	36%
2011	53.06	6.82	26.90	19.34	13%	51%	36%
2012	53.45	6.41	26.87	20.17	12%	50%	38%
2013	53.88	6.15	26.95	20.78	11%	50%	39%

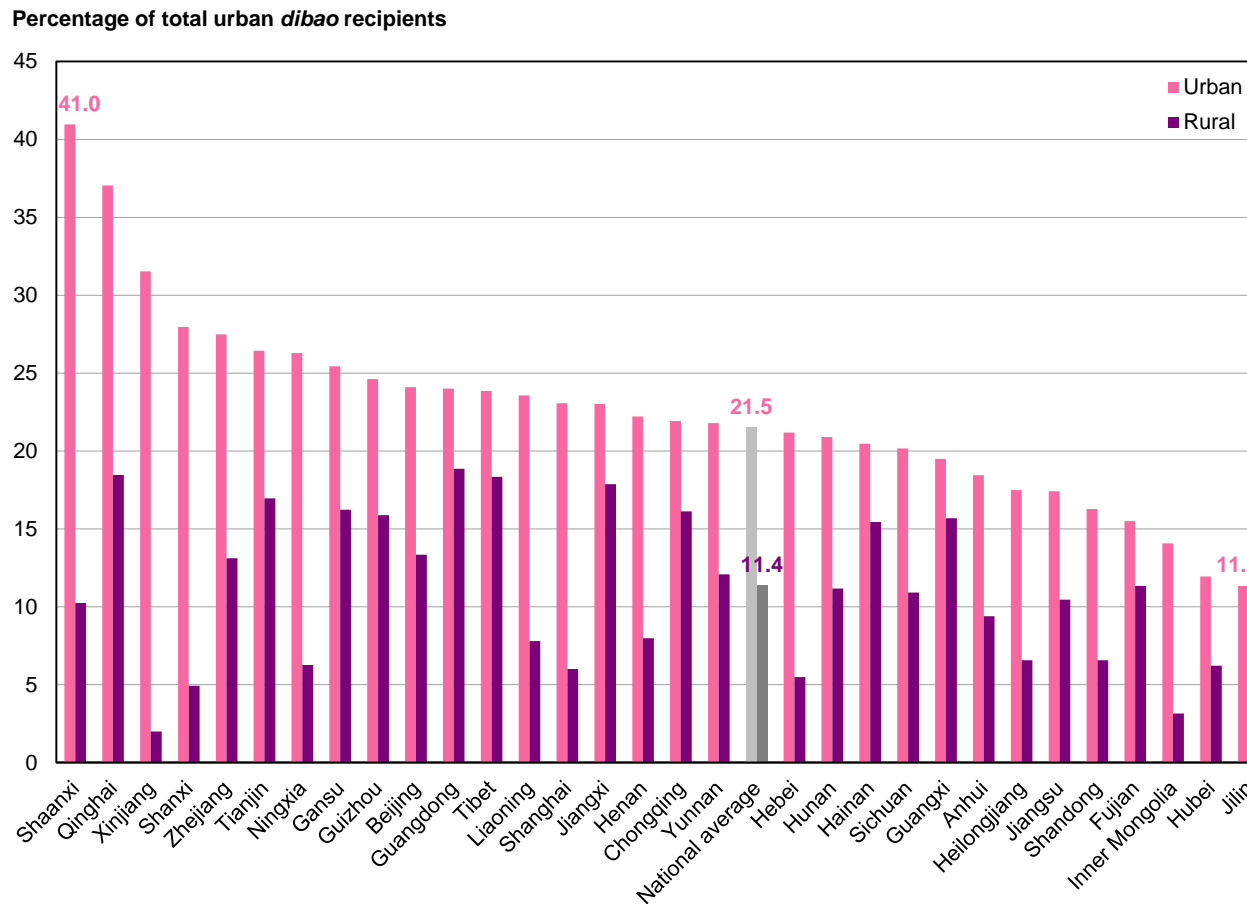


Source: Ministry of Civil Affairs, *China Civil Affairs' Statistical Yearbook*, 2014

Figure 2.17

Increasing number of rural children were covered by *dibao* since its adoption in rural areas in 2007. However, children only accounted for 11–13 per cent of rural *dibao* recipients during 2007–2013. The proportion of senior citizens was relatively high, ranging from 29–39 per cent of rural *dibao* recipients during 2007–2013. Children accounted for 22–25 per cent of urban *dibao* recipients during 2007–2013. In 2013, *dibao* covered 10.6 million children nationally, including 4.45 million in urban areas and 6.15 million in rural areas.

Figure 2.18
The share of children among total urban and rural *dibao* recipients, by province, 2013

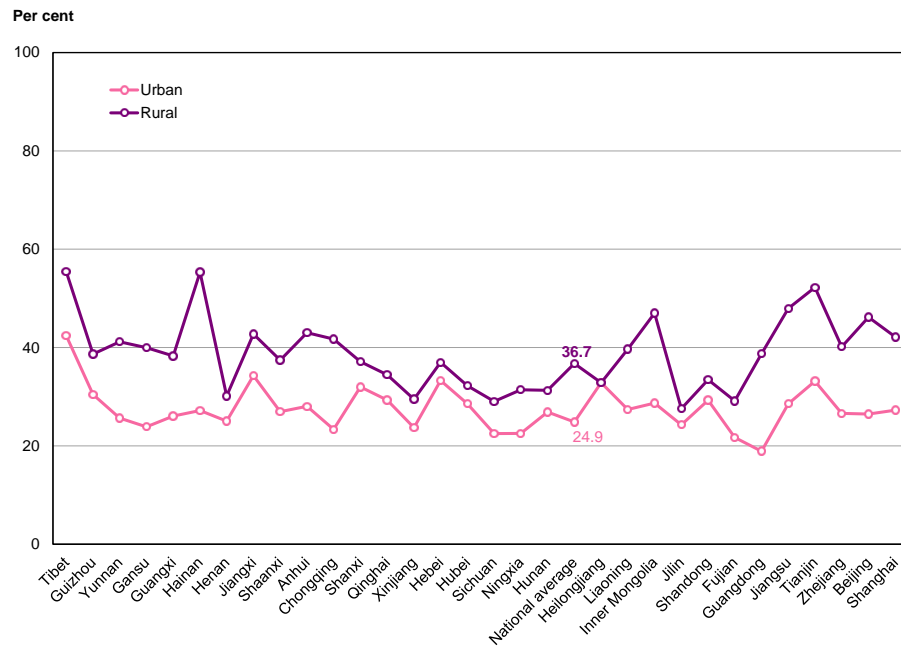


Source: Ministry of Civil Affairs, *China Civil Affairs' Statistical Yearbook*, 2014

Figure 2.18

Children in poor households have benefited from *dibao* cash transfers, which have facilitated improvements in their nutrition, education and health³⁵.

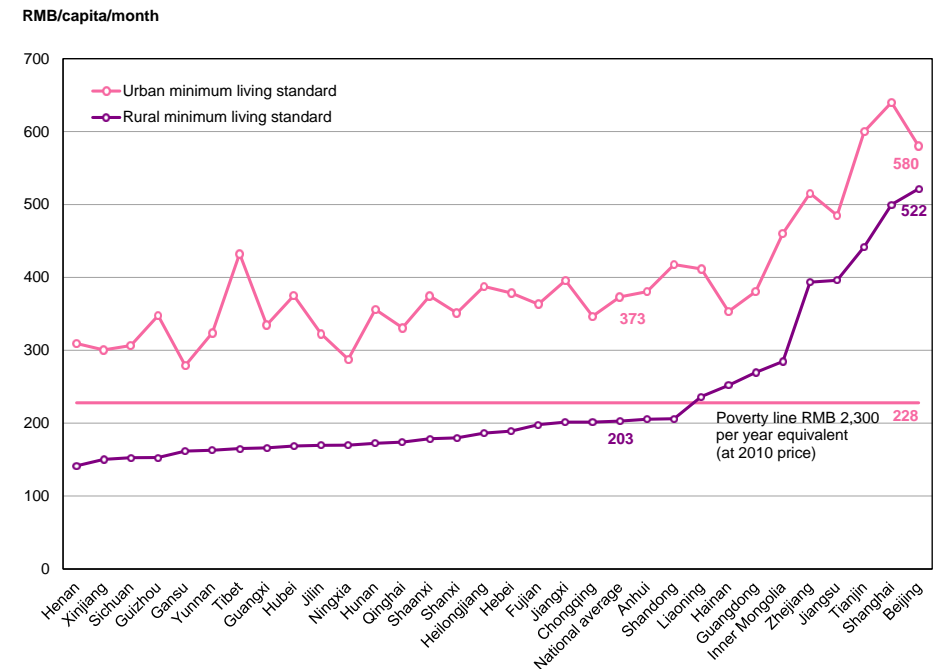
Figure 2.19
Urban and rural minimum living standards as a percentage of consumption expenditures, by province, 2013



Sources: Ministry of Civil Affairs, *China Civil Affairs' Statistical Yearbook*, 2014; National Bureau of Statistics, *China Statistical Yearbook*, 2014

Note: X-axis of Figure 2.19 is sorted by rural per capita consumption expenditures of provinces in descending order.

Figure 2.20
Urban and rural minimum living standards and national poverty lines, by province, 2013



Source: Ministry of Civil Affairs, *China Civil Affairs' Statistical Yearbook*, 2014

Figure 2.19 and 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, and between rural and urban areas, reflecting local development conditions and local government fiscal capacity. Nationally, the rural *dibao* line is equivalent to 37 per cent of rural consumption expenditure, while the urban *dibao* line is 25 per cent of urban consumption expenditure. All provinces have set urban *dibao* lines while 9 provinces set rural *dibao* lines higher than the new national poverty line of RMB 2,300 (at 2010 prices) per person per year. Rural *dibao* lines of provinces in eastern China are generally higher than in provinces in other parts of the country.



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 2013 Millennium Development Goals (MDG) Report³⁶ 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 among 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 continued to grow rapidly to reach its peak of 60 per cent in 2001 and by 2005 it still accounted for more than half of total health spending. In recent years, while the share of out-of-pocket expenditures decreased to reach 34 per cent in 2013³⁷ in China, this is still far above the 15-20 per cent threshold above which can incur catastrophic expenditures³⁸. The Government of China is aware of these problems and is making determined efforts to address them. The national target is to reduce the share of out-of-pocket expenditure to below 30 per cent by 2015, but global evidence indicates a more substantial reduction is desirable.

The Government in recent years 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 national 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. The reliability of estimates of maternal and child mortality however depend on accurate estimates of live births. In 2013, the estimated number of live births in China varied between 15.1 and 18.5 million children per year³⁹.

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 obstetric haemorrhage, pregnancy-related hypertension, amniotic fluid embolism, and heart disease. 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 intrapartum-related complications, preterm birth complications, pneumonia, injuries, congenital abnormalities and diarrhoea⁴⁰. Under-nutrition remains a significant risk factor for pregnant woman and children alike.

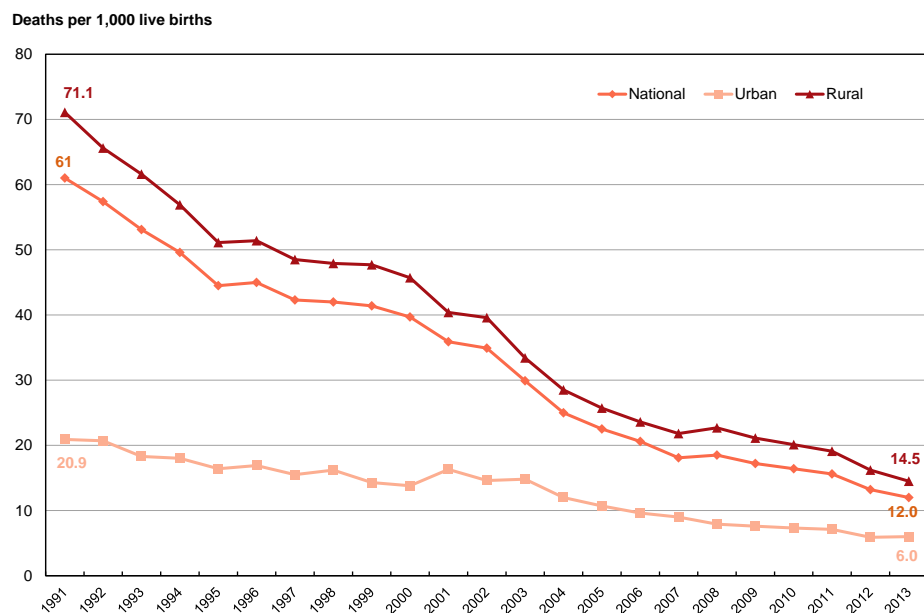
Overall, coverage of MCH services is high, with more than 3,000 MCH institutes across China and about 250,000 professionals engaged directly in MCH work in 2013. However, there are still extensive opportunities for further reducing China's child and maternal mortality rates, by improving staff quality and increasing 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 National Plans of Action for Women and Children (1990s, 2001–2010, 2011–2020) 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 initiative, financing and capacity of local authorities. As a result, great variations in maternal and child mortality rates between provinces continue to exist.

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 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.

While the expansion of health insurance in both geographic and population coverage terms is very impressive, insufficient attention is still given to insuring the youngest children, who are at the greatest risk of dying. A UNICEF supported study in Wuhan, Guiyang and Suzhou indicates that children below 1 year of age are three times less likely to be insured compared to their 1 to 3 year old peers and almost six times less likely than children 3 to 5 years of age⁴¹.

Figure 3.1
Under-five mortality rate, 1991–2013

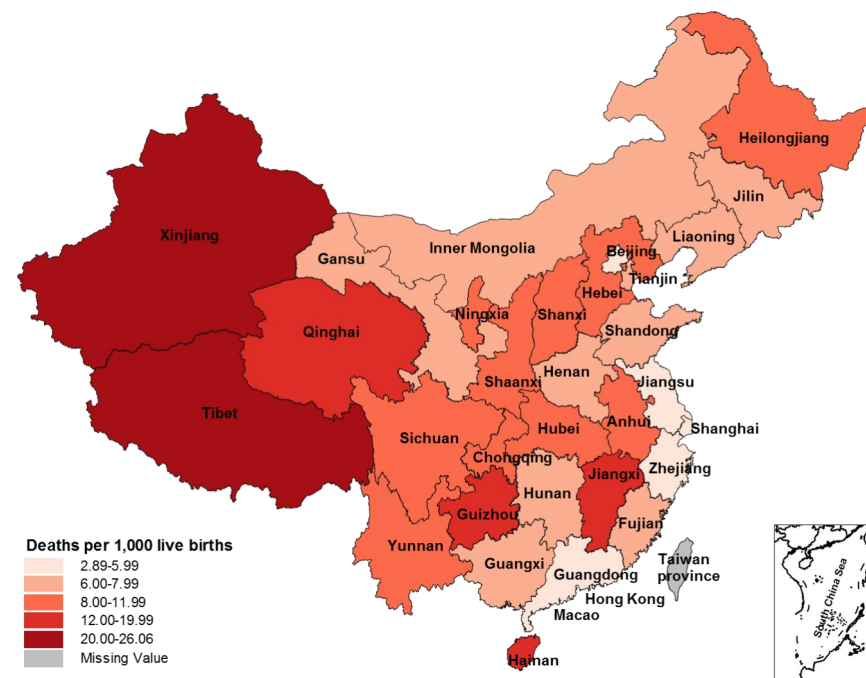


Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook*, 2014

Figure 3.1

China's national Under-Five Mortality Rate (U5MR)⁴² declined, from 61 per thousand live births in 1991 to 12 per thousand live births in 2013, with an average annual reduction of 7 per cent. During this period, the under-five mortality rate dropped by 71 per cent in urban areas and 80 per cent in rural areas. In 1991, the under-five mortality rate was 2.4 times higher in rural than in urban areas. By 2013, this risk ratio had decreased to 1.4 times higher in rural areas. However, this does not take into account the undocumented numbers of rural migrant children who die in urban areas.

Figure 3.2
Under-five mortality rate, 2013

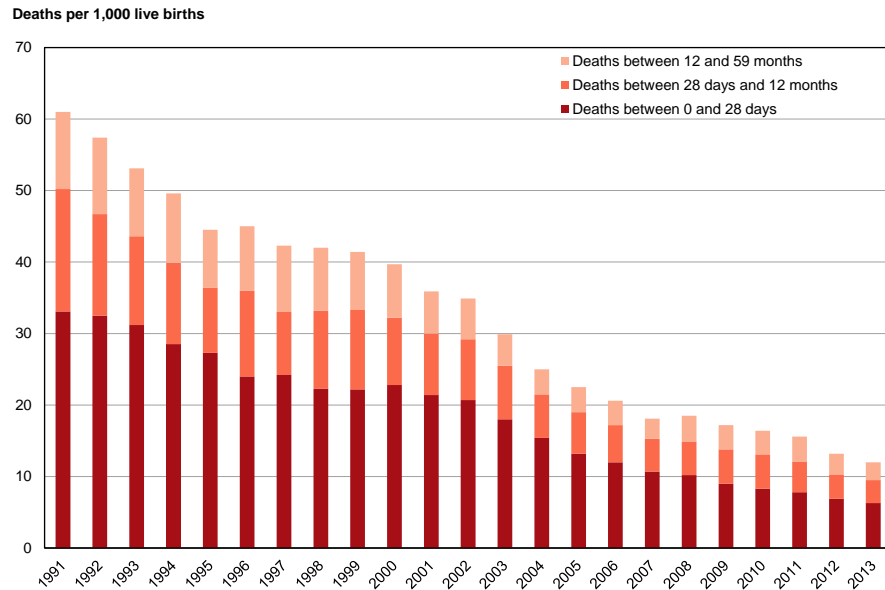


Source: National Bureau of Statistics, NPA Monitoring Statistics, 2014

Figure 3.2

Great disparities in the under-five mortality rate exist among the different provinces. In general, the under-five mortality rate is highest in western provinces and lowest in eastern provinces. In Beijing, it is less than 4 per thousand live births, while in Xinjiang and Tibet, it is around 25 per thousand live births.

Figure 3.3
Age distribution of deaths among under-five children, 1991–2013

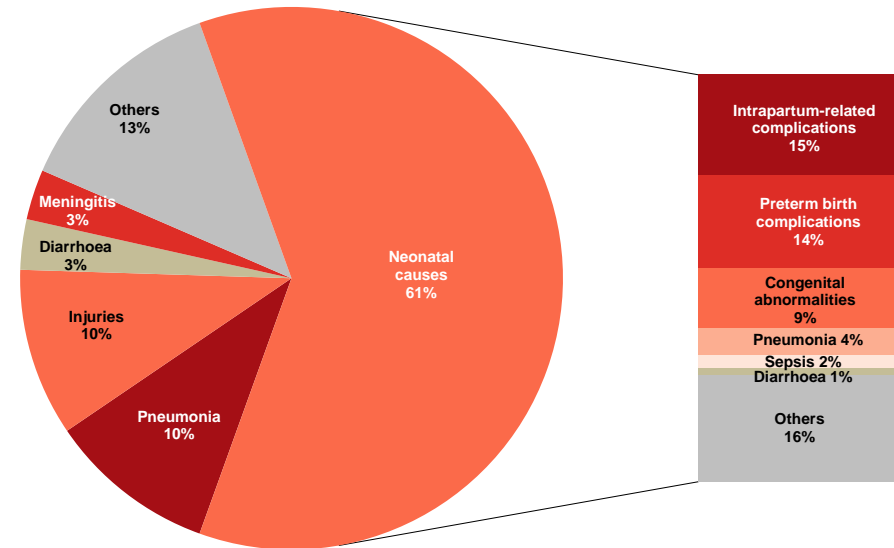


Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook*, 2014

Figure 3.3

Between 1991 and 2013, the under-five mortality rate decreased steadily, according to the national MCH surveillance system. In 2013, 79 per cent of the under-five mortality occurred during infancy (deaths before 12 months), while neonatal mortality (deaths between 0 and 28 days of age) accounted for 53 per cent of all under-five deaths.

Figure 3.4
Causes of under-five mortality, 2013



Source: United Nations Children's Fund, *Committing to Child Survival: A promise Renewed Progress Report 2014*, 2014

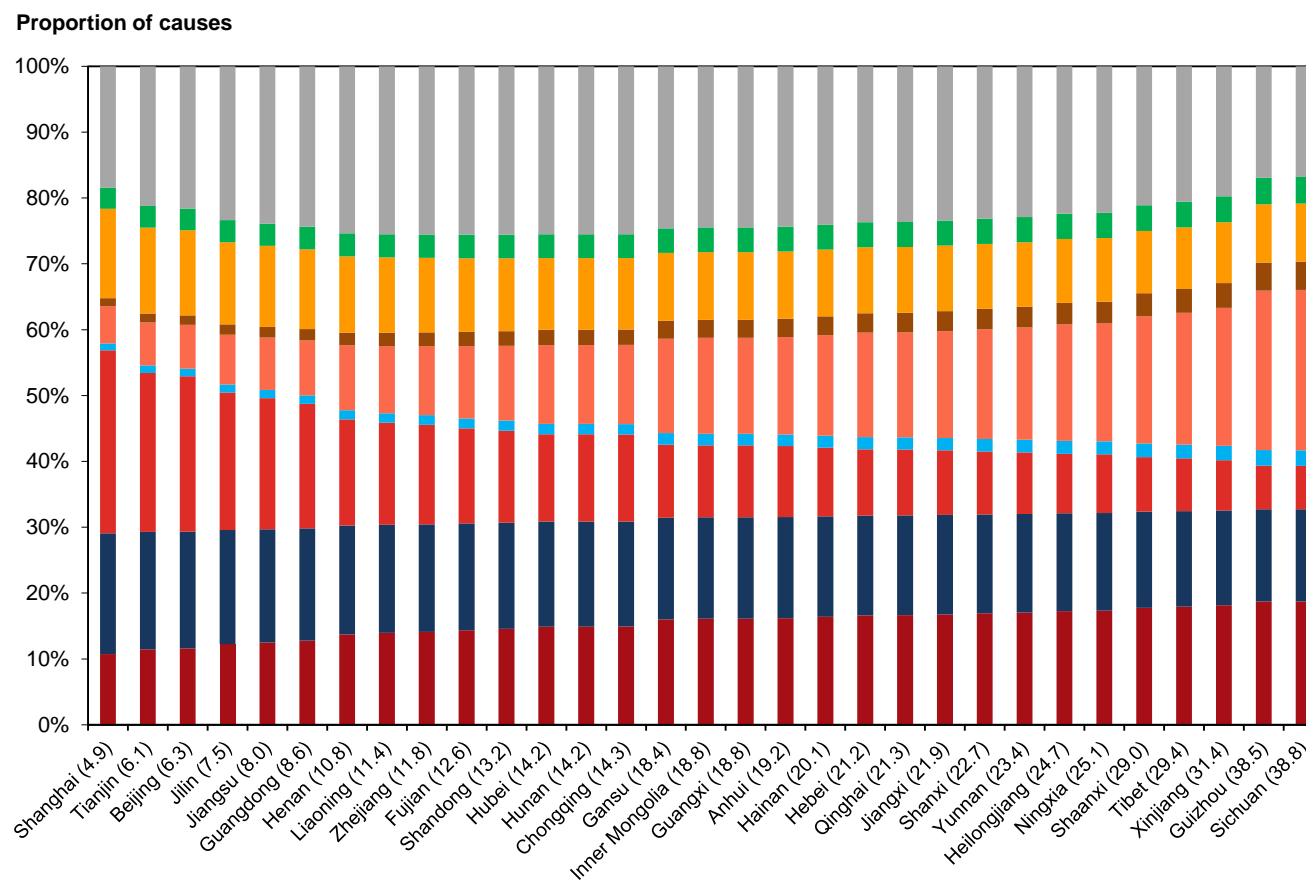
Figure 3.4

According to UN estimation, 61 per cent of under-five deaths in 2013 are neonatal, many of which can be prevented. Among the leading causes of under-five deaths, 15 per cent are caused by intrapartum-related complications, 14 per cent are caused by preterm birth complications, 14 per cent by pneumonia (including neonatal pneumonia), 10 per cent by injuries, 9 per cent by congenital abnormalities and 4 per cent by diarrhoea (including neonatal diarrhoea). Increased efforts to prevent and manage premature and low birth weight, to improve labour management and neonatal resuscitation, to improve treatment of common childhood illnesses such as pneumonia and diarrhoea and child injury prevention will contribute to reducing under-five mortality.

* According to UN IGME estimates of under-five mortality⁴³, in 2013 China ranks 122 in under-five mortality rate in the world but fifth in absolute number of under-five deaths with 236 thousand under-five deaths per year.

Figure 3.5
Causes of under-five mortality, by province, 2008

- Other
- Sudden infant death syndrome
- Accidents
- Diarrhoea
- Pneumonia
- Neonatal sepsis
- Congenital abnormalities
- Preterm birth complications
- Birth asphyxia

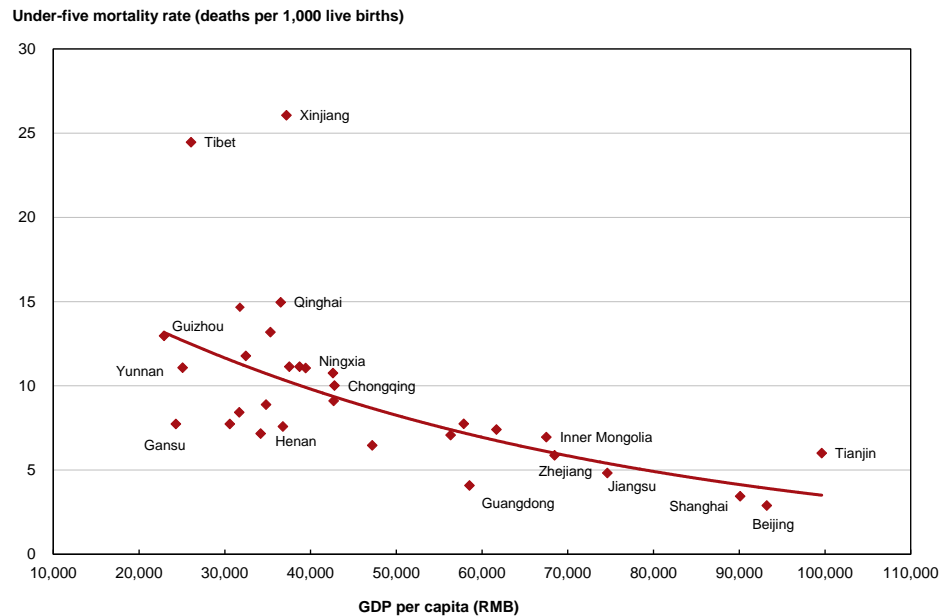


Source: Igor Rudan, Kit Yee Chan, Jian SF Zhang, Evropi Theodoratou, Xing Lin Feng, Joshua A Salomon, Joy E Lawn, Simon Cousens, Robert E Black, Yan Guo, Harry Campbell on behalf of CHERG, 'Causes of deaths in children younger than 5 years in China in 2008', *The Lancet*, 27 March 2010, Volume 375, Issue 9720, Pages 1083–1089

Figure 3.5

This chart shows the causes of child deaths in 31 provinces (ranked according to under-five mortality rates indicated in the bracket) in 2008 based on estimates from a statistical model. Under-five mortality rates range from fewer than five in Shanghai to more than 38 in Sichuan and Guizhou, which is about seven times higher than Shanghai. Although congenital abnormalities are leading cause of child deaths in the six wealthier provinces (Shanghai, Tianjin, Beijing, Jilin, Jiangsu, and Guangdong), the poorest provinces still have a large burden of deaths from pneumonia and birth asphyxia, and accidents.

Figure 3.6
GDP per capita and under-five mortality rate,
by province, 2013

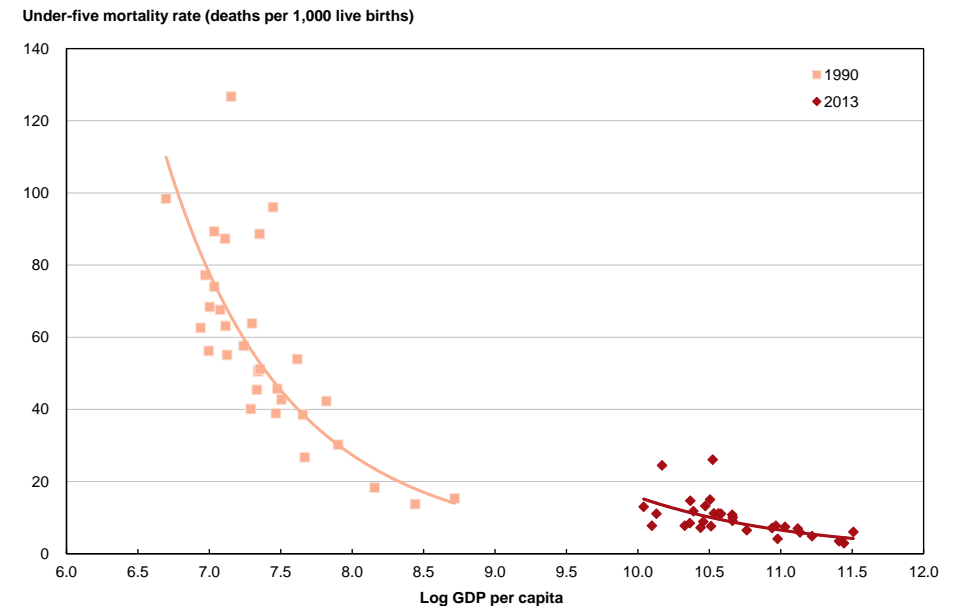


Sources: National Bureau of Statistics, *China Statistical Yearbook*, 2014 (GDP);
National Bureau of Statistics, NPA Monitoring Statistics, 2014 (U5MR)

Figure 3.6

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

Figure 3.7
GDP per capita and under-five mortality rate,
1990 and 2013

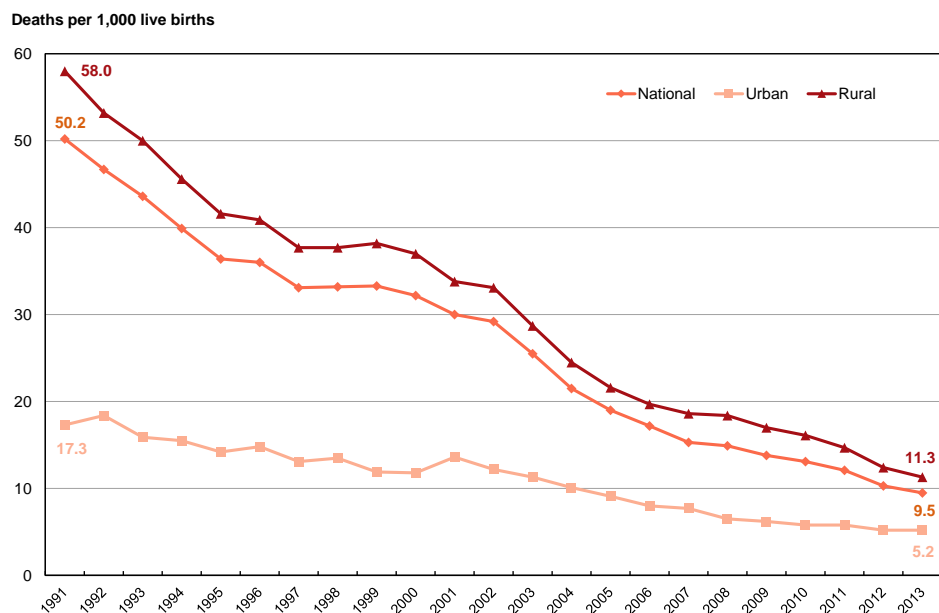


Sources: National Bureau of Statistics, *China Statistical Yearbook*, 1991 and 2014 (GDP);
National Bureau of Statistics, NPA Monitoring Statistics, 1991 and 2014 (U5MR)

Figure 3.7

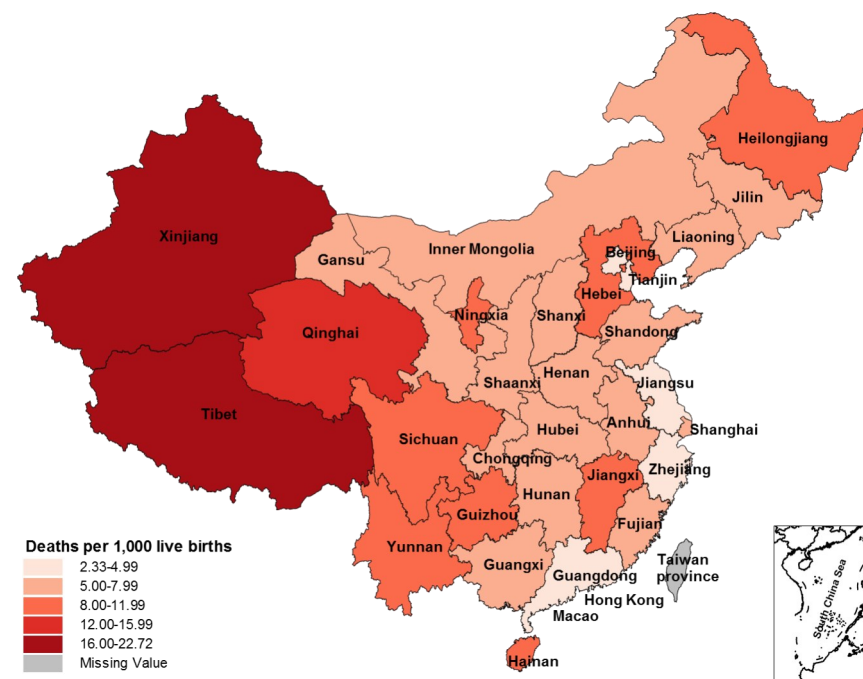
China made remarkable progress on both economic and health indicators between 1990 and 2013. Along with the increase in per capita GDP, under-five mortality rates of the worst-off provinces in 2013 are similar to those of the wealthiest provinces in 1990.

Figure 3.8
Infant mortality rate, 1991–2013



Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook, 2014*

Figure 3.9
Infant mortality rate, 2013



Source: National Bureau of Statistics, NPA Monitoring Statistics, 2014

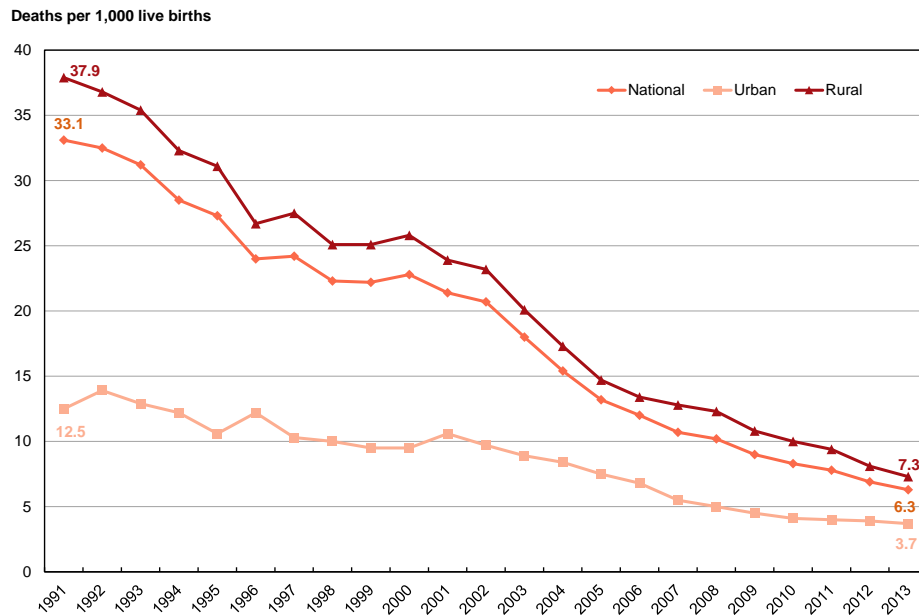
Figure 3.8

Since 1991, there has been a significant decline in the Infant Mortality Rate (IMR)⁴⁴. Nationally, the infant mortality rate dropped from 50 per thousand live births in 1991 to 9.5 per thousand live births in 2013, according to the national MCH surveillance system. Between 1991 and 2013, the infant mortality rate dropped by 70 per cent in urban areas and 81 per cent in rural areas. Again, great disparities remain, as rural infant mortality rates in 2013 were 1.2 times higher than those in urban areas.

Figure 3.9

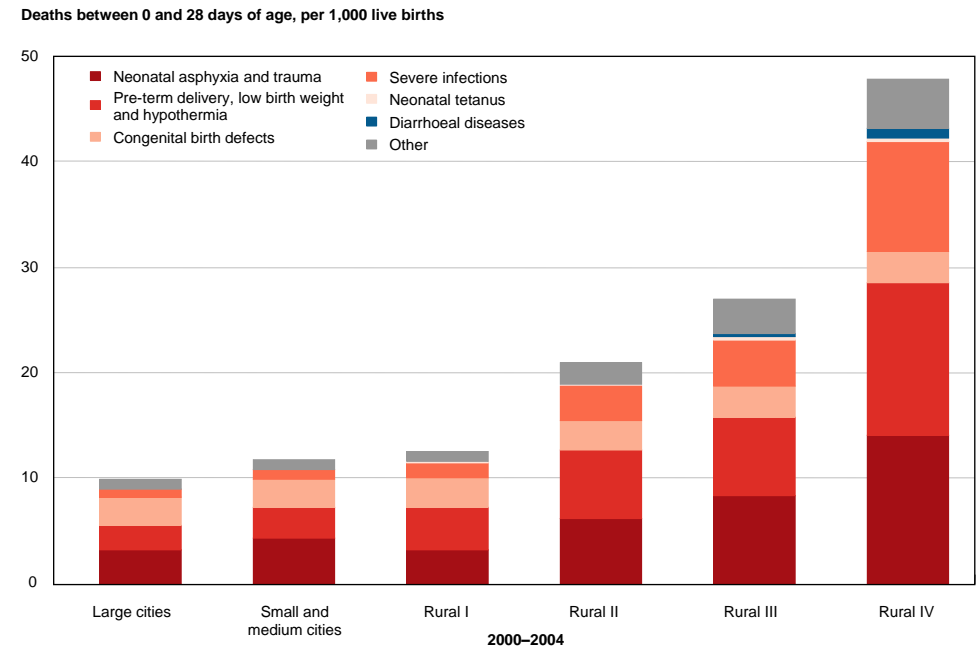
Great disparities exist in the infant mortality rates of different provinces. The infant mortality rate is generally highest in western provinces and lowest in eastern provinces, while central provinces mainly fall in between. The infant mortality rate ranges from 2.3 per thousand live births in Beijing to around 20 per thousand live births in Xinjiang and Tibet.

Figure 3.10
Neonatal mortality rate, 1991–2013



Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook*, 2014

Figure 3.11
Cause-specific neonatal mortality, by locality, 2000–2004



Source: Former 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

Figure 3.10

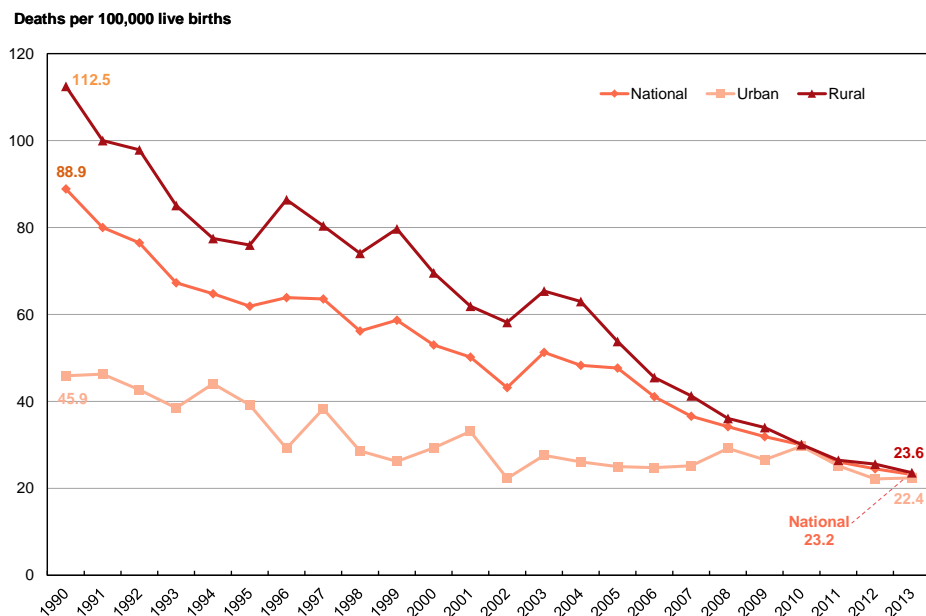
Since 1991, there has been a significant decline in the Neonatal Mortality Rate (NMR)⁴⁵. China's neonatal mortality rate dropped from 33 per thousand live births in 1991 to 6.3 per thousand live births in 2013. In 1991, the neonatal mortality rate was 2 times higher in rural areas than in urban areas, and remained one time higher in 2013.

