ADOPTION EDUCATION, LLC

SPECIAL REGIONAL CONSIDERATIONS

CHINA

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CHINA

Introduction [1]

The People's Republic of China (PRC), commonly known as China, is the largest country in East Asia and the most populous in the world with over 1.3 billion people, approximately a fifth of the world's population. China borders the East China Sea, Korea Bay, Yellow Sea, and South China Sea, between North Korea and Vietnam. Border countries include Afghanistan, Bhutan, Burma, India, Kazakhstan, North Korea, Kyrgyzstan, Laos, Mongolia, Nepal, Pakistan, Russia (northeast), Russia (northwest), Tajikistan, and Vietnam. Its regional borders are Hong Kong and Macau. The world's tallest peak Mount Everest is on the border with Nepal. Beijing is the capital city and is China's second largest city. Shanghai is the largest city in China in terms of population and one of the largest metropolitan areas in the world, with over 20 million people.

The PRC officially recognizes 56 distinct ethnic groups, the largest of which are the Han Chinese, who constitute about 91.9% of the total population. Large ethnic minorities include the Zhuang (16 million), Manchu (10 million), Hui (9 million), Miao (8 million), Uyghur (7 million), Yi (7 million), Tujia (5.75 million), Mongols (5 million), Tibetans (5 million), Buyei (3 million), and Koreans (2 million).

There are five recognized religions by the state: Buddhism, Taoism, Islam, Catholicism, and Protestantism. About 200 million people are Buddhists, Taoists or worshippers of legendary figures such as the Dragon King and God of Fortune, accounting for 66.1% of all believers, while Christianity accounted for 12% of believers, or 40 million people.

The national language is Putonghua (the common speech) or Mandarin, which is one of the five working languages at the United Nations. Most of the 55 minority nationalities have their own languages. Cantonese is one of the local dialects of southern China. As a written language, Chinese has been used for 6,000 years.

For 4,000 years, China was ruled by hereditary monarchs or dynasties beginning with the Xia until the Qing. This finally ended in 1911 with the founding of the Republic of China (ROC). The first half of the 20th century saw China plunged into a period of disunity and civil wars that divided the country into two main political camps – the Nationalist Kuomintang (KMT) and the Communist Party of China. In 1949, major hostilities ended when the People's Republic of China was established in mainland China by the victorious Communists. The Nationalist led Republic of China government retreated to Taipei, its jurisdiction limited to Taiwan. Even today, the PRC is still involved in potentially bloody disputes with the ROC over issues of sovereignty and the political status of Taiwan.

China is considered to be a major power and an emerging superpower. It holds a permanent seat on the UN Security Council and has memberships in the WTO (World Trade Organization), APEC (Asia-Pacific Economic Cooperation), East Asia Summit, and Shanghai Cooperation Organization. China is a nuclear state and has the world's largest standing army and fourth largest defense budget. China is one of the world's fastest growing economies in terms of nominal GDP growth, and is the fastest-growing major economy. Since the introduction of market-based economic reforms in 1978, the poverty rate has decreased from 53% in 1981 to 8% in 2001. However, China is now faced with a number of other economic problems including a rapidly aging population,] a widening rural-urban income gap, and environmental degradation.

However, China's growth has been uneven when comparing different geographic regions and rural and urban areas. Urban-rural income gap is getting wider in China. Development has also been mainly concentrated in the eastern coastal regions while the remainder of the country is left behind. The economy is also highly energy-intensive and inefficient – it uses 20%-100% more energy than OECD (Organization for Economic Co-operation and Development) countries for many industrial processes. China now became the world's second largest energy consumer behind the US but relies on coal to supply about 70% of its energy needs. The Chinese government seeks to add energy production capacity from sources other than coal and oil as its double-digit economic growth increases demand. Coupled with a lax environmental regulation, this has led to the deterioration in the environment - notably air pollution, soil erosion, and the steady fall of the water table, especially in the north. China has 20 of the world's 30 most polluted cities.

The People's Republic of China has a nationwide system of public education, which includes primary schools, middle schools (lower and upper), and universities. Nine years of education is technically compulsory for all Chinese students. Based on 2002 estimates, the total literacy rate in China was 90.8% (male 95.1%; female 86.5%). China's youth (age 15 to 24) literacy rate is 98.9% (99.2% for males and 98.5% for females) in 2000. Many parents are highly committed to their children's education, often investing large portions of the family's income on education. Private

lessons and recreational activities, such as in foreign languages or music, are popular among the middle-class families who can afford them.

The one-child policy is the population control policy of the People's Republic of China (PRC). The Chinese government refers to it under the official translation of family planning policy. It officially restricts the number of children married urban couples can have to one, although it allows exemptions for several cases, including rural couples, ethnic minorities, and parents who are only children themselves. A spokesperson of the Committee on the One-Child Policy has said that approximately 35.9% of China's population is currently subject to the one-child restriction.

The Chinese government introduced the policy in 1979 to alleviate social, economic, and environmental problems in China, and authorities claim that the policy has prevented 250 million births from its implementation. The policy is controversial both within and outside China because of the manner in which the policy has been implemented, and because of concerns about negative economic and social consequences. The policy has been implicated in an increase in forced abortions and female infanticide, and has been suggested as a possible cause behind China's significant gender imbalance. The decreasing reliability of population statistics since family planning began in the late 1970s has made evaluating the effectiveness of the policy difficult. Estimates by Chinese demographers of the average number of children for a Chinese woman vary from 1.5 to 2.0. The government is particularly concerned with the large imbalance in the sex ratio at birth, apparently the result of a combination of traditional preference for boys, and family planning pressure, which led to the ban of using ultrasound devices for the purpose of preventing sex-selective abortion. Nonetheless, a 2008 survey undertaken by the Pew Research Center showed that over 75% of the Chinese population supports the policy.

