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## Executive Summary

There has been considerable progress in China in the field of Sexual and Reproductive Health and Rights (SRHR) since the International Conference on Population and Development (ICPD) in 1994.

Following on the ICPD, the Chinese Government collaborated with NGOs to make a number of policy changes that relate broadly to family planning, public health, and gender equality. More specifically, these changes address the following areas in SRR: gender equity and social equality and equity, maternal mortality, safe motherhood and abortion; the promotion and protection of sexual health and rights; safe contraception; prevention and treatment of HIV/AIDS and reproductive cancer. These provide evidence of China's attempts to achieve the goals set by the ICPD Programme of Action (PoA).

Chinese women participate in a wide range of political activities and play a number of social roles. The proportion of women who have received education at different levels has been on the rise with women's educational levels seeing significant improvement. Female employment rates have increased to 46.0 percent in 2000 from 45.7 percent in 1995. This ratio is high and stable and the female employment structure is reasonable. The life expectancy of women in China increased from 70.47 years in 1990 to 73.33 years in 2000, an increase of 2.86 years while that of men has gone up from 66.84 years in 1990 to 69.63 in 2000. The figure for women is close to the life expectancy norms for women in developed countries.

In the field of SRHR, the Maternal Mortality Rate (MMR) of China dropped from 89 per 100,000 in 1990 to 53 in 2000, and further declined to 43.2 per 100,000 in 2002. This decline is largely due to improvements in health services and the decline in fertility levels. As an aspect of safe motherhood, child mortality dropped dramatically. The number of abortions in 2001 was 53 percent less than that in 1990, abortion rates showed a steady decline by 30 to 40 percent in the period 1991-2000, and are now lower than in most Asian countries. The Contraception Prevalence Rate (CPR) in 2001 was 87 percent for married women of childbearing age and was above 90 percent for women aged 30-44. Compared with contraceptive use in 1992, the proportion of users of irreversible methods such as male and female sterilisation, has started to decline while the users of reversible methods such as intrauterine devices has obviously risen. Although the popularity of user-controlled methods such as condoms has increased, and they are becoming more widely known, condom usage is still low.

Because China is moving towards a market-oriented economy, there are problems in the process of decentralisation and privatisation. The public health service, especially the 3-level public health network, is not as effective now as it was before health sector reforms were put in place, and while women's SRHR has been promoted widely, progress remains far from satisfactory, especially when compared with the social-economic progress. Problems such as the spread of HIV/AIDS and sex ratio imbalances need urgent attention.

# Introduction and Objectives

## Introduction

China, one of the world's most ancient civilisations, has a recorded history of nearly 4,000 years. The People's Republic of China (PRC) came into being in October 1949. China has a population of 1,295.33 million (one fifth of the world's total) according to its fifth national population census on November 1, 2000. China's territory covers 9.6 million square km, the population density is high, with 133 people per square km. China is the most populous developing country in the world.

The system of multi-party cooperation and political consultation led by the Communist Party of China (CPC) is the basic political system in China. The CPC, as the sole party in power, consults with representatives of all ethnic groups, political parties and democrats without party affiliation, and all other social sectors, in order to reach a common understanding on major issues having a bearing on the national economy and people's livelihoods.

Since the 1990s, the Chinese Government has followed a policy centred on economic reconstruction and openness and reform in economic and social development. Its pursuit of the strategy of national development has been through the advancement of science and education and sustainable development. As a result, China has undergone significant changes in its economy and society. In 2002, the national gross domestic product (GDP) reached Ren Ming Bi (RMB) 10.479 trillion Yuans, the average GDP per capita increased from 1,634 Yuans RMB in 1990 to 8,184 Yuans in 2002. The Socialist market-economy system has now been established, and reforms in the social security system, the education system, and the medical health system have all made remarkable progress.

The large population size provides both a growing economic base, and a lack of resources on a per capita basis – these characterise the basic national condition of China. Population is the principal factor and the major constraint to China's economic and social development. The Chinese Government has made family planning a long-term and sustainable national policy, and has also addressed issues related to sexual and reproductive rights and health.

Since the 1994 International Conference on Population and Development (ICPD), the Chinese Government has adopted sustainable development as a crucial strategy according to the ICPD PoA while taking its own country specific situation into account. Control of the population, the economical use of resources and the protection of the environment are all issues that have been emphasised. The Chinese Government has also worked out principles, policies and measures that are beneficial to sexual and reproductive rights and health and a number of follow-up actions have been initiated.