Figure 3.11

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.

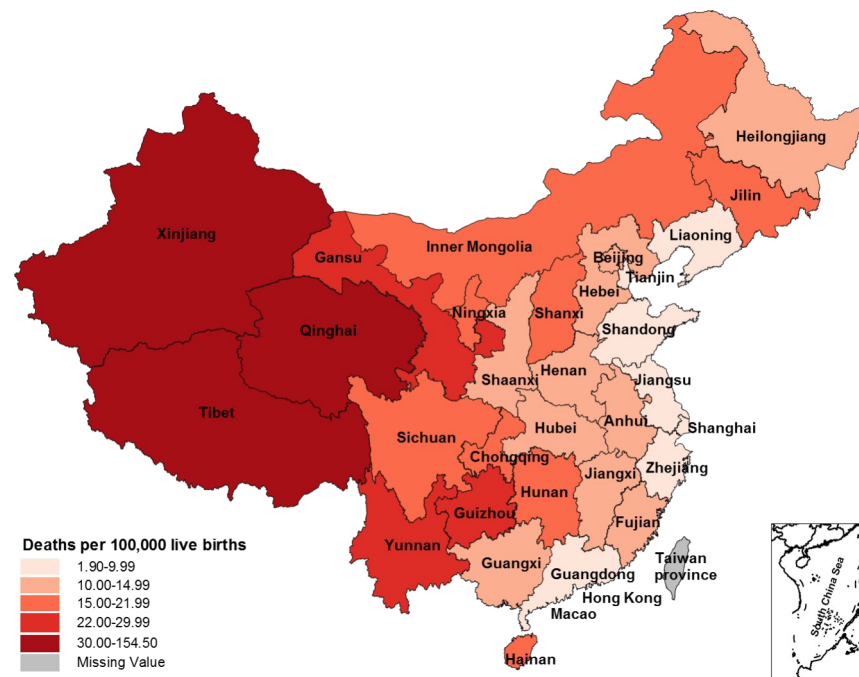
Note: Figure 3.11 uses a 1993 classification by the former Ministry of Health whereby all counties and districts in China are categorized as being within large cities or small and medium cities, or are rural areas of four types (I, II, III and IV). The classification used a development index that included the most recent values for indicators such as industrialization, education, illiteracy, infant mortality rate, GDP per capita and population demographics.

Figure 3.12
Maternal mortality ratio, 1990–2013



Sources: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook*, 2014; Former Ministry of Health, *China Health Statistical Abstract*, 2010 (1990 data)

Figure 3.13
Maternal mortality ratio, 2013



Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook*, 2014

Figure 3.12

Since 1990, the Maternal Mortality Ratio (MMR)⁴⁶ has decreased significantly. The disparity between urban and rural areas has also decreased; the maternal mortality ratio was 1.5 times higher in rural than urban areas in 1990, but only 5.4 per cent higher in 2013. The chart shows the convergence of national, urban and rural figures in recent years, mainly due to the decrease of MMR in rural areas. The influence of maternal deaths amongst urban migrant women is suggested by the roughly static urban maternal mortality ratio since 1998.

Figure 3.13

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 15 in central provinces, and above 30 in western provinces.

Figure 3.14
Causes of maternal mortality, 1989–2013

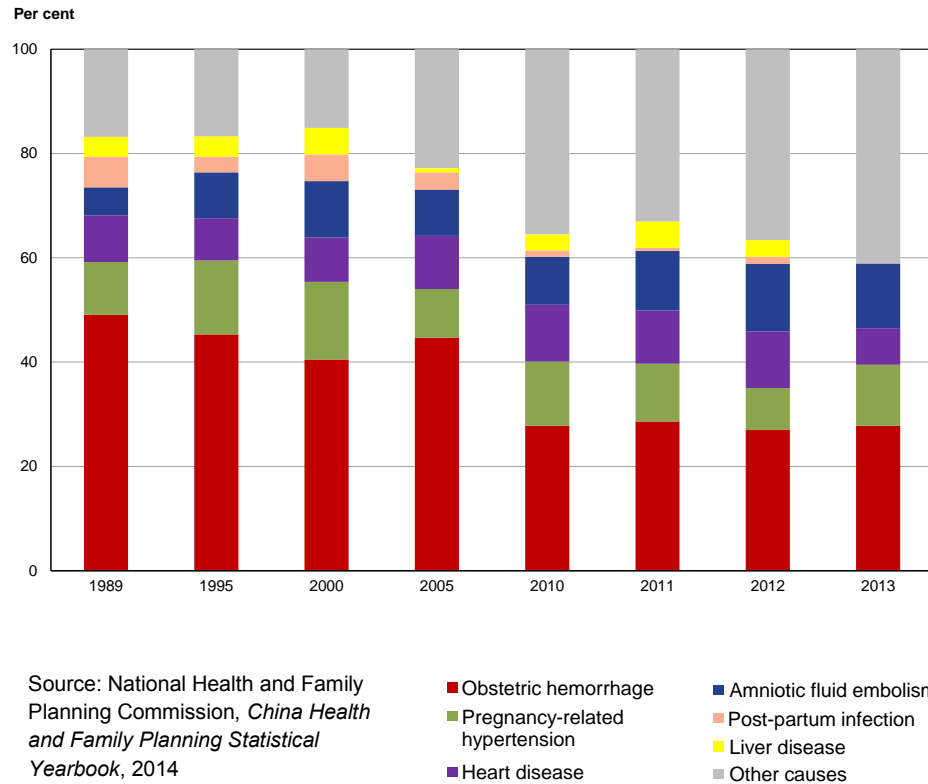


Figure 3.14

Obstetric haemorrhage remains the leading cause of maternal mortality across all years, but whereas it accounted for 49 per cent of maternal deaths in 1989, it accounted for 28 per cent of maternal deaths in 2013. Post-partum infection is no longer a major cause of maternal death in China.

Figure 3.15
Cause-specific maternal mortality, by locality, 2000–2004

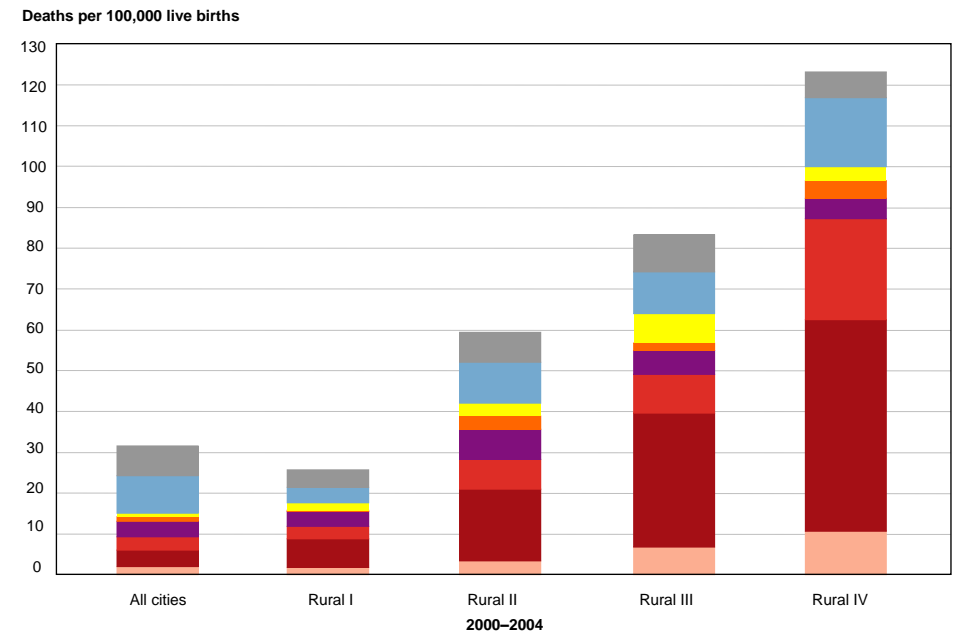
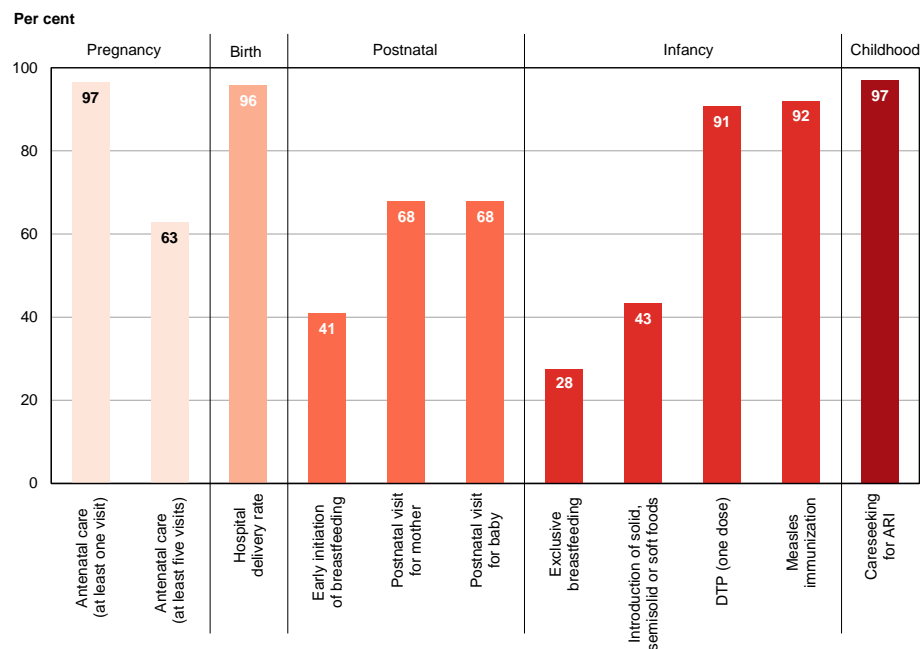


Figure 3.15

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 3.16
Coverage of interventions across the continuum of care for maternal and child health, 2008 and 2011*



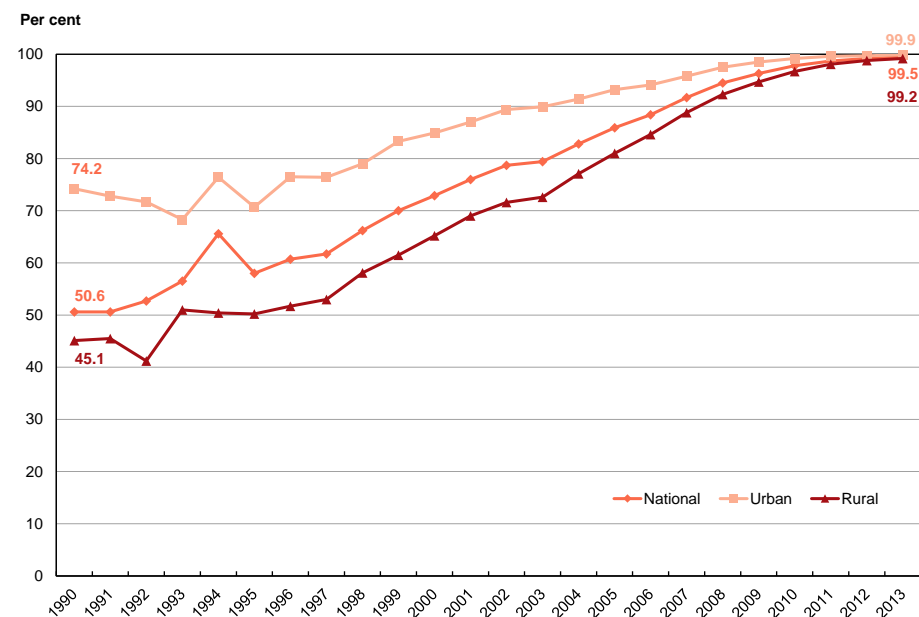
Source: Former Ministry of Health, National Health Services Survey (NHSS) in China, 2008 and 2011

Figure 3.16

Coverage of interventions varies across the continuum of care. It reflects the advancements in maternal health care such as antenatal care and hospital delivery, child immunization and care seeking for pneumonia. Coverage lags behind for key interventions such as antenatal care for at least five visits, postnatal care and infant and young child feeding.

*The *National Health Services Survey* (NHSS) is conducted every five years by the National Health and Family Planning Commission (NHFPC), with five rounds of the survey conducted between 1993 and 2013. A mini NHSS was also conducted in 2011 to assess the progress of health sector reform. As of 15 December 2014, the survey results of 2013 NHSS have not yet been released by the NHFPC.

Figure 3.17
Hospital delivery rate, urban and rural, 1990–2013

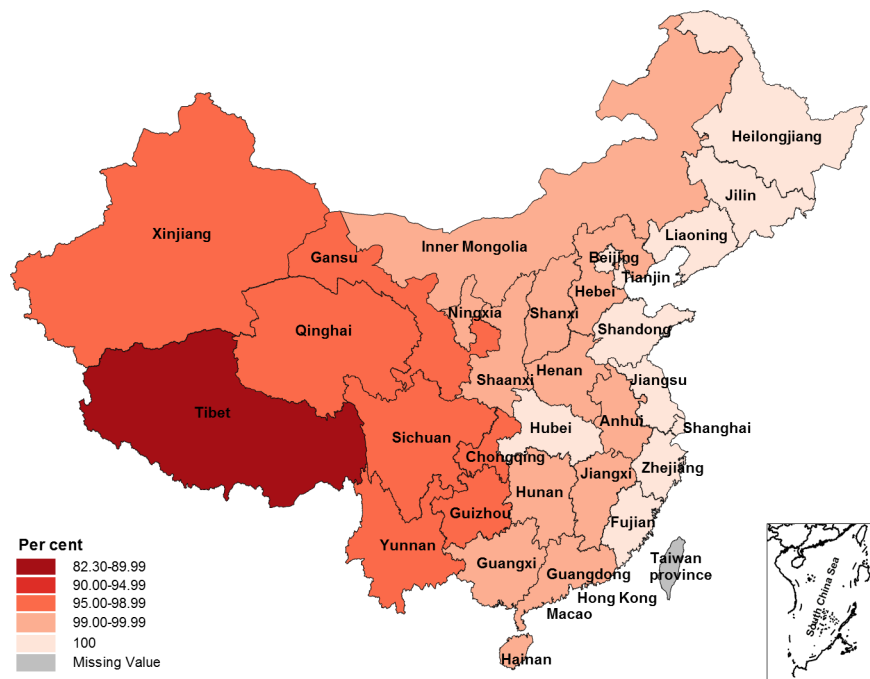


Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook*, 2014

Figure 3.17

China's hospital delivery rate has increased steadily over the last two decades. While 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 3.18
Hospital delivery rate, 2013

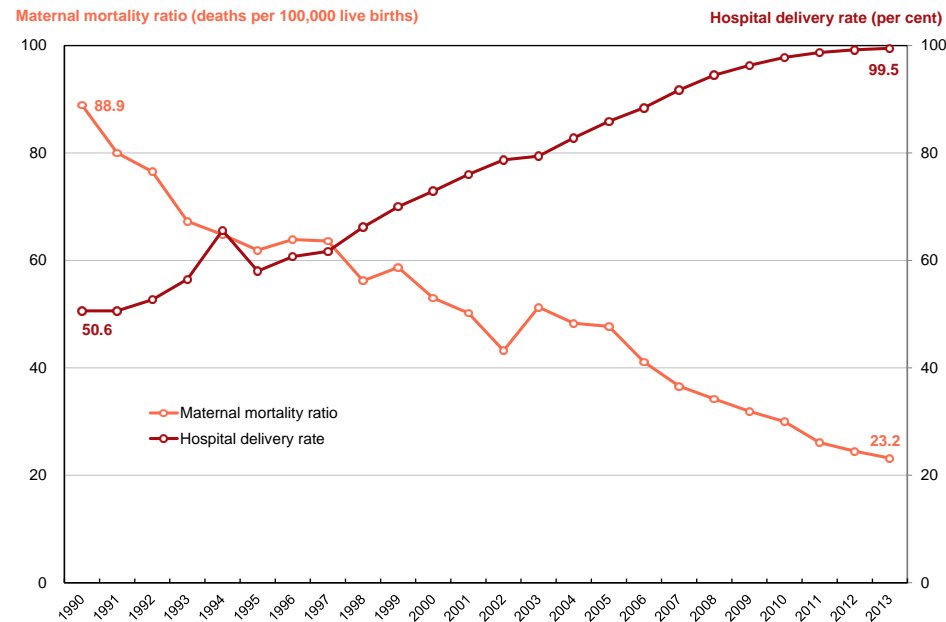


Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook, 2014*

Figure 3.18

Overall, the hospital delivery rate is high across all provinces, but relatively low rates persist in some western provinces. Tibet has the lowest hospital delivery rate at 82 per cent.

Figure 3.19
Hospital delivery rate and maternal mortality ratio, 1990–2013

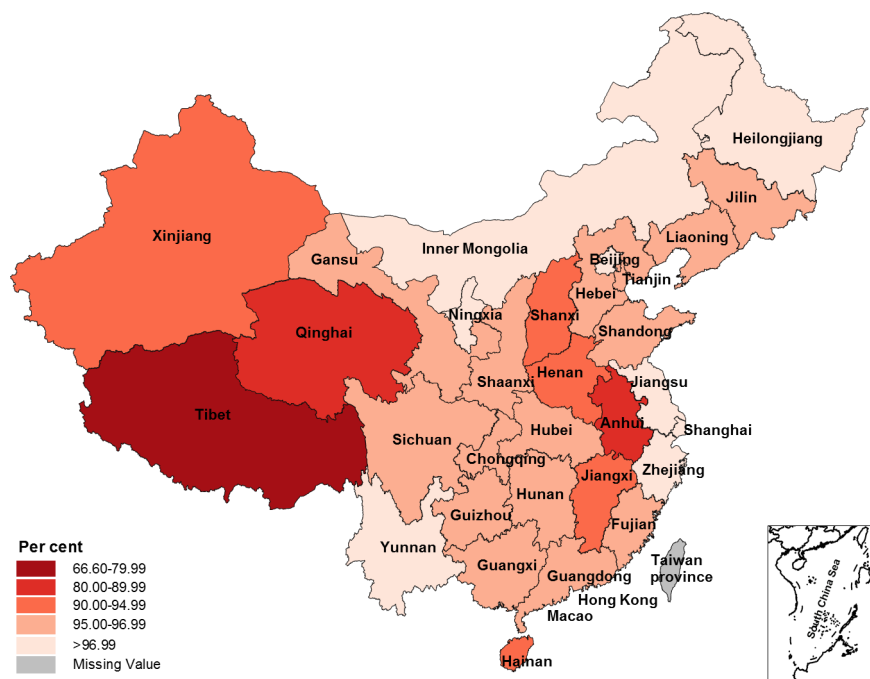


Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook, 2014*

Figure 3.19

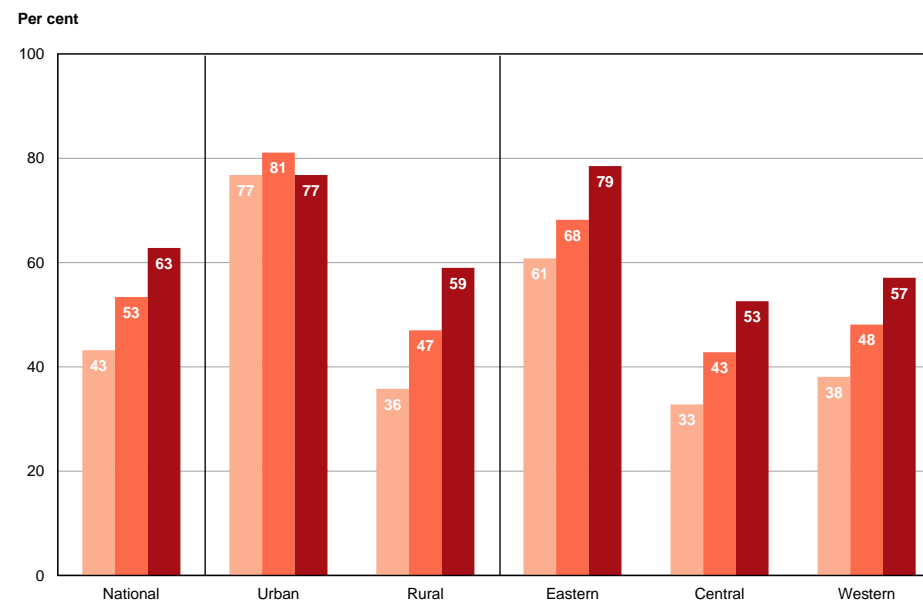
There is an inverse relationship between China's maternal mortality ratio and hospital delivery rate. From 1990 to 2013, the hospital delivery rate increased from 50.6 per cent to 99.5 per cent. Over the same period, the maternal mortality ratio decreased from 88.9 per 100,000 live births to 23.2 per 100,000 live births.

Figure 3.20
Antenatal care coverage: at least one visit, 2013



Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook*, 2014

Figure 3.21
Antenatal care coverage: at least five visits, 2003, 2008 and 2011



Source: Qun Meng, Ling Xu, Yaoguang Zhang, Juncheng Qian, Min Cai, Ying Xin, Jun Gao, Ke Xu, J Ties Boerma, Sarah L Barber, 'Trends in Access to Health Services and Financial Protection in China Between 2003 and 2011: a Cross-sectional Study', *The Lancet*, 3 March 2012, Volume 379, Issue9818, Pages 805–814 (Note: Data from the *National Health Services Surveys* in various years were used in this paper.)

Figure 3.20

Antenatal care coverage⁴⁷ 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 3.21

Among the indicators included on the *National Health Services Surveys* (NHSS) is reported antenatal care coverage of five or more visits. Estimates from the latest three rounds of NHSS show the coverage of antenatal care of five or more visits increased by 20 percentage points between 2003 and 2011 to reach 63 per cent. This increase was mainly attributed to progress in rural areas, and in central and western provinces. However, gaps between rural/urban areas and among regions are still large.

Figure 3.22
Skilled attendant at birth, 2013

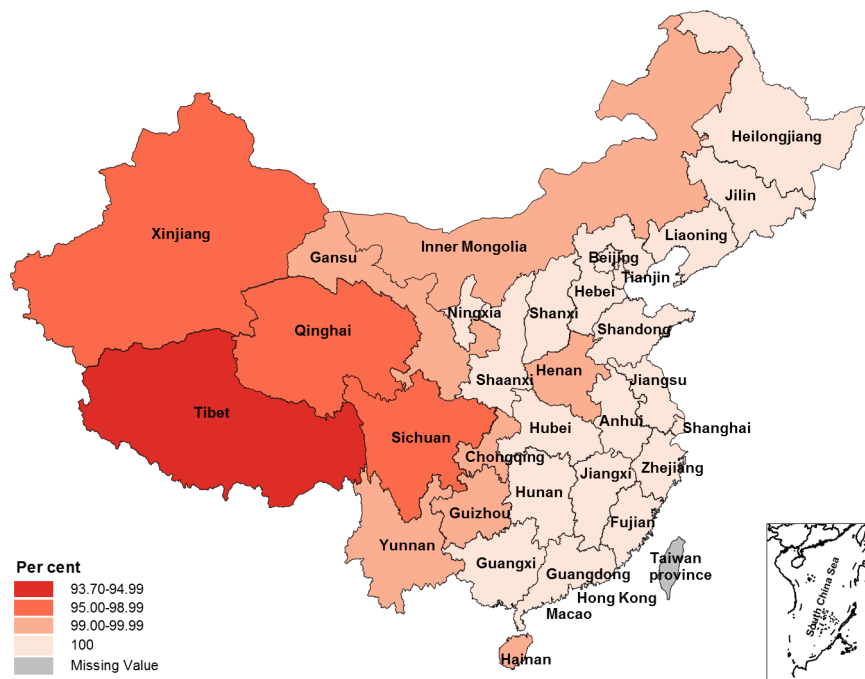


Figure 3.22

Overall, the per cent of births attended by skilled health personnel⁴⁸ is high across all provinces, but is slightly lower in western China and the lowest in Tibet (94 per cent).

Figure 3.23
Caesarean section rate, 2003, 2008 and 2011

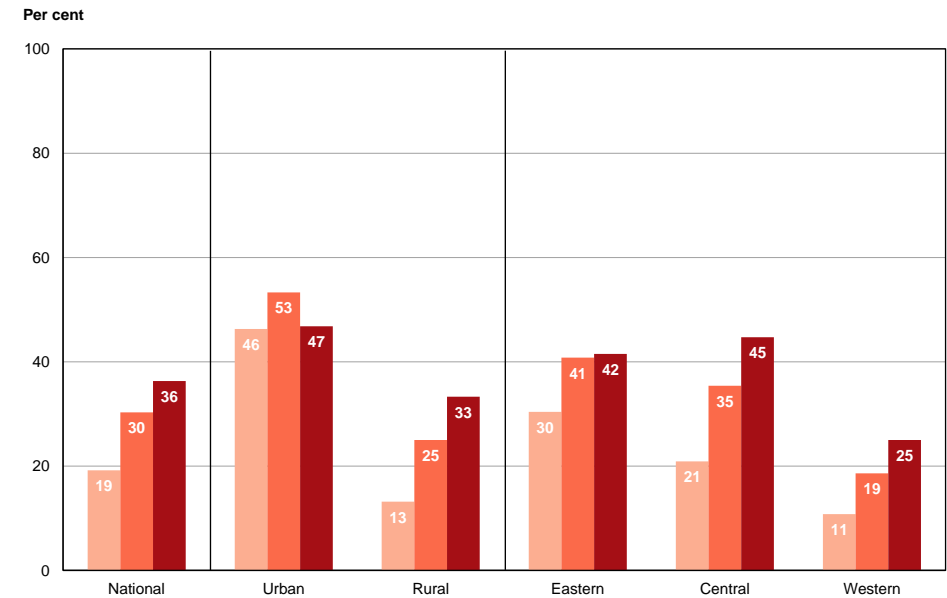


Figure 3.23

Estimates from the latest three rounds of NHSS show a general increase in caesarean section rates both nationally and at the sub-national level, except for a decrease in urban areas during 2008–2011. Caesarean section deliveries have reached numbers that exceed clinical need⁴⁹. Nationally, one in three women delivered by caesarean section in 2011, compared with one in five in 2003. Although urban women continue to have the highest rates of caesarean section, rural areas and central and western provinces experienced a more significant increase in caesarean rates during 2003 and 2011.

Figure 3.24
Number of physicians and nurses, 1980–2013

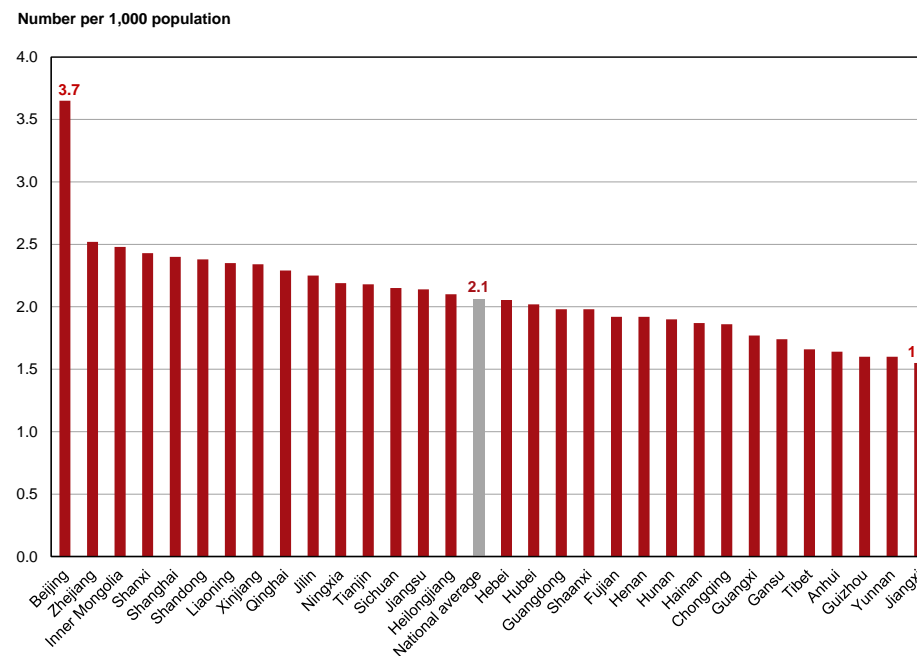


Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook*, 2014

Figure 3.24

Over the last three decades, the number of physicians has increased from around 1.2 to 2.1 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 3.25
Number of physicians, by province, 2013

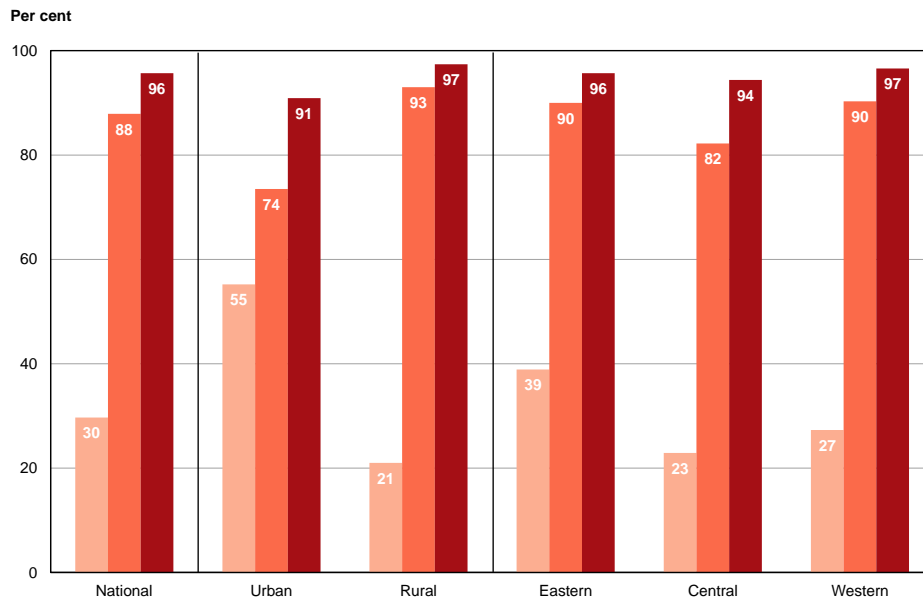


Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook*, 2014

Figure 3.25

The number of physicians per thousand⁵⁰ population varies among provinces from 3.7 in Beijing to less than 2 in half of China's provinces, including some eastern and central provinces.

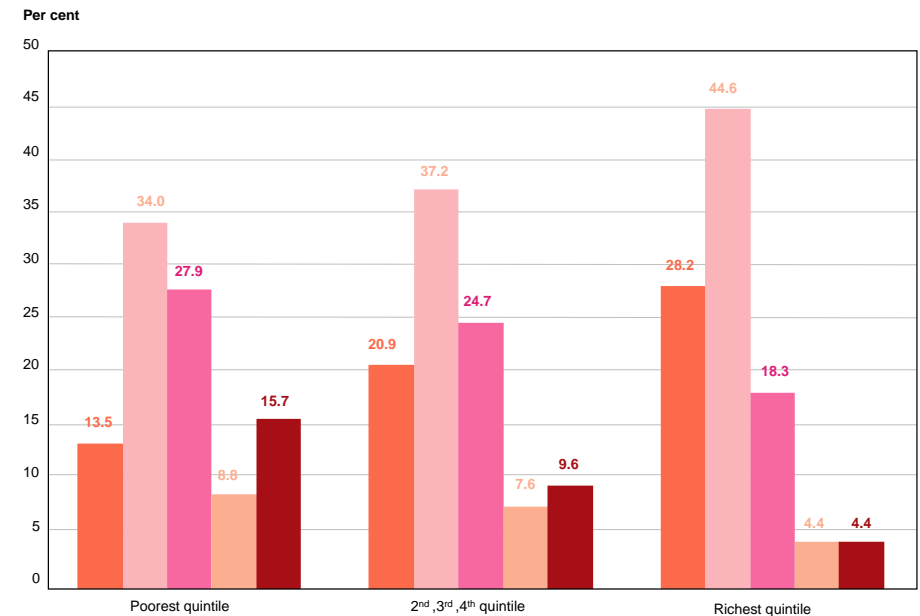
Figure 3.26
Health insurance coverage, 2003, 2008 and 2011



Source: Qun Meng, Ling Xu, Yaoguang Zhang, Juncheng Qian, Min Cai, Ying Xin, Jun Gao, Ke Xu, J Ties Boerma, Sarah L Barber, 'Trends in Access to Health Services and Financial Protection in China Between 2003 and 2011: a Cross-sectional Study', *The Lancet*, 3 March 2012, Volume 379, Issue 9818, Pages 805–814 (Note: Data from the *National Health Services Surveys* in various years were used in this paper.)

■ 2003
■ 2008
■ 2011

Figure 3.27
Choice of urban health provider by income group, 2006



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

■ Provincial
■ City
■ District
■ Community
■ Private clinic

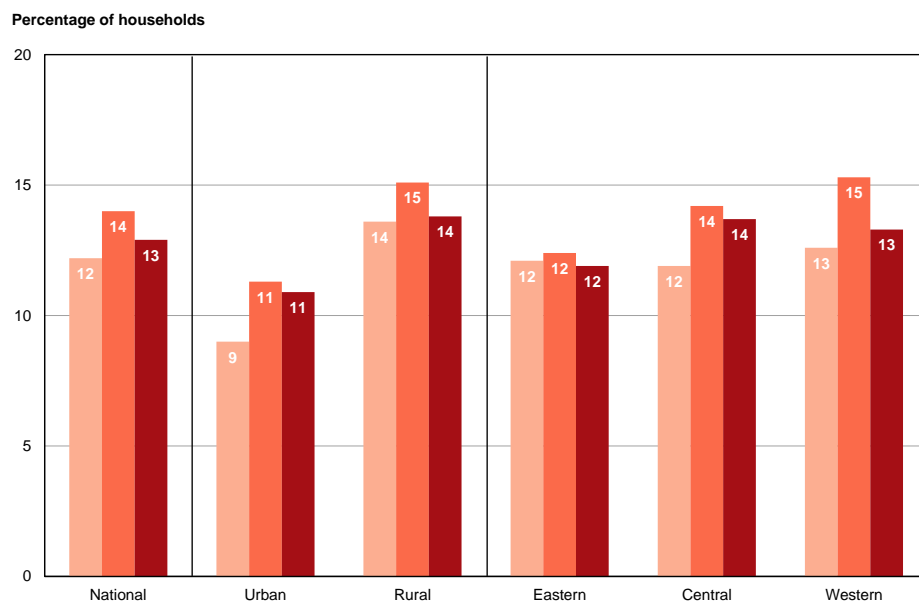
Figure 3.26

Health insurance coverage increased steadily from 2003 to 2011, both nationally and at the sub-national level. In 2011, 96 per cent or 1.29 billion rural and urban residents were covered by health insurance. The remarkable increase in health insurance coverage in rural areas was due to the introduction of the Rural Cooperative Medical Scheme (RCMS)⁵¹ in early 2000. The Scheme now covers almost all of the country's rural residents, improving their access to health services.

Figure 3.27

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 3.28
Percentage of households with catastrophic health expenses, 2003, 2008 and 2011



Source: Qun Meng, Ling Xu, Yaoguang Zhang, Juncheng Qian, Min Cai, Ying Xin, Jun Gao, Ke Xu, J Ties Boerma, Sarah L Barber, 'Trends in Access to Health Services and Financial Protection in China Between 2003 and 2011: a Cross-sectional Study', *The Lancet*, 3 March 2012, Volume 379, Issue9818, Pages 805–814 (Note: Data from the *National Health Services Surveys* in various years were used in this paper.)

■ 2003
 ■ 2008
 ■ 2011

Figure 3.28

According to NHSS data, about 12 to 14 per cent of households had catastrophic health expenses every year during 2003–2011, while households in rural areas and western and central provinces were more likely to have catastrophic health expenses. Relatedly, households in rural areas and western and central provinces reported higher rates of self-discharge from hospital for financial reasons, and these households normally spent a higher portion of their living expenditures on health⁵².

Figure 3.29
Ratios of the poorest and the richest quartile for selected indicators, 2003, 2008 and 2011

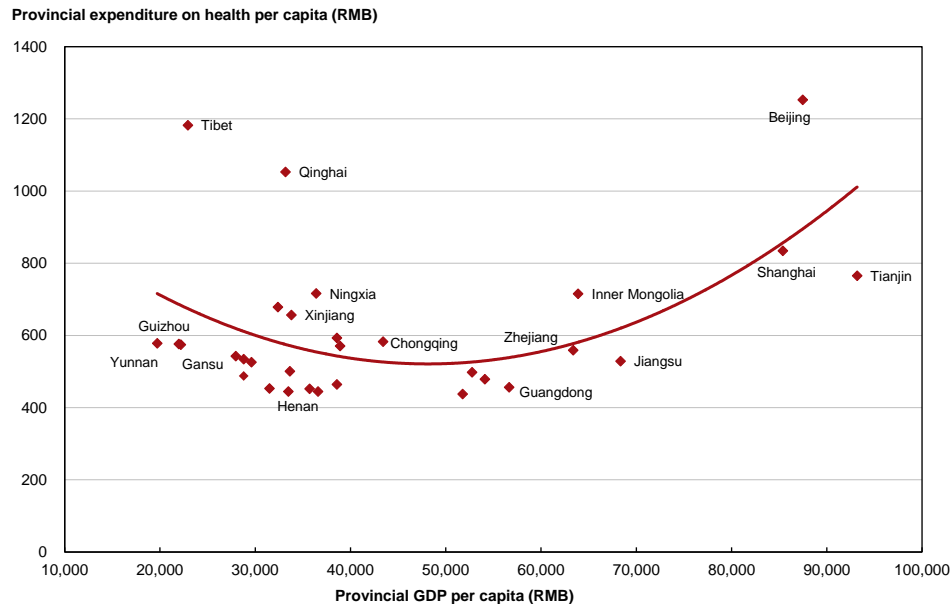
	2003	2008	2011
Antenatal care coverage (at least five visits)	0.74	0.79	0.94
Hospital delivery rate	0.91	0.97	1.01
Health insurance coverage	0.63	0.93	0.98
Outpatient utilisation rate	0.86	0.94	0.98
Inpatient reimbursement rate	0.37	0.85	0.97
Proportion of households with catastrophic health expenses (inversed)	0.54	0.50	0.49

Source: Qun Meng, Ling Xu, Yaoguang Zhang, Juncheng Qian, Min Cai, Ying Xin, Jun Gao, Ke Xu, J Ties Boerma, Sarah L Barber, 'Trends in Access to Health Services and Financial Protection in China Between 2003 and 2011: a Cross-sectional Study', *The Lancet*, 3 March 2012, Volume 379, Issue9818, Pages 805–814 (Note: Data from the *National Health Services Surveys* in various years were used in this paper.)

Figure 3.29

Dramatic progress has been achieved from 2003 to 2011 for the first five indicators listed in this table, as seen by the narrowing gap between the poorest and richest quintiles. In contrast, households from the poorest quintile were still twice as likely as those from the richest quintile to experience catastrophic health expenses in 2011.

Figure 3.30
Provincial expenditure on health per capita in relation to provincial GDP per capita, by province, 2012

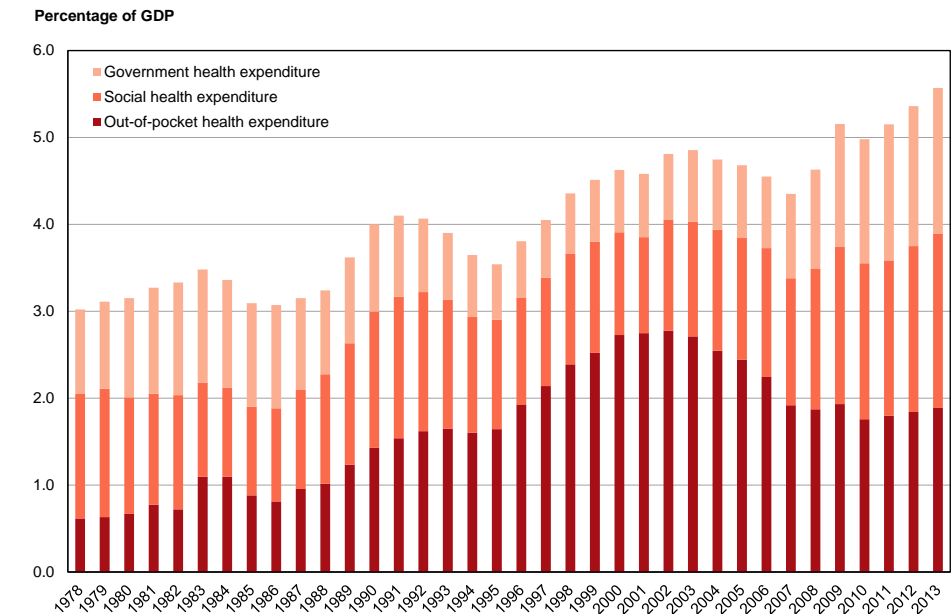


Source: National Bureau of Statistics, *China Statistical Yearbook*, 2013

Figure 3.30

Plotting the provinces by their respective per capita spending on healthcare and per capita GDP reveals a general pattern in which eastern provinces spent more on health than western provinces. However, the relationship is not linear. Some western provinces with a low GDP per capita may have similar levels of per capita expenditure on healthcare as some eastern provinces.