History of International Adoption

In 1992, China instituted its first Adoption Law. Very few children were adopted from China by Americans before 1994. In 1994 suddenly the number entering the U.S. increased from approximately 200 per year to 787. The following year, 2,130 children arrived from China, the most from a single country. Since then, China has maintained its position as one of the top sending countries.

ADOPTION FROM CHINA TO THE UNITED STATES

FY 2008 3,001
FY 2008 3,911
FY 2007 5,453
FY 2006 6,493
FY 2005 7,906
FY 2004 7,044
FY 2003 6,859
FY 2002 6,119
FY 2001 4,681
FY 2000 5,053
FY 1999 4,101
FY 1998 4,206
FY 1997 3,597
FY 1996 2,454
FY 1995 2,130
FY 1994 787
FY 1993 330
FY 1992 206
FY 1991 61

NOTE: All statistics given correspond with the U.S. Government fiscal year, which begins on October 1 and ends on September 30.
SOURCE: US Department of State, Intercountry Adoption, http://adoption.state.gov/news/total_chart.html

Virtually all children adopted from China are girls. This peculiar lopsidedness reflects the strong Chinese preference for male children coupled with the government's mandated "one child policy". These social forces result in the selective abandonment, abortion, infanticide, or failure to register births of female infants, and a skewed gender distribution of international adoptees and of children residing in institutional care. Population demographers estimate that over 1 million Chinese girls are "missing" each year. Some regions report sex ratios as high as 145 males to 100 females; overall there are about 116 boys for every 100 girls.

The sociology of abandonment is complex and painful. In one analysis, most of the 237 families who abandoned a child in the late 1980s-90s were married couples residing in rural villages. The decision to abandon the child was usually made by the birth father or both parents together. Gender, birth order, and gender composition of siblings determined who was to be abandoned; approximately 90% of the abandoned children were healthy girls. It was rare for the only or first girl born to be abandoned. Of the abandoned girls, 87% had no brothers, 40% were second daughters, and 36% were third daughters. Only 6% were first-borns. The few abandoned boys were usually disabled or ill or born to an unwed mother. Most children were abandoned within the first 6 months of life. Thus, the typical abandoned child was a healthy newborn girl with one or more older sisters and no brothers. Most abandonments took place at some distance from the family home, in a crowded location such as a market or bus station. Once the child was removed from the local jurisdiction, the incentive for local officials to investigate was reduced. Many of the girls were placed on doorsteps of families thought to be likely adoptive parents.

Only a small number of these abandoned girls are adopted, most by Americans (about 600 per year go to other countries, usually Canada). In China, prosecution for abandonment is usually perfunctory, requiring fines similar to those for having an "over-quota" child. Occasionally, the birth mother is sterilized. However, abandonment is not regarded as a criminal offense endangering the child.

Realistic estimates of the number of abandoned children are unavailable; as a rough estimate, only about 20% of abandoned children end up in government care. Some estimate that about 15 million baby girls have been abandoned

since 1980. From 1986 to 1990 in Hunan Province, over 16,000 abandoned children entered government care; 92% were girls and 25% were handicapped. In Hengyang City in Hunan Province, the number of abandoned children increased more than threefold within 3 years coincident with stricter enforcement of birth-planning policies. Between 1988 and 1993, as many as 16 children were abandoned each day in Shaoyang District.

As many as one million Chinese children reside in orphanages. Coincident with political enforcement of the "one child" policy, orphanage populations increased drastically in the late 1980s and early 1990s. During those years, mortality rates in orphanages exceeded 40%, and in some settings were as high as 80%. Most children died within the first few months after arrival. After sending 201 children to the United States in 1989, China virtually closed international adoption for the next 2 years. In the mid-1990s, an enormous controversy erupted after broadcast of a television documentary called "The Dying Rooms" and the publication of *Death by Default*, a report by Human Rights Watch. These reports purported to show that the state-run orphanages practiced a "policy of fatal neglect" and that "most orphaned or abandoned children in China died within one year of their admittance to state-run orphanages. The Human Rights Watch report accused the Shanghai Children's Welfare Institute of practicing "a deliberate policy of child murder in numerous cases," citing a mortality rate from the late 1980s to early 1990s that "was probably running as high as 90%." After these accusations, an international furor arose. The charges were vigorously denied by the Chinese government.

Over the next few years, international adoptions increased and changes were made to the care provided to abandoned children. With revenue obtained from international adoptions, some of the larger orphanages improved their facilities and medical care. However, poorer welfare centers outside of major cities have not yet benefited much from this. Foster care programs have been initiated in some regions. Chinese adoptions are now overseen by the China Center for Adoption Affairs, a central authority, somewhat similar to the process in South Korea. China now releases more detailed pre-adoptive medical information, permits healthy children to be adopted by foreigners, and has allowed considerably more transparency to enter the process.

Moreover, in 1999, Chinese couples were legally given the right to adopt abandoned children, something that had been banned or restricted. China does not have cultural traditions that preclude domestic adoption. Nonetheless, domestic adoption is uncommon: only about 8,000 – 10,000 per year are registered. Restrictions on adoption for Chinese citizens were recently liberalized, lowering the age from 35 to 30, but still require prospective adoptive parents to be childless (although this requirement may change soon). Adoptive parents with children are punished and fined as if they themselves had violated birth planning by having an over-quota child. In a recent survey, only 11 out of 392 of Chinese adoptive families received their child from a government welfare center. Most domestic adoptions are arranged informally.

Logistics [2]

China is party to the *Hague Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption (Hague Adoption Convention).* Therefore all adoptions between China and the United States must meet the requirements of the Convention and U.S. law implementing the Convention.

Special transition provisions apply to adoptions initiated before April 1, 2008. More information can be found here - http://adoption.state.gov/hague/overview/transition.html.