In 1995, for example, the Chinese Government changed its approach to the implementation of family planning from focussing on family planning alone to taking a holistic approach that combines socio-economic development with the improvement of gender equity. Government strategy also changed from relying primarily on administrative measures to using a new mechanism that integrates incentives and administration, publicity and education, quality services as well as scientific management.[1] More specifically, the family planning programme in urban areas, according to the Government, needs to meet the ever-increasing needs of people with respect to reproductive health and family planning. Equally, in rural areas the programme must be integrated with economic development,

poverty alleviation and the assistance to farmers in their endeavour to become better off and have happy families. The general principles of family planning policy have been broadened to pay more attention to the needs and interests of people, including women's sexual and reproductive health needs, to improve the mental and physical health of women and children, and to enhance people's participation.

### Objectives

This study attempts to assess progress in policies, laws, programmes and services at the local and national levels over the last ten years, in understanding, accepting and implementing the critical ICPD gender equality and SRHR objectives. The study further aims to assess the impact of these changes on women's health, women's status and women's lives; to identify and analyse the main ICPD implementation barriers and facilitating factors for change perceived by NGOs and government in relation to: a. The political, economic and social context (country and global); b. Institutional factors (government lack of action/ inertia, regulation, enforcement); c. Effectiveness of NGOs and civil society participation and advocacy; d. Presence of ICPD adversaries (threats or enemies); e. Impact of health sector reform (e.g. decentralisation, financing, community participation, accountability). The objectives of the study also include an analysis of the differences in the Government's assessment of ICPD progress in its country reports to the 5th Asian and Pacific Population Conference (APPC) and UNFPA Field Inquiry 2003 Reports compared to the country study assessment, to look at the reasons for these; and to recommend critical actions to be taken by Government, NGOs and donors at local, national and regional levels.

## Methodology and Country Team

### Overall Methodology

The overall methodology of the research includes desk research and field based research. Desk research was used to collect and analyse data to measure progress according to clearly identified indicators on the three broad ICPD areas and the two crosscutting issues. Data were collected either from the Statistical Yearbook of China or from published documents. In-depth interviews (see annexure 1 for a list of people interviewed) were conducted and focus group discussions (FGDs) held (see annexure 2 for a list of participants) to collect information from government officers and NGOs about policies and changes after ICPD, especially information that was not available from the Statistical Yearbook and published documents.

Documents consulted include annual reports, laws, regulations from the National Population and Family Planning Commission of China (NPFPC), Ministry of Health (MOH) and the National Working Committee of Children and Women (NWCCW) during 1990-2002. In addition, annual reports and assessment reports from UNFPA, WHO and World Bank were also used. While most of the interviews and discussions were with officials at the national level, interviews were also held with local officers at the provincial level and county levels. Inputs from a strategic planning meeting organised by ARROW at Langkawi in Malaysia also contributed to making this report.

## Country Team

The country level research team included 12 persons (see Annexure 3 for a list of team members). The team members are mainly researchers from the universities in Beijing and Shanghai with multi-disciplinary skills, such as health demography, health economics, health sociology, economic demography, epidemiology, etc.

## Research Constraints

China is a huge country with great regional disparities, and any research conducted at the country level cannot reflect the situation in all its variations in both the more developed and the less developed areas. For example, the Maternal Mortality Rate in 2002 was 43.2 per 100,000 live births at the country level, while it was as low as 19.7 per 100,000 live births in the coastal region, and there were 53.8 per 100,000 live births in inland China and 71.6 per 100,000 live births in remote areas. These vast differences have not been dealt with in any detail here.

# Country Context focussing on Population and Development

## History Before ICPD

Zheng (1999) has documented the various family planning policy and programme phases in China from 1949-1989. This study follows her history framework, and combines information on population policies, sexual and reproductive rights and health to describe the history of population in the People's Republic of China before ICPD.

1) The years from 1949-1952 count as the 'laissez-faire' period. After the establishment of the People's Republic of China in 1949, the country's population policy in the fifties was determined by the political perception of the population issue by its top leaders. Chairman Mao Zedong declared that to 'have more people is a good thing' for China. He also held the view that 'people are the most precious of all things in the world'. China followed the Soviet Union's policy of encouraging people to have large numbers of children. Abortion was restricted. Over time, the Government started to pay attention to sexual and reproductive health, the incidence of sexually transmitted diseases decreased dramatically, but mortality from complications of pregnancy, childbirth and puerperium remained high; indeed, it was among the top five causes of death in 1950. Policies during this period were mainly influenced by the high mortality rate and low population increase rate, and China lost a large section of its population to the Anti-Japan War and the Civil War. This, too, contributed towards the Chinese Government adopting a policy of encouraging population growth.

2) The period from 1953-1957 can count as one when population problems began to become evident. The 1953 Census revealed a rapid increase in the population. The possible long-term implications of such rapid growth began to be understood, thus abortion was legalised and restrictions on the production, import and supply of contraceptives to both females and males were lifted. The incidence of sexually transmitted diseases continued to decrease, and mortality from complications of pregnancy, childbirth and puerperium also started to decrease.