Figure 3.31
Government, social and out-of-pocket expenditure on health, 1978–2013



Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook*, 2014

Figure 3.31

Over the past three decades, China has seen its total health spending increase from about 3 to 5.6 per cent of its GDP. This increase was driven almost entirely by out-of-pocket payments until the mid-2000s. In recent years, out-of-pocket share decreased to reach 34 per cent in 2013. The national target is to offer citizens better financial protection in health, by increasing the share of government health expenditure, and reducing the share of out-of-pocket expenditure to below 30 per cent by 2015.



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 2011, China reported its first polio case in Xinjiang since being declared free of polio 11 years ago. The Government recognised the polio outbreak as a national public health emergency and launched an immediate response, including polio supplementary immunization activities in Xinjiang. In November 2012 China was confirmed by WHO as retaining its polio-free status.

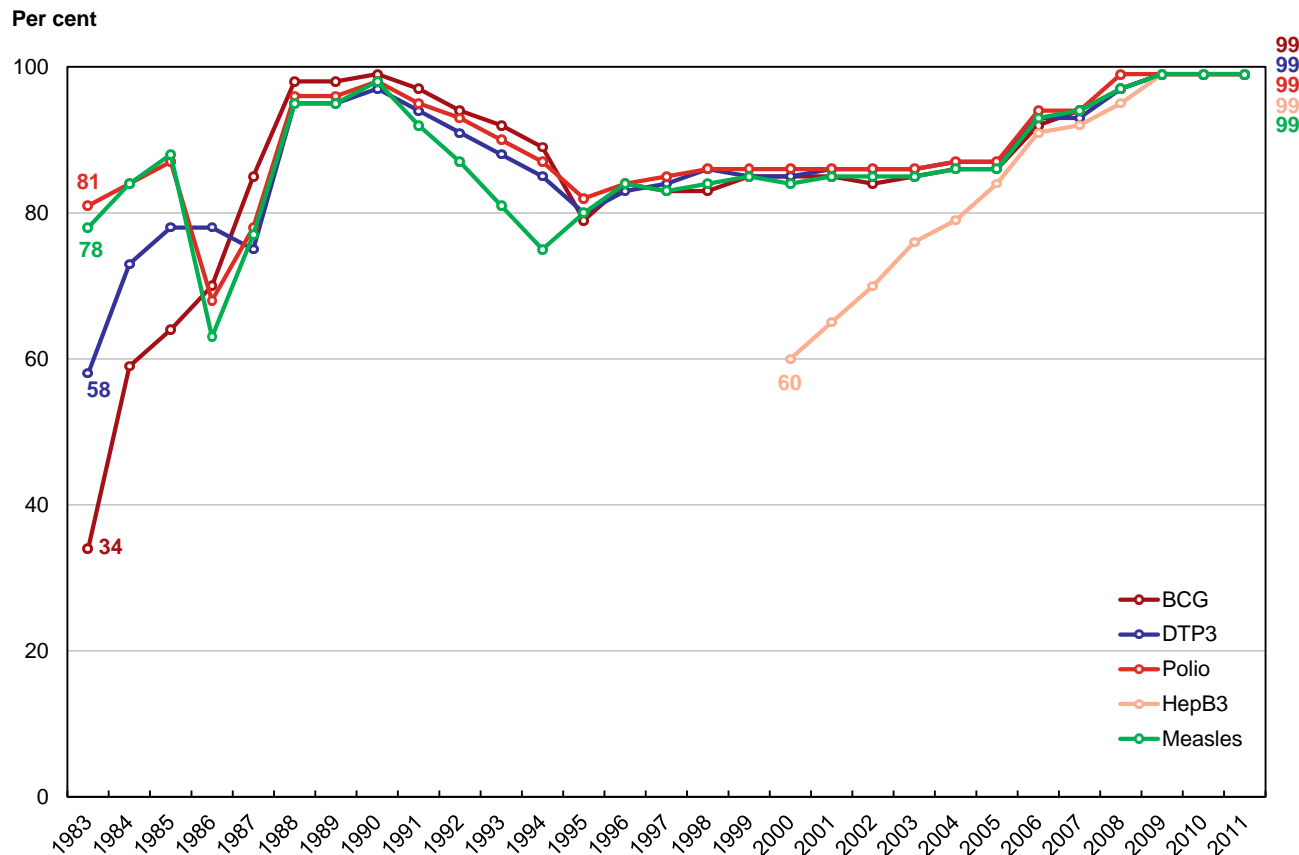
In 2004, the State Council adopted the revised *Law on Infectious Disease Control and Prevention*, making routine immunization for children free of charge. In 2008, China increased the number of vaccines included in the routine EPI schedule, to protect children against 12 infectious diseases. The Government of China has also made a strong commitment to eliminate maternal and newborn tetanus by 2010 and measles by 2015. Indeed on 30 October 2012, WHO formally declared that maternal and newborn tetanus had been eliminated in China. Overall, China is protecting millions of children from vaccine-preventable diseases.

Since the implementation of health sector reform in 2009, and in recognition of the previously inadequate attention given to immunization in the public health service package, the central Government increased funding for EPI⁵³. However, challenges remain, as there are insufficient operational funds and human resources to administer the increased number of vaccines and accordingly increased number of monitoring activities. The limited capacity in numbers and expertise of health personnel, and logistical and geographical factors in some areas, also pose hurdles. There are still inequities regarding uneven quality of immunization service, and persistent circulation of certain vaccine preventable diseases, such as the measles virus in western areas and among migrant children, and the 2011 outbreak of imported polio in southern Xinjiang. National and provincial disease reporting systems have also shown that migrant children living in urban areas have relatively low rates of vaccination coverage.

The Hib, pneumococcal and rotavirus vaccines, all of which can contribute to reducing under-five mortality, in particular mortality due to pneumonia, are available in China as secondary category vaccines, but are not part of the national immunization programme.

Province-level implementation of the 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,
1983–2011

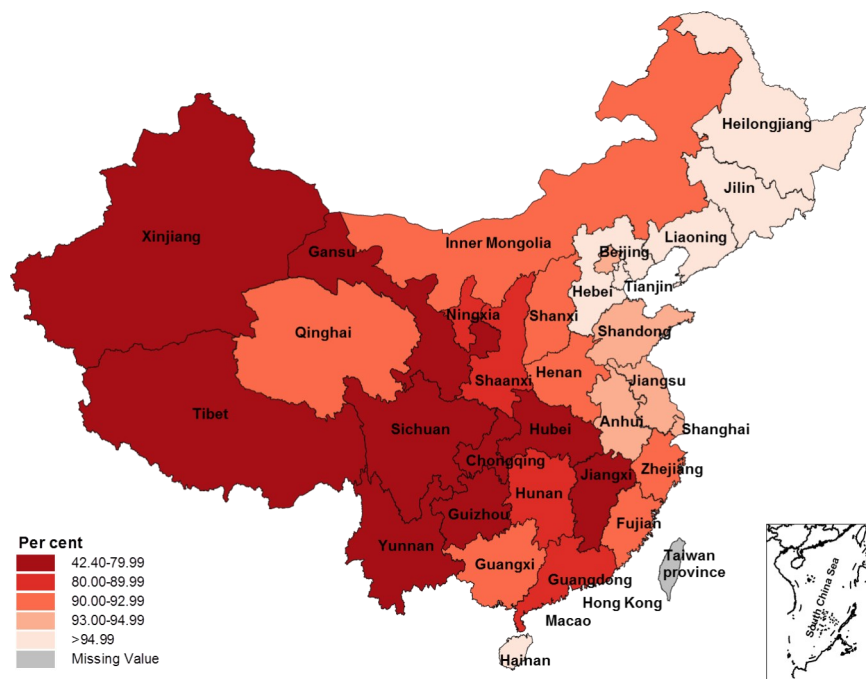


Source: Former Ministry of Health, World Health Organization and United Nations Children’s Fund, *Joint Report on Child Immunization Coverage*, 2012

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 2004, the Government implemented a new policy that made routine immunization services free of charge for children. Vaccination coverage has since risen accordingly. Vaccination coverage of BCG, DTP3, polio, HepB3 and measles all reached 99 per cent since 2009.

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

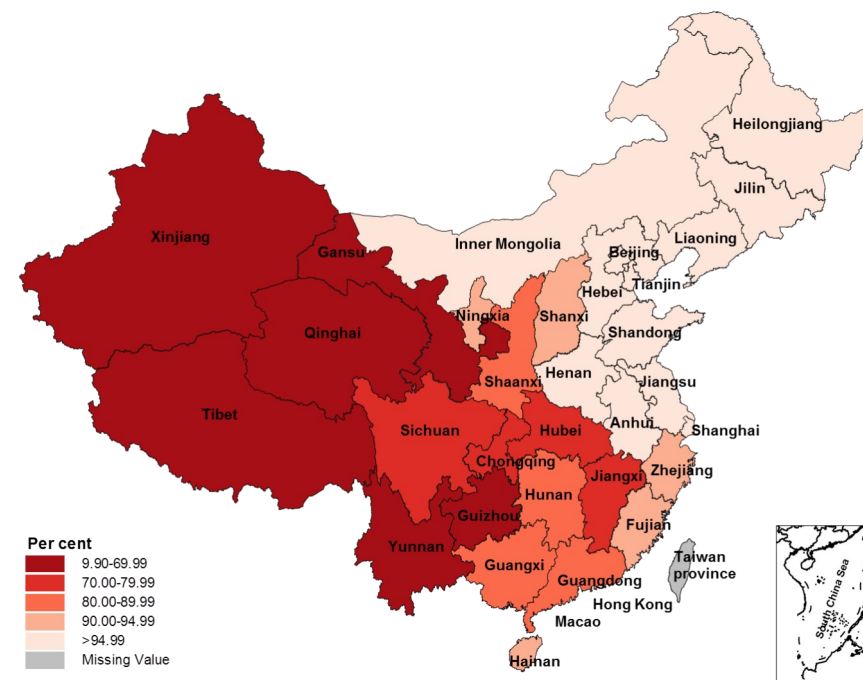


Source: Former Ministry of Health, *National Immunization Survey Report, 2004*

Figure 4.2

Full vaccination coverage⁵⁴ 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



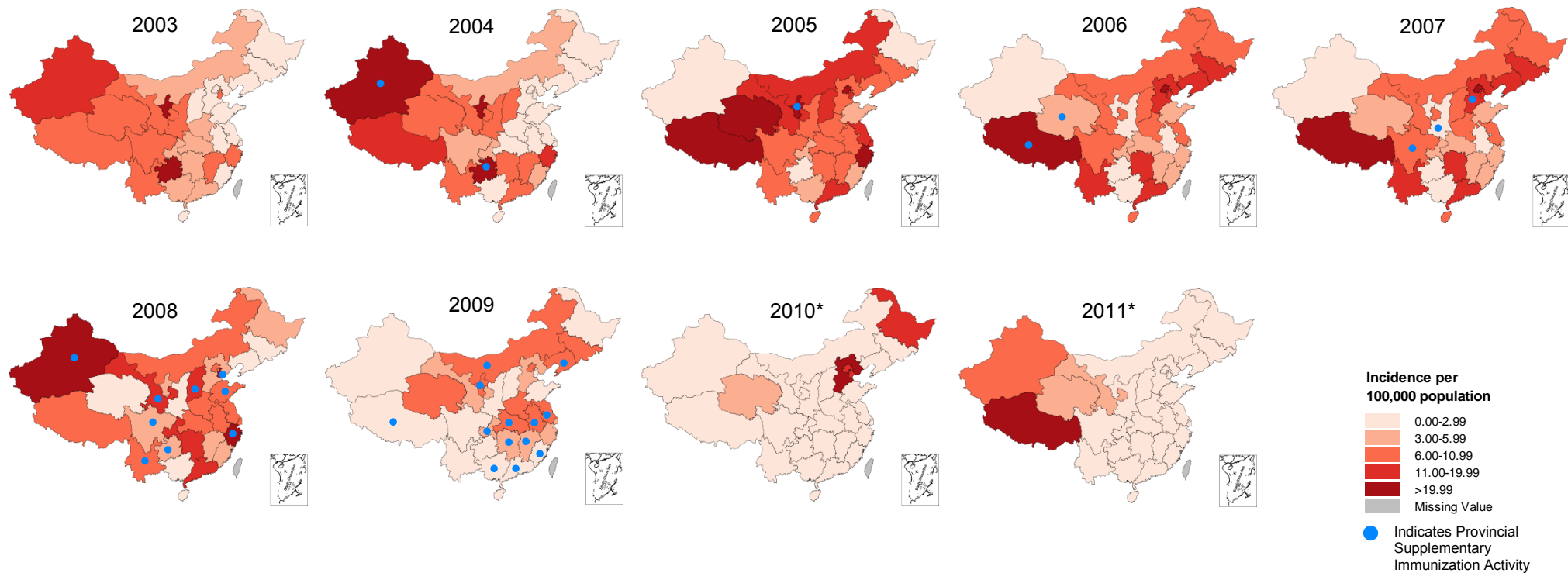
Source: Former Ministry of Health, *National Immunization Survey Report, 2004*

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, exacts a human toll and puts a great economic burden on communities.

The 2004 National Immunization 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 years 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 among ethnic minority groups.

Figure 4.4
Measles incidence and supplementary immunization activities, 2003–2011



Sources: Chinese Centre for Disease Control and Prevention, *National Measles Surveillance Reporting System*, 2012

Figure 4.4

The map shows provincial-level measles incidence and Supplementary Immunization Activities (SIA) between 2003 and 2011. Many SIAs have been conducted in western provinces during the past several years, but lack sustained impact, because of the inadequate level of follow-up routine vaccination. This is due to insufficient financial support and low operational capacity. Since 2008, a number of SIAs have taken place in eastern and western provinces, in response to a higher incidence of measles in these areas, largely linked to the inflow of migrant populations.

* National SIA was conducted in 2010. No SIAs in 2011.



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. China has 6.5 per cent of the world's stunted children globally, second only to India⁵⁵. Based on the 2010 China Food and Nutrition Surveillance, the stunting prevalence of children under 5 years was as high as 20.3 per cent in poor rural areas. Stunting is caused by poor feeding over a prolonged period and by the inadequate prevention and treatment of disease and infection.

Evidence⁵⁶ indicates that the first 1,000 days of life is the most critical period as this is when nutritional deficiencies have a significant and often irreversible adverse impact on child survival and growth, affecting their ability to learn in school and productivity in later life.

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 addition, intestinal worms and hemoglobin disorders play a role in some areas in China⁵⁷. Studies report persisting lower cognitive and motor test scores among children who had iron deficiency anaemia as young children. Based on 2010 China Food and Nutrition Surveillance, the anaemia prevalence of children under 5 years was 13.3 per cent in rural areas. For children aged 6–12 months, the prevalence was 28.2 per cent. In 2009, China approved general standards on complementary food supplement (*Ying Yang Bao*) to prevent and control micronutrients deficiency of infants and young children. Effectiveness studies on *Ying Yang Bao* intervention among children in poverty areas have demonstrated its impact on iron and other micronutrients deficiency⁵⁸.

The process of becoming malnourished in children typically begins in utero. Pregnant women have increased iron requirements, placing them at increased risk of iron deficiency and related adverse consequences. Based on a survey in 2006⁵⁹, the anaemia prevalence of pregnant women was 37.7 per cent in China. Prevention and control of multiple micronutrient deficiency among pregnant women is an important nutritional intervention.

Sustainable elimination of iodine deficiency

Globally, iodine deficiency is the primary cause of preventable learning disabilities and brain damage for a developing foetus. In line with World Health Organization (WHO) recommendations, China has adopted Universal Salt Iodization (USI) as the national strategy since 1994 for improving iodine intake and preventing iodine deficiency. The global USI target is for 90 per cent of households to consume adequately iodized salt. China has established a more rigorous target: at least 90 per cent of households to be consuming adequately iodized salt in at least 95 per cent of counties by 2010. In 2011, about 98 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.

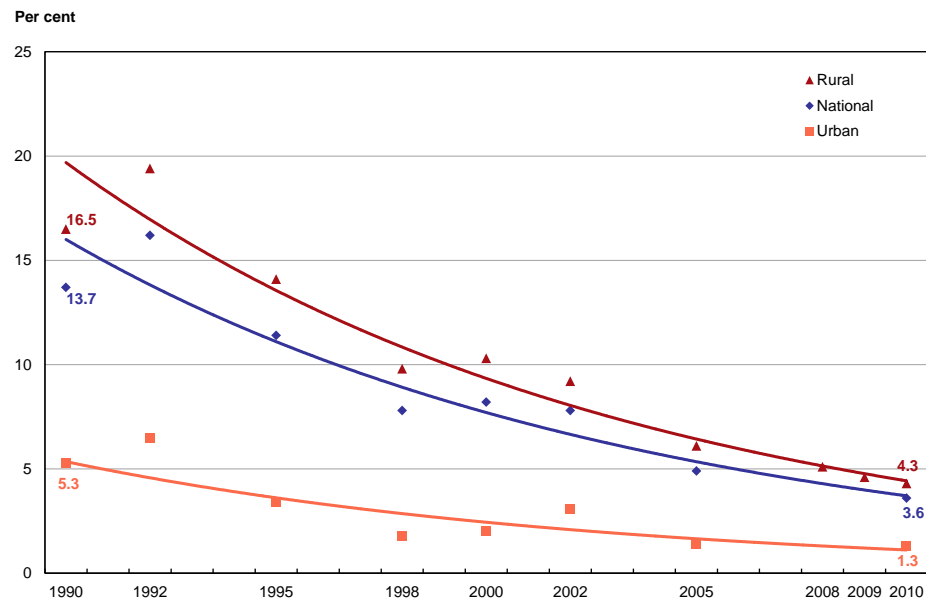
Despite the benefits, many mothers do not exclusively breastfeed their babies, and instead replace breastmilk with substitutes. Formula feeding is expensive, and is not nutritionally equivalent to breastmilk. Formula feeding exposes children to dangers, such as infections and contamination, and increases the risk of certain chronic diseases later in life. The rate of exclusive breastfeeding in China is 28 per cent nationally, with 16 per cent in urban areas and 30 per cent in rural areas⁶⁰.

While the majority of mothers produce enough milk to support the normal growth and development of their baby, breastfeeding in China is undermined by the aggressive marketing of infant formula. Other reasons why mothers do not breastfeed is that they are ill-advised by relatives, friends or health workers or not adequately supported to do so after returning back to work. Breastfeeding women need to be supported, protected and promoted.

Preventing childhood overweight and obesity

The China National Nutrition and Health Survey indicated that the prevalence of overweight and obesity⁶¹ increased three times from 1982 to 2002 among urban children and adolescents aged 7-17 years old. In 2002, the prevalence was 11.5 per cent in cities and was as high as 16.7 per cent in bigger cities⁶². Preventing child overweight and obesity is an emerging issue in China.

Figure 5.1
Prevalence of underweight among children under-five years old, 1990–2010

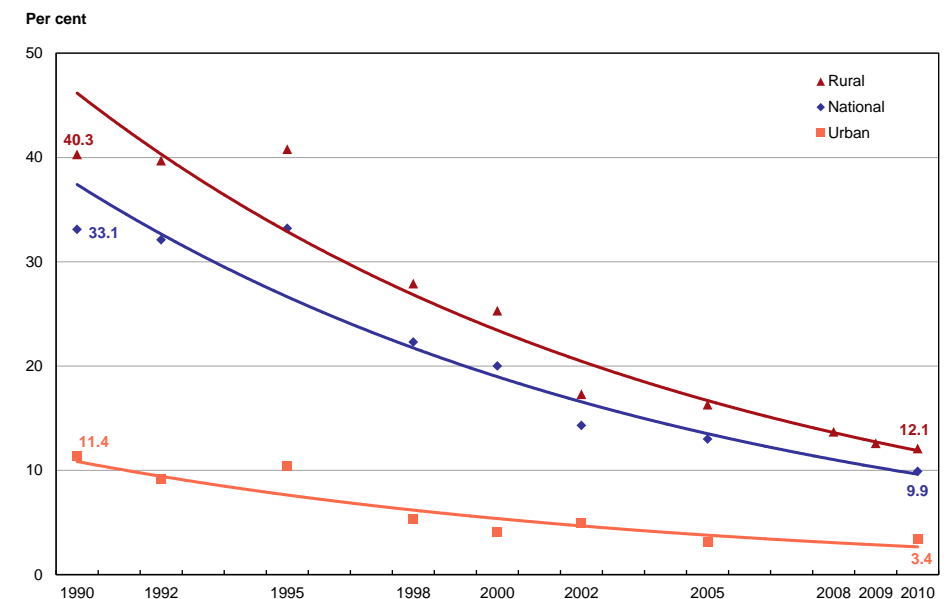


Source: Chinese Centre for Disease Control and Prevention, National Nutrition Survey (1992 and 2002 data); China Food and Nutrition Surveillance System, other years

Figure 5.1

In 1990, the national prevalence of underweight⁶³ (low weight-for-age) among under-five children was 13.7 per cent (5.3 per cent in urban areas and 16.5 per cent in rural areas). Between 1990 and 2010, the prevalence of underweight among under-five children decreased significantly to 3.6 per cent nationally, to 1.3 per cent in urban areas and to 4.3 per cent in rural areas. Prevalence of underweight was much higher in poor rural areas at 8 per cent. Underweight is measured according to WHO child growth standards.

Figure 5.2
Prevalence of stunting among children under-five years old, 1990–2010

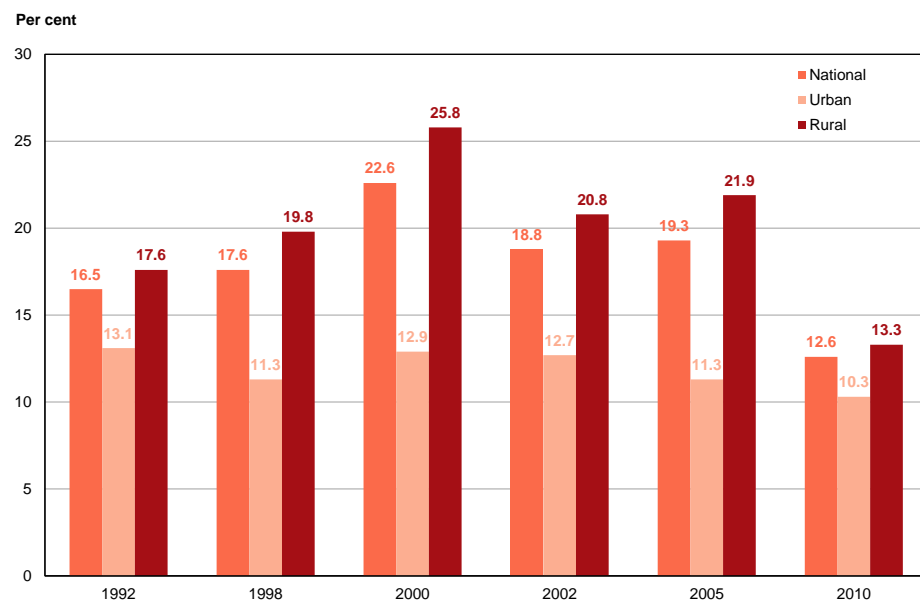


Source: Chinese Centre for Disease Control and Prevention, National Nutrition Survey (1992 and 2002 data); China Food and Nutrition Surveillance System, other years

Figure 5.2

The prevalence of stunting⁶⁴ (low height-for-age) decreased from 33.1 per cent in 1990 to 9.9 per cent in 2010. Stunting among urban children decreased from 11.4 per cent in 1990 to 3.4 per cent in 2010 and from 40.3 per cent to 12.1 per cent among rural children. In poor rural areas, the prevalence of stunting still remains high in 2010, at about 20.3 per cent. Stunting is measured according to WHO child growth standards.

Figure 5.3
Prevalence of anaemia among children under-five years old, 1998–2010

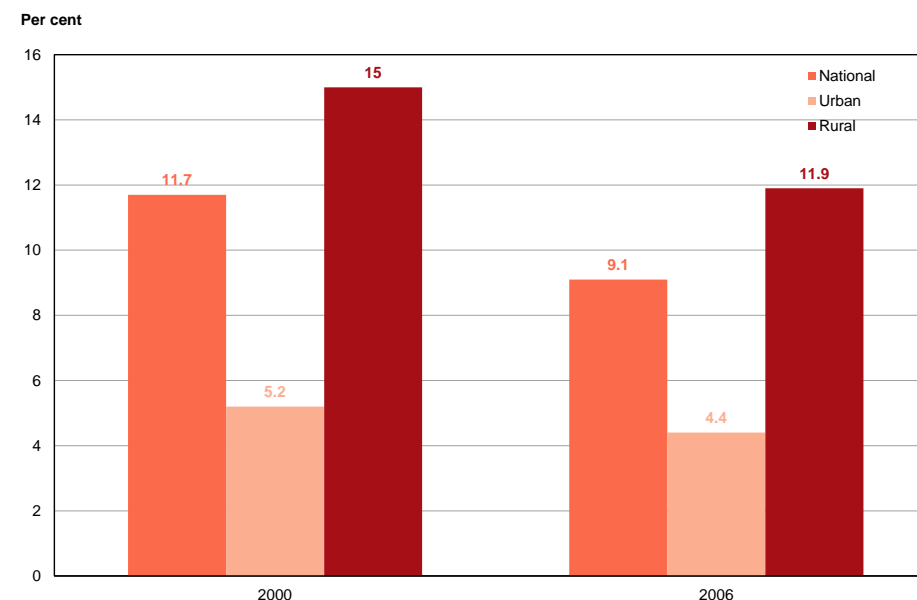


Sources: Chinese Centre for Disease Control and Prevention, *China Food and Nutrition Surveillance Report*, 2005; Former Ministry of Health, *2012 National Report on the Nutritional Status of Children Aged 0–6 Years*, 2012 (2010 data)

Figure 5.3

Anaemia⁶⁵ remains a persistent problem among children in China. Between 1998 and 2005, the prevalence of anaemia fluctuated between 17 to 23 per cent, without obvious decline. Since 2005, anaemia prevalence began to decrease, reaching 12.6 per cent in 2010, with around one in eight children reported as anaemic. The prevalence of anaemia varies with age and is highest among children 6–12 months old.

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

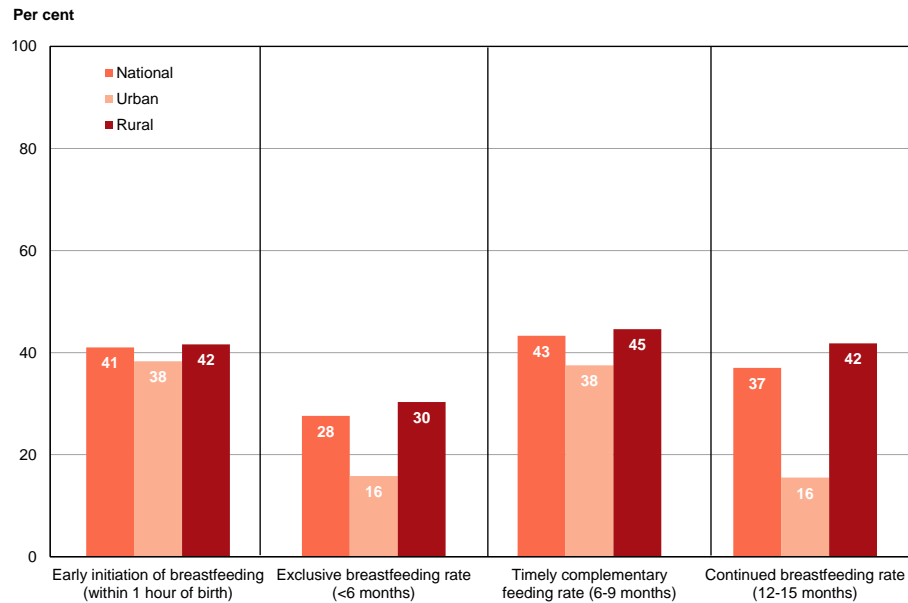


Sources: Chen Chunming, He Wu and Fu Zhenying, *Ten-Year Tracking of Nutritional Status in China*, 2004 (2000 data); The National Working Committee on Children and Women under the State Council, *Mid-term Evaluation Report on the implementation of the National Program of Action for Child Development in China (2001–2010)*, 2007 (2006 data)

Figure 5.4

A national 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
Infant and young child breastfeeding and complementary feeding, 2008



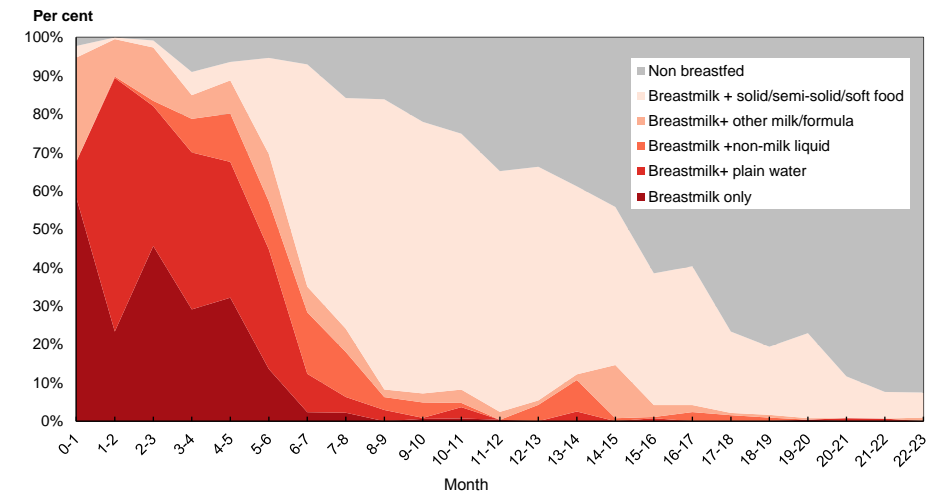
Sources: Former Ministry of Health, *An Analysis Report of 2008 National Health Services Survey in China*, 2009

Figure 5.5

Results from the 2008 NHSS found that in 2008 the national rate for early initiation of breastfeeding within one hour of birth was 41 per cent, 28 per cent for exclusive breastfeeding, 43 per cent for timely complementary feeding and 37 per cent for continued breastfeeding. This chart shows sub-optimal infant and young child feeding from the birth to fifteen months old in general, and large urban and rural differences in breastfeeding.

* UNICEF and WHO recommend early initiation of breastfeeding, exclusive breastfeeding for the first six months of life without any other fluids or food, and continued breastfeeding along with appropriate complementary feeding until at least two years of age. (WHO, *Global Strategy for Infant and Young Child Feeding*, WHO, 2003)

Figure 5.6
Infant and young child feeding practices in the first two years of life in poor rural areas of China, 2010



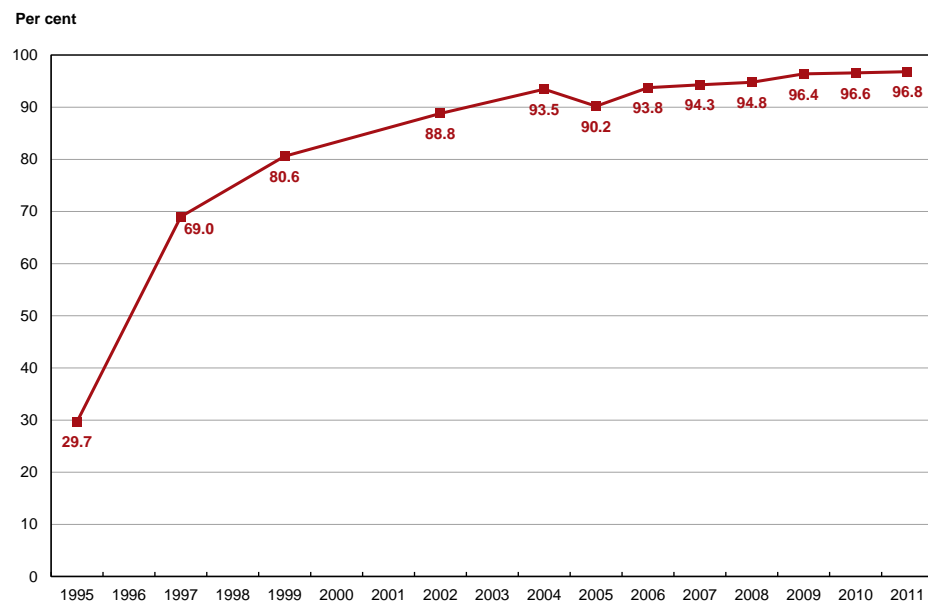
Source: Sufang Guo, Xulan Fu, Robert W Scherpbier, Yan Wang, Hong Zhou, Xiaoli Wang, David B Hipgrave, 'Breastfeeding Rates in Central and Western China in 2010: Implications for Child and Population Health', *Bulletin*, World Health Organization, 2013;91:322–331

Figure 5.6

This chart shows infant and young child feeding practices during the first two years of life in poor rural areas*. The rate of exclusive breastfeeding was only 58.3 per cent one month after delivery and declined to 29.1 per cent at four months and 13.6 per cent at six months. Except during the first month, the administration of water was the most common reason given for non-exclusive breastfeeding up to six months; intake of breastmilk substitute was the second most common reason. Around 40 per cent of newborns (aged less than one month) were given intake other than breastmilk, including water (9.4 per cent), other milk (27.1 per cent) or soft/semi-solid/solid food (3.0 per cent).

* Data are derived from a community-based cross-sectional survey conducted in 2010 on infant and young child feeding practices in 26 UNICEF project counties (total population 11 million) in 12 central and western provinces of China (Gansu, Qinghai, Jiangxi, Xinjiang, Chongqing, Sichuan, Guizhou, Guangxi, Shaanxi, Inner Mongolia, Shanxi and Tibet). Counties were selected by UNICEF and the former Ministry of Health as representative of poor rural counties based on their socio-economic development and maternal and child health performance. Child mortality was up to 65 per 1,000 live births in surveyed counties, and county GDP per capita ranged from RMB 1,000–15,000 in 2009 (compared to a national average of RMB25,000).

Figure 5.7
Household consumption of adequately iodized salt
(20–50 parts per million), 1995–2011

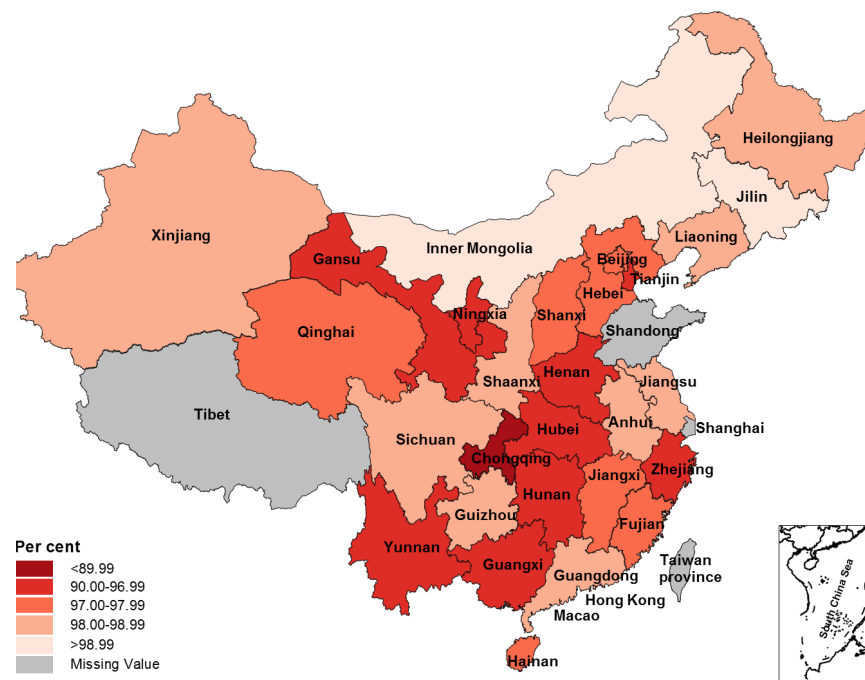


Sources: Former Ministry of Health, *National IDD Surveillance*, 1995, 1997, 1999, 2002 and 2005; Former Ministry of Health, *National Iodized Salt Monitoring Report*, 2004 and 2006–2011

Figure 5.7

National iodized salt monitoring data indicate that household consumption of adequately iodized salt⁶⁶ has risen dramatically from around 30 per cent in 1995 to more than 90 per cent in 2004, and steadily increased to 96.8 per cent in 2011.

Figure 5.8
Household consumption of adequately iodized salt,
2013



Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook*, 2014

Figure 5.8

National iodized salt monitoring data from 2013 indicate that in almost all provinces, with very few exceptions, coverage of adequately iodized salt has reached more than 90 per cent of households. Until 2012, adequately iodized salt in China was defined as that in which the level of iodine was in the 20–50 parts per million (ppm) range. In 2012, China adopted a revised national standard, with adequately iodized salt now defined as salt with iodine content of 20, 25 or 30 ppm.



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.

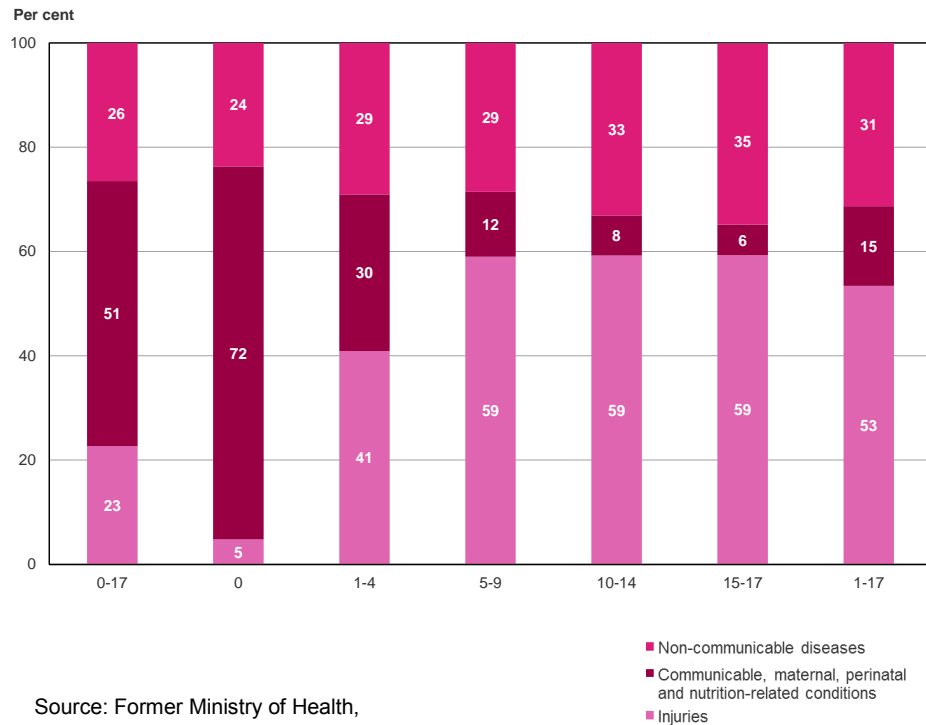
In China, it is estimated that over 10 million children under 18 years of age are injured each year, and more than 50,000 children die from drowning, traffic accidents, accidental suffocation, falls, poisoning and other accidents. Annually, 80 per cent of injured children require hospitalization or medical 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 conducted with NWCCW also indicate that the risk of accidental death is significantly higher among children who are left behind in rural areas when 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 before, during and after natural disasters.

Child injury prevention has recently received greater attention among policymakers and the general public. The *National Programme of Action for Children (2011-2020)* set a target to reduce, by one-sixth, between 2010 and 2020, the injury-related child death rate.