Effective January 1, 2009, all adoption cases between the U.S. and China will be processed by China as Hague Inter-country Adoption Convention cases. The Department of State has received assurances that under the new process, transition cases (as defined by the Inter-country Adoption Act), will not be negatively affected. CCAA has assured us that even though they officially consider all adoption cases to be Convention cases as of January 1, the actual process for transition cases will not significantly change. Under the new process, as of January 1, 2009, CCAA will send out the same documents for all cases (transition cases and Convention cases). These documents will include the "Letter of Seeking Confirmation from the Adopter" and the "Letter of Seeking Confirmation from the U.S. Central Authority" at the time the referral is sent. For transition cases, families will continue to sign and return the "Letter of Seeking Confirmation from the Adopter" but no action is required on the "Letter of Seeking Confirmation from the U.S. Central Authority."

For cases in which I-800A's are filed after April 1, 2008, China now requires a "Letter of Seeking Confirmation from the Adopter," which must be signed by the petitioners and returned to CCAA, and a "Letter of Seeking Confirmation from the U.S. Central Authority." U.S. Consulate Guangzhou will sign and return this second letter to CCAA after they have received and reviewed the petitioner's visa application (DS-230) and their provisionally approved I-800. In Convention cases prospective adoptive parents will receive notice to travel and finalize the adoption from CCAA only after CCAA receives the two "Letters of Seeking Confirmation." As with the transition process, in order to prevent unpredictable length of stays in China, prospective adoptive parents should not travel until they have received notice to travel from CCAA to finalize the adoption, and confirmation from the U.S. Consulate Guangzhou that their visa interview has been scheduled.

Chinese authorities are extremely sensitive about the operation of foreign entities in China. Moreover, adoption is also a sensitive subject in China. It is therefore advisable for any person interested in adopting a child from China to act with discretion and decorum. High-profile attention to adoption in China could curtail or eliminate altogether adoption of Chinese children by persons from countries, including the United States, that have caused adoption to become the subject of public attention.

WHO CAN ADOPT

China adoption law is very clear on which types of prospective adoptive parents can adopt children from China. The China Center for Adoption Affairs (CCAA) has issued the following new regulations for foreigners who wish to adopt children in China. These regulations became effective for all applications received after May 1, 2007:

- **Residency Requirements**: China does not require that prospective adoptive parents reside in China for a specified period prior to completing an adoption. However, in order to finalize an adoption, at least one adopting parent must travel to China to execute the required documents in person before the appropriate Chinese authorities. If only one member of an adopting married couple travels to China, that person must have in his/her possession a power of attorney from the other spouse, notarized and authenticated by the Chinese Embassy in Washington or one of the Chinese Consulates General elsewhere in the United States.

- **Age Requirements**: Both parents must be between the ages of 30 and 50. Those couples who apply to adopt a special needs child must be between the ages of 30 and 55.

- **Marriage Requirements**: Chinese law permits adoption by married couples, defined as one man and one woman. They must adopt the child jointly. In addition, they must have been married at least two years. If either person has previously divorced, the couple must have been married at least five years. No more than two divorces are allowed.

- **Income Requirements**: At least one member of the couple must have stable employment. The total value of family assets must be at least $80,000. The family's annual income equals at least $10,000 for each family

member in the household (including the child to be adopted). Annual income excludes welfare, pensions, unemployment insurance, Government subsidies and the like. Both prospective parents must be high school graduates or have vocational training equivalent to a high school education.

- **Health Requirements**: Both partners must be physically and mentally fit, with none of the following conditions:
    - AIDS;
    - Mental disability;
    - Infectious disease that is actively contagious;
    - Blind in either eye;
    - Hearing loss in both ears or loss of language function (those adopting children with hearing or language function loss are exempted from this requirement);
    - Non-function or dysfunction of limbs or trunk caused by impairment, incomplete limbs, paralysis or deformation;
    - Severe facial deformation;
    - Severe diseases that require long-term treatment and that may affect life expectancy, including malignant tumors, lupus, nephrosis, epilepsy, etc;
    - Major organ transplant within ten years;
    - Schizophrenia;
    - Severe mental disorders requiring medication for more than two years, including depression, mania, or anxiety neurosis; and
    - Body Mass Index (BMI) of 40 or more
- **Other Requirements**: The family must have fewer than five children under the age of 18, and the youngest is at least one year old (those adopting special needs children are exempted from this requirement).

  Neither partner may have a significant criminal record, and both must have a history of honorable behavior and good moral character with no evidence of:
    - Domestic violence, sexual abuse, abandonment or abuse of children;
    - Use of narcotics or any potentially addictive medication prescribed for mental illness;
    - Alcohol abuse, unless the individual can show she/he has been sober for at least ten years

Note: *Applications from persons with past criminal records will be considered on a case-by-case basis if the individual has fewer than three minor criminal convictions (none in the last ten years) and fewer than five minor traffic violations.*

The prospective parents must demonstrate the ability to provide a warm family environment capable of meeting the needs of an orphaned child and providing for her/his development, and an understanding of the special risks (including potential diseases, developmental delays, and post-placement maladjustment) that could come with inter-country adoption.

Note: *In each instance above where a specific age or time span is cited, it will be computed from the time that the CCAA officially logs the adoption application documents.*

WHO CAN BE ADOPTED

Because China is party to The Hague Adoption Convention, children from China must meet the requirements of the Convention in order to be eligible for adoption. Chinese law allows for the adoption of children up to and including age 13; children ages 14 and up may not be adopted. Adoption applicants can only adopt one child at a time in China (with the exception of the adoption of twins or the siblings living in the same welfare institute). Those prospective adoptive parents who have already adopted one child and who wish to adopt a second Chinese child, may, in principle, do so only one year after the first adoption, by resubmitting adoptive applications and certified materials.

There are specific requirements for children with special needs or medical conditions. Once a prospective adoptive parent decides to accept a special needs referral, they have 48 hours to fill out the necessary forms to complete the dossier. Cases of children with special needs who are available for international adoption are posted on the CCAA website. The prospective adoptive parent can view the case, including the medical and growth records and a photo of the child. The reason the child is considered special needs is documented and the prospective parent can decide if this child would fit into their family, if their insurance would cover the medical needs, and whether they themselves are able to provide any educational or rehabilitative needs, etc. After they decide they want this child, they click a button and from that point onward they have 48 hours to fill out the necessary forms to complete the dossier. The reason this short time limit is set is so that the child is not taken off the list unless the family truly wants to adopt her or him. If the prospective parent have not completed the forms and submitted them within 48 hours, the child's name goes back on the list and another family could possibly select her or him.