Figure 6.1
Leading causes of death among children in China
aged 0–17 years, by age group, 2004–2005



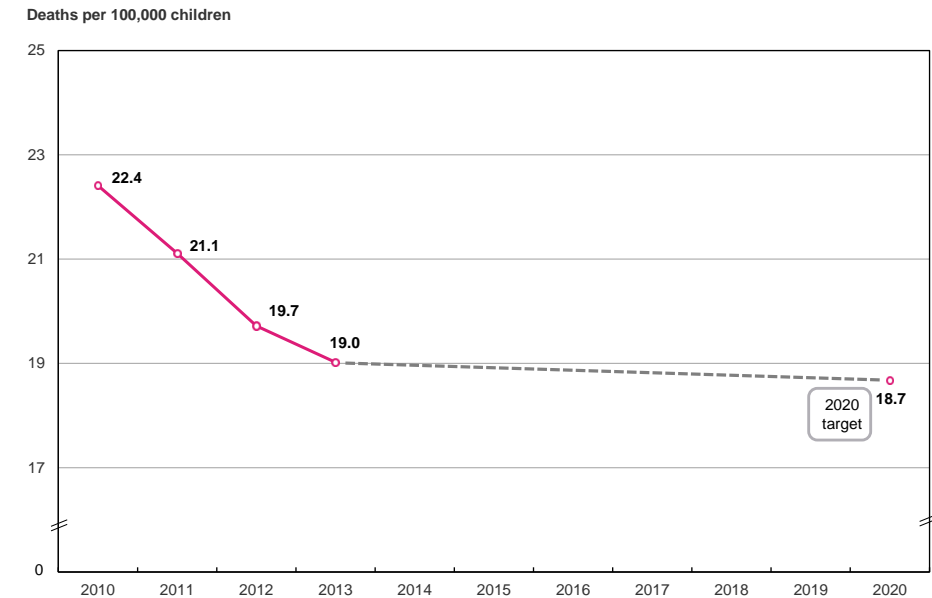
Source: Former Ministry of Health,
China Child Injury Report, 2012

Figure 6.1

Injury is one of the leading causes of death among children in China. In 2004-2005, injury accounted for 23 per cent of all deaths of children aged 0-17 years.

When infant deaths are omitted, injury becomes the leading cause of death for children aged 1-17 years in China as illustrated in this chart, with injury accounting for more than half of all deaths of children in this age group.

Figure 6.2
Injury-related death rate among children in China
aged 0–17 years, 2010–2013

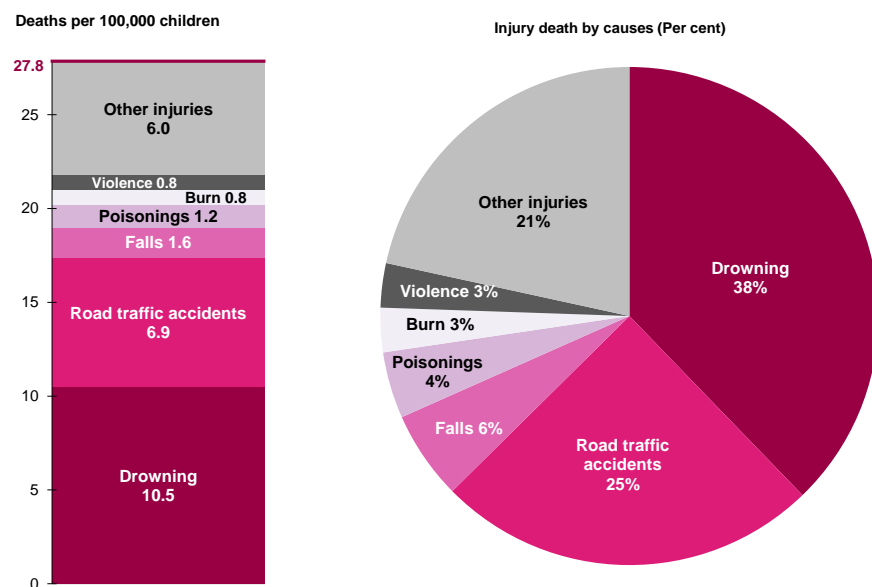


Source: National Bureau of Statistics, *NPA Monitoring Statistics, 2014*

Figure 6.2

Injury-related child death rate decreased from 22 per 100,000 children in 2010 to 19 per 100,000 children in 2013, making feasible the possibility of meeting the 2011-2020 NPA for Children target to reduce the injury-related child death rate by one-sixth between 2010 and 2020.

Figure 6.3
Leading causes of injury-related death among children in China aged 0–17 years, 2004–2005



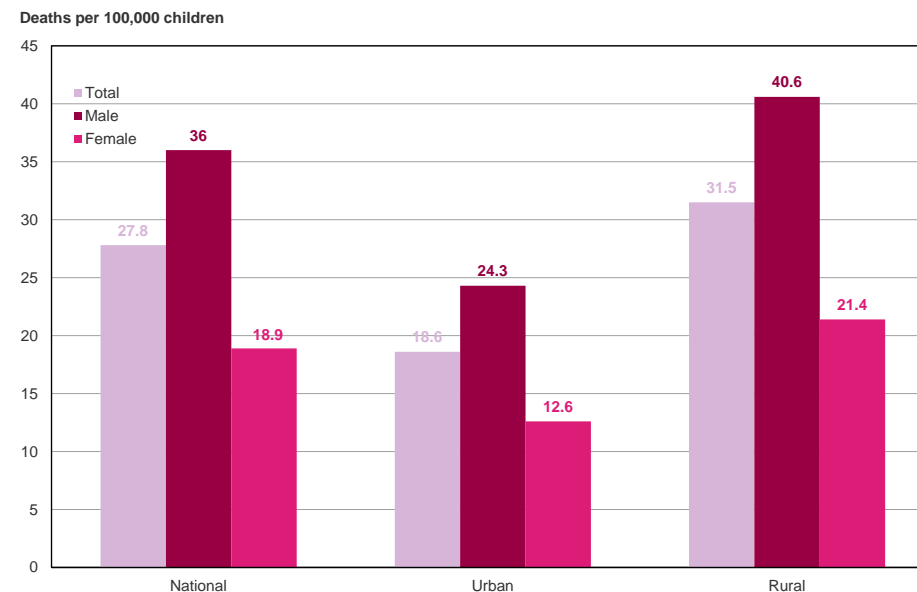
Source: Former Ministry of Health, *China Child Injury Report*, 2012

Figure 6.3

Injury-related child death rate was 28 per 100,000 children aged 0–17 in 2004–2005. About 88,000 children in China die from injuries every year.

Drowning accounted for 38 per cent of all injury deaths. Leading causes of injury death vary by age group. In 2004–2005, drowning was the leading cause of injury death among children aged 1–14, while road traffic accidents were the leading cause of injury death among children aged 15–17.

Figure 6.4
Injury-related death rate among children in China aged 0–17 years, by urban/rural and sex, 2004–2005

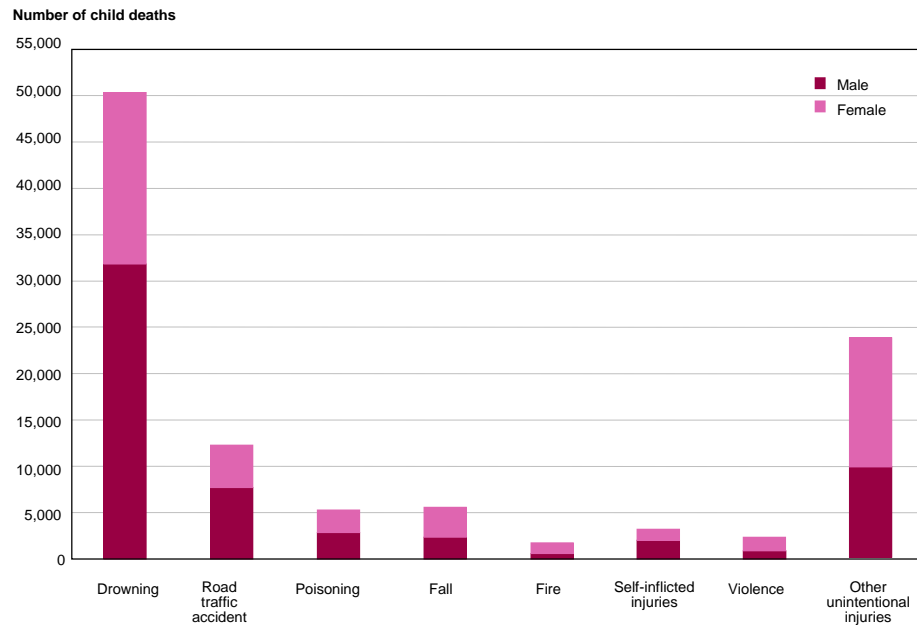


Source: Former Ministry of Health, *China Child Injury Report*, 2012

Figure 6.4

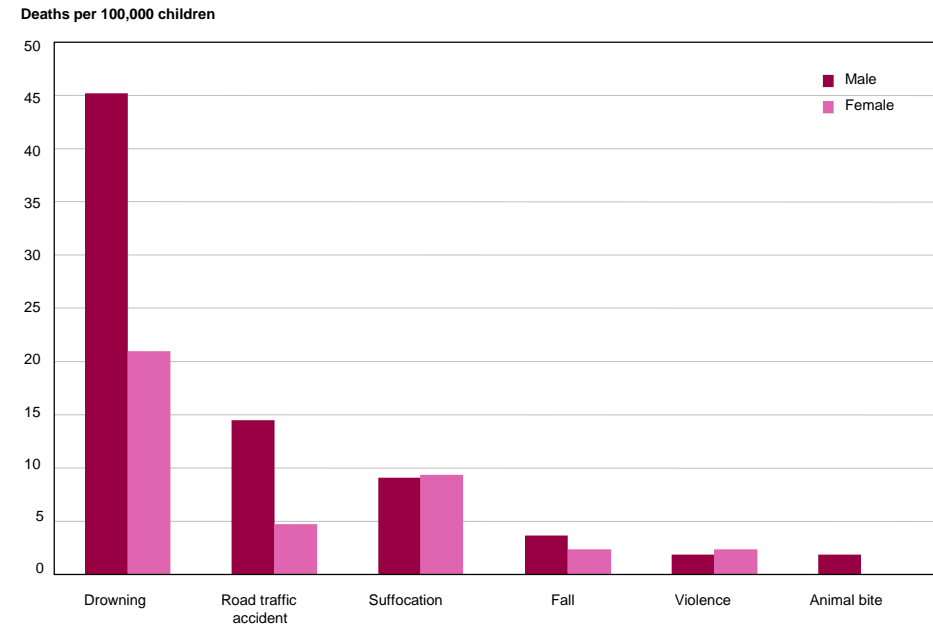
Injury-related child death rates were higher among boys than girls, and higher in rural than urban areas.

Figure 6.5
Leading causes of injury-related death among children
in China aged 0–14 years, by sex, 2004



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

Figure 6.6
Leading causes of injury-related death among children
aged 0–17 years, by sex, Jiangxi Province, 2005

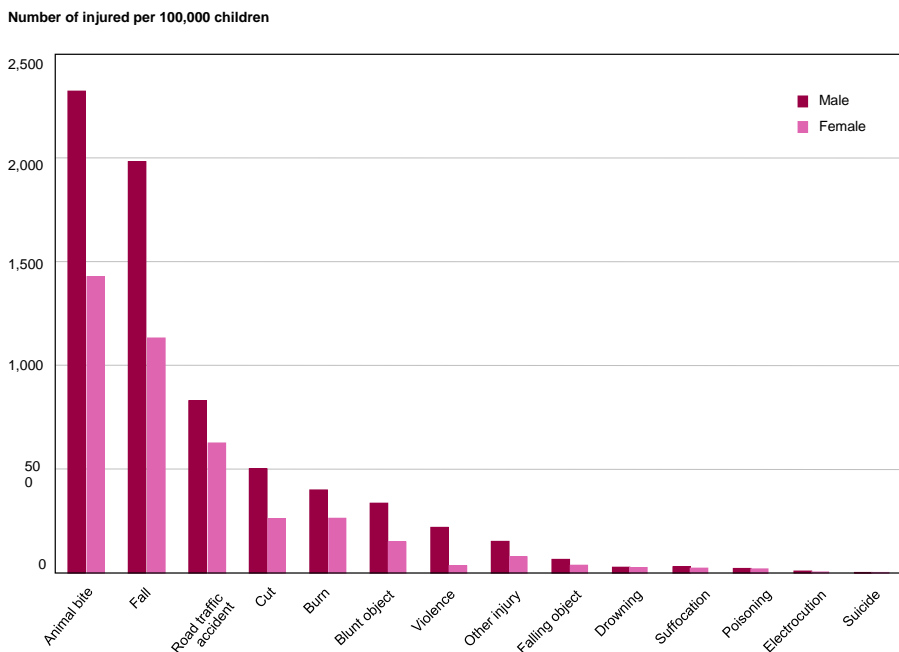


Source: Former Ministry of Health and United Nations Children's Fund, *Jiangxi Child Injury Survey, 2007*

Figure 6.5 and 6.6

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

Figure 6.7
Leading causes of injury-related morbidity among children aged 0–17 years, by cause and sex, Jiangxi Province, 2005

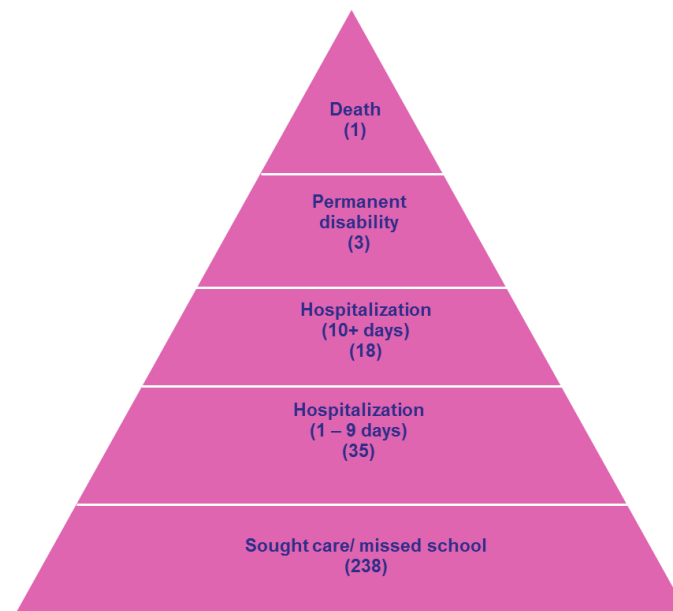


Source: Former Ministry of Health and United Nations Children’s Fund, *Jiangxi Child Injury Survey, 2007*

Figure 6.7

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-related morbidity.

Figure 6.8
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 6.8

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 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.

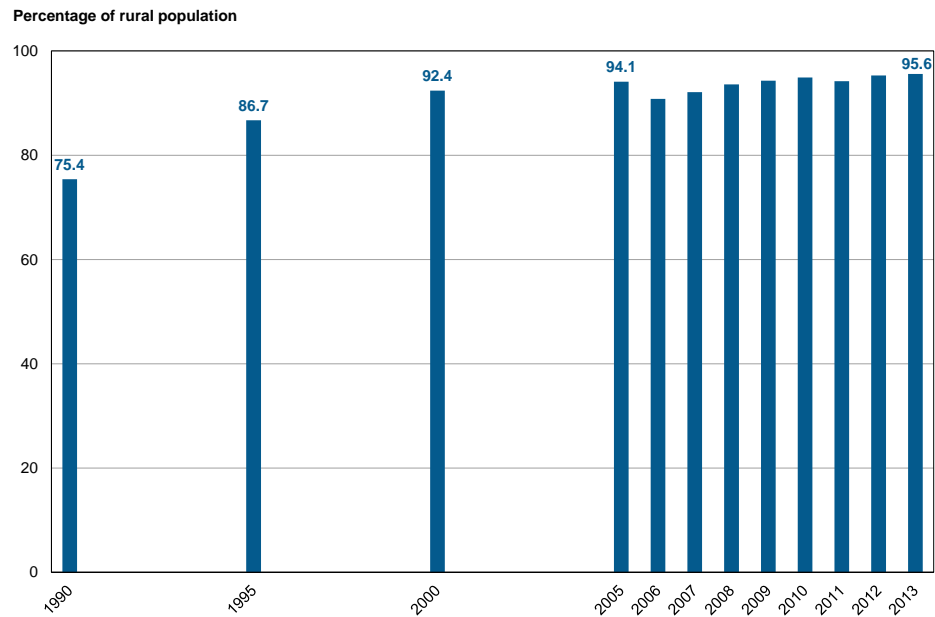
In 2000, the central Government began to allocate funds for rural water supply. Monitoring activities between 2003 and 2005 found elevated levels of arsenic in the rural water supply of many provinces, which led to the integration of rural water supply into the Eleventh Five-Year National Development 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 and to more than 20 billion per year in 2009, 2010 and 2011. This momentum continued in 2012.

Improvements in rural sanitation are supported by general fund transfers from the central Government to local budgets, and by some designated programmes, such as for 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 Sector Reform Programme started from 2009, which led to a central Government allocation of around 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 regional 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 local matching funds to fully implement programmes that only receive partial funding from 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 and rural health facilities. A survey in 2007⁷² 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. Another survey⁷³ in 2010 found that only 31 per cent of township hospitals had indoor toilets, and that only 55 per cent of those with indoor toilets had handwashing facilities.
- Water quality continues to be a challenge. Drinking water sources are becoming scarcer, and the treatment of water has become increasingly 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 (2014) estimates show that around 470 million people in China did not use improved sanitation facilities in 2012, accounting for 35 per cent of the total population. In rural areas, 44 per cent of people did not use improved sanitation facilities. Although China achieved the sanitation-related MDG target in 2010 according to UNICEF/WHO estimates, special efforts are needed to improve sanitation status in less developed areas, including in rural schools and hospitals.
- 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, 1990–2013

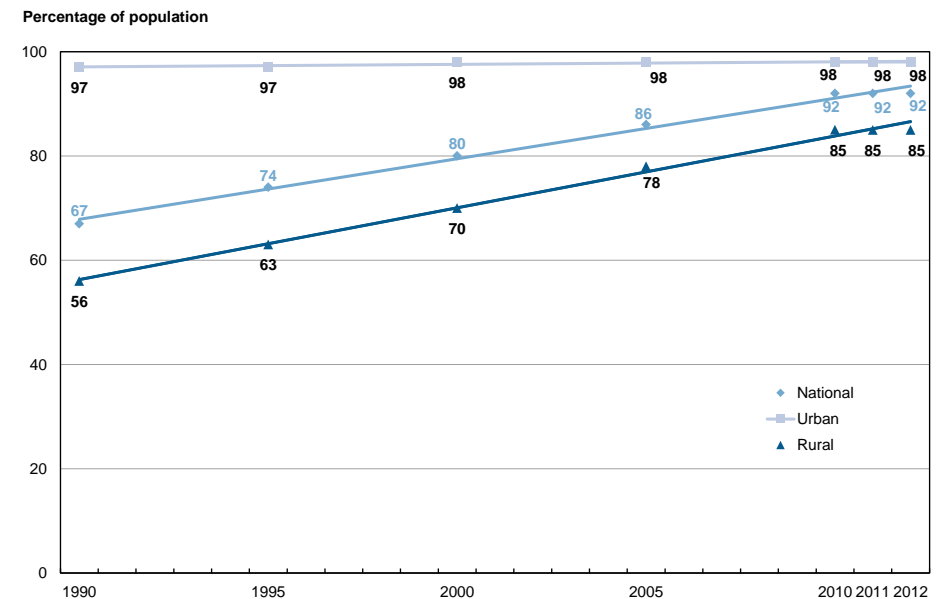


Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook*, 2014

Figure 7.1

Access to improved water sources⁷⁴ has generally increased in rural China over the past two decades⁷⁵.

Figure 7.2
Percentage of population using improved water sources, 1990–2012

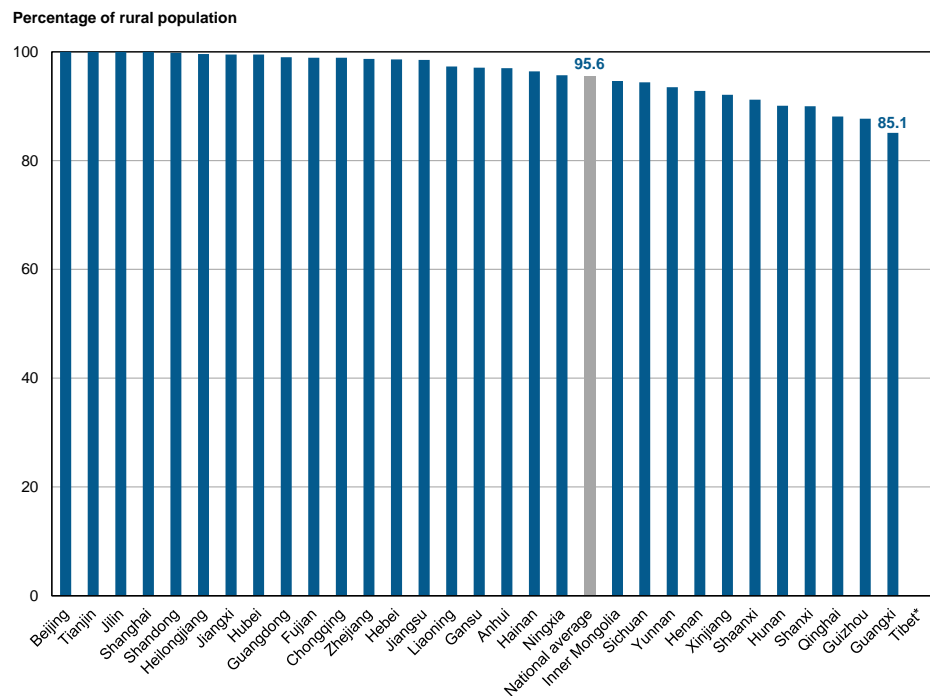


Source: United Nations Children's Fund and World Health Organization Joint Monitoring Programme for Water Supply and Sanitation, *Estimates for the use of Improved Drinking-Water Sources, China*, updated April 2014

Figure 7.2

WHO and UNICEF publish a *Joint Monitoring Programme (JMP)* report biannually to assess the status of household use of improved water sources⁷⁶. According to the most recent JMP estimates, 92 per cent of people in China had access to improved water sources in 2012. The use of improved water sources was 85 per cent in rural areas, 13 percentage points lower than that in urban areas. JMP estimates on household use of improved water sources differ from the corresponding figures reported by NHFPC/NPHCCO (Figure 7.1) and published in the *China Health and Family Planning Statistical Yearbook*⁷⁷.

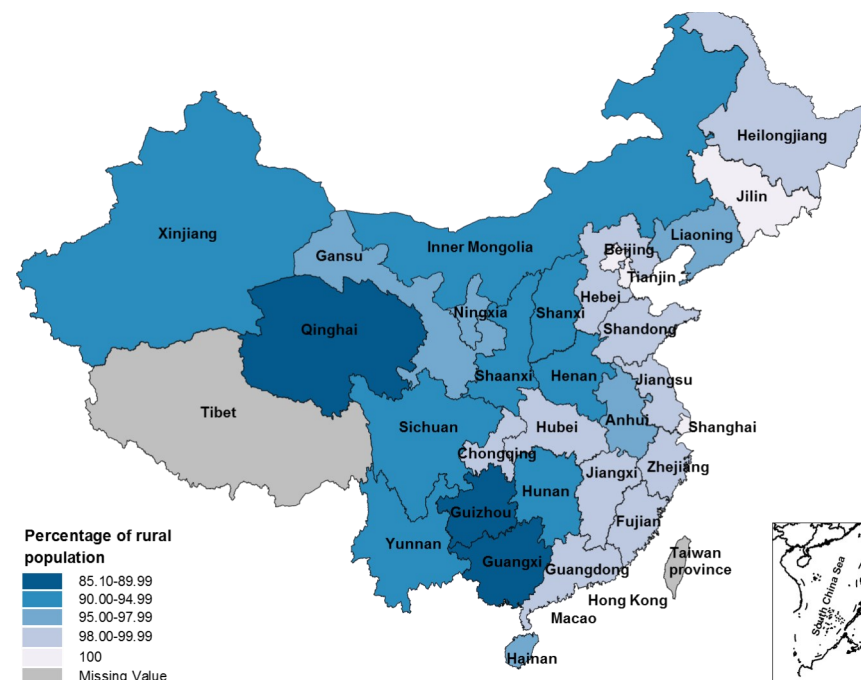
Figure 7.3
Rural access to improved water sources, by province, 2013



* Data is not available for Tibet.

Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook, 2014*

Figure 7.4
Rural access to improved water sources, 2013



Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook, 2014*

Figure 7.3 and 7.4

There are great disparities among provinces in access to improved water sources. Provinces with less access to improved water sources also tend to be less economically developed.

Figure 7.5
Rural access to improved water sources, by type, 1990–2013

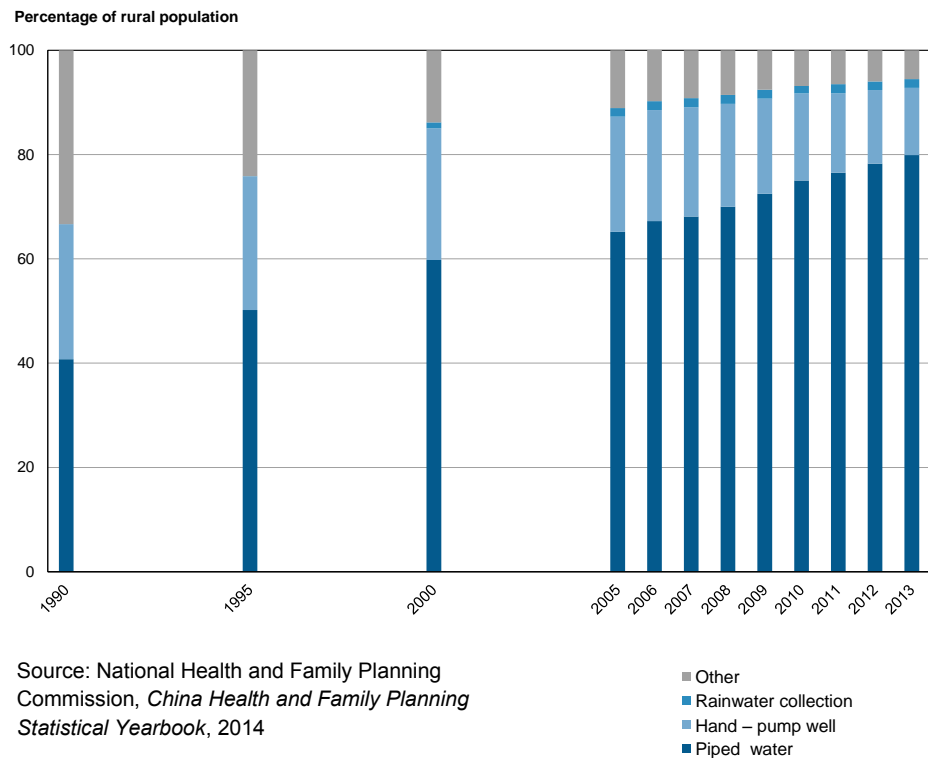


Figure 7.5

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, 2000–2013

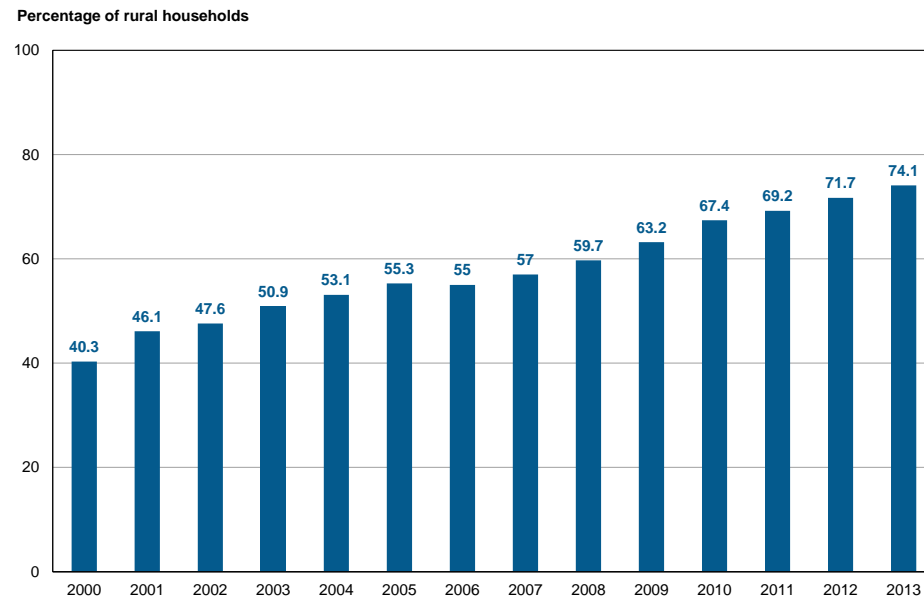
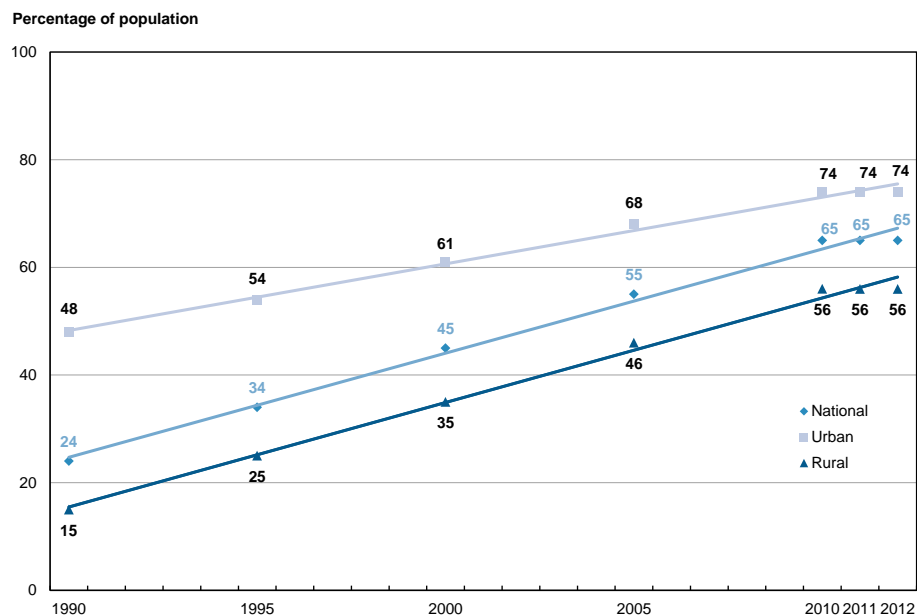


Figure 7.6

Between 2000 and 2013, the proportion of rural households with access to sanitary latrines⁷⁸ increased dramatically, from around 40 to 74 per cent, according to data from NHFPC/NPHCCO.

Figure 7.7
Percentage of population using improved sanitation facilities, 1990–2012

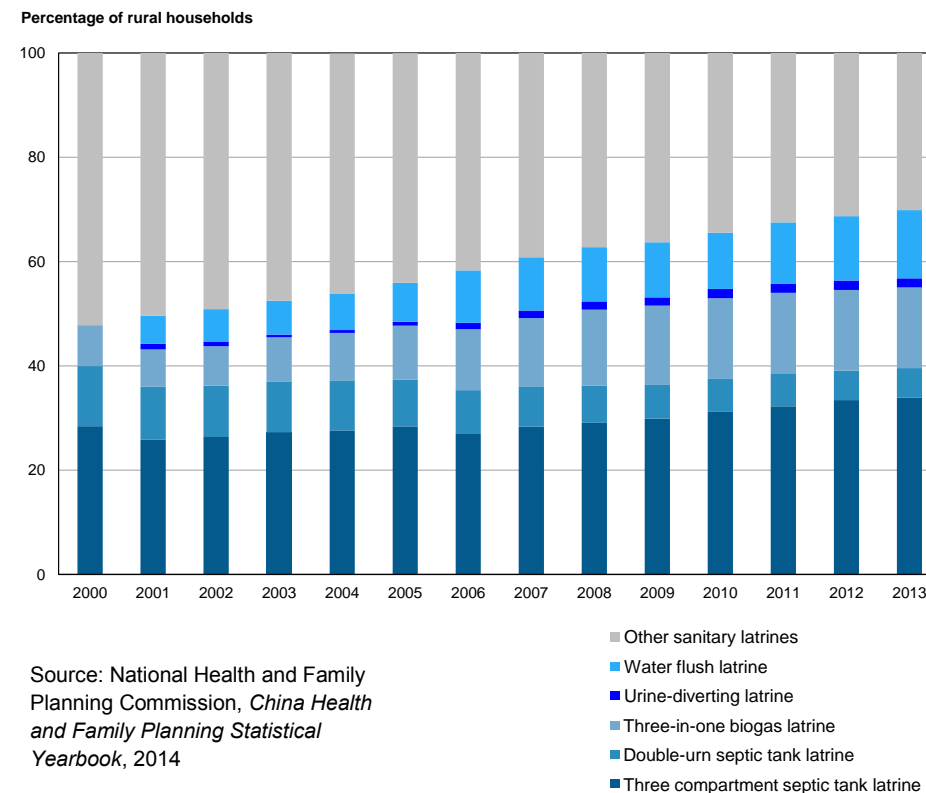


Source: United Nations Children's Fund and World Health Organization Joint Monitoring Programme for Water Supply and Sanitation, *Estimates for the use of Improved Sanitation Facilities, China*, updated April 2014

Figure 7.7

WHO and UNICEF publish a *Joint Monitoring Programme (JMP)* report biannually to assess the status of household use of improved sanitation facilities⁷⁹. According to the most recent JMP estimates, 65 per cent of people in China had access to improved sanitation by 2012. The use of improved sanitation facilities was 56 per cent in rural areas, 18 percentage points lower than that in urban areas. JMP estimates on household use of sanitation facilities are different from the data reported by NHFPC/NPHCCO (Figure 7.6) and published in the *China Health and Family Planning Statistical Yearbook*.

Figure 7.8
Rural access to sanitary latrines, by type, 2000–2013



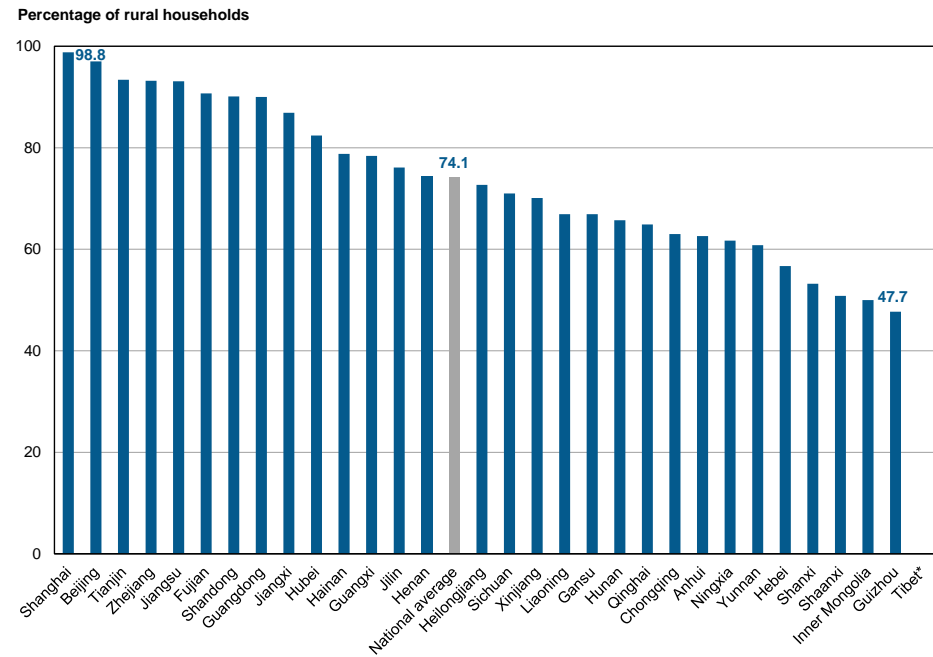
Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook*, 2014

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 three-compartment septic tank latrine is now the most common type of latrine and preferred by rural households. Three-in-one biogas septic tank latrines and water-flush latrines are also becoming increasingly common.

* Since 2007, the twin-pit alternating latrine was introduced by NPHCCO as one of the 6 recommended types of harmless sanitary household latrines. By 2013, 1.7 million households nationally used this type, accounting for less than one per cent of the total sanitary latrines. The figure is too small in coverage and therefore it is combined into other sanitary latrines in this chart.

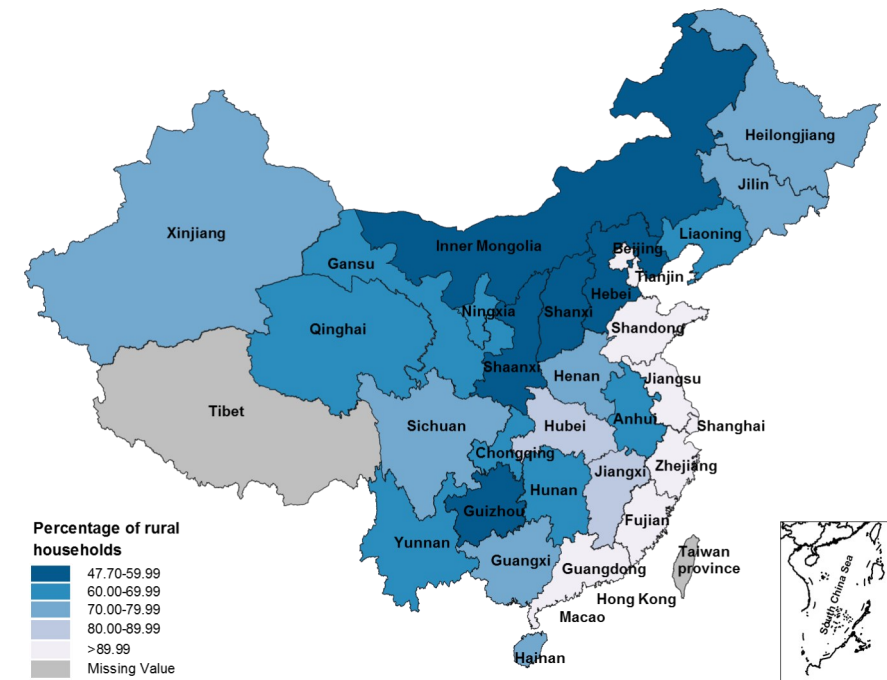
Figure 7.9
Rural access to sanitary latrines, by province, 2013



* Data is not available for Tibet.

Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook, 2014*

Figure 7.10
Rural access to sanitary latrines, 2013

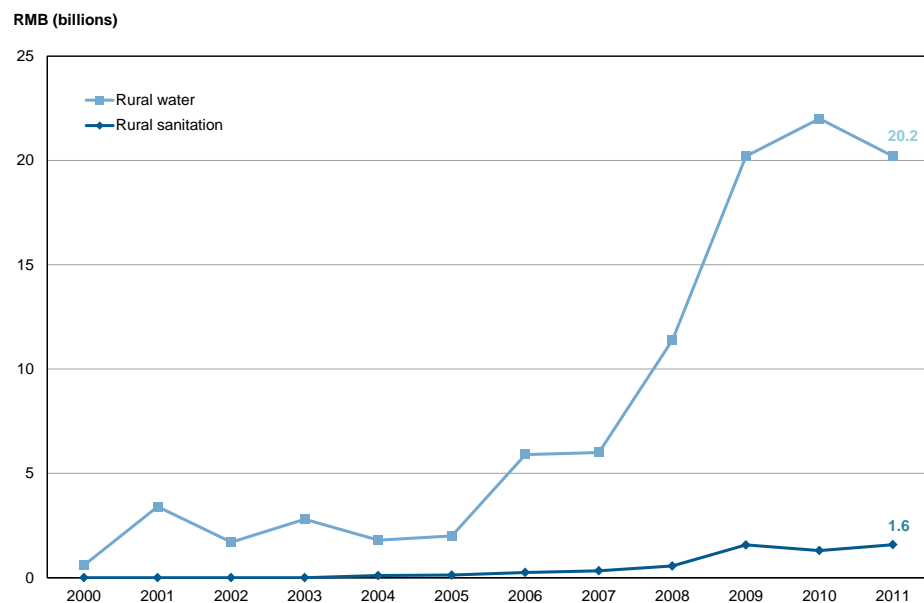


Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook, 2014*

Figure 7.9 and 7.10

The percentage of rural households with access to sanitary latrines varies widely across provinces. For example, 99 per cent of rural households in Shanghai have access to sanitary latrines, compared to only 48 per cent in Guizhou.

Figure 7.11
Central government expenditure on rural water and sanitation, 2000–2011

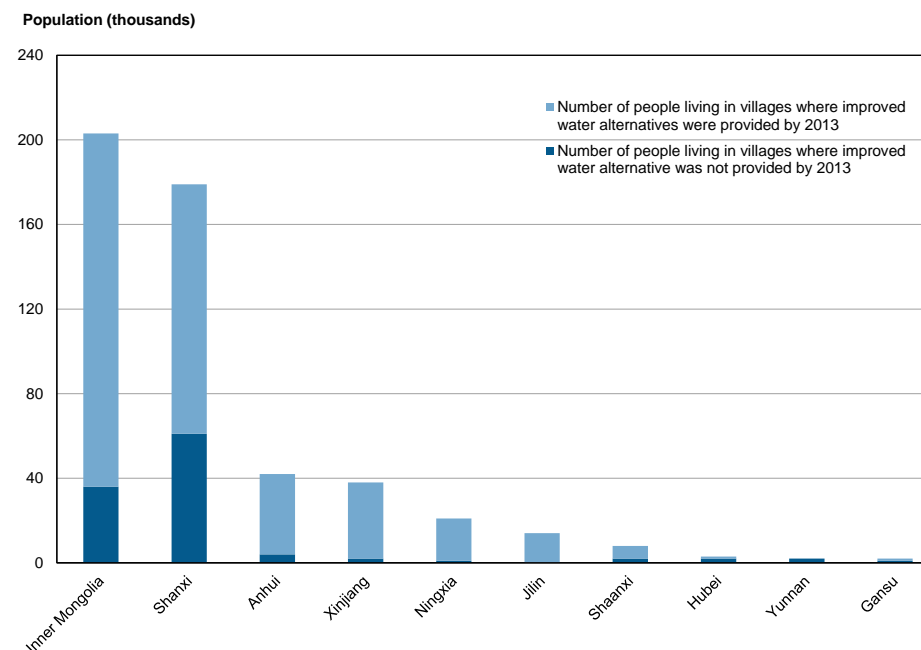


Source: Ministry of Water Resources, National Patriotic Health Campaign Committee Office, 2012

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, 2013



Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook, 2014*

Figure 7.12

Arsenic has been found in groundwater in about half of the country's provinces. Since 2006, great efforts have been made in providing alternative safe water sources to people in the affected areas. By 2013, there were still 110,000 people, mainly living in northern China, being affected by water with high levels of arsenic and not using alternative safe water sources. Arsenic is present in geological formations and enters the groundwater naturally. It affects people when it enters people's water supply, e.g. water wells.

Figure 7.13
Population living in coal-borne arsenic-affected areas, 2013

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	1,007,000	911,000

Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook, 2014*

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.

Figure 7.14
Arsenic-affected provinces, 2013



Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook, 2014*

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 some areas of Guizhou and Shaanxi provinces. 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, 2013

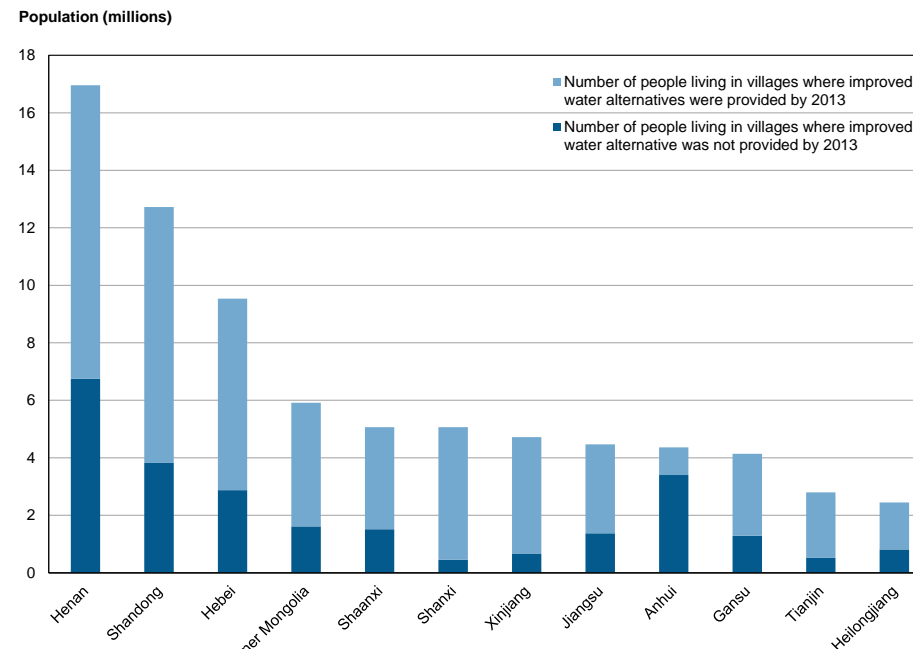


Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook, 2014*

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. Eleven 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 often out of their reach.

Figure 7.16
Rural population affected by water-borne fluorosis, selected provinces, 2013

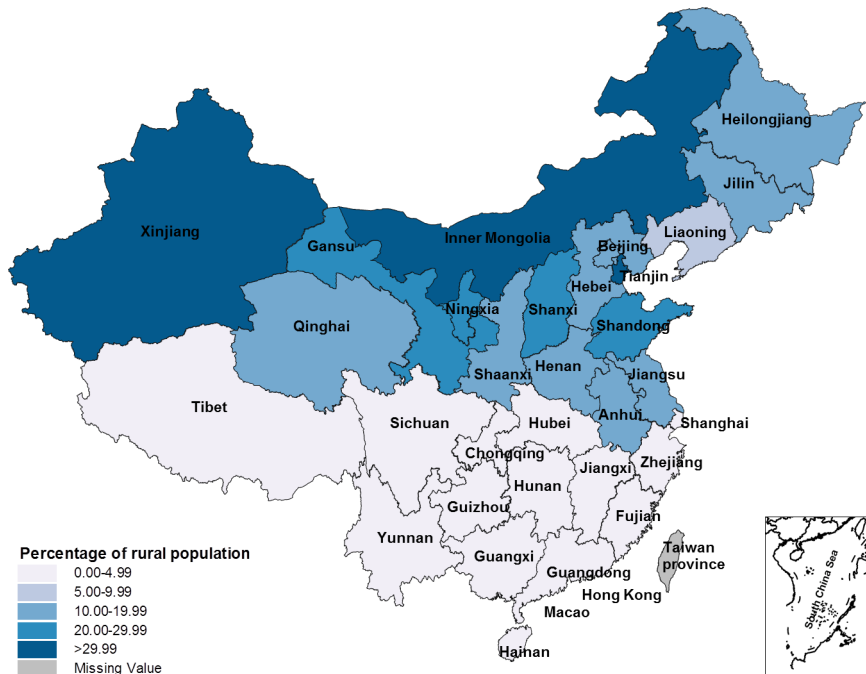


Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook, 2014*

Figure 7.16

In 2013, some 86 million people lived in villages with high levels of fluoride in the water. Approximately 69 per cent of these people have been provided with alternative safe water sources.

Figure 7.17
Percentage of rural population affected by water-borne fluorosis, 2011



Sources: Former Ministry of Health, *China Health Statistical Yearbook*, 2012; National Bureau of Statistics, *China Population and Employment Statistics Yearbook*, 2011 (rural population 2010)

Figure 7.18
Schistosomiasis-affected provinces, 2013



Source: National Health and Family Planning Commission, *China Health and Family Planning Statistical Yearbook*, 2014

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 is a disease that is endemic in southern China, where the parasitic *Schistosoma*^{B2} micro-organism and its host snail live. In 2013, 69 million people were affected in rural areas of schistosomiasis-afflicted provinces. Schistosomiasis 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.



8

EDUCATION AND CHILD DEVELOPMENT

OVERVIEW

By the end of 2010, the Government's objective of providing free nine-year education (covering primary and junior secondary school), was achieved in all 2,856 counties. In parallel with its efforts to achieve 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 within a teaching district, and supporting efforts to recruit teachers for special education in rural schools of western regions.

Since 2006, the primary net enrolment ratios⁸³ for females and males show that the gender disparity in primary education has been eliminated. The Millennium Development Goal to eliminate gender disparity at all levels of education by 2015 has already been met according to China's 2013 Millennium Development Goals (MDG) Report.

The Government increased its investment in education by 3.7 times in nominal terms between 2001 and 2012. 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 exemption of tuition and miscellaneous fees was also expanded to urban areas in 2008. The Two Exemptions and One Subsidy policy has benefited 160 million rural and urban students since its implementation. School infrastructure and facilities in rural areas were also improved through two schemes: construction of junior secondary schools with quality dormitory facilities, and provision of distance education facilities.

In 2012, as expected, China has met the national target set in 2006 of allocating 4 per cent of its GDP to education. In spite of the increased allocations, 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 *National Plan for Medium and Long-Term Education Reform and Development* (2010–2020) set forth several targets for pre-primary education, including attainment of a 70 per cent gross enrolment ratio for three-years of pre-primary education by 2020. In order to meet these targets, the central Government has begun to appropriate RMB 50 billion for pre-primary education development in rural areas of western and central China during the period spanning the Twelfth Five-Year Plan (2011-2015). Since 2011, local governments have been gradually implementing three-year action plans to build and improve pre-primary education. With commensurate budget allocations to support policy for pre-primary education, including kindergartens and pre-school classes, children from the poorest communities will likely gain better access to pre-primary education services.

In recent years, with the growing numbers of migrant workers, the issue of education for their children 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. The *National Plan for Medium and Long-Term Education Reform and Development* (2010–2020) requires the governments of the receiving cities to bear the main responsibility of providing basic education for migrant children, primarily by accommodating them in public schools.

Despite progressive government policies and regulations, which prohibit discrimination against children of migrants, many are unable to attend local public schools due to related costs (though compulsory nine-year education is mandated free by the Compulsory Education Law), special regulations, and their high rates of mobility. Instead, many children of migrants are enrolled in private, and often low-quality schools. 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. However, most recently in July 2014, the Government issued its *Opinions on Further Promoting Reform of the Household Registration System*, which will play a positive role in expanding essential public services including education to cover more migrant children.

There are some measures to address the education and care of children left behind by migrant parents, with the boarding schools and custodial and support mechanisms established as part of the School Merger Programme⁸⁴. While the school merges consolidated resources and aimed to improve teacher quality, management and supervision in boarding facilities remain a concern.

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, 2013

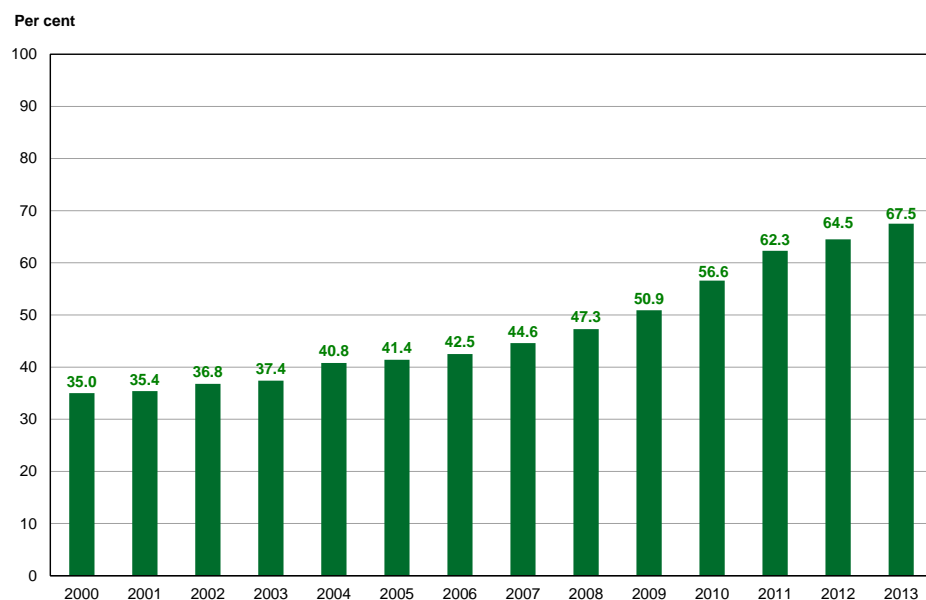
	Students (in school)	Teachers (full-time)	Schools
Pre-primary	38,946,903	1,663,487	198,553
Primary	93,605,487	5,584,644	213,529
General Junior Secondary	44,401,248	3,480,979	52,804
General Senior Secondary	24,358,817	1,629,008	13,352
Total	201,312,455	12,358,118	478,238

Figure 8.2

In 2013, China's general education system has a total of approximately 201 million students taught by 12 million full-time teachers in about half a million schools.

Source: Ministry of Education, *Essential Statistics of Education in China*, 2014

Figure 8.3
Gross enrolment ratio in three-year pre-primary education, 2000–2013

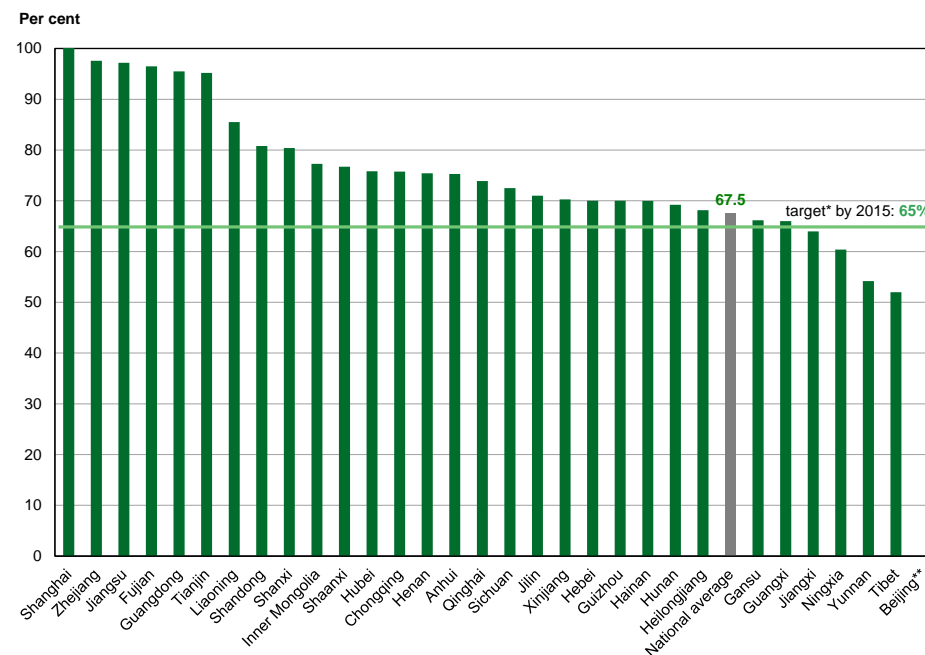


Source: Ministry of Education, *China Education Development Essential Statistical Analysis*, 2014

Figure 8.3

The gross enrolment ratio in three-year pre-primary education⁸⁵ has been steadily growing — exceeding 50 per cent in 2009, and reaching 67.5 per cent in 2013. China has already met the 2015 target of 65 per cent set by the Government in the *Twelfth Five-Year Plan of the National Education Development* (2011-2015).

Figure 8.4
Gross enrolment ratio in three-year pre-primary education, by province, 2013



** Data is not available for Beijing.

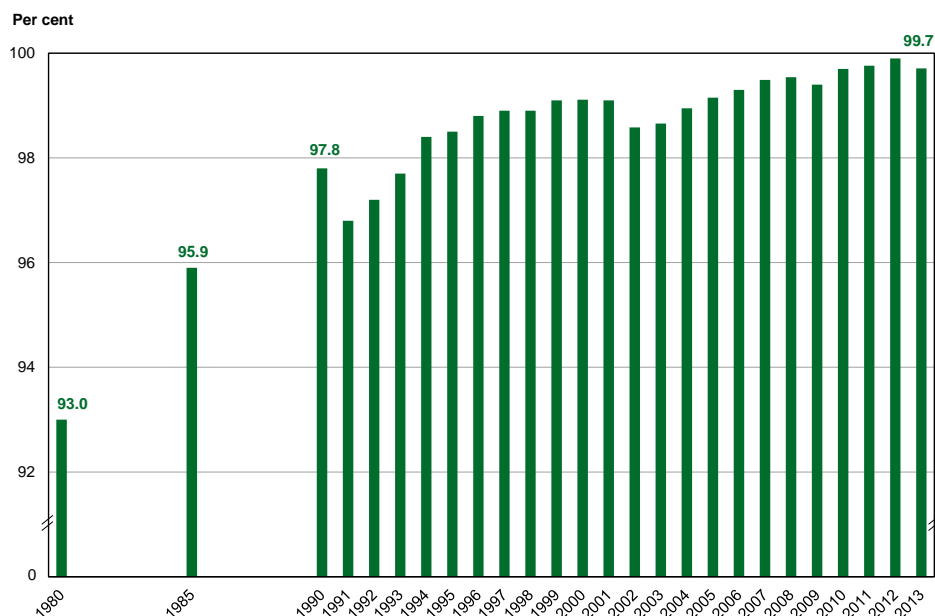
Source: National Bureau of Statistics, *NPA Monitoring Statistics*, 2014

Figure 8.4

Provinces in the western region record the lowest rates of access to three-year pre-primary education. In 2013, the gross enrolment ratio for three-year pre-primary education was only 52 per cent in Tibet and 54 per cent in Yunnan, in contrast to the average national gross enrolment ratio of 67.5 per cent, or Shanghai's estimated 100 per cent gross enrolment.

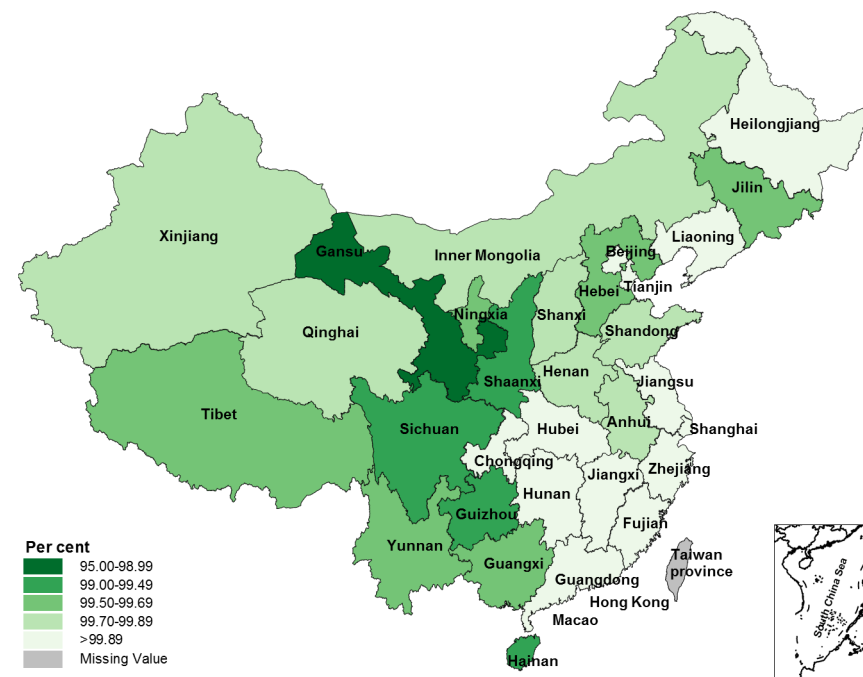
* The 2015 target for the three-year pre-primary education enrolment ratio is 65 per cent set in the *Twelfth Five-Year Plan of the National Education Development* (2011-2015).

Figure 8.5
Net enrolment ratio in primary education, 1980–2013



Source: Ministry of Education, *Essential Statistics of Education in China*, 2014

Figure 8.6
Net enrolment ratio in primary education, 2013



Source: Ministry of Education, *Essential Statistics of Education in China*, 2014

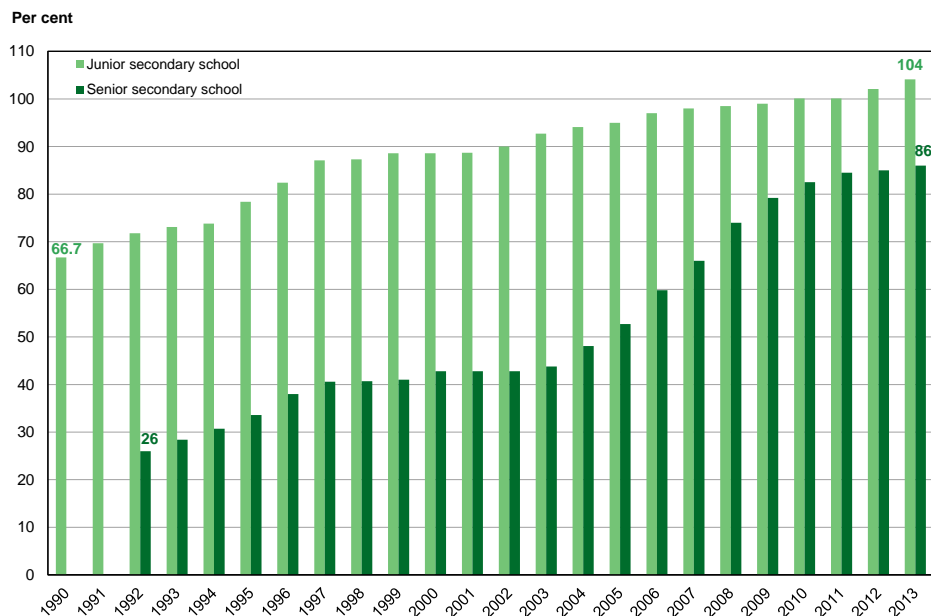
Figure 8.5

The primary net enrolment ratio has increased over the past three decades to reach 99.7 per cent in 2013, achieving the Millennium Development Goal on universal primary education well in advance of the 2015 target. However, the remaining 0.3 per cent account for significant numbers of primary-school-aged children, most of them concentrated in poor rural areas of western and central China.

Figure 8.6

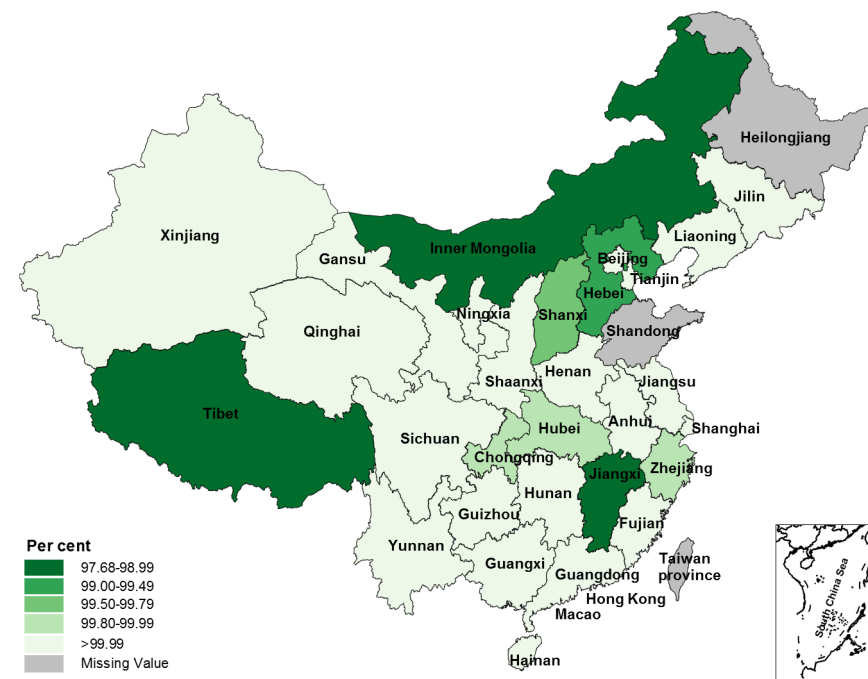
Within the general high levels of primary school enrolment, provinces in the west lag behind those in the east.

Figure 8.7
Gross enrolment ratio in junior and senior secondary education, 1990–2013



Source: National Bureau of Statistics, *China Statistical Yearbook*, 2014

Figure 8.8
Gross enrolment ratio in junior secondary education, 2013



Source: National Bureau of Statistics, NPA Monitoring Statistics, 2014

Figure 8.7

Gross enrolment levels in both junior and senior secondary education⁸⁶ have increased steadily over the last decade. Gross enrolment in junior secondary education, which is covered under the Compulsory Education Law, increased from 67 per cent in 1990 to 104 per cent in 2013 and is much higher than enrolment in senior secondary education. Yet, about a million children of junior secondary school age are out of school, mainly in the poorer regions of western and central China.

Figure 8.8

Gross enrolment ratios in junior secondary school reached 100 per cent in 21 provinces in 2013. Inner Mongolia had the lowest enrolment level but is also high at 97.7 per cent.

Figure 8.9
Gross enrolment ratio in senior secondary education, 2013



Source: National Bureau of Statistics, NPA Monitoring Statistics, 2014

Figure 8.9

Large disparities among provinces are evident in senior secondary education enrolment, with some provinces recording over 100 per cent gross enrolment and Guizhou Province falling short of the 70 per cent mark in 2013.

Figure 8.10
Transition rates from one level to the next level of education, 1985–2013

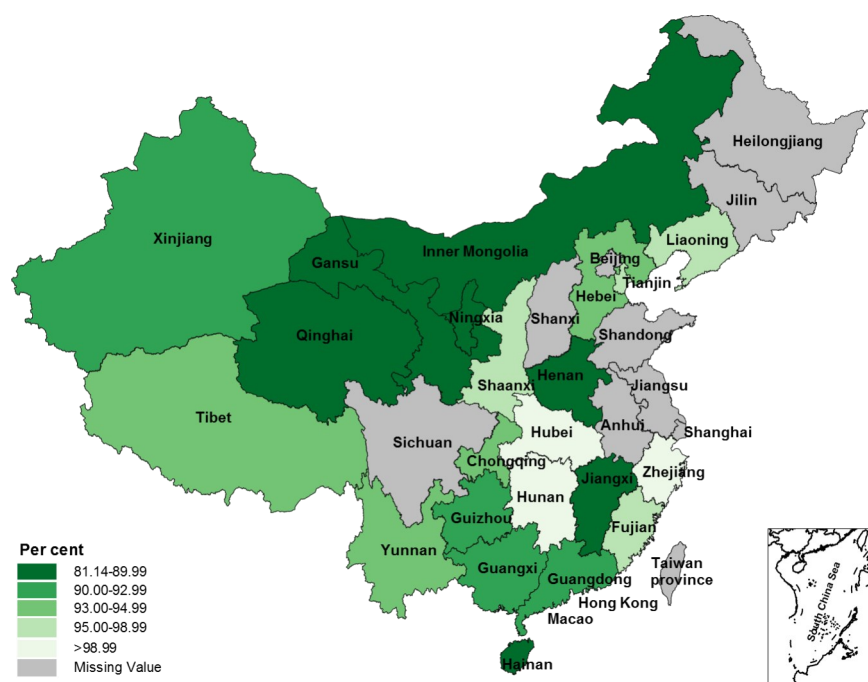


Source: Ministry of Education, *Essential Statistics of Education in China*, 2014

Figure 8.10

Transition rates⁸⁷ from one level of schooling to the next have increased dramatically at primary level but still need attention at the junior secondary and senior secondary levels. More than a million children failed to transfer from junior secondary school to senior secondary school in 2013. The surge in transition rates from senior secondary education from 1999 to the mid-2000s is a result of China's expansion in higher education since 1999.

Figure 8.11
Cohort survival rate in junior secondary education, 2013

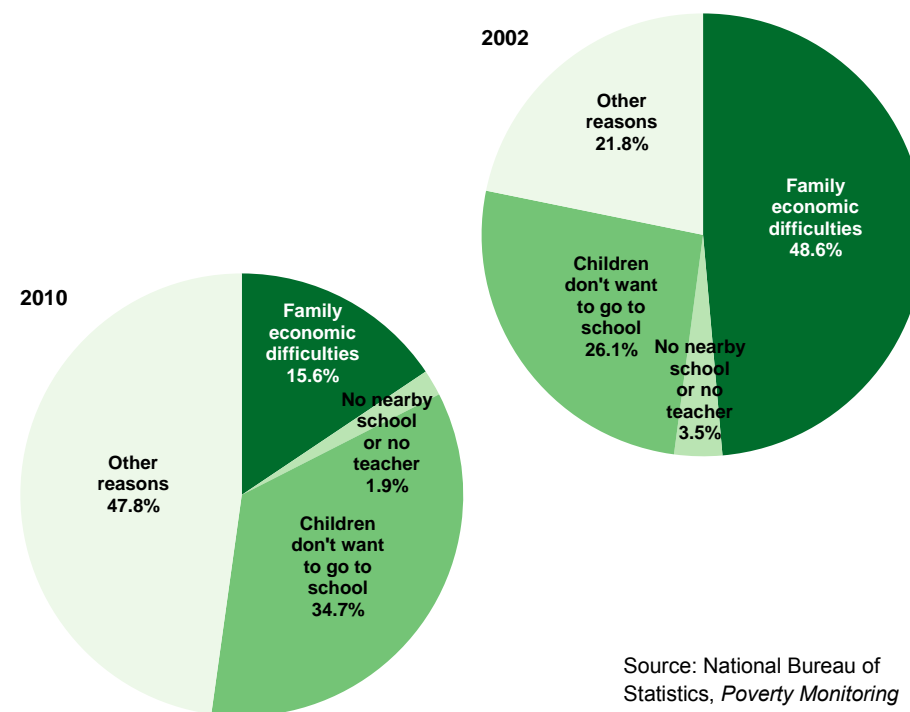


Source: National Bureau of Statistics, NPA Monitoring Statistics, 2014

Figure 8.11

The majority of eastern and central provinces continue to do better on junior secondary school survival rates⁸⁸ compared to western provinces in 2013. Qinghai Province has the lowest junior secondary school survival rate of 81.1 per cent.

Figure 8.12
Reasons for drop-out among children aged 7–15 years in national poverty counties, 2002 and 2010

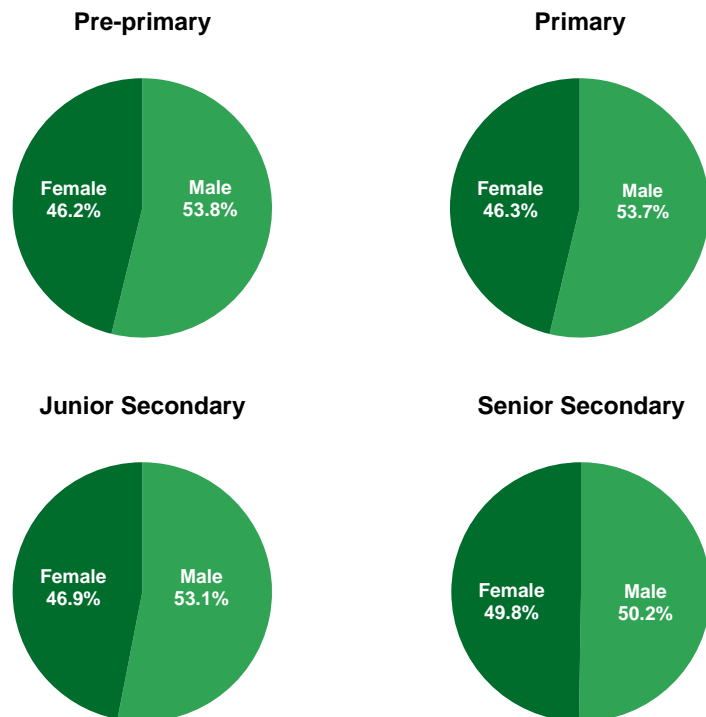


Source: National Bureau of Statistics, *Poverty Monitoring Report of Rural China*, 2011

Figure 8.12

Children drop out of school for a variety of reasons. As per the annual Poverty Monitoring Survey conducted by the National Bureau of Statistics in the 592 nationally designated poverty counties, economic difficulties were still an important reason for dropping out in 2010, but not as dominant a reason as in 2002. A small share of children dropped out of school due to the lack of a nearby school or no teachers in the school. Other children dropped out of school because they did not want to go to school, or for other reasons such as illness, failure to transition to higher education, or because of pressures to support the family in income generation.

Figure 8.13
Distribution by sex of enrolled students at different education levels, 2013

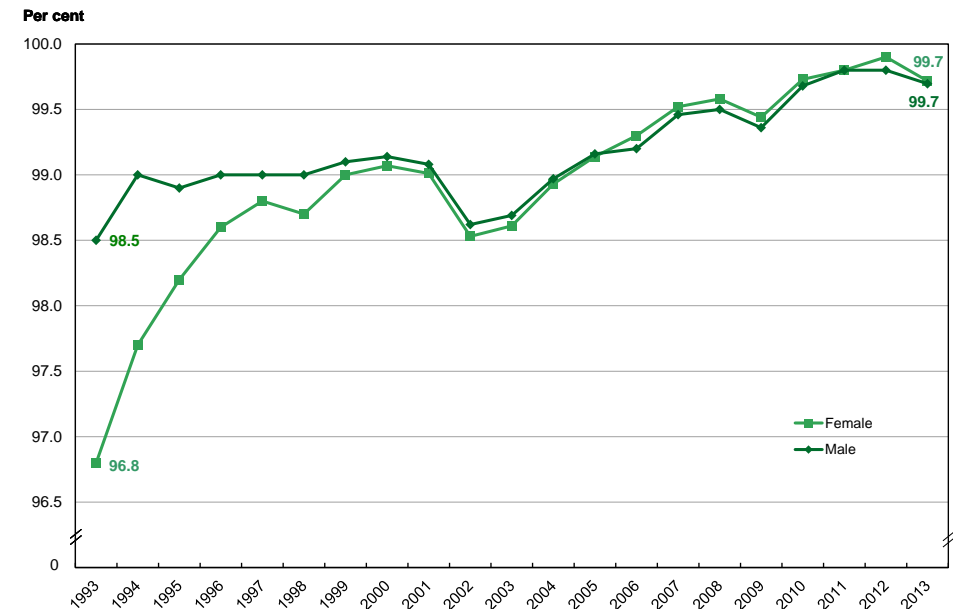


Source: Ministry of Education, *Essential Statistics of Education in China*, 2014

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 skewed 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, by sex, 1993–2013

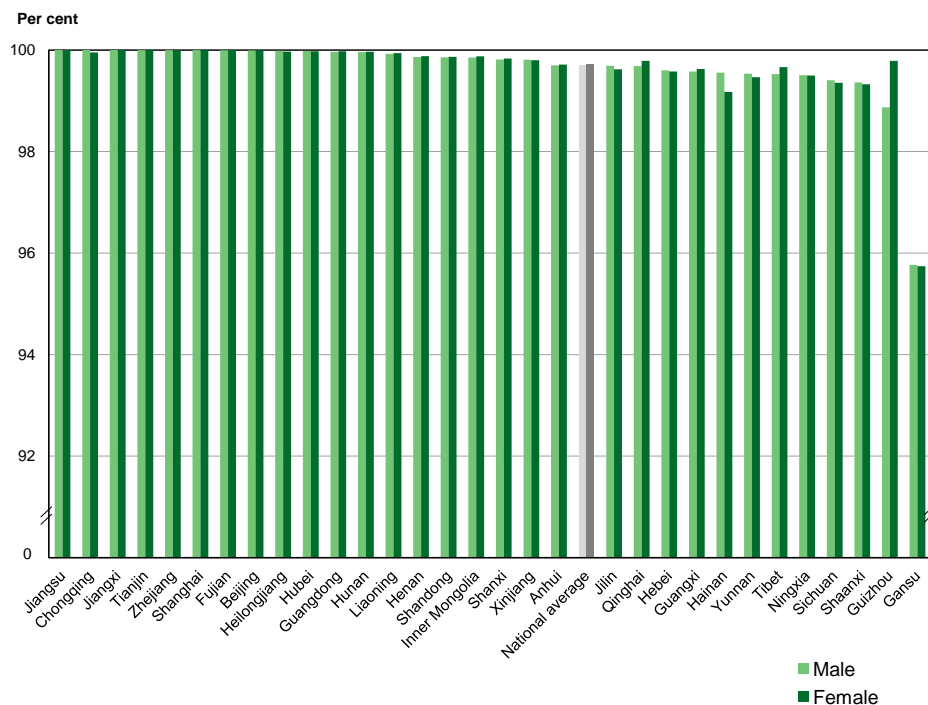


Source: Ministry of Education, *Essential Statistics of Education in China*, 2014

Figure 8.14

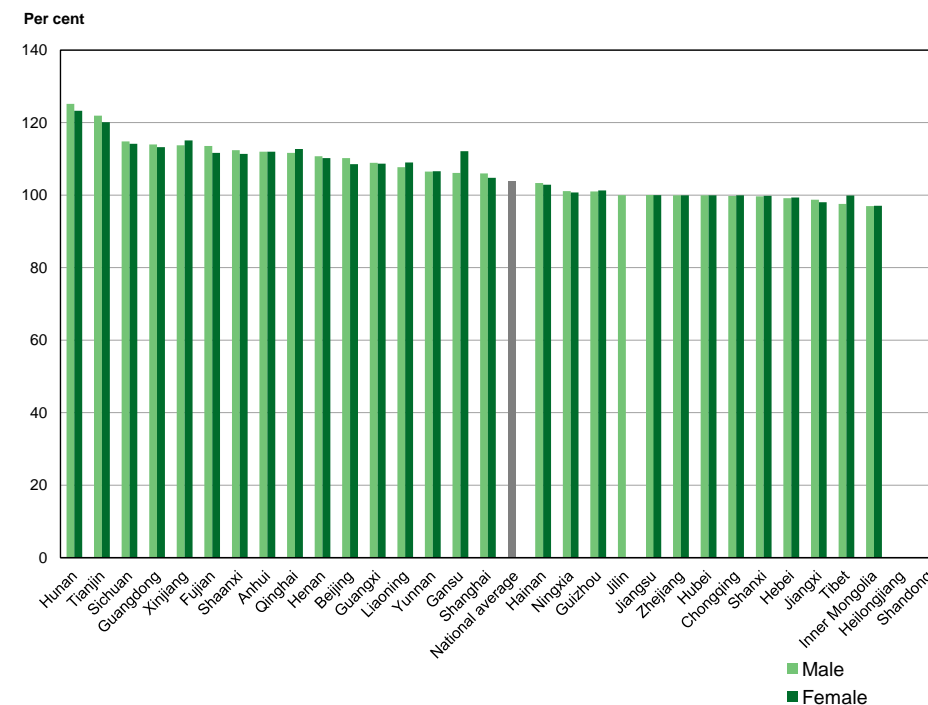
China has achieved gender parity at the primary school level. There are no significant differences between male and female primary net enrolment ratios.

Figure 8.15
Net enrolment ratio in primary education,
by province and sex, 2013



Source: Ministry of Education, *Essential Statistics of Education in China*, 2014

Figure 8.16
Gross enrolment ratio in junior secondary education,
by province and sex, 2013



Source: National Bureau of Statistics, *NPA Monitoring Statistics*, 2014

Figure 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.

* Sex-disaggregated estimates of gross enrolment ratio in junior secondary education are not available for the national average and for Jilin Province. Aggregated figures were used to produce the column for this chart. Data are not available for Heilongjiang and Shandong provinces.

Figure 8.17
Migrant students as a percentage of all students in primary education of receiving cities, 2013



Source: Ministry of Education, *China Education Development Essential Statistical Analysis*, 2014

Figure 8.18
Migrant students as a percentage of all students in junior secondary education of receiving cities, 2013

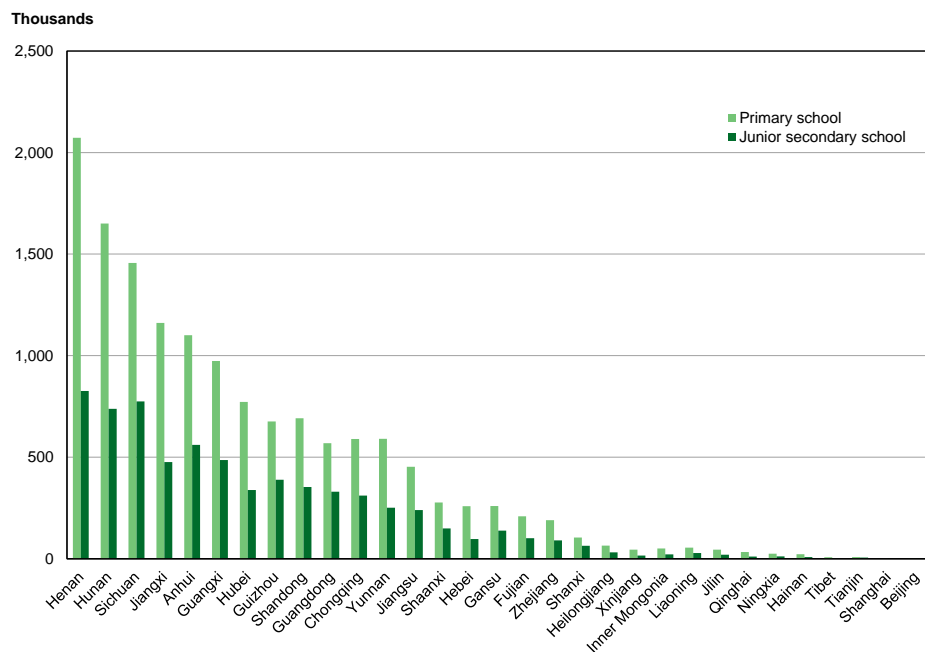


Source: Ministry of Education, *China Education Development Essential Statistical Analysis*, 2014

Figure 8.17 and 8.18

In 2013, 9.3 million migrant children attended primary education and 3.5 million attended junior secondary education in receiving cities, accounting for 34 per cent and 24 per cent of all students in receiving cities at primary and junior secondary education respectively. 56 per cent of migrant children attended primary and junior secondary schools in eastern China. Across different provinces, the proportion of migrant children as a percentage of total school enrolment in receiving cities ranged from 16 to 63 per cent in primary schools, and 11 to 45 per cent in junior secondary schools. Nationally, 30 per cent of students in basic education of receiving cities were migrant children.