HOW TO ADOPT

The Chinese Adoption Authority is the China Center of Adoption Affairs (CCAA). Only these agencies and attorneys who are accredited can provide adoption services between the United States and China. Once the U.S. Government determines that the prospective adoptive parents are "eligible" and "suitable" to adopt, their CCAA-licensed agency may submit adoption applications directly to the CCAA for consideration. The application may include any preferences the prospective adoptive parent may have about the child's age, sex, physical/medical condition, or region of origin within China.

Once the CCAA approves the application, it matches the application with a specific child. The CCAA then sends the prospective adoptive parent(s) a letter of introduction about the child, including photographs and the child's health record. This document is commonly called a 'referral.' Prospective adoptive parents who still have questions about the child after reviewing this information may follow up with their adoption agency.

The prospective adoptive parent then either accepts or refuses the referral and sends the document to their agency, which forwards it to CCAA. CCAA requires a response on a referral within 45 days of sending a referral to a family. If prospective adoptive parent(s) are considering refusing a referral they should discuss with their agency the possibility of getting a second referral. CCAA will only accept referral rejections if there is a justified explanation provided. If the reason for the rejection is considered justifiable, such as a medical problem, the CCAA will refer the second child to the prospective adoptive parents within a month's time. If CCAA regards the rejection as unreasonable, the prospective adoptive parents will have difficulty obtaining a second referral and CCAA is more likely to suggest that the parents withdraw their application for adoption in China.

Prospective adoptive parents who have accepted a specific referred child will receive an approval notice from the CCAA ("Notice of Coming to China for Adoption"). This document will bear the "chops," or red-inked seals of the CCAA. Prospective parents must have this approval notice in hand before departing for China to finalize the adoption.

After the prospective adoptive parents accept a match with a child, they apply to the U.S Government, Department of Homeland Security, U.S. Citizenship and Immigration Services (USCIS) for provisional approval to adopt that particular child (Form I-800). USCIS will determine whether the child is eligible under U.S. law to be adopted and enter the United States.

Intercountry Adoption News
The latest news affecting adoptions can be found here: http://adoption.state.gov/adoption.homepage.html

Information about the CCAA can be found at their website: http://www.china-ccaa.org/frames/index_unlogin_en.jsp

General Health Issues in the Population

The Ministry of Health, together with its counterparts in the provincial health bureaus, oversees the health needs of the Chinese population. An emphasis on public health and preventative treatment characterized health policy since the early 1950s. At that time, the party started the Patriotic Health Campaign, which was aimed at improving sanitation and hygiene, as well as attacking several diseases. This has shown major results as diseases like cholera, typhoid, and scarlet fever were nearly eradicated. [1]

The end of the famed "barefoot doctor" system based in the people's communes and the increasing privatization of medicine, often poorly regulated, have made corruption and inefficiency in the delivery of health services serious problems. Mistaken political policies led to the starvation of millions during the Great Leap Forward (*An economic and social plan used from 1958 to 1961 which aimed to use China's vast population to rapidly transform mainland China from a primarily agrarian economy dominated by peasant farmers into a modern, agriculturalized and industrialized communist society*). Epidemic disease rebounded during the dislocations of the Cultural Revolution, (*a struggle for power within the Communist Party of China that manifested into wide-scale social, political, and economic violence and chaos, which grew to include large sections of Chinese society and eventually brought the entire country to the brink of civil war*) which seriously harmed public health in China. The effective public health work in controlling epidemic disease during the early years of the Peoples Republic of China and, after reform began in 1978, the dramatic improvements in nutrition greatly improved the health and life expectancy of the Chinese people. By 2000, when the World Health Organization made a large study of public health systems throughout the world, they found that China's health care system before 1980 performed far better than countries at a comparable level of development, since 1980 China ranks much lower than comparable countries.[3]

Despite significant improvements in health and the introduction of western style medical facilities, China has several emerging public health problems, which include respiratory problems as a result of widespread air pollution and millions of cigarette smokers, a progressing HIV-AIDS epidemic, and an increase in obesity among urban youths. Estimates of excess deaths in China from environmental pollution (apart from smoking) are placed at 760,000 people per annum from air and water pollution (including indoor air pollution). China's large population and close living quarters has led to some serious disease outbreaks in recent years, such as the 2003 outbreak of SARS (a pneumonia-like disease) which has since been largely contained.[1]

After the foundation of The People's Republic of China in 1949, China entered its demographic transition: first mortality began to fall rapidly and second, fertility remained for many years at about an average of six children per woman. As a result of this, China experienced rapid population growth due to the high number of children born, to a sharp decline of infant mortality rate and to the increase of life expectancy at birth. [4]

Life expectancy at birth is a key measurement of economic development and health care levels. In China, life expectancy at birth has shown a large increase within a short period of time. The country's life expectancy at birth jumped from about 35 years in 1949 to 63 in 1975 and to 73.18 years in 2008. According to a study, published recently by Beijing-based Science Press, average life expectancy will be 85 in 2050.[1]

From 1950 China has had a period of high fertility with the total fertility rate around six children per woman. Between 1958 and 1961, China experienced a period of famine that lead to a large drop in fertility and a large excess of deaths. This period of crisis was followed by a recovery period in which fertility rate increased rapidly and reached a peak in 1963 because of compensatory childbearing after the famine. In 1970 the Government formulated the first anti-natalist policy named 'later-longer-fewer', and that promoted later births, longer spacing between births and fewer births. This policy was followed in 1979 by the family planning program 'one-child policy'.[4] Since the introduction of the one-child policy, the fertility rate in China has fallen from over three births per woman in 1980 (already a sharp reduction from more than five births per woman in the early 1970s) to approximately 1.8 births in 2008. [1]