Figure 8.19
Number of left-behind children in primary and junior secondary education in rural areas, by province, 2013

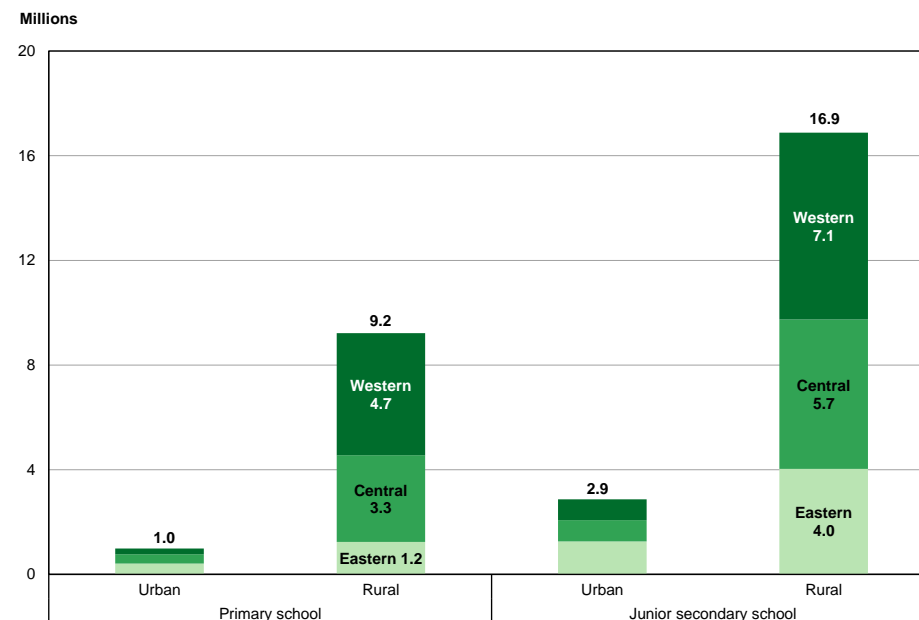


Source: Ministry of Education, *China Education Development Essential Statistical Analysis*, 2014

Figure 8.19

In 2013, 14.4 million primary and 6.9 million junior secondary school students were children left behind by migrating parents, accounting for 22 per cent of all students in rural primary schools and 23 per cent of those in rural junior secondary schools. Overall, left-behind students were more concentrated in central and western provinces, with 58 per cent of left-behind children in primary and junior secondary education in six provinces, namely Henan, Hunan, Sichuan, Anhui, Jiangxi and Guangxi.

Figure 8.20
Number of boarding students in primary and junior secondary education, 2013

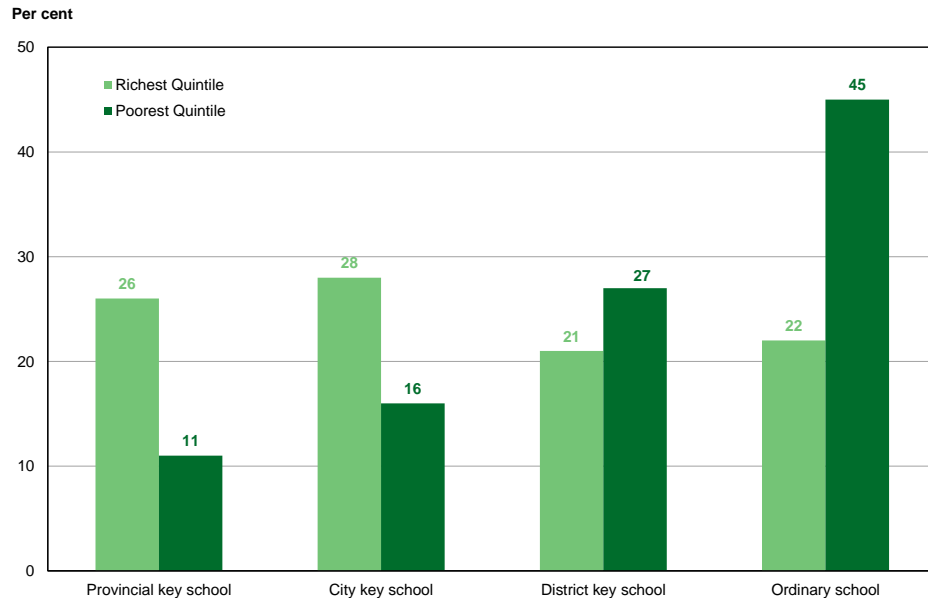


Source: Ministry of Education, *China Education Development Essential Statistical Analysis*, 2014

Figure 8.20

In 2013, 10.2 million primary and 19.8 million junior secondary school students were boarding students, representing 11 per cent of all students in primary schools and 44 per cent of those in junior secondary schools. There were many more boarding students at the junior secondary level in rural areas and in western and central China. For example, the proportion of boarding students in junior secondary education exceeded 80 per cent in rural areas of Guangxi, Tibet and Yunnan in 2013.

Figure 8.21
Type of urban school attended by income group, 2006

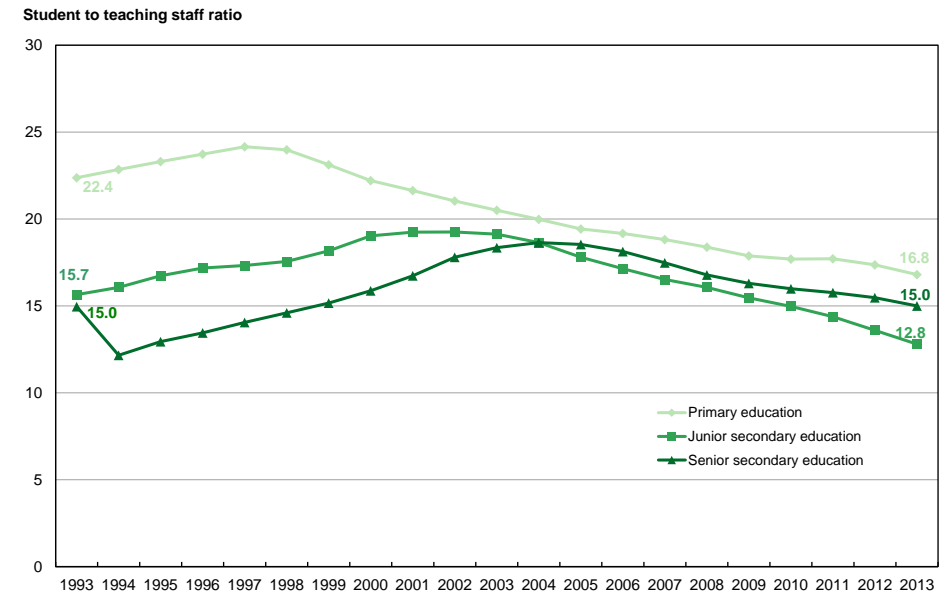


Source: Hana Brixi, *China: Urban Services and Governance*, Policy Research Working Paper No 5030, World Bank, 2009

Figure 8.21

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 8.22
Student to teaching staff ratio, 1993-2013

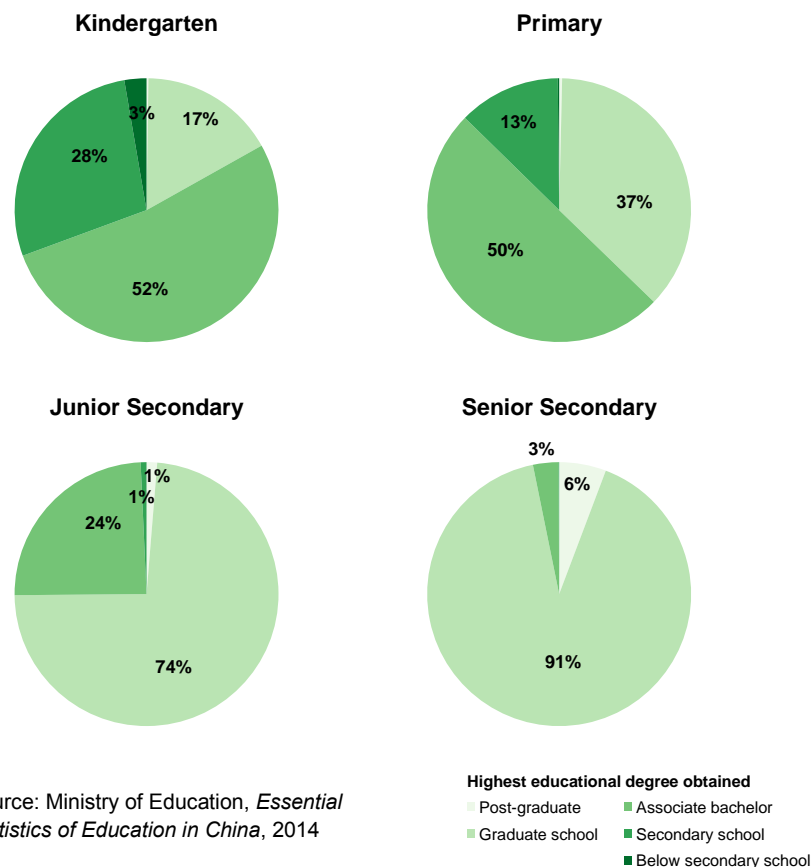


Sources: National Bureau of Statistics, *China Statistical Yearbook*, 2013; Ministry of Education, *China Education Development Essential Statistical Analysis*, 2014 (2013 data)

Figure 8.22

In general, the national ratio of students to teaching staff in primary education kept decreasing in the past 20 years. The ratios of student to teaching staff in junior and senior secondary education increased during 1993-2004 and then decreased steadily. In 2013, the national student to teaching staff ratios in primary, junior and senior secondary education were on average, higher than the world, and reached the level of upper-middle-income countries.

Figure 8.23
Teachers' qualification, 2013

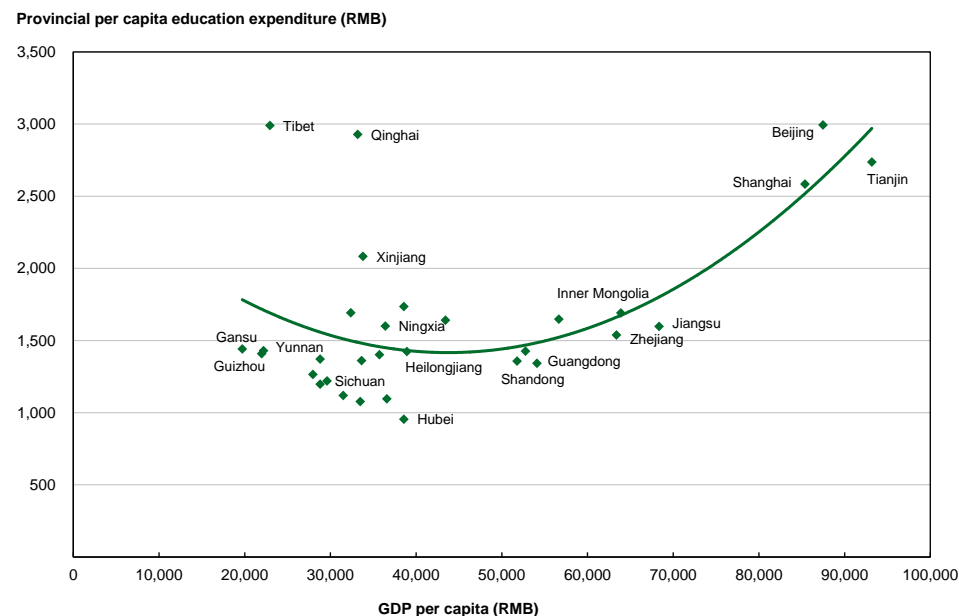


Source: Ministry of Education, *Essential Statistics of Education in China, 2014*

Figure 8.23

The majority of teachers have the necessary educational qualifications⁸⁹ according to China's Law on Teachers. In 2013, almost all teachers at kindergarten level and primary level, 98 per cent at junior secondary level, and 97 per cent at senior secondary level had the required educational qualifications.

Figure 8.24
Provincial per capita education expenditure and provincial per capita GDP, by province, 2012

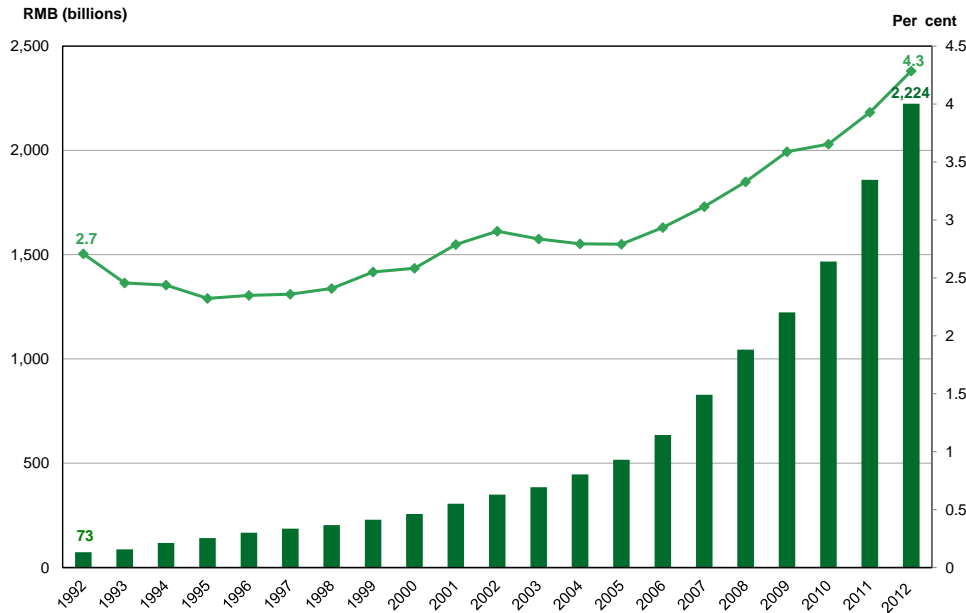


Source: National Bureau of Statistics, *China Statistical Yearbook, 2013* (GDP); Ministry of Education, *Statistical Communiqué on the 2012 National Education Expenditure, 2013* (education expenditure)

Figure 8.24

Plotting the provinces by their respective per capita spending on education and per capita GDP reveals a general pattern in which eastern provinces spent more than western provinces. However, the relationship is not linear. Some western provinces with a low GDP per capita may have similar levels of per capita expenditure on education as some eastern provinces. For example, although Tibet and Qinghai had a much lower per capita GDP, their education expenditures reached almost RMB 3,000 per capita, among the highest of all provinces and at the same level of Beijing.

Figure 8.25
Government expenditure on education and its percentage of GDP, 1992-2012

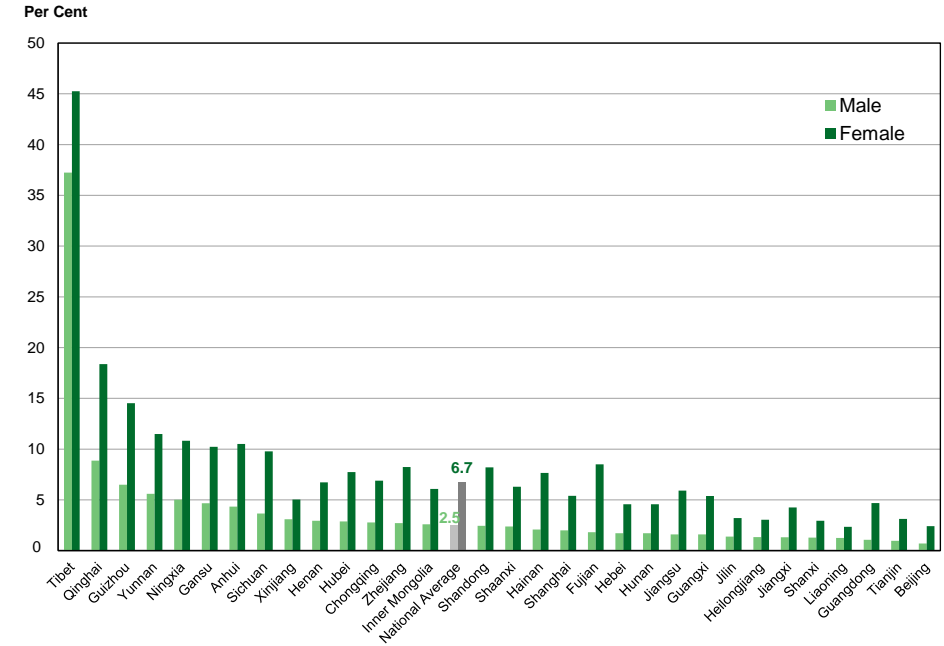


Source: National Bureau of Statistics, *China Statistical Yearbook*, 2013

Figure 8.25

Government expenditure on education has increased substantially from 1992, to reach RMB 2,224 billion in 2012 which is equivalent to 4.3 per cent of China's GDP. This means the national target of 4 per cent has been met as expected.

Figure 8.26
Adult (15+) illiteracy rate by sex, 2013



Source: National Bureau of Statistics, *China Statistical Yearbook*, 2014

Figure 8.26

Basic reading, writing and numeracy skills are essential to individual well-being and societal development. Along with social and economic progress, there has been a substantial increase in educational attainment for people in China over the past five decades. Back in 1964, one third of China's adult population was illiterate. The illiteracy rate decreased to only 4.6 per cent in 2013, however with significant gender disparities. Females living in western provinces are the least literate, and the highest illiteracy rate is observed in Tibet.



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, and to implement the commitments made by China after its ratification of the Convention on the Rights of the Child (CRC) in 1992, 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 Children⁹⁰.

A second NPA for Children was adopted by the Government in May 2001 for the period 2001–2010, and the third was launched in July 2011 for the period 2011-2020.

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 improving well-being of children and women.

Convention on the Rights of the Child (CRC)

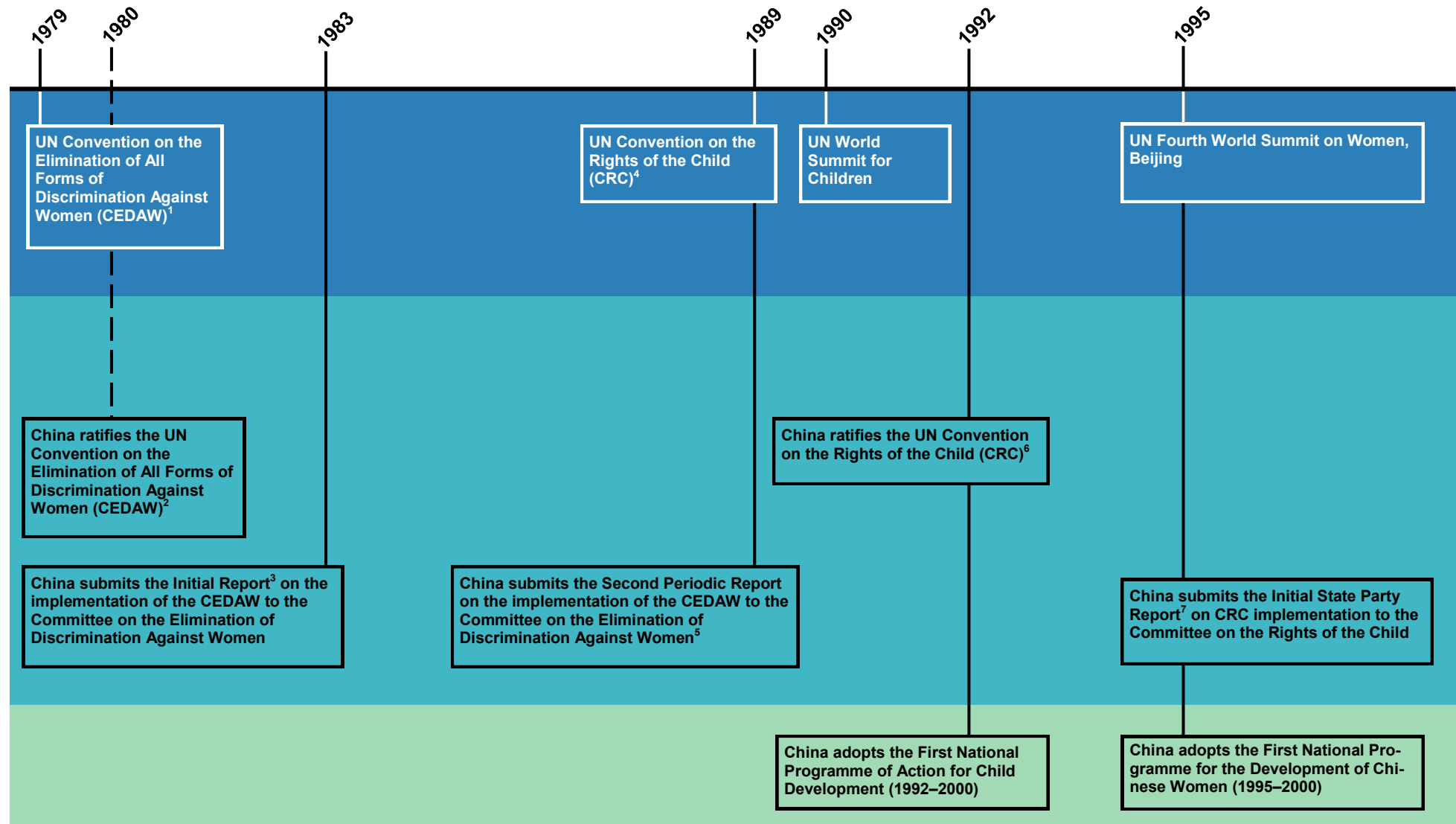
Since China's ratification of the Convention on the Rights of the Child (CRC) in 1992, the Government of China has submitted several State Party Reports to report on progress made in implementing the CRC and improving child rights in the country. China's Initial State Party Report was submitted to the Committee on the Rights of the Child in March 1995 through the Ministry of Foreign Affairs; China's Second State Party Report was submitted in June 2003; and China's latest Combined Third and Fourth State Party Report was submitted in July 2010.

In October 2013, the Committee on the Rights of the Child convened to review the latest report, and subsequently issued Concluding Observations to China's State Party Reports.

Law on the Protection of Minors

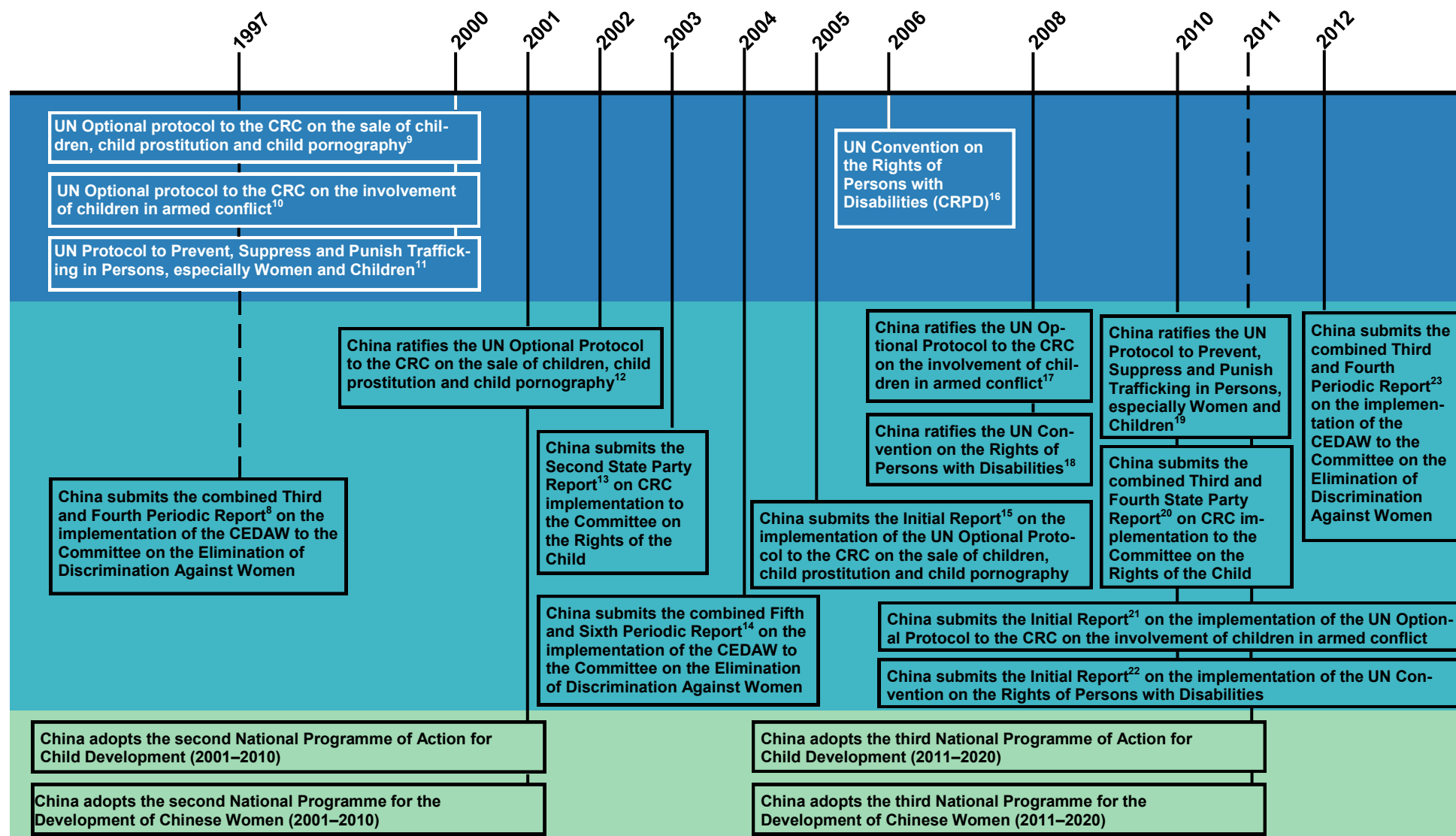
In 2006, the National People's Congress approved revisions of the Law on the Protection of Minors which came into force in June 2007. Compared with the 1991 version, the revised law explicitly stipulates that minors shall have the right to survival, development, protection and participation in line with 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 12 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 The Initial Report on the implementation of the UN Optional Protocol to the CRC on the sale of children, child prostitution and child pornography was submitted on 5 November 2005*

¹⁶ General Assembly Resolution of 13 Dec 2006 entered into force on 3 May 2008

¹⁷ China ratified the UN Optional Protocol to the CRC on 20 Feb 2008* and it entered into force on 20 March 2008

¹⁸ 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

¹⁹ China ratified the UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children on 8 Feb 2010*

²⁰ The combined Third and Fourth State Party Report on CRC was submitted on 16 July 2010*

²¹ The Initial Report on the implementation of the UN Optional Protocol to the CRC on the involvement of children in armed conflict was submitted on 17 November 2010*

²² The Initial Report on the implementation of the UN Convention on the Rights of Persons with Disabilities was submitted on 30 August 2010*

²³ The combined Third and Fourth Periodic Report on the implementation of the CEDAW was submitted on 20 January 2012*

* 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.



10

CHILDREN
AFFECTED BY
MIGRATION

OVERVIEW

Massive internal migration

China's migrant population has increased substantially since 1990s and reached 245 million in 2013, representing the largest movement of people in modern history. In the *Twelfth Five-Year Plan for Social and Economic Development (2011–2015)*, the Government continued to embrace internal migration as essential to the national development strategy. If framed with the appropriate measures, migration can drive a gainful urbanization process, increase employment opportunities and rural incomes, restructure the economy, and reduce urban-rural and regional disparities. However, maximizing the benefits of internal migration, while mitigating its adverse effects, is a difficult balancing act for the Government.

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* (household registration) status; those with an urban *hukou* are able to benefit from social security coverage and access to public services. The lack of permanent residence status in cities (an urban *hukou*) has become the main constraint for migrant populations to access public benefits and services.

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. In the latest *Twelfth Five-Year Plan for Basic Public Services (2011-2015)*, the Government calls for the equalization of essential public services for the migrant population.

Children affected by migration⁹¹

Many migrant parents 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. The number of those children affected by migration, including migrant children and left-behind children, largely increased in the ten-year period between 2000-2010. In 2000, the number of migrant children aged 0-17 was 19.82 million, and the number of children left behind by migrating parents was 22.9 million; together, the number of children affected by migration totaled 42.72 million, accounting for 12.4 per cent of the total child population in 2000. In 2010, the number of migrant children and left-behind children reached 35.81 million and 69.73 million

respectively. The total number of children affected by migration was 106 million, accounting for 38 per cent of the total child population in China. That is, about two out of every five children in China were directly affected by migration in 2010.

The Government has attached importance to addressing the challenges faced by children affected by migration, as demonstrated by several government initiatives. In late 1990s, the Government declared that receiving municipal governments bore the main responsibility for providing basic education for migrant children, through public school enrolment. In recent years, as migration challenges have grown in scale and prominence, the Government released a series of new policies related to education, health and social security. The *National Programme of Action for Children (2011-2020)*, promulgated in 2011 and which facilitates cross-sectoral government policies, sets out development objectives specifically related to migrant and left-behind children, including reducing infant and under-five mortality rates among migrant children, guaranteeing equal access to compulsory education by migrant children, and meeting the basic public service needs of migrant and left-behind children. More specifically, to meet these objectives, the NPA outlines the following measures:

- The healthcare system of the receiving communities should cover migrant children.
- Efforts should be made to facilitate migrant children's enrollment in kindergartens. The governments of the receiving areas continue to bear the major responsibilities of providing basic education for migrant children, primarily by accommodating them in public schools. Measures should also be taken to allow migrant children to take entrance exams for higher education in receiving areas. Efforts should be made to facilitate the construction of boarding schools in rural areas and prioritize meeting the accommodation needs of left-behind children.
- A service provision mechanism for migrant and left-behind children should be established and improved. A registration system for migrant children under 16 years of age and a sound service system for rural left-behind children should be established. Efforts to provide mental, emotional and behavioural guidance to left-behind children should be strengthened, and the sense of parental responsibility (for children) should be improved.

Migrant children

In 2010, with a total of 35.81 million migrant children nationwide, one out of every eight children in China was a migrant child. The majority of migrant children moved from rural areas to urban areas. Nationally, in urban areas, migrant children comprised 26.3 per cent of urban children on average; one out of every four children in urban areas was a migrant child.

Children who moved with their parents generally became long-term migrants. Most migrant children had lived and studied in destination cities or areas for an average duration of 3.7 years. For migrant children aged 7-14 years, one third had lived in the receiving areas for more than six years.

When children migrate, they lose their traditional and community support structures, and face hardship and discrimination in their new environment. Many are not registered in their new place of residence and their public service needs remain “invisible” to the local authorities. Further, being born in a city does not entitle a child to receive an urban *hukou* and thus migrant status can be retained for generations.

Despite government policies and regulations barring discrimination against children of migrants and obligating municipal governments to provide public health and education services for them, there is inadequate implementation and enforcement of these policies. Many migrant children are unable to attend public schools. Instead, they have to enroll in low-quality private schools. High private school fees, as well as the tendency for some older migrant children to enter the labour market, mean relatively higher dropout rates for migrant children than for urban resident children. The completely separate health insurance schemes for urban and rural areas, combined with the non-transferability of benefits across schemes, means that migrants and their families have inadequate and incomplete health insurance coverage where they live. As a result, migrants are subject to high urban medical expenses and inhibited access to health services.

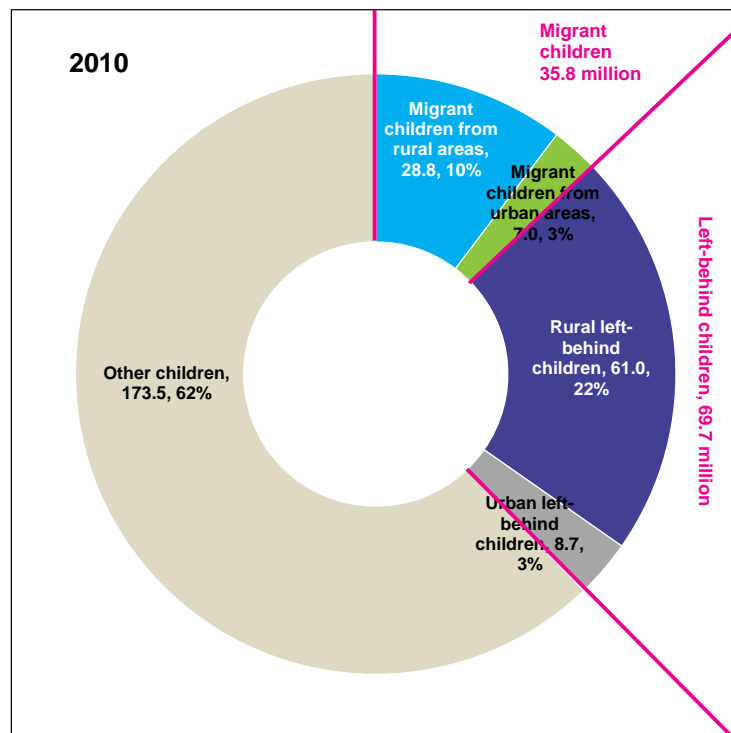
Rural left-behind children

Left-behind children, defined as being deprived of either one or both parents for more than 6 months at a time, face particularly significant, multifaceted problems. Of all left-behind children nationwide, 61.03 million lived in rural areas, accounting for 87.5 per cent of all left-behind children and 40 per cent of all rural children.

Surveys suggest that most left-behind children maintain irregular and limited contact with their parents and feel lonely, isolated and deprived of support, with some seeing their parents only once a year during Spring Festival. Their caregivers, often their grandparents, are frequently unable to provide adequate care and supervision, including emotional support, adequate hygiene and nutrition, sufficient guidance to prevent child injury and homework supervision. This has had a negative impact on their physical, educational and psychosocial development and well-being.

The Government places a high priority on addressing inequalities among urban, rural and migrant populations, and on ensuring that the benefits of economic growth and development reach the most vulnerable. In recent years, policy reforms and new legislation have been introduced specifically to improve migrants’ access to equal civil rights, labour 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 as a percentage of all children, 2010



Note: In the doughnut chart the first number refers to the child population in millions; the second refers to its share of the total child population.

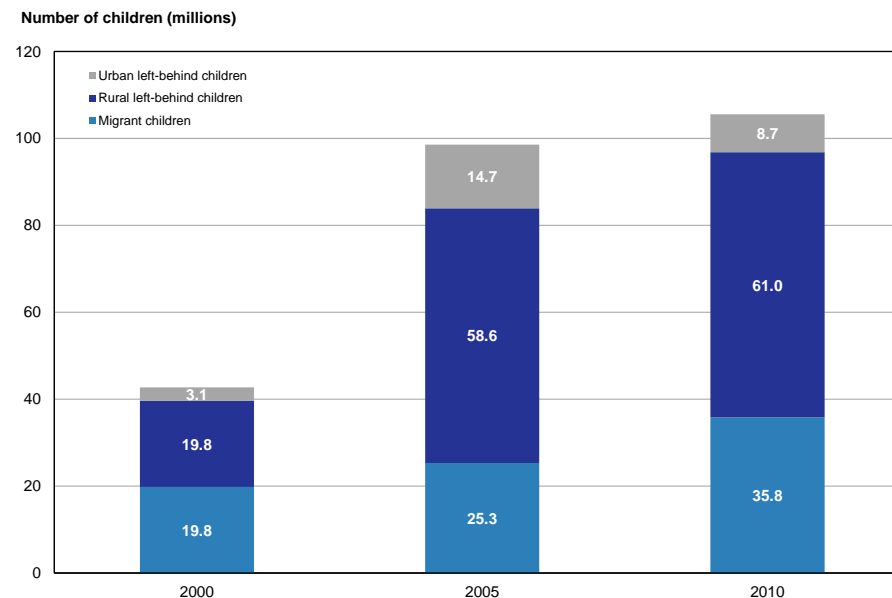
Source: Duan Chengrong et al. of the School of Sociology and Population Studies, Renmin University of China, estimation based on the 2010 Population Census conducted by the National Bureau of Statistics

Figure 10.1

In 2010, the number of migrant children aged 0-17 years was 35.81 million, and the number of left-behind children was 69.73 million. Adding these two groups together, the total number of children affected by migration reached 106 million, accounting for 38 per cent of the total child population in China.

The vast majority of children affected by migration came from or lived in rural areas. Of the 35.81 million migrant children, 80.4 per cent or 28.77 million were from rural areas. Of all the left-behind children nationwide, 61.03 million of them were in rural areas, accounting for 87.5 per cent of all left-behind children and 40 per cent of all rural children.

Figure 10.2
Children affected by migration, 2000, 2005 and 2010



Sources: Duan Chengrong et al. of the School of Sociology and Population Studies, Renmin University of China, estimation based on the 2000 and 2010 Population Censuses, and the 2005 One Per cent Population Sample Survey conducted by the National Bureau of Statistics

Figure 10.2

The number of migrant children and left-behind children increased significantly in 2010, compared to 2000 and 2005. While the number of migrant children increased more rapidly between 2005 and 2010, the number of left-behind children was more stable. This reflects the current shift in the tendency of migrants “moving with spouses and children”. A continuation of this trend implies that the number of migrant children in China will continue to increase in the future.

Figure 10.3
Number of migrant children, 2010



Source: Duan Chengrong et al. of the School of Sociology and Population Studies, Renmin University of China, estimation based on the 2010 Population Census conducted by the National Bureau of Statistics

Figure 10.3

In 2010, seven provinces had more than 1.5 million migrant children in each province, namely Guangdong, Zhejiang, Jiangsu, Sichuan, Shandong, Henan and Fujian. In total these provinces had 16.4 million migrant children, accounting for 46 per cent of China's migrant children.

In terms of distance and place of migration, 70 per cent of migrant children migrated within their provinces of origin.

Figure 10.4
Number of left-behind children in rural areas, 2010

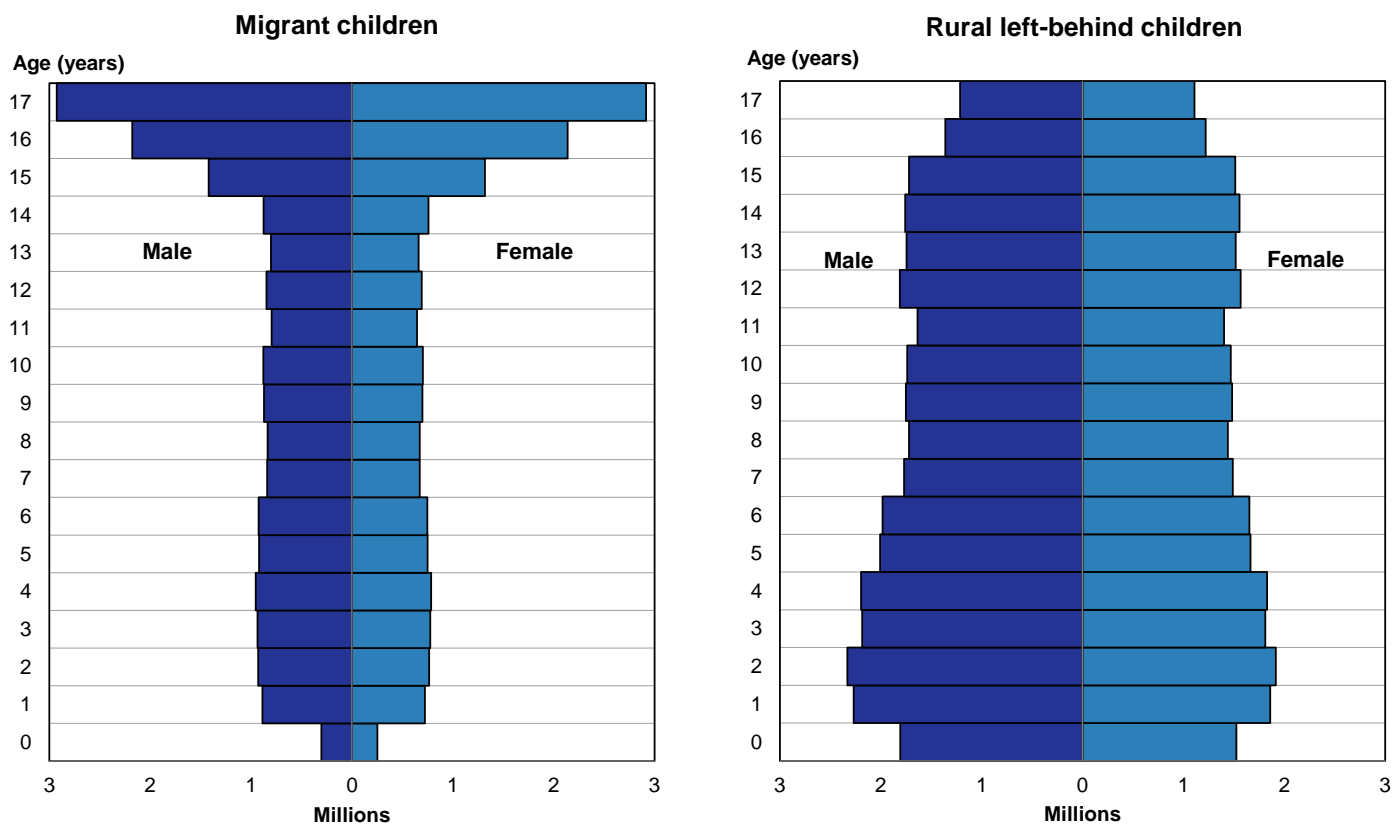


Source: Duan Chengrong et al. of the School of Sociology and Population Studies, Renmin University of China, estimation based on the 2010 Population Census conducted by the National Bureau of Statistics

Figure 10.4

About half of rural left-behind children were concentrated in six major labour-exporting provinces, namely Sichuan, Henan, Anhui, Guangdong, Hunan and Guangxi. The number of left-behind children in each of these six provinces was more than 4 million, accounting for more than 40 per cent of the rural child population in each province.

Figure 10.5
Age structure of migrant children and rural left-behind children, 2010



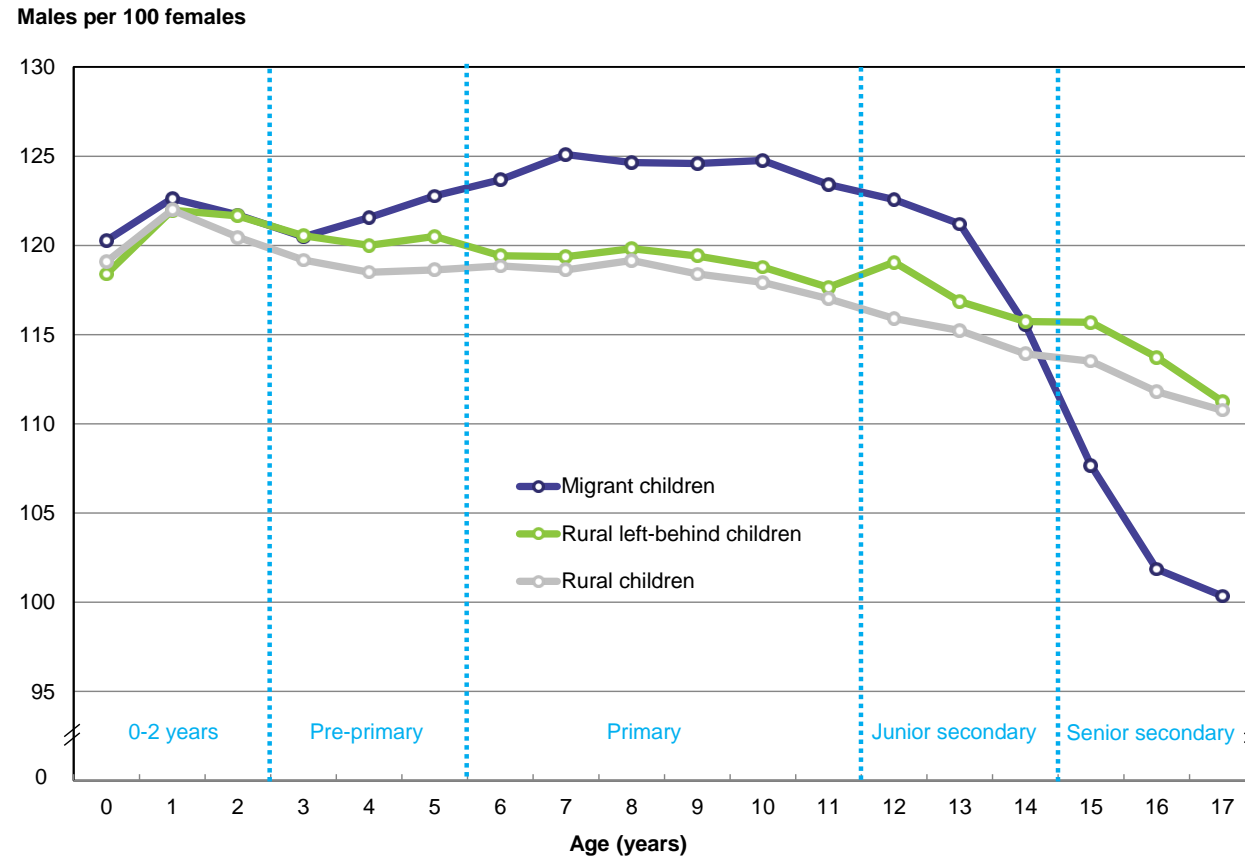
Age	Level of education	Number of migrant children (millions)	Number of rural left-behind children (millions)	Total child population (millions)
17	Senior Secondary	12.90	8.13	57.59
16				
15				
14	Junior Secondary	4.64	9.95	46.52
13				
12				
11	Primary	9.29	19.53	84.54
10				
9				
8				
7				
6	Pre-primary	5.12	11.70	45.20
5				
4				
3	0-2 years	3.86	11.72	45.06
2				
1	Total 0-17	35.81	61.03	278.91
0				

Source: Duan Chengrong et al. of the School of Sociology and Population Studies, Renmin University of China, estimation based on the 2010 Population Census conducted by the National Bureau of Statistics

Figure 10.5

Number of migrant children was evenly distributed across age except for children less than one year old and children aged 15-17 years. Many migrant children are confronted with challenges to quality education and face difficulties in affordable healthcare services. Receiving cities should concretely consider and respond to the needs of migrant children in overall education and healthcare planning. Some 36 per cent of migrant children are between 15-17 years of age. Most of them attend school, but quite a few of them abandon senior secondary education to become new-generation migrant workers and face the challenges of the migrant population, including the issue of social exclusion. Proportions of rural left-behind children for each age group were similar.

Figure 10.6
Sex ratio of migrant children and rural left-behind children, 2010

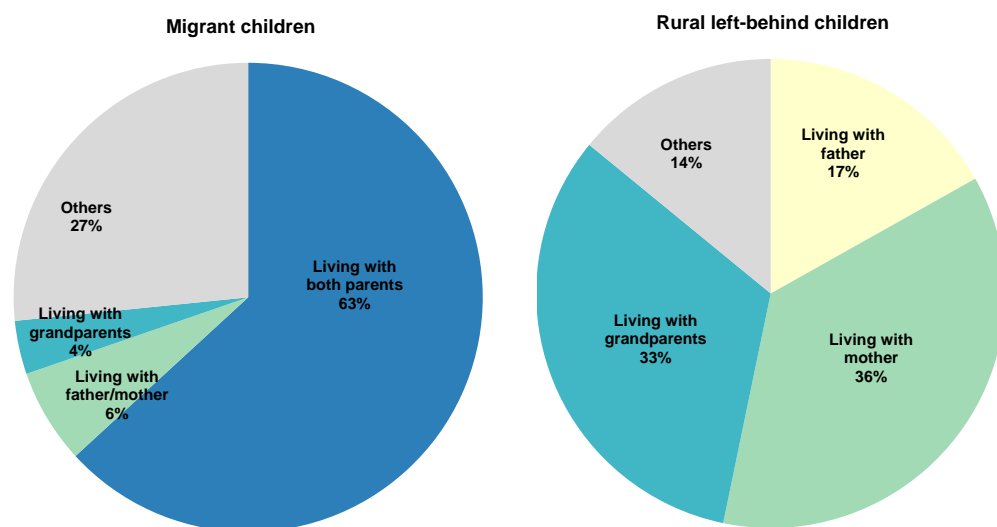


Source: Duan Chengrong et al. of the School of Sociology and Population Studies, Renmin University of China, estimation based on the 2010 Population Census conducted by the National Bureau of Statistics

Figure 10.6

The migrant population was somewhat more likely to bring sons than daughters with them to their place of migration. At both the preschool stage and the compulsory education stage, the male to female sex ratio of migrant children was higher than that of left-behind children. The data indicate that at the preschool education age, and especially at the compulsory education stage, boys were more likely to live with their migrant parents and benefit from urban educational resources.

Figure 10.7
Family arrangement of migrant children and rural left-behind children, 2010



Source: Duan Chengrong et al. of the School of Sociology and Population Studies, Renmin University of China, estimation based on the 2010 Population Census conducted by the National Bureau of Statistics

Figure 10.7

Large-scale migration was the key factor behind variation in the structure of children's families and was the most common reason for children not living with both parents. Among the 84.5 million children who did not live with both parents nationwide in 2010, 61.03 million were rural left-behind children and some 13 million were migrant children.

Half of the rural left-behind children (47 per cent) did not live with either parent, as both parents had migrated from home. A total of 36 per cent of rural left-behind children had migrant fathers and lived with only their mothers, while 17 per cent of left-behind children had migrant mothers and lived with only their fathers. Grandparents are the main caregivers of left-behind children, especially younger left-behind children.

Figure 10.8
Proportion of children who failed to receive or complete compulsory education as required, 2010

	Total	Urban	Rural	Migrant children	Rural left-behind children
Failed to receive or complete compulsory education as required* (%)					
Aged 6-17	3.0	2.0	3.9	2.7	3.4
Aged 6-11	3.2	2.9	3.5	3.5	3.3
Aged 12-14	2.0	1.1	2.6	1.7	2.3
Aged 15-17	3.7	1.5	5.8	2.4	4.8

Source: Duan Chengrong et al. of the School of Sociology and Population Studies, Renmin University of China, estimation based on the 2010 Population Census conducted by the National Bureau of Statistics

Figure 10.8

In terms of receiving or completing compulsory education, rural left-behind children did slightly better than rural children overall, while migrant children lagged behind urban children but did better than rural children. Older children aged 15-17 years in rural areas, and within this category older left-behind children, received the least compulsory education, with 5.8 per cent and 4.8 per cent, respectively, not receiving compulsory education as required. Among left-behind children, those whose mothers left home had the poorest education status, with 5.1 per cent of them failing to receive or complete compulsory education as required.

* According to the *Compulsory Education Law of the People's Republic of China* promulgated in 1986, children of school age are subject to nine years of compulsory education. In this table, children (aged 6-17 years) who fail to receive or complete compulsory education include those who have never been to school, those who have graduated from primary school only, and those who have dropped out of primary school or junior secondary school.



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 August 2010, China submitted the Initial Report on the implementation of the UN Convention on the Rights of Persons with Disabilities.

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.

To better monitor the situation of people with disabilities after the 2006 *National Sample Survey on Disability*, the China Disabled Persons’ Federation (CDPF) conducted national follow-up monitoring surveys on the situation of people with disabilities annually since 2007.

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

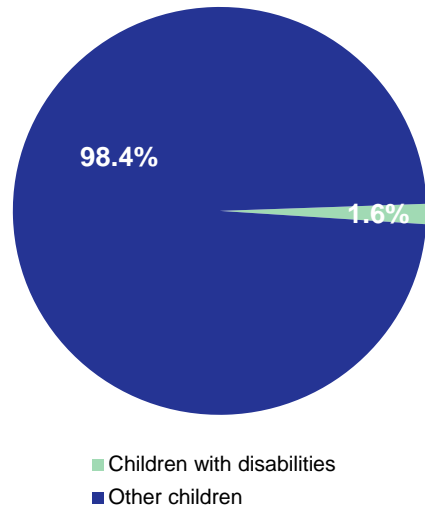
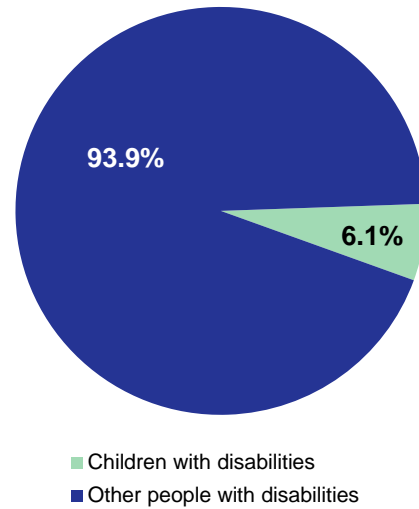


Figure 11.2
Children with disabilities as a percentage of all people with disabilities in China, 2006

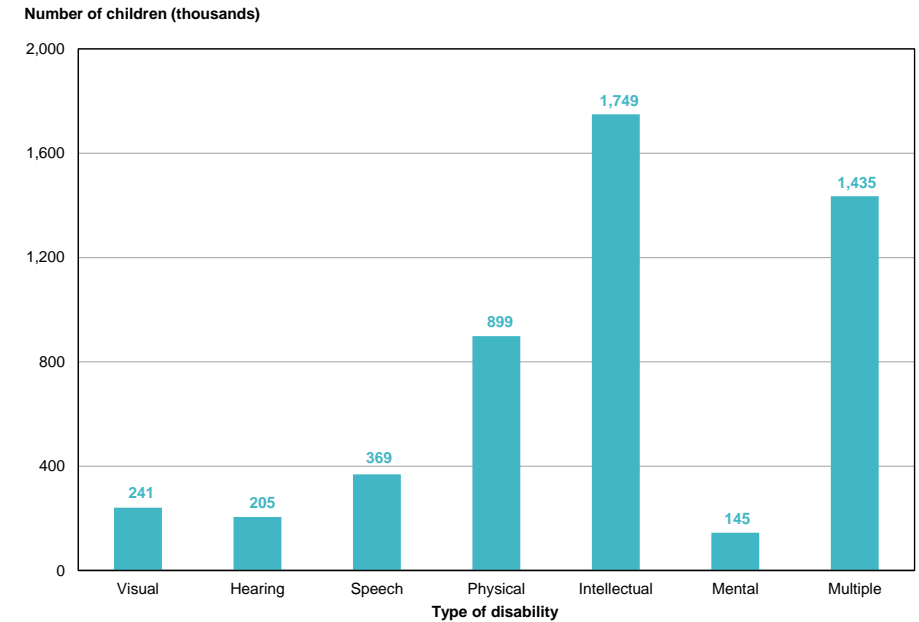


Source: China Disabled Persons' Federation, *The Status Analysis and Strategies Study of Children With Disability in China*, 2008

Figure 11.1 and 11.2

According to the *Second National Sample Survey on Disability* conducted in 2006, 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
Children with disabilities, by type of disability, 2006

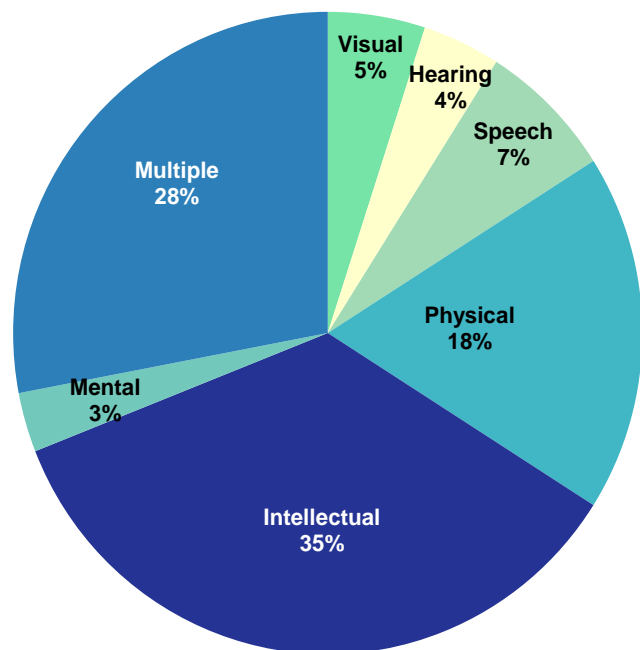


Source: China Disabled Persons' Federation, *The Status Analysis and Strategies Study of Children With Disability in China*, 2008

Figure 11.3

The estimated number of children with specific types of disabilities⁹² has been extrapolated from data from the *Second National Sample Survey on Disability*.

Figure 11.4
Types of disabilities among children with disabilities, 2006

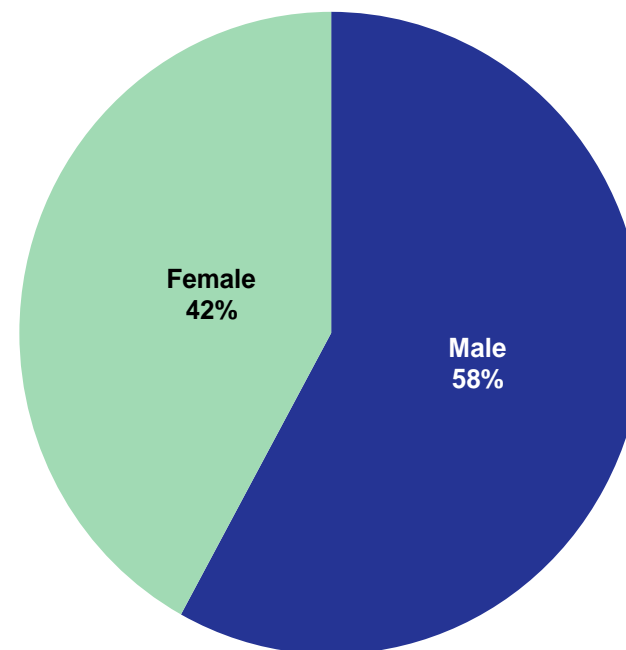


Source: China Disabled Persons' Federation, *The Status Analysis and Strategies Study of Children With Disability in China, 2008*

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 structure of children with disabilities, 2006



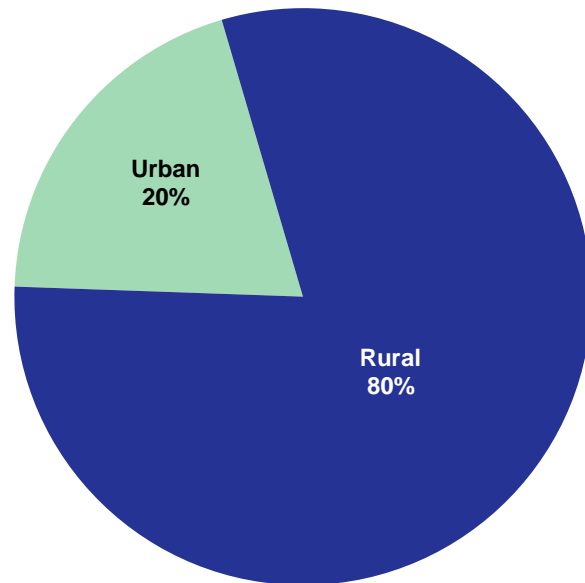
Source: China Disabled Persons' Federation, *The Status Analysis and Strategies Study of Children With Disability in China, 2008*

Figure 11.5

Of the number of children aged 0–17 identified with a disability during the Second National Sample Survey on Disability in 2006, 58 per cent were male and 42 per cent female, resulting in a sex ratio of 141 males to 100 females, much higher than the sex ratio of all children in 2006 (118 males to 100 females).

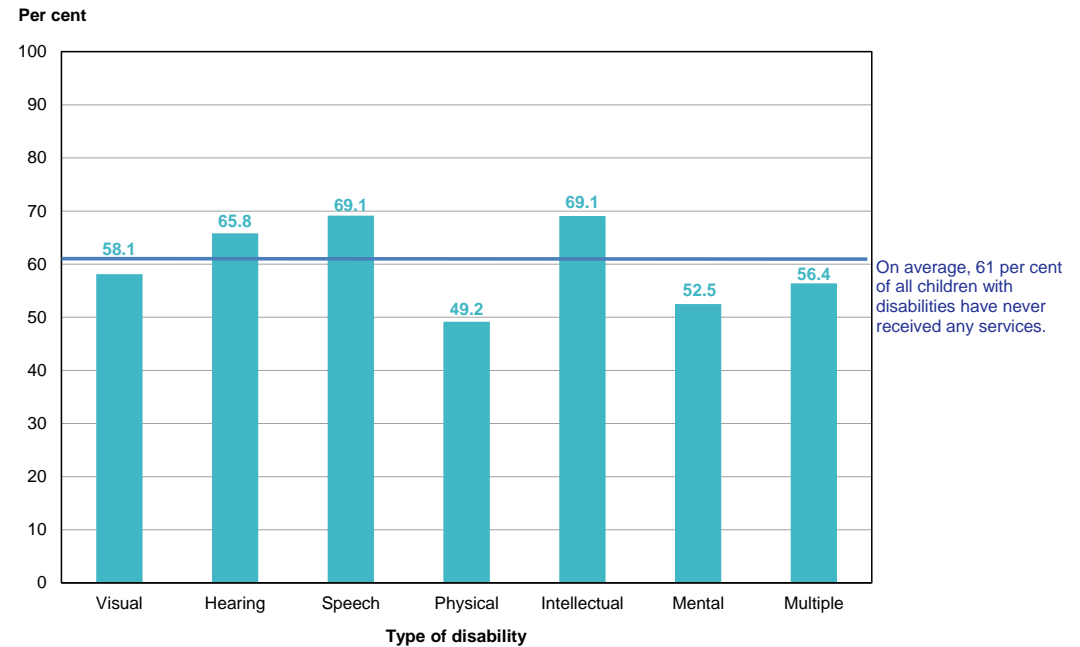
According to the *First National Sample Survey on Disability*, conducted in 1987, out of the total number of children identified with a disability, 56 per cent were male and 44 per cent were female. In 1987, the sex ratio of children with disabilities was 126 males to 100 females.

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 11.7
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 11.6

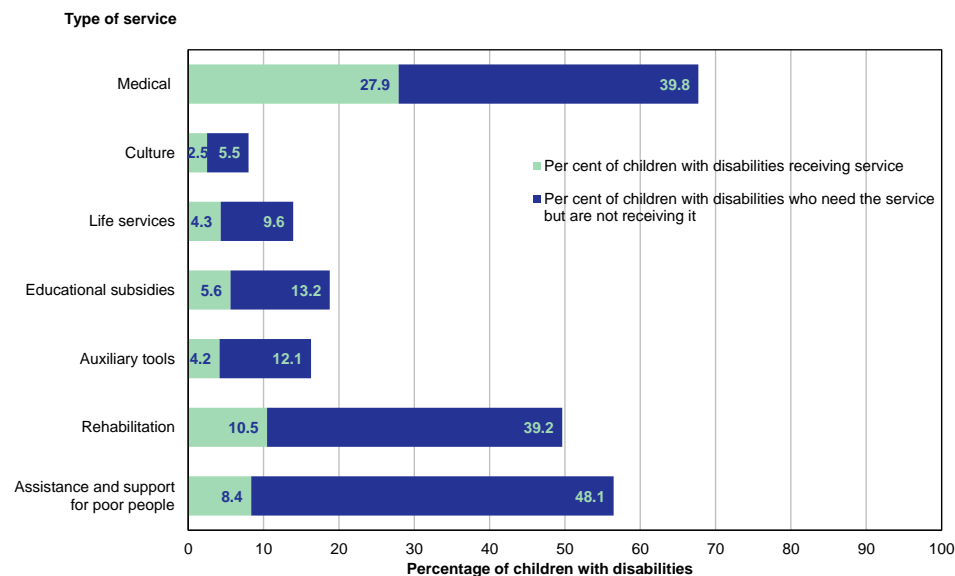
The percentage of children with disabilities living in urban and rural areas did not vary significantly between 1987 and 2006. The *2006 National Sample Survey on Disability* found that 20 per cent of children with disabilities aged 0–17 lived in urban areas, while 80 per cent of them lived in rural areas, higher than the national average (63 per cent of all children lived in rural area in 2006).

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 services⁹³.

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



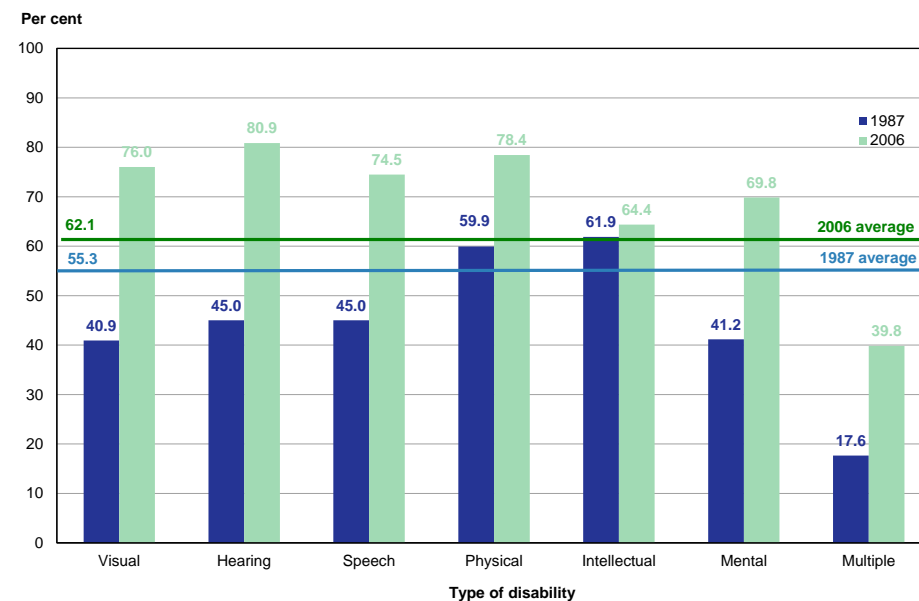
Source: (Derived from) China Disabled Persons' Federation, *The Status Analysis and Strategies Study of Children With Disability in China*, 2008

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, by type of disability, 1987 and 2006



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

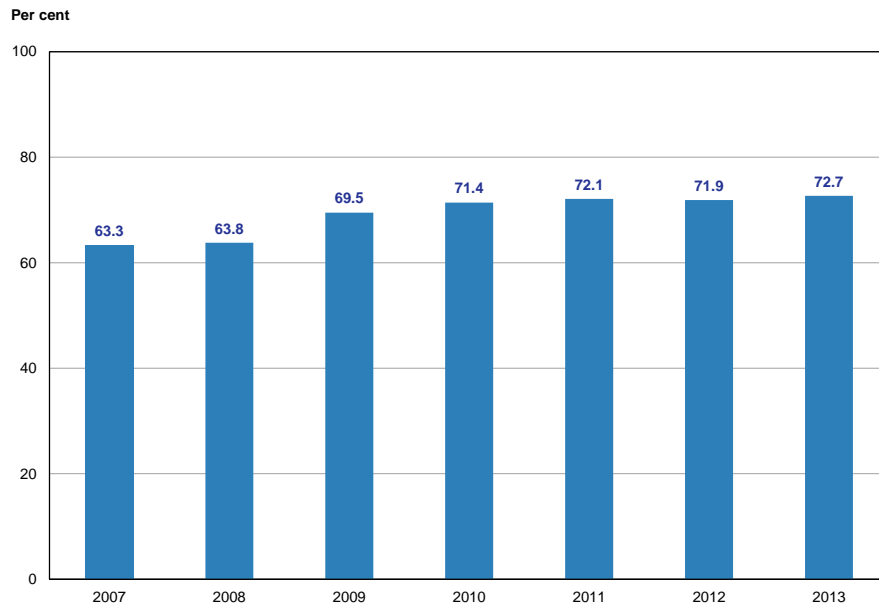
Figure 11.9

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, 2007–2013

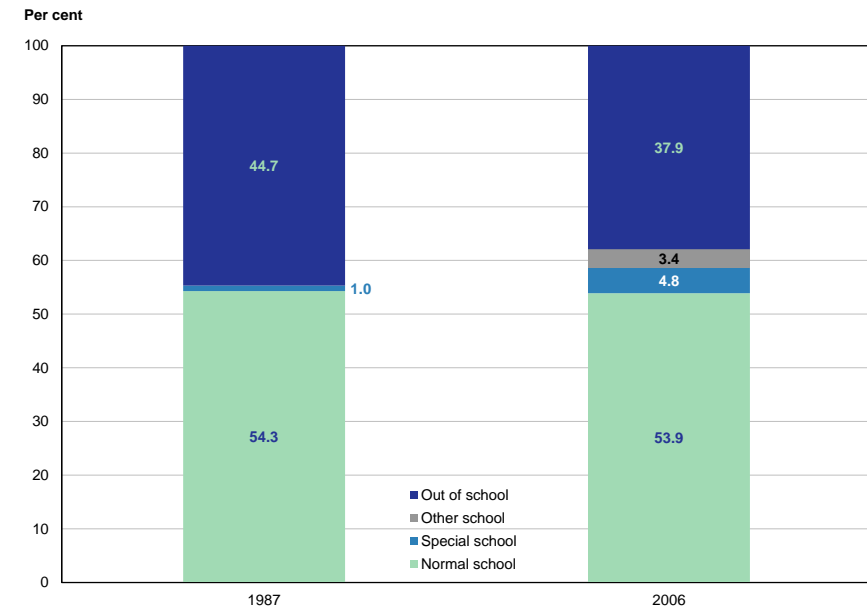


Source: China Disabled Persons' Federation, *2013 National Monitoring Report on the Situation of People with Disabilities*, 2014

Figure 11.10

The China Disabled Persons' Federation (CDPF) conducted national follow-up monitoring surveys on the situation of people with disabilities annually since 2007. 2007-2008 monitoring surveys selected 734 communities, one from each of the counties sampled during the Second National Sample Survey on Disability in 2006. The number of communities doubled since 2009 survey with two communities selected from each sample county. 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 (66 per cent in urban areas and 63 per cent in rural areas). In 2013, the proportion of school-aged children with disabilities receiving nine-year basic education increased to 73 per cent. CDPF did not release disaggregated data by urban and rural residence in 2013 for this indicator, however derived from statistics for 2011 and 2012, the urban and rural gap of children with disabilities receiving nine-year basic education was within 3 percentage points.

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 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 proportion of children receiving nine-year basic education in special education schools has increased by 4 percentage points during 1987 and 2006.

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 violence⁹⁴ 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):

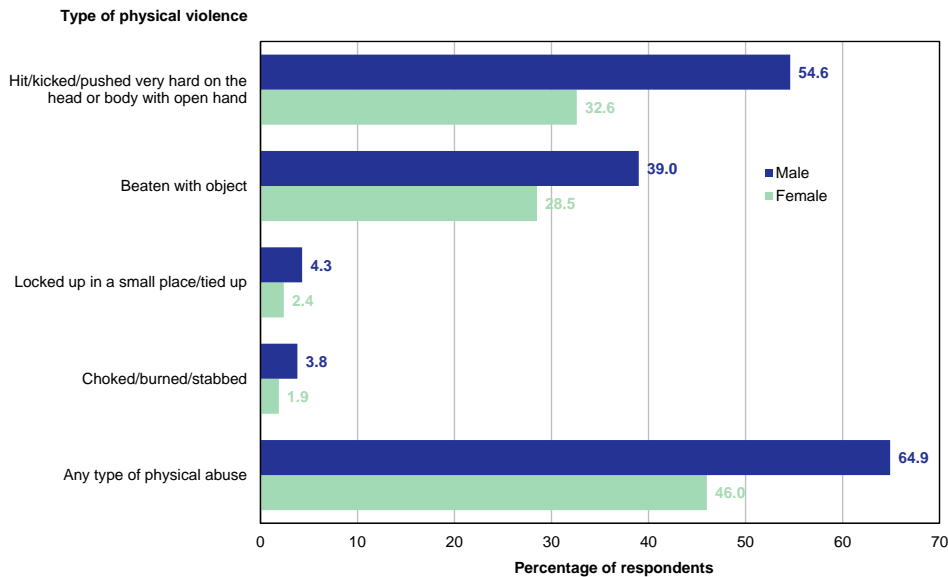
Article 19.1 of the CRC: States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while 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



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

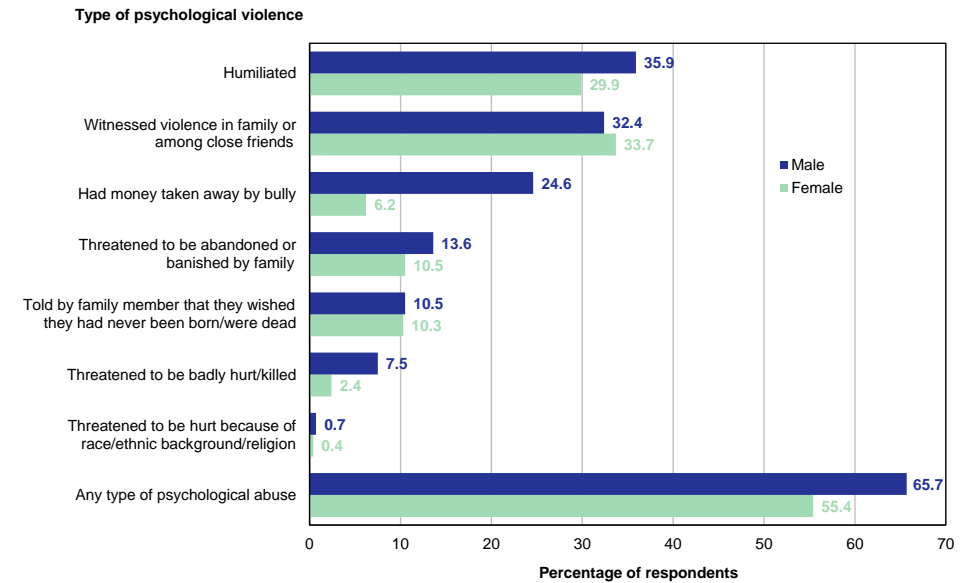
Figure 12.1

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



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

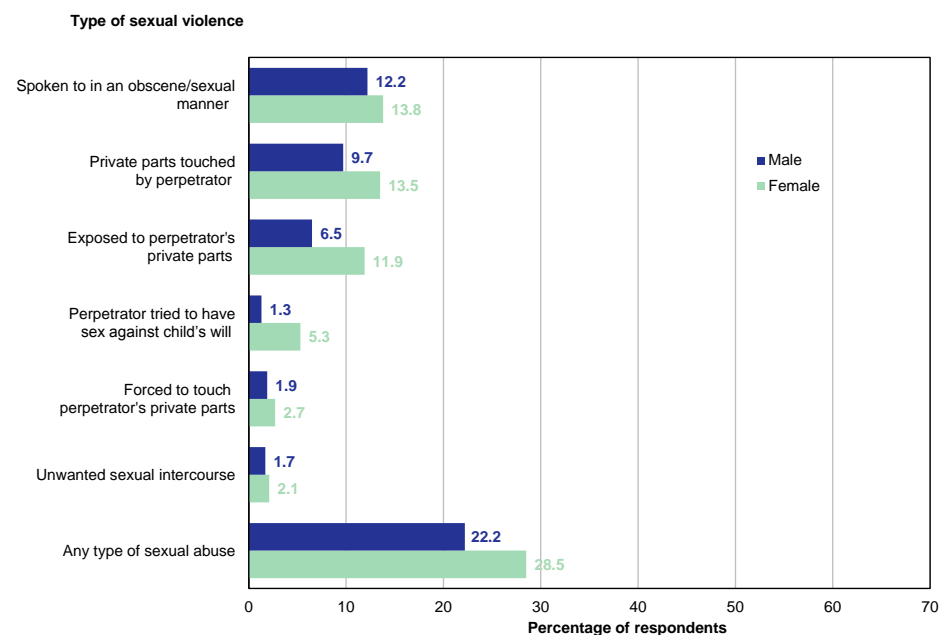
Figure 12.2

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



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

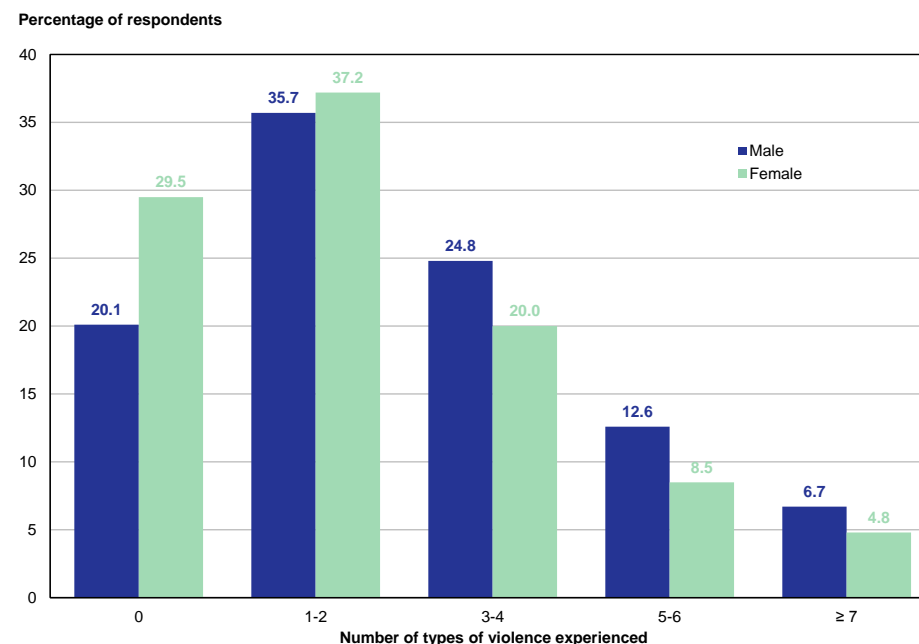
Figure 12.3

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



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

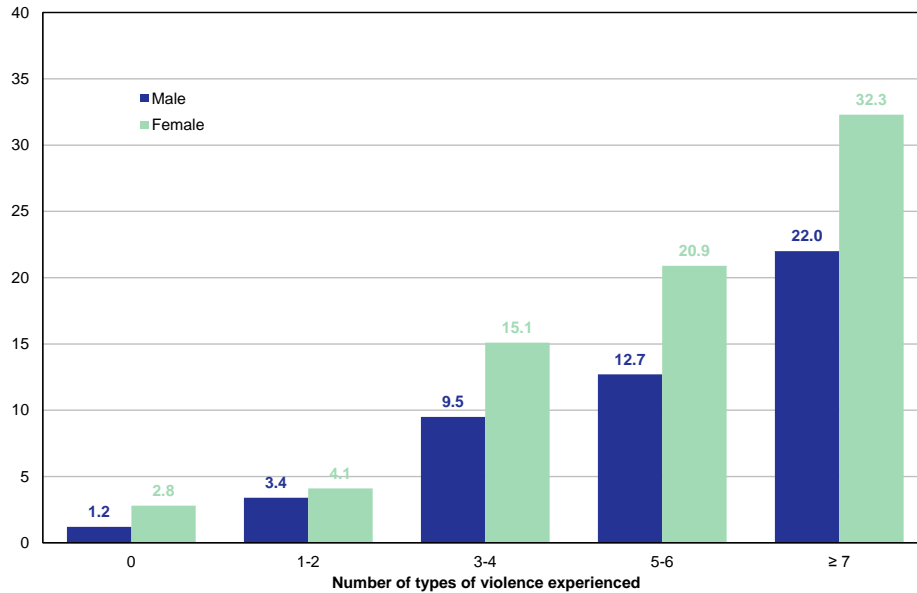
Figure 12.4

The survey 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 no or fewer 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

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.



13

TRAFFICKING

OVERVIEW

Children are trafficked for various reasons, including the purposes of illegal adoption, sexual exploitation and labour exploitation. In general, there is a greater risk of trafficking among migrant and left-behind children.

Between 2000 and 2013, the Ministry of Public Security (MPS) recorded 92,851 cases of trafficking in women and children, with cases generally involving several victims. The Government of China launched a National Campaign to Combat Trafficking of Women and Children in April 2009. About 33,505 cases of trafficking in women and children were detected in 2009-2013.

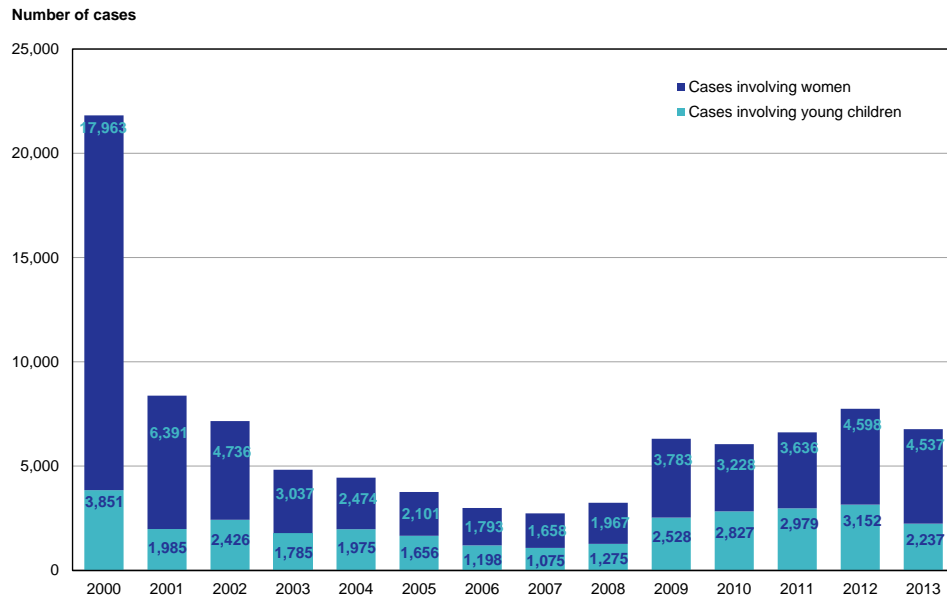
The Government of China issued its first *National Plan of Action to Combat Trafficking in Women and Children* (2008–2012) in December 2007. The Plan detailed the anti-trafficking responsibilities of 32 ministries and appointed the Ministry of Public Security as the coordinator of the Government's anti-trafficking efforts. In March 2013, the Government developed a new *National Plan of Action to Combat Trafficking in Women and Children* (2013–2020).