Infant mortality went down from 300 per 1,000 live births in the 1950s to about 21 per 1,000 live births in 2008.[1,5] The under-five mortality rate also has steadily decreased in the last 20 years. The rate has dropped from 64 per 1,000 live births in 1980 to 49 in 1990, 41 in 2000 and to the rate of 31 in 2004.[6] However, infant and under-five mortality rates remain high where access to services is low, particularly due to communicable diseases and perinatal conditions. Despite overall improvements in child mortality, inequalities persist with higher rates in western China and in rural areas.[7] The infant mortality rate in the urban areas in 2004 was 10.1 compared to 24.5 per 1000 live births in the rural areas. Under-five mortality is just 16.3 in cities, but more than 40 per 1,000 live births in rural areas. In poor areas, major causes of neonatal and early childhood death include poor obstetrical and neonatal care, neonatal tetanus, asphyxia, pneumonia, premature birth, low birth weight and diarrhea. While not a direct cause of death, malnutrition is another underlying factor that increases the risk of severe complications for many diseases.[8]

In the last two decades, China has made substantial progress in reducing maternal mortality. According to government statistics, China's maternal mortality rate dropped from 94.7 mother deaths per 100,000 live births in 1990 to 48.3 in 2004. Maternal hemorrhage, hypertension, embolism and sepsis — all largely preventable or treatable — cause 77 per cent of maternal deaths in China.[8]

Nationally, the percentage of births delivered in hospitals increased from 39 per cent to 68 per cent between 1992 and 2002, in rural areas these figures grew from 22 per cent to 62 per cent and in urban areas from 87 to 93 per cent. The proportion of total births (inside or outside a hospital or clinic) attended by skilled personnel had risen to 87 per cent by 2001, and the percentage of children born in hospitals grew from 50.6 per cent in 1990 to 82.8 per cent in 2004.[8]

National figures for maternal mortality mask large disparities, which exist between urban and rural populations, and across different regions of China. Maternal mortality in the urban areas in 2004 was 26.1 compared to 63 per 100,000 live births in rural areas. Maternal death rates are highest among the rural poor and migrant populations, and in those regions with least access to antenatal and intrapartum care, such as the western provinces.[8]

In 1949 crude death rates were probably higher than 30 per 1,000 population. Beginning in the early 1950s, mortality steadily declined; it continued to decline through 1978 and remained relatively constant through 1987. Based on 2008 estimates, the death rate was 7.03 deaths per 1,000 population.[5] Noncommunicable diseases and injuries account for over 80% of deaths. Leading causes of death in China include cerebrovascular disease (including stroke), heart disease and cancer (accounting for approximately more than 50% of all deaths). Road-traffic injuries, depression and suicide are also leading causes of mortality and morbidity, especially in the young and economically active age groups.[7] According to the Ministry of Public Security, China has ranked first worldwide in terms of traffic deaths since 1996. In 2007, China recorded 5.1 road accident deaths for every 10,000 motor vehicles. The world average was two deaths per 10,000 vehicles. [9]

In the past two decades, traditional attitudes towards sex, marriage and family have changed, and pre-marital sex is more acceptable. Reproductive health care is available through government services. A variety of contraceptive services including induced abortion are widely available at township and upper level health facilities. Contraceptive tablets and condoms are also available at drug stores and supermarkets. "Backstreet" abortion, often seen in many other developing countries, has become rare in China, particularly in the urban areas. This is largely because of effective rectification of medical care market by the Chinese government. However, the current National Family Planning Program targets married couples and the young people have little access to information or advice about contraception.[10]

Research by the United Nations Population Fund published in 2003 indicates that the use of contraception in China is almost universal – at 83 percent. China, in fact, leads the world in the use of contraception. However, that does not reflect the whole picture. China's family planning policy is aimed mainly at married women, and it emphasizes long-term or permanent methods of contraception. A study conducted in 2004 by the Medical Center of Fudan University in Shanghai and the International Health Research Group found premarital sex among China's urban youth was becoming more common. It also found that the abortion rate among unmarried women was alarmingly high. [1] Use of contraception such as condoms or the contraceptive pill remains low, which accounts in part for the high abortion rate among China's young women.[11]

The abortion rate in China is about 28 percent, only slightly higher than the 25 percent rate in the United States, [2] but it is still surprisingly high considering the high usage rate of permanent forms of contraception. Research conducted by the Medical Center of Fudan University in Shanghai and the International Health Research Group found unmarried women in China's cities were more likely to have abortions than married women elsewhere in the country. [11]

Sex education lags in China due to cultural conservatism. A survey conducted in 2003 by the Chinese Youth and Children Research Center, which involved 5,000 college students across China, indicated a mere 6.6 percent of respondents had received scientific and thorough sex education at the college level. An alarming 36 percent said they had not received any sex education at college. [11]

Obesity

The twin problems of overweight and obesity is a growing trend which is fueled by changes in diet and lifestyle brought about in part by China's growing prosperity. In 1970 the Chinese diet was only 10 percent fat. Today about 40 percent of Chinese consume a diet composed of roughly 30 percent fat, and most Chinese take in 400 percent more edible oil, eggs, and meat than they did a generation ago. Roughly 15 percent of Chinese men and 16 percent of women

are overweight, and the percentage is higher in major cities. According to studies by the Beijing Center for Disease Control and the China Medical Association, one-third of all Beijing residents are overweight, while more than one-fifth of Shanghai residents are obese. The problem represents a particular threat to children. Studies show 18 percent of Beijing's primary and middle school students are obese, more than double the percentage 10 years ago.[12]

Tobacco

Tobacco, alcohol, and illicit drug use has expanded in China as in other Asian nations. Although men are the chief users, women are involved with these substances in increasing numbers. China is home to one-fifth of the world's population and one-third of the world's smokers. Only about 4% of women smoke (compared with approximately 64% of men), but smoking is becoming more widespread among young people of both sexes. [13]

China is the world's largest producer and consumer of tobacco. China has 350 million smokers, the highest of any country in the world. In many parts of China, the social etiquette of entertaining guests with cigarettes and giving tobacco products as gifts is prevalent; offering cigarettes is viewed as polite and necessary for socializing. Some smokers believe the phrase, "smoking is my right and others can't intervene." Some non-smokers also share this belief, so they don't have the rationale to stand up against smoking in public places. China does not have a national law or national regulation specifically banning smoking in public places. [13]

Based on research and estimates, as many as 540 million people are exposed to the hazards of secondhand smoke in China, of which 180 million are children below the age of fifteen. Secondhand smoke exposure rates are 49.7% and 54.0%, respectively, in urban and rural areas, with the rural areas higher than the urban areas. Compared to developed countries, the rate of female smokers in China is not high. However, since the male smoking rate remains high, more than half of all Chinese women are exposed to secondhand tobacco smoke every day and are the main victims of passive smoking. [13]

Alcohol

Alcoholic beverages in China have a long history. Wine was said to have been invented during the Xia Dynasty, around the 21st century B.C. Alcohol is part of many traditional festivals and of celebrations such as weddings and is also associated with the arts and poetry. Alcohol is commonly used, particularly by men, as part of business meetings, to maintain good relations between supervisors and employees and to promote camaraderie among colleagues.[14]

Until the early 1980s, alcohol-related problems were far less prevalent in China than in many western countries. Since then, China has undergone rapid social and economic change with increasing urbanization, westernization and changes to traditional family structure. The change towards a free-market economy has provided a new and vast market for producers and importers of alcoholic beverages. Commercial production figures do not provide a precise measure of consumption, and in particular do not capture home alcohol production, and considerable change within Chinese society. [14]

While alcohol is a traditional part of Chinese life, commercial alcohol production in China has increased more than 50-fold per capita since 1952. In parallel there is evidence of a marked increase in prevalence of alcohol dependence, which has moved from the ninth to the third most prevalent mental illness. [14]

Alcohol use has increased substantially; in some studies nearly half of females use alcohol regularly, although, in general, alcohol use by women lags behind that of men. Traditionally, drinking and smoking have been more accepted for Chinese men than for women. A 2001 WHO-sponsored survey of 24,992 subjects aged 15 years or older across five areas in China revealed that men drank 13.4 times more than women. The average annual consumption in pure alcohol for male, female and total 1-year drinkers was 10.1, 1.5 and 7.6 liters respectively. Anecdotal evidence suggests that people living in Northern China have higher levels of alcohol consumption than those in the south, that urban residents drink lower-strength beverages than do rural residents, and that some minority ethnic groups, such as those of Tibetan and Mongolian background, drink more than other ethnic groups. However, no data documenting these differences were identified. This same survey found that heavy drinkers accounted for 6.7% of the sample and consumed 55.3% of the total alcohol consumption. Heavy drinking was defined as consumption of more than 50 ml (40 g) of pure alcohol per day.[15]

Drug Use

Drug use is harder to quantify, and data about women are lacking. In 1995, there were approximately 100,000 drug users in Yunnan Province alone; in a single county (Kunming) there were an estimated 20,000 to 30,000 drug users, mostly injection drug users. Injection drug use varies in different regions (58% of drug users in Guangxi, 20-30% in

Guangdong and Sichuan, 5% in Guizhou in 1993; by 1996 rates increased to 75% in Xinjiang, 90% in Guangxi). The preferred drug is heroin; other favored choices include diazepam, opium, and cannabis. About 90% of drug users are below 30 years of age, and over 80% are male.

China is a major transshipment point for heroin produced in the Golden Triangle region of Southeast Asia. It is the source country for chemical precursors, despite new regulations on its large chemical industry. China is seeing a growing domestic drug abuse problem. [5]

Tuberculosis

Tuberculosis is one of China's major public health problems. According to WHO estimates, China has the world's second largest tuberculosis epidemic, behind only India. Tuberculosis has been the number one cause of death from infectious disease in adults.[3] It is estimated that 1.4 million people across the country develop active TB each year, of which 600,000 have the highly infectious form of TB. The disease kills several hundred people each day in China. The disease continues to blight the country's poor and vulnerable.

China began implementing DOTS (Directly Observed Therapy, Short-course) in 1991. In 1995 only 49 percent of the population lived in areas covered by DOTS and by 2006, this figure jumped to 100 percent of the population. DOTS stipulates that sputum samples should be taken and tested for all suspected TB cases, and that patients should not only be prescribed (and have access to) the right drugs but take them in a supervised manner to ensure they finish the course. As a consequence of DOTS being more widely available, TB detection rates in China have improved. It was estimated that in 1995 only 15 percent of new infectious TB cases in China were being detected. This increased to 64 percent in 2004 and 79 percent by the end of 2006.[16]

The emergence of strains of tuberculosis (TB) that are resistant to one or more major anti-TB drugs is a growing concern in China. The full extent of the problem is unknown but in some provinces 10 per cent of all new TB cases are multi-drug resistant. China as a whole is thought to have one of the world's highest rates of drug-resistant TB. Poor quality treatment is the primary cause of multi-drug resistance. People with HIV/AIDS are especially vulnerable to developing TB and TB is a major cause of death among HIV/AIDS patients, yet the links between China's TB and HIV/AIDS programs remain weak. Another group vulnerable to TB is China's large migrant population. Urban migrants, who have relocated from poor rural areas to seek a better livelihood, are not eligible for free tuberculosis services. Little has been done to control the spread of TB in this population.[17]