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 and respond to trafficking. Key interventions include raising community awareness, increasing the understanding and skills of law enforcement officials, court and judicial officers, social workers, health workers and the broader community on the need to respect the rights of trafficking victims in the rescue and rehabilitation process.

Figure 13.1
Number of trafficking cases involving young children and women, 2000–2013

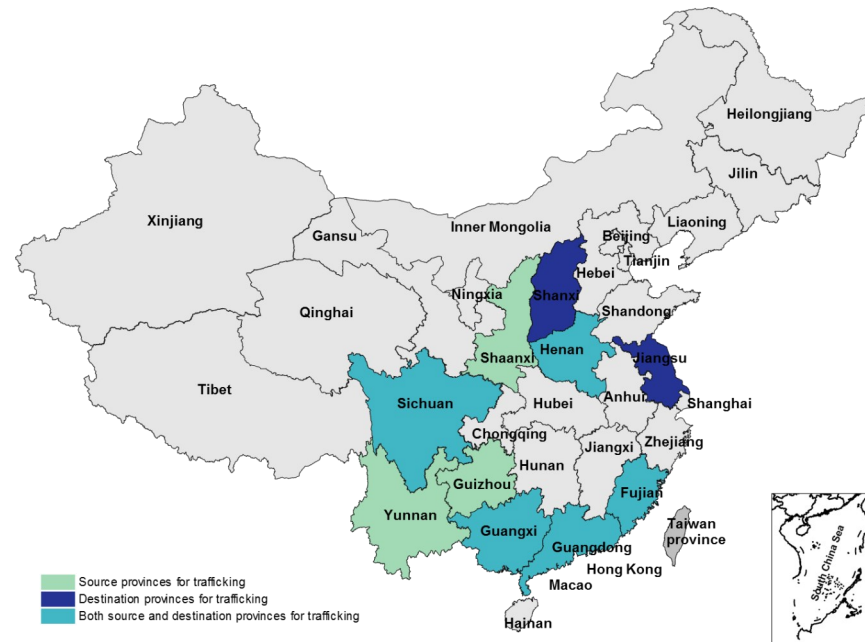


Source: National Bureau of Statistics, NPA Monitoring Statistics, 2014

Figure 13.1

The total number of trafficking cases detected in China from 2000–2013 was 92,851. 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, the number of trafficking cases detected by the police declined, with some 2,500–5,000 cases detected each year between 2003 and 2008. In April 2009, the Ministry of Public Security launched another National Campaign to Combat Trafficking of Women and Children. In 2009-2013, 13,723 cases of trafficking in children and 19,782 cases of trafficking in women were detected. However, the actual number of cases is believed to be much greater than the officially registered number, and each trafficking case likely involving several victims.

Figure 13.2
Source and destination provinces for trafficking, 2007



Source: Bu Wei, *Study on Human Trafficking Based On Reports of Printed Media*, Institute of Journalism and Communication, Chinese Academy of Social Sciences, May 2008

Figure 13.2

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

Globally, China is both a source and destination country for human trafficking. Women and children from poorer areas in mainland China are trafficked to richer destinations such as Hong Kong SAR, 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.



14

HIV / AIDS

OVERVIEW

Epidemic estimates show that at the end of 2011, the estimated number of people living with HIV (PLHIV) in mainland China stood at 780,000 people, and there were a total of 154,000 AIDS cases⁹⁵. The share of women as a percentage of PLHIV rose from 15 per cent in 1998 to 28.6 per cent in 2011. There were approximately 48,000 new infections and 28,000 deaths in 2011. Currently, China's HIV epidemic, at 0.058 per cent of the total population, remains one of low prevalence overall, but has pockets of high infection rates among specific sub-populations.

In 2007, sexual transmission replaced injecting drug use as the main mode of transmission, comprising 42.3 per cent of all transmissions⁹⁶. In 2013, sexual transmission accounted for as high as 90.8 per cent of the newly reported HIV infections⁹⁷.

Case estimate data indicate that, as of 2013, the total cumulative reported cases of HIV stood at around 440,000, far lower than the estimated 780,000, indicating that a large percentage of people with HIV have not been identified or do not know their status. About 76 per cent of total HIV infections occur in just six provinces, namely Yunnan, Guangxi, Henan, Sichuan, Xinjiang and Guangdong⁹⁸.

Among the total number of reported cases, the percentage of mother-to-child transmissions increased over years from 0.1 per cent⁹⁹ in 1998 to 1.4 per cent in 2009. However, with the steady government promotion of the prevention of mother to child transmission (PMTCT) services since October 2010, the percentage of mother-to-child transmission has gradually declined over the past few years to 0.9 per cent in 2013. The percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth was 45.3 per cent (1,433/3,162) in 2013¹⁰⁰, up from 14.9 per cent (362/2,437) in 2010.

Between the launch in June 2005 of the National Paediatric AIDS Programme and end of 2013, a cumulative 4,449 children have received treatment, with 3,527 children currently undergoing treatment in 2013 and 385 children on second line drugs.

As of 2013, a total of 278,080 adults received anti-retroviral (ARV) treatment cumulatively, with 223,962 or 80.5 per cent receiving treatment in 2013, and 32,348 on second line drugs. The proportion of adults and children receiving ART was 52.1 per cent in 2013. The proportion of patients alive after 12 months of treatment and remaining on ART reached 85.2¹⁰¹.

Infection rates among youth 15–24 years old is on the steady increase. From January to October 2012, there were a total of 9,514 reported cases, a 12.8 per cent increase compared to the same period of 2011¹⁰². Young people still lack awareness of the risks of unplanned pregnancy, HIV/AIDS and sexually transmitted infections (STIs). In a 2010 survey among 22,288 young people aged between 15 and 24 years, two-thirds of young people are open to premarital sex, and 22.4 per cent have had sex before marriage. Over half of the young people surveyed had no form of protection in their first sexual encounter¹⁰³. According to the 2011 National AIDS Sentinel Surveillance, the HIV infection rate among young people aged 15-24 years is 0.05 per cent.

It is estimated that 39.1 per cent of young people need sexual and reproductive health consultation, and that 27.1 per cent of young people need treatment. However, over half of the needs for counselling and treatment are not fulfilled. Embarrassment, the lack of seriousness associated with these issues, and inadequate knowledge about where and from whom they can receive information and services, are the main barriers to young people's access to services¹⁰⁴.

Although China has built an extensive HIV Sentinel Surveillance System (HSS), with 1,888 sentinel sites to monitor HIV epidemic trends by population groups, HSS faces challenges in representativeness. There is no national data on key affected young populations (including injecting drug users, men having sex with men, and commercial sex workers), their HIV/STI infection status and utilization of services.

The economic impact on families affected by AIDS can be significant as fewer family members are able to work given new care responsibilities, and household finances need to be diverted towards the treatment and care of AIDS patients. A study¹⁰⁵ 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, 2011

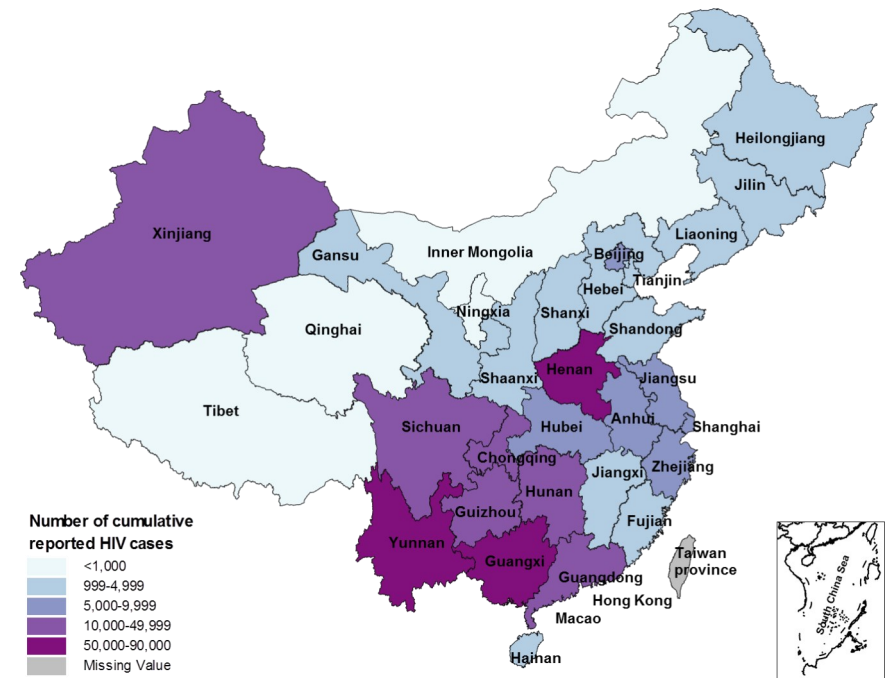


Source: Former Ministry of Health, Joint United Nations Programme on HIV/AIDS and World Health Organization, *2011 Estimates for the HIV/AIDS Epidemic in China, 2011*

Figure 14.1

In 2011, 780,000 people in China were estimated to be living with HIV. Five provinces, namely Yunnan, Sichuan, Guangxi, Xinjiang and Guangdong, account for 60 per cent of the country's estimated number of people living with HIV¹⁰⁶.

Figure 14.2
Number of cumulative reported HIV cases, 1985–2011



Source: Former Ministry of Health, *2012 China AIDS Response Progress Report, 2012*

Figure 14.2

Between 1985 and 2011, the cumulative number of reported people living with HIV was approximately 445,000, including 170,000 of reported AIDS cases and 90,000 AIDS-related deaths. Yunnan, Guangxi, Sichuan, Henan, Xinjiang and Guangdong accounted for 76 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)

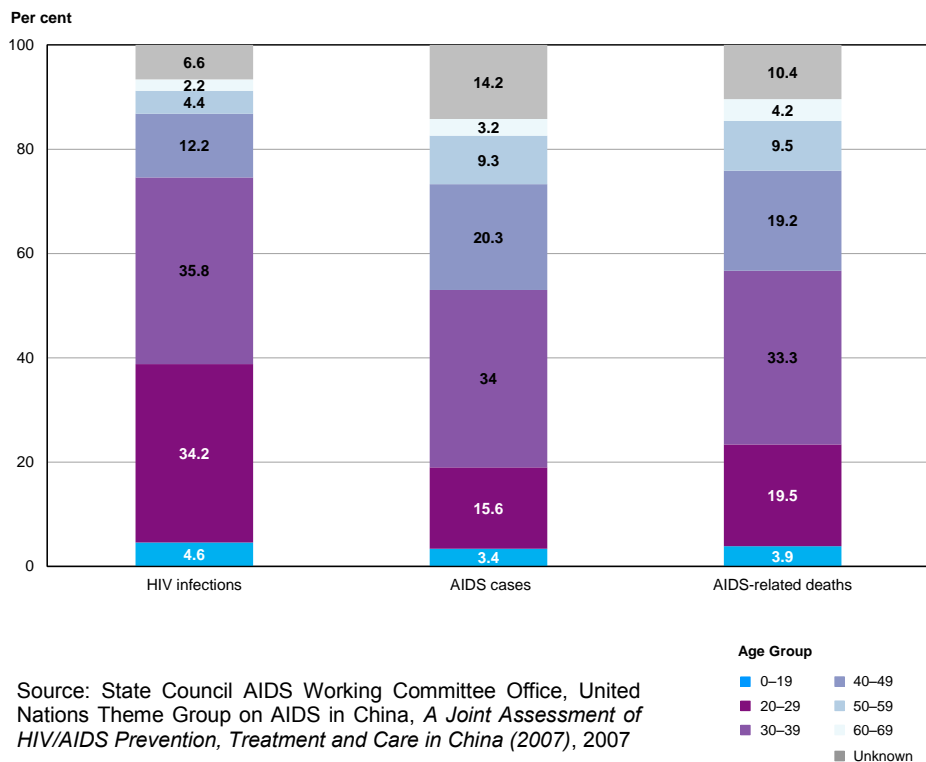


Figure 14.3

Reported cases show that HIV infections were concentrated in the 20–29 and 30–39 age groups, which together account for 70 per cent of all infections. In addition, half of the AIDS cases and half of AIDS-related deaths were concentrated in these two age groups.

Figure 14.4
Transmission modes of reported HIV/AIDS cases, 1985–2013

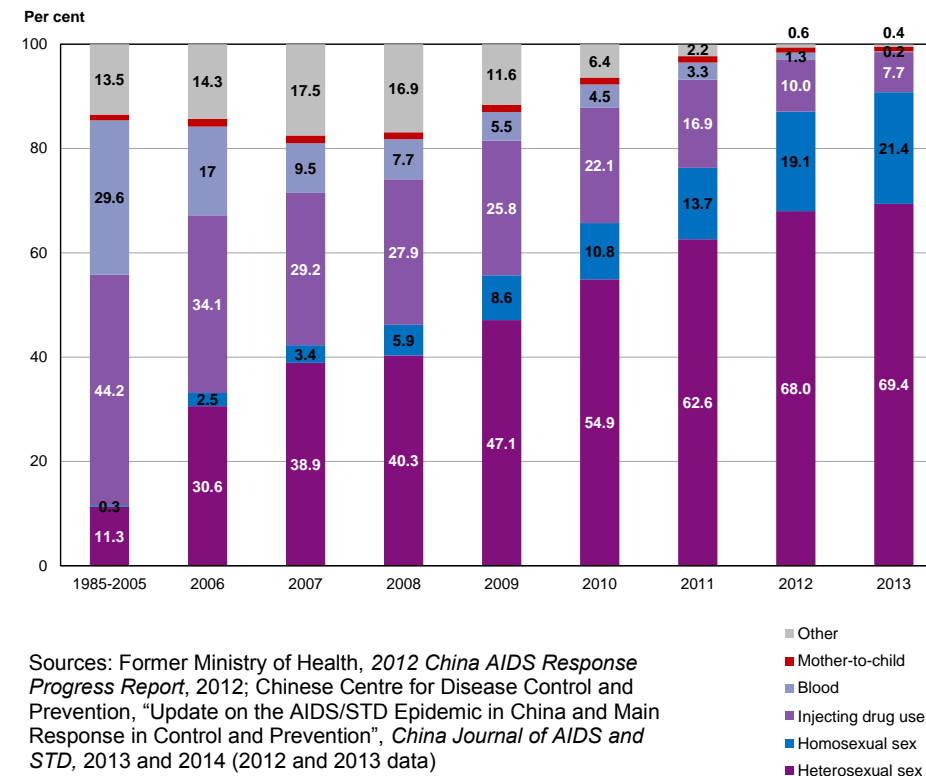
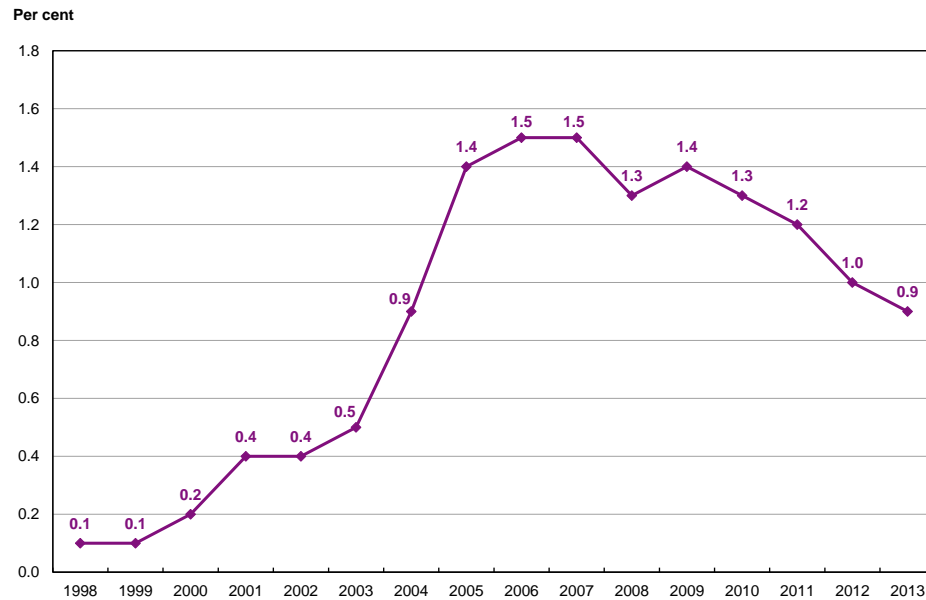


Figure 14.4

In 2007, sex became the main mode of HIV transmission for the first time and accounted for one-third of all HIV infections. Sexual transmission as share of all transmissions increased to 76 per cent in 2011 and 90.8 per cent in 2013. Throughout this time, injecting drug use (IDU) decreased from accounting for roughly one-third of all HIV infections in 2006 to less than 10 per cent in 2013.

Figure 14.5
Percentage of reported HIV/AIDS cases attributed to mother-to-child transmission, 1998–2013

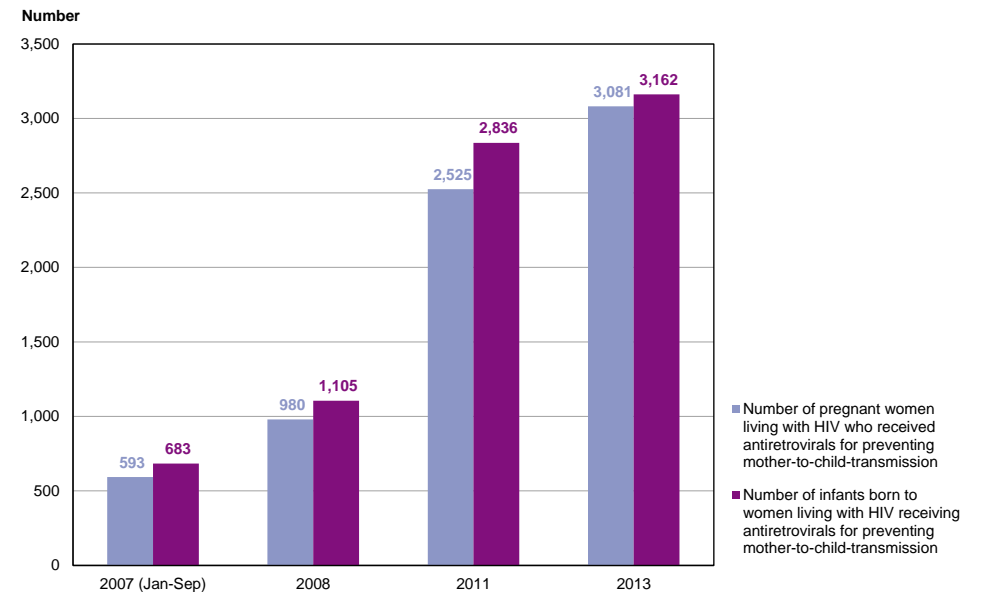


Sources: China Former Ministry of Health, United Nations Children's Fund, World Health Organization, United Nations Population Fund, United Nations Theme Group on AIDS in China, Clinton Foundation, United States Centre for Disease Control and Prevention, Family Health International, Chinese PMTCT and Paediatric AIDS Experts, *PMTCT and paediatrics inter-agency task team joint mission report*, 21–30 April 2008 (1998–2005 data); Former Ministry of Health, *2012 China AIDS Response Progress Report*, 2012 (2006–2011 data); Chinese Centre for Disease Control and Prevention, "Update on the AIDS/STD Epidemic in China and Main Response in Control and Prevention", *China Journal of AIDS and STD*, 2013 and 2014 (2012 and 2013 data)

Figure 14.5

Between 1998 and 2007, mother-to-child transmission as a proportion of all new HIV cases increased steadily, from less than 0.2 per cent to around 1.5 per cent of all reported HIV/AIDS cases. With the steady promotion of PMTCT and paediatric care services by the Government of China since October 2010, the percentage of mother-to-child transmission has been brought under control.

Figure 14.6
Prevention-of-mother-to-child-transmission services, 2007–2013

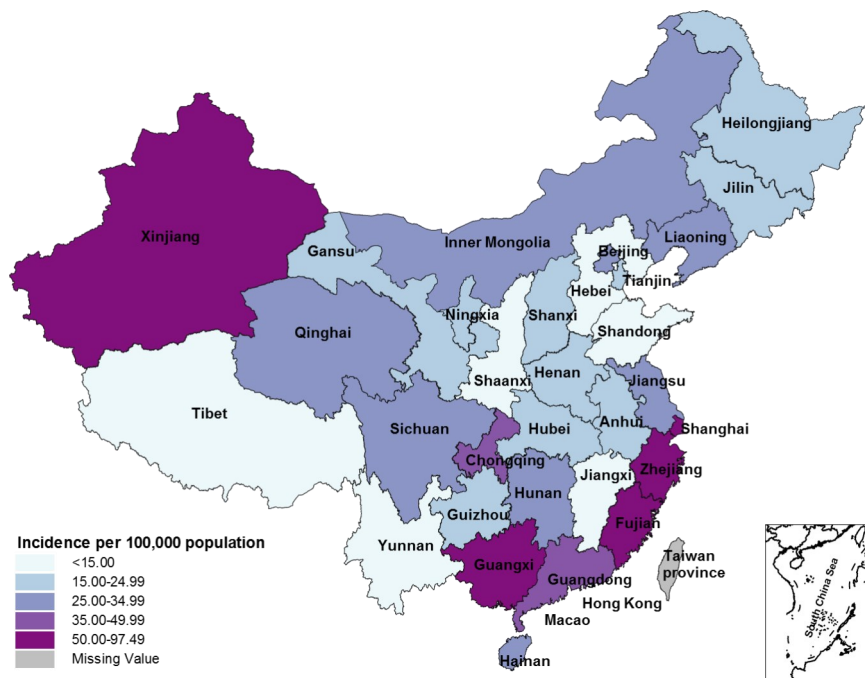


Sources: World Health Organization, United Nations Joint Programme on HIV/AIDS and United Nations Children's Fund, *Towards Universal Access, Scaling up priority HIV/AIDS interventions in the health sector, progress reports, 2008 and 2009 (2007–2008 data)*¹⁰⁸; Former Ministry of Health, *2012 China AIDS Response Progress Report*, 2012 (2011 data); State Council AIDS Working Committee Office, *Global AIDS Response Progress Reporting (GARPR) – China 2013, 2014* (2013 data)

Figure 14.6

Approximately 8 million pregnant women were tested for HIV in 2011 with the steady progress in PMTCT, increasing coverage from 10 per cent in 2008 to 44 per cent in 2011. In 2013, about 3,081 pregnant women living with HIV were receiving antiretroviral drugs for the prevention of mother-to-child-transmission, accounting for 81 per cent of all pregnant women living with HIV. Among infants born to women living with HIV, the infection rate declined from 12.8 per cent in 2005 to 6.7 per cent in 2013¹⁰⁷.

Figure 14.7
Syphilis incidence rate, 2010



Source: National Centre for HIV/AIDS of the Chinese Centre for Disease Control and Prevention, 2011

Figure 14.7

As sexual transmission is now the main mode of HIV transmission in China, data on sexually transmitted infections, such as the 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's ethnic minority groups are, by population size: Zhuang, Hui, Manchu, Uyghur, Miao, Yi, Tujia, Tibetan, Mongolian, Dong, Bouyei, Yao, Bai, Korean, Hani, Li, Kazak, Dai, She, Lisu, Dongxiang, Gelao, Lahu, Va, Shui, Naxi, Qiang, Tu, Mulam, Xibe, Kirgiz, Jingpo, Daur, Salar, Blang, Maonan, Tajik, Pumi, Achang, Nu, Ewenki, Jing, Jino, De'ang, Bonan, Russian, Yugur, Ozbek, Moinba, Oroqen, Drung, Hezhen, Gaoshan, Lhoba and Tatar. (China National Bureau of Statistics, *China Statistical Yearbook*, NBS, 2013)

² China National Bureau of Statistics, *China Statistical Yearbook*, NBS, 2014

³ **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 2014*, UNICEF, 2014)

⁴ **Crude birth rate** – Annual number of births per 1,000 population. (United Nations Children's Fund, *The State Of the World 's Children 2014*, UNICEF, 2014)

⁵ UNDESA/Population Division, *World Population Prospects: The 2010 Revision*, extended CD-Rom

⁶ **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)

⁷ China National Bureau of Statistics, *China Statistical Yearbook*, NBS, 2014

⁸ United Nations Children's Fund, *The State Of the World's Children 2014*, UNICEF, 2014

⁹ Number of children in 2013 is estimated by UNICEF China Office using age-specific population structure in percentages based on the 2013 National Sample Survey on Population Changes conducted by the National Bureau of Statistics of China. Results of this survey are published in *China Population and Employment Statistics Yearbook 2014*.

¹⁰ China National Bureau of Statistics, *China Statistical Yearbook*, NBS, 2014

¹¹ **Sex ratio at birth** – Number of male births per one female birth. (UNSD)

¹² China National Bureau of Statistics, *2008 China Population*, NBS, 2009

¹³ China National Bureau of Statistics, *Statistical Communiqué of the People's Republic of China on the 2012 National Economic and Social Development*, NBS, 2013

¹⁴ China National Bureau of Statistics, *China Statistical Yearbook*, NBS, 2014

¹⁵ **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 2014*, UNICEF, 2014)

¹⁶ China Ministry of Health, *China Health Statistical Yearbook*, MOH, 2009

¹⁷ World Bank Development Indicators database, World Bank, 2014

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 2014*, UNICEF, 2014)

¹⁸ James WH, 'The human sex ratio. Part 1: a review of the literature', *Human Biology*, 1987, 59:721-5

¹⁹ **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 2014*, UNICEF, 2014)

²⁰ **Fatalities** (Disaster casualties) – Number of deaths caused directly by natural disasters (includes deaths of non-permanent residents). (China Ministry of Civil Affairs)

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

²¹ **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)

²² World Bank, Development Indicators database, World Bank, 2014. International Monetary Fund (IMF) predicts that in 2014, China will surpass the United States to be the largest economy in the world when measured by purchasing power parity.

²³ World Bank, Development Indicators database, World Bank, 2014

²⁴ According to World Bank 2010 Classification Standards, countries with Gross National Income (GNI) per capita from US\$3,976 to US\$12,275 are classified as upper-middle income countries.

²⁵ World Bank, *From Poor Areas to Poor People: China's Evolving Poverty Reduction Agenda*, World Bank, 2009

²⁶ World Bank, *From Poor Areas to Poor People: China's Evolving Poverty Reduction Agenda*, World Bank, 2009

²⁷ According to the 2013 Report on *China's Progress towards the Millennium Development Goals* prepared by the Government of China and the UN System, China has already met the Millennium Development Goals/targets: halving poverty, achieving universal access to primary education, promote gender equality and empower women, reducing child mortality and access to safe drinking water and basic sanitation. Other MDGs are likely to be met on time.

²⁸ **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)

²⁹ Shaohua Chen, Martin Ravallion and Youjuan Wang, *Di Bao: A Guaranteed Minimum Income in China's Cities?*, working paper 3805, World Bank, 2006

³⁰ **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 2012*, UNICEF, 2012)

³¹ **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)

³² **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)

³³ China National Bureau of Statistics, *China Statistical Yearbook*, NBS, 2014

³⁴ **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)

³⁵ Qin Gao, Fuhua Zhai and Irwin Garfinkel, *How Does Public Assistance Affect Family Expenditures? The Case of Urban China*, World Development Vol. 38, No. 7, pp. 989–1000, 2010

3. Maternal and child health

³⁶ Prepared jointly by the Government of China and the UN system

³⁷ China National Health and Family Planning Commission, *Health and Family Planning Statistical Yearbook*, NHFPC, 2014

³⁸ World Health Organization, *World Health Statistics*, WHO, 2012

³⁹ There are three available sources of data for the number of live births. In 2013, 15.1 million live births were routinely reported through the Ministry of Health of China and published in the *China Health and Family Planning Statistical Yearbook (2014)*. National Bureau of Statistics of China reported 16.4 million annual births in 2013. NBS' annual estimation of live births is based on population censuses and sample surveys and disseminated on its official website, but could also be derived by using total midyear population and annual birth rate recorded in *China Statistical Yearbook*. The UN's projection for China for 2012 was 18.5 million and published in *The State of the World's Children 2014*.

⁴⁰ United Nations Children's Fund, *Committing to Child Survival: A promise Renewed Progress Report 2014*, UNICEF, 2014

⁴¹ Xiong J et al., 'Child Health Security in China: A Survey of Child Health Insurance Coverage in Diverse Areas of the Country', *Social Science & Medicine*, 97 (2013) 15-19 (DOI <http://dx.doi.org/10.1016/j.socscimed.2013.08.006>)

⁴² **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 2014*, UNICEF, 2014)

⁴³ United Nations Children's Fund, *Committing to Child Survival: A promise Renewed Progress Report 2014*, UNICEF, 2014. The UN Inter-agency Group for Child Mortality Estimation (UN IGME) annually updates country-specific child mortality estimates. Methodologically, national data from different sources of each country are used to fit regression models to get a smoothed trend curve for the estimation. UN IGME estimates may differ from corresponding national statistics.

⁴⁴ **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 2014*, UNICEF, 2014)

⁴⁵ **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 2014*, UNICEF, 2014)

⁴⁶ **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 2014, UNICEF, 2014)

⁴⁷ **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 2014*, UNICEF, 2014)

⁴⁸ **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 2014*, UNICEF, 2014)

⁴⁹ Qun Meng, Ling Xu, Yaoguang Zhang, Juncheng Qian, Min Cai, Ying Xin, Jun Gao, Ke Xu, J Ties Boerma, Sarah L Barber, 'Trends in access to health services and financial protection in China between 2003 and 2011: a cross-sectional study', *The Lancet*, 3 March 2012, Volume 379, Issue 9818, Pages 805-814 (Note: Data from the *National Health Services Surveys* in various years were used in this paper.)

⁵⁰ **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. (WHO)

⁵¹ **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)

⁵² Qun Meng, Ling Xu, Yaoguang Zhang, Juncheng Qian, Min Cai, Ying Xin, Jun Gao, Ke Xu, J Ties Boerma, Sarah L Barber, 'Trends in access to health services and financial protection in China between 2003 and 2011: a cross-sectional study', *The Lancet*, 3 March 2012, Volume 379, Issue 9818, Pages 805-814 (Note: Data from the *National Health Services Surveys* in various years were used in this paper.)

4. Expanded programme on immunization

⁵³ China Centre for Health Development Studies of Peking University. UNICEF China Office. WHO China Office, Chinese Centre for Disease Control and Prevention, *Delivery of EPI and Its Influencing Factors in the Context of New Health Sector Reform: A Case Study in Southern Xinjiang Autonomous Region, China*, 2012

⁵⁴ **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 2014*, UNICEF, 2014)

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 2014*, UNICEF, 2014)

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 2014*, UNICEF, 2014)

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

5. Nutrition

⁵⁵ UNICEF, *Tracking progress on child and maternal nutrition: a survival and development priority*, 2009

⁵⁶ Horton S, Shekar M, MacDonald C et al., *Scaling up nutrition: what will it cost?*, World Bank, 2009

⁵⁷ Steinmann P, Du Z, Wang L et al., 'Extensive Multiparasitism in a Village of Yunnan Province, People's Republic of China, Revealed by a Suite of Diagnostic Methods'. *The American Journal of Tropical Medicine and Hygiene*, 2008, Volume 78, Issue 2, Pages 760–769; HF Pan, GF Long, Q Li, 'Current status of thalassemia in minority populations in Guangxi, China', *Human Genetics*, 1992, Volume 98, Issue 2, Pages 585-589

⁵⁸ UNICEF, 'Final report on baseline and follow-up surveys evaluating the effect of YingYangBao distribution in areas affected by the Wenchuan earthquake' (unpublished report)

⁵⁹ Zhao L, Yu D, Liu A, 'Analysis of nutrition and health survey result of children and pregnant and lactation women in China in 2006', *Journal of hygiene research*, 2008, Volume 37, Issue 1, Pages 65-67

⁶⁰ China Ministry of Health, *An Analysis Report of 2008 National Health Services Survey in China*, 2009

⁶¹ The estimation of the prevalence of overweight and obesity was based on cut-off points derived from international data as recommended by the Childhood Obesity Working Group. (Cole TJ, Bellizzi MC, Flegal KM et al., 'Establishing a standard definition for child overweight and obesity worldwide: international survey', *British Medical Journal*, 2000, Volume 320, Issue 7244, Pages 1240-1243)

⁶² Li Y, Schouten E, Hu X et al., 'Obesity prevalence and time trend among youngsters in China, 1982-2002', *Asia Pacific Journal of Clinical Nutrition*, 2008, Volume 17, Issue 1, Page 131

⁶³ **Underweight (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 WHO reference population. (United Nations Children's Fund, *The State Of the World's Children 2014*, UNICEF, 2014)

⁶⁴ **Stunting (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 WHO

reference population. (United Nations Children's Fund, *The State Of the World's Children 2014*, UNICEF, 2014)

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 2014*, UNICEF, 2014)

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 Wang SY, Li YH, Chi GB, Xiao SY, Ozanne-Smith J, Stevenson M, Phillips MR, '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 Health Development Research Centre, Ministry of Health, China

⁷⁴ China National Health and Family Planning Commission/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.

⁷⁵ China Ministry of Water Resources (MWR) and other ministries, such as China National Health and Family Planning Commission (NHFPC), 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. After data is collected at county level, it is submitted by local PHCCOs to provincial PHCCOs and subsequently to the NHFPC for publication in *China Health and Family Planning Statistical Yearbook*.

⁷⁶ UNICEF/WHO Joint Monitoring Programme classifies a water source as "improved," if it comes from 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.

⁷⁷ UNICEF/WHO Joint Monitoring Programme (JMP) estimates the percentage of population using improved water sources through national statistical offices and nationally representative household surveys and National Population Censuses, including *National Health Services Surveys* (NHSS) which are conducted every five years by China NHFPC. The differences between the three sets of data from NPHCCO, NHSS and UNICEF/WHO Joint Monitoring Programme lie in the definition, methodology and different types of data used to report on the use of/access to sanitation facilities.

⁷⁸ China National Health and Family Planning Commission/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 twin-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.

⁷⁹ 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.

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 2014*, UNICEF, 2014)

⁸⁴ The School Merger Programme began in the late 1990s, early 2000s. Small village schools were shut down and larger centralized schools were made available in towns and county seats.

⁸⁵ **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.

⁸⁶ **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 2014*, UNICEF, 2014)

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.

⁸⁷ **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)

⁸⁸ **Survival rate to the third grade of junior secondary school** – Percentage of children entering the first grade of junior secondary school who eventually reach the third grade of junior secondary school.

⁸⁹ China's Law on Teachers issued in 1993 requires that teachers should have corresponding educational qualifications as below: (1) nursery normal school or above for being teachers at kindergarten level; (2) secondary normal school or above for being teachers at primary level; (3) college/associate bachelor or above for being teachers at junior secondary level; (4) university/graduate school or above for being teachers at senior secondary level.

9. The rights of children and women

⁹⁰ *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

⁹¹ Data about migrant children and left-behind children used in this chapter are estimated by Prof. Duan Chengrong and team (of the School of Sociology and Population Studies, Renmin University of China) based on the National Population Censuses in 2000 and 2010, and One Per Cent Population Sample Survey in 2005. Data analysis for 2010 Population Census received support of the NBS/UNFPA/UNICEF Joint Data Project. Major data analysis results about migrant children were published in "Survival and development of migrant children in China: issues and measures - data analysis based on 2010 Population Census", *South China Population*, Vol 4, 2013; about left-behind children published in "Survival and development of rural left-behind children – data analysis based on 2010 Population Census", *Population Journal*, Vol 3, 2013.

11. Children with disabilities

⁹² **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 behavioral 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 disabilities (7) refer 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)

⁹³ **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 counseling, 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 counseling, 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 grassroots 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) refer 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) refer 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

⁹⁴ World Health Organization, *World Report on Violence and Health*, WHO, 2002

14. HIV / AIDS

⁹⁵ China Ministry of Health, *2012 China AIDS Response Progress Report*, MOH, 2012

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 Unless otherwise specified, 2013 data used in the OVERVIEW of HIV/AIDS chapter are from: Chinese Centre for Disease Control and Prevention, "Update on the AIDS/STD Epidemic in China and Main Response in Control and Prevention in December, 2013", *China Journal of AIDS and STD*, Vol 20, No. 2, February 2014

⁹⁸ This proportion is 2011 data. (China Ministry of Health, *2012 China AIDS Response Progress Report*, MOH, 2012)

⁹⁹ 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

¹⁰⁰ State Council AIDS Working Committee Office, Global AIDS Response Progress Reporting (GARPR) – China 2013, 2014

¹⁰¹ State Council AIDS Working Committee Office, Global AIDS Response Progress Reporting (GARPR) – China 2013, 2014

¹⁰² Ministry of Health Press Office, *China AIDS Response Progress*, 29 Nov 2012

¹⁰³ Institute of Population Research of Peking University, UNFPA, NWCCW, *Survey of Youth Access to Reproductive Health in China*, 2010

¹⁰⁴ Institute of Population Research of Peking University, UNFPA, NWCCW, *Survey of Youth Access to Reproductive Health in China*, 2010

¹⁰⁵ 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

¹⁰⁶ China Ministry of Health, *2012 China AIDS Response Progress Report*, MOH, 2012

¹⁰⁷ State Council AIDS Working Committee Office, Global AIDS Response Progress Reporting (GARPR) – China 2013, 2014

¹⁰⁸ 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.

ANNEX 2: Acronyms

AIDS	Acquired Immune Deficiency Syndrome	MWR	Ministry of Water Resources
BCG	Bacille Calmette-Guérin	NBS	National Bureau of Statistics
CDPF	China Disabled Persons' Federation	NCHS	(USA) National Centre for Health Statistics
CEDAW	UN Convention on the Elimination of All Forms of Discrimination Against Women	NHFPC	National Health and Family Planning Commission
CMS	Cooperative Medical Scheme	NHSS	National Health Services Survey
COMMIT	Coordinated Mekong Ministerial Initiative Against Trafficking	NMR	Neonatal Mortality Rate
CRC	Convention on the Rights of the Child	NPA	National Programme of Action for Children
CRPD	UN Convention on the Rights of Persons with Disabilities	NPHCCO	National Patriotic Health Campaign Committee Office
DTP	Diphtheria Tetanus and Pertussis	NWCCW	National Working Committee on Children and Women
EMIS	Education Management Information System	OPV	Oral Polio Vaccine
EPI	Expanded Programme on Immunization	PHCCO	Patriotic Health Campaign Committee Offices
GAVI	Global Alliance for Vaccines and Immunization	PMTCT	Prevention of Mother-To-Child Transmission
GDP	Gross Domestic Product	PPM	Parts Per Million
GNI	Gross National Income	PPP	Purchasing Power Parity
HepB	Hepatitis B	RCMS	New Rural Cooperative Medical Scheme
HIV	Human Immunodeficiency Virus	RMB	Renminbi (China's currency)
HSS	HIV Sentinel Surveillance System	SIA	Supplementary Immunization Activities
ICD	International Classification of Diseases	STD	Sexually Transmitted Disease
ICFDH	International Criteria of Functions, Disabilities and Health	TFR	Total Fertility Rate
IDD	Iodine Deficiency Disorders	U5MR	Under-Five Mortality Rate
IDU	Injecting Drug Use	UN	United Nations
IMR	Infant Mortality Rate	UNAIDS	Joint United Nations Programme on HIV/AIDS
JMP	Joint Monitoring Programme	UNESCO	United Nations Educational, Scientific and Cultural Organization
MCH	Maternal and Child Health	UNICEF	United Nations Children's Fund
MDG	Millennium Development Goals	UN IGME	UN Inter-agency Group for Child Mortality Estimation
MFAS	Medical Financial Assistance Scheme	UNPD	United Nations Population Division
MMR	Maternal Mortality Ratio	UNSD	United Nations Statistics Division
MMRP	Maternal Mortality Reduction Project	USI	Universal Salt Iodization
MOH	Ministry of Health	VIP	Ventilated Improved Pit
MPS	Ministry of Public Security	WHO	World Health Organization