SARS

Although not identified until later, in November 2002, China's first case of a new, highly contagious disease, severe acute respiratory syndrome (SARS) otherwise known as Yellow Pneumonia, occurred in the Guangdong province of China, which borders on Hong Kong, Within three months, the Ministry of Health reported 300 SARS cases and five deaths in the province. By May 2003, some 8,000 cases of SARS had been reported worldwide; about 66 percent of the cases and 349 deaths occurred in China alone. That same month, foreign adoptions in China were temporarily halted in an attempt to reduce the transmissions of SARS. By early summer 2003, the SARS epidemic had ceased. A vaccine was developed and first-round testing on human volunteers completed in 2004. On May 19, 2004, as no new infections were reported in a three-week period, WHO announced China as free of further cases of SARS.[3]

Infectious Diseases

There are several major infectious diseases that are likely to be encountered in China where the risk of such diseases is assessed to be very high as compared to the United States. Food or waterborne diseases are those acquired through eating or drinking on the local economy and include bacterial diarrhea, hepatitis A, and typhoid fever. Vector borne diseases which are acquired through the bite of an infected arthropod include Crimean Congo hemorrhagic fever, Japanese encephalitis, and malaria. Leptospirosis is a water contact disease that can be acquired through swimming or wading in freshwater lakes, streams, and rivers. Rabies can be acquired through direct contact with infected local animals.[5]

Strains of avian flu outbreaks in recent years among local poultry and birds, along with a number of its citizens, have caused great concern for China and other countries. While the virus is currently mainly animal-human transmissible (with only two well documented cases of human-human have been to the present known of to scientists), experts expect an avian flu pandemic that would affect the region should the virus morph to be human-human transmissible. [3]

The World Health Organization (WHO) maintains situation updates at their website http://www.who.int/csr/disease/avian_influenza/updates/en/index.html. More information about avian flu can be found at CDC's website, http://www.cdc.gov/flu/avian/gen-info/avian-flu-humans.htm.

In 2005, an outbreak of the pig-human transmission of the *Streptococcus suis* bacteria in 2005, led to 206 cases in humans with 38 deaths in and around Sichuan province, an unusually high number. Although the bacteria exists in other pig rearing countries, the pig-human transmission has only been reported in China.[3]

Malaria remains a serious public health problem in China. The provinces of Yunnan and Hainan are the areas where malaria has been the most endemic with high transmission of *P. falciparum*. Malaria resurgence has occurred for three consecutive years since 2000. In addition to the southern mountainous area of Hainan and the border area of Yunnan, malaria is also prevalent in several provinces of central China where *A. anthropophagus* is the principal transmitting vector. Fluctuating incidence has been recorded in the past several years with focal epidemics from time to time. Although the annual incidence has been reduced to less than 1/10,000 in most areas where *A. sinensis* plays a role as the major vector, focal resurgence or outbreaks were reported in some areas as a result of increased population movement.[18]

Hepatitis B is recognized as endemic in China by the World Health Organization (WHO). Roughly 400 million people are infected with hepatitis B virus (HBV) worldwide. Over one-third of the world's population has been or is actively infected by hepatitis B virus (HBV). An estimated 130 million Chinese are infected with the disease, about 10 percent of China's total population and about one-third of the world's cases. The incidence of hepatitis B continues to increase, from 21.9 in 100,000 people in 1990 to 53.3 in 100,000 in 2003. Almost 1 million new cases were reported in China in 2005.[19]

Public awareness of the disease, which is spread through the exchange of bodily fluids, is not as high as it is for HIV and AIDS. In some rural areas, doctors have reused syringes and unknowingly spread the disease, particularly among children. There have been relatively few campaigns aimed at ending the practice of reusing needles. Another problem is the growing size of China's migrant labor force or "floating population." Farmers or peasants who become urban laborers move frequently around the country and often do not seek medical attention. According to China CDC, the immunization rate among them remains low.[19]

The increase in incidence has occurred despite a vaccination program for newborn babies since the 1990s, which showed good effectiveness for reducing chronic HBV infection in children. By 2006, China had successfully immunised 11.1 million children living in the country's poorest provinces against hepatitis B. However, even within the vaccination project's target area, over one million newborns went unvaccinated each year because of access issues; health-care costs, lack of birth attendants, and the remoteness of their birthplaces—in herder's huts, mountain villages, and remote farms. The reason for this increased HBV infection is unknown, because hepatitis B has no clear transmission routes in many people in China, although both neonatal infection and horizontal transmission (*transmission of a bacterial, fungal, or viral infection between members of the same species that are not in a parent-child relationship*) during early childhood are still the most common routes.[19]

Hepatitis B sufferers in China frequently face discrimination in all aspects of life and work. For example, many Chinese employers and universities refuse to accept anyone who tests positive. Some kindergartens refuse admission to children who are carriers of the virus. The hepatitis problem is a reflection of the vast developmental gap between China's rural and urban areas.[19]

HIV/AIDS

China, similar to other nations with migrant and socially mobile populations, has experienced increased incidences of HIV/AIDS. By the mid-1980s, some Chinese physicians recognized HIV and AIDS as a serious health threat but considered it to be a "foreign problem". As of mid-1987 only two Chinese citizens had died from AIDS and monitoring of foreigners had begun. Within China, the rapid increase in venereal disease, prostitution and drug addiction, internal migration since the 1980s and poorly supervised plasma collection practices, especially by the Henan provincial authorities, created conditions for a serious outbreak of HIV in the early 1990s. As of 2005 about 1 million Chinese have been infected with HIV, leading to about 150,000 AIDS-related deaths. Projections are for about 10 million cases by 2010 if nothing is done. [3]

According to China's health ministry, as of September, 2008, there were 264,302 registered cases of HIV/AIDS, up from 183,733 in 2006, with 34,864 deaths. But the real figures are likely to be much higher as testing and surveillance techniques are limited, especially in the countryside, and entrenched discrimination may have discouraged many from reporting. Public ignorance about AIDS is a major problem in China. A recent survey found 20 percent of people had never heard of the disease.[20]

The Chinese government has been widely criticized for its failure to respond to the HIV/AIDS threat and for systematic suppression of information about the size of the problem. Effective preventive measures have become a priority at the highest levels of the government, but progress is slow.[20]

China has a low overall HIV prevalence but high prevalence in certain population groups and at some sites. HIV prevalence is high among injecting drug users, especially in Yunnan, Guangxi, Sichuan, Xinjiang and Guangdong provinces. Injecting drug users are the largest vulnerable population group (more than 3 million), with HIV infection rates up to 80% in some areas in Xinjiang and more than 20% in Guangxi and Yunnan. A prevalence of 7% or more is reported among injecting drug users in 16 provinces. Data from sentinel surveillance also indicate that infection rates among sex workers and men who have sex with men are increasing. A HIV prevalence of 0.5–1% is reported among sex workers, and one-off surveys among men who have sex with men have shown rates of 1% or more in Beijing, Shenyang and Guangzhou. Former paid plasma donors, mostly concentrated in central China, had prevalence rates as high as 65%.[21]

Although the epidemic is still concentrated among certain population groups, evidence now suggests that the epidemic is spreading into the general population. The proportion of total HIV cases among females increased from 15% in 1998 to 39% in September 2004 and that of mother-to-child transmission from 0.1% in 1997 to 1.0% in 2004. Risk factors include low awareness of HIV/AIDS, low rates of condom use, pervasive stigma and discrimination, high rates of mobility and migration and the availability and affordability of commercial sex. Most new infections are identified among young people.[21]

The local capacity of the public health sector to treat HIV/AIDS remains limited, and the national response is constrained by several factors including limited human resource capacity, limited availability of laboratory support and insufficient community support mechanisms for counseling and adherence. People are often unaware of their HIV status, and access to voluntary testing and counseling is limited. Capacity to deliver antiretroviral therapy is inadequate due to a scarcity of trained health care staff and infrastructure shortages, especially below the county level. Access to services at the county and village level is further restricted by the lack of incentives for health workers to provide free services to poor people in rural areas who do not have any health care insurance.[21]

Procurement mechanisms for antiretroviral drugs need to be strengthened. Many of the marginalized and vulnerable populations are difficult to reach. The links between HIV/AIDS treatment services and drug dependence treatment services and outreach programs for vulnerable populations need to be strengthened. Planning for scaling up antiretroviral therapy is multi-sectoral, but coordination among national or international partners and initiatives needs to be strengthened, and a comprehensive, long-term nationwide plan needs to be developed. Community participation also needs to be built into efforts to scale up antiretroviral therapy and to reduce fear, social stigma and discrimination. Surveillance and information systems need to be strengthened.[21]

Iodine Deficiency

Even reasonably well-nourished populations can be devastated by “hidden hunger”—the body's unmet need for micronutrients such as iodine, folic acid, and zinc. Iodine deficiency is still a widespread problem in western, southern and eastern parts of China as their iodized salt intake level was much lower than the average national level. In 1995 an iodized salt program was started by the Chinese government, aimed to eliminate iodine deficiency disorders (IDDs) by the year 2010. In 2007, 94.3 percent of Chinese used iodized salt, up from 39 percent in 1995. However, the country's program to fortify salt with iodine has not been fully implemented in some areas. The iodized salt intake rate was below 90 percent in Guangdong, Hainan, Qinghai, Shanghai, Tibet, and Xinjiang.[22, 23]

People with iodine deficiencies are prone to suffering goitre, a swelling of the neck resulting from enlargement of the thyroid gland, which can also lead to learning disabilities. Iodine deficiencies can also cause miscarriages of pregnant women.[23]

Special Considerations for Children Adopted from China

Before the adoption

Children reside in state-run orphanages prior to adoption. A small number of children are placed in foster care. Some children receive "modified institutional care," sometimes returning home at night with a caregiver but spending the day in the group setting. Some children are removed from foster care a month or two prior to adoption and returned to the orphanage "to prepare them for adoption." Sometimes parents do not know the living circumstances of their child prior to adoption. It remains unusual for adoptive parents to meet or be given contact information for foster parents, although in some regions this is changing.

Specific information about the arrival of the child into state care is sometimes given at the time of the adoption. Details about the location where the child was found may be provided (the market, the police station, etc.). Parents may be given notes found with the child, for example:

> This healthy baby girl was born on ---------, 1992 at 5:30 am and is now 100 days old … She is in good health and has never suffered any illness. Due to the current political pressures that are too difficult to explain, we, who were her parents for these first days, cannot continue taking care of her. We can only hope that in this world there is a kind-hearted person who will care for her. Thank you … In regret and shame, your father and mother.

After the adoption

Prospective adoptive parents must provide an adoption application letter that makes clear the applicants' willingness to allow post-placement follow-ups and provide post-placement reports as required. [2]

Are Chinese adoptees healthier and more developmentally intact than children from other countries? The young age of most children at the time of placement, better prenatal care, fewer adverse prenatal exposures, and superior institutional care have been cited as possible protective factors. No published studies have yet specifically compared the health of children adopted from China to that of adoptees from other countries. Most experts agree that the risks of fetal alcohol syndrome and fetal alcohol effect are considerably less than in children from Russia and other Eastern European countries. However, a survey of 452 children adopted from China reported prevalence of infectious diseases and growth and developmental delays similar to that of children from other countries. Hepatitis B was found in 6%, intestinal parasites in 9% and latent tuberculosis infection in 3.5% of Chinese adoptees. Delayed growth was found in 39% of children for height, 18% for weight, and 24% for head circumference. Seventy-five percent of children had significant developmental delays in one or more domains; 44% had global delays. This report only evaluated children at entry into the United States; the prevalence of learning disabilities, language delays, persistent developmental delays, and behavioral and emotional problems was not assessed. Notably, 14% of the children had elevated lead levels, a much higher prevalence than that for children from other countries. The long-term effects of lead intoxication may not be fully apparent until affected children reach school age.

Adoptive parents need to be aware of stereotypical attitudes that they and their children will face. Chinese and other Asian children are perceived in positive but stereotypical terms, such as assuming that they are clean, bright, obedient, etc. Another stereotype is that they are invariably adept in math and science. However, this is not so.[24]

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