3) The years between 1957-1961 counted as the Great Leap Forward[2] and the famine periods. Discussion on population issues became taboo and birth control activities stopped during the political 'anti-rightist' campaign of late 1957. Demographers and sociologists who supported population control were criticised, as they contradicted Chairman Mao's 'more people is a good thing' slogan.

4) The years from 1962-1965 showed some initial success in population control in urban areas: After the years of famine and natural disasters of 1959-1961, a sharp increase in population size again drew the attention of national leaders. The State Council issued a directive on promoting family planning seriously in 1962. Family planning committees were established in the various provinces. Birth control programmes involving both female and male methods were launched in urban and densely populated areas. As a result, fertility in urban areas started to decline in the mid-1960s and the practice of contraception became more common. This intensive birth control programme, however, did not extend to the rural areas until the early 1970s.

5) The years between 1966-1970 were the years of the Cultural Revolution. The Cultural Revolution[3] slowed down the family planning programme for a number of years. Family planning organisations were paralysed or in chaos and programme activities were suspended. Disruptions in the publicity and distribution of contraceptive supplies contributed to an upsurge in fertility.

6) The years from 1971-1994 represent the period when the national family planning programme came to be based on population control. As the implications of such rapid population growth became clear, a nation-wide family planning programme was re-established under a State council directive issued in 1971. In 1973, the reproductive norm of 'later, longer and fewer' was proposed as a guideline for the family planning programme. In 1979, the Government stepped up the family planning programme through a new policy of 'promoting late marriage, late childbearing, few and healthy childbirths and encouraging one child per family'. The State Family Planning Commission (SFPC), the ministerial level organisation in charge of the national family planning programme, was formed in 1981, the administrative powers of the family planning organisations were strengthened and the number of personnel employed was increased.

The Chinese family planning programme has been criticised for its reliance on mass female sterilisation and its use of intra-uterine device (IUD) to achieve its population control targets in the 1980s. Around 1990, the Government adopted the 'three preferences' policy to address reproductive health and rights. This includes: 1) integrated information, education and communication (IEC) with quality care services so as to help people solve their practical difficulties in practising family planning; 2) promotion of informed and free choice in contraceptive use rather than abortion: and 3) emphasis on a sustained and continual delivery of family planning services and population education, rather than short-term bursts of activity. The family planning programme was also integrated with other programmes, such as rural economic development, mother and child healthcare (MCH), the prevention of sexually transmitted diseases, the improvement of water supply, transformation of modern toilets in rural areas, and other community services.

## Changes after ICPD

To meet the goals of ICPD, the Government of China made some adjustment in its population and family planning policy. In 1995, China formulated the objectives of its population and family planning programme for the next 5 years (NFPC, 1995). They include four key aspects that need attention in order to control the population size, improve population quality, and ensure that couples enjoy reproductive health quality services as well as better service provision.

1) To develop client-centred and quality services on reproductive health/ family planning for men and women in the reproductive age . While stabilising the low fertility rate, the Chinese Government changed the focus of population policy from population control to human development, and showed more concern for the needs and interests of people, and for integrating the population and family planning programme with the protection of women's legal rights, and with the improvement of women's reproductive health.

2) To carry out activities to enhance women's participation in social development .The Government and NGOs have jointly undertaken many activities that aim at the improvement of women's status. Some of these are the Spring Bud Project, to keep girl children from dropping out of school, the Happiness Project, to help poor children continue their education, the Women Perform Meritorious Deeds Project, to advocate that women be respected, that they be self-confident and independent and contribute more to society and the Re-employment Project, to help laid-off female labour to find work.

3) To actively promote male participation in family planning, and to provide adolescent sex education . The National Population and Family Planning Commission (NPFPC), Ministry of Health (MOH) and All China Women's Federation work jointly to publicise the idea of men and women being equal, to promote the idea of husbands sharing responsibility in family planning, and to advocate that men should take more responsibility in family planning and contraception. The State Family Planning Commission has been promoting informed choices in contraception, and widely disseminating the no-scalpel vasectomy and reversible vas occlusion. The Chinese Government and related social organisations have provided adolescent sexual health education, mainly through the media. The NPFPC, MOH, Ministry of Science and Technology cooperate closely in organising exhibitions, seminars, and television lectures on sex education. In most middle schools courses on population and puberty development are offered to teach young people about their physical hygiene, sexual psychology and sex morals. The SRH service in China is available to everybody without any certification from the family, so adolescents can get SRH services easily.

4) To work at strengthening community services, in improving population quality, and in encouraging non-governmental organisations to develop their programmes in terms of democratic participation and supervision.

The Population and Family Planning Law of the People's Republic of China, adopted at the 25th Meeting of the Standing Committee of the Ninth National People's Congress on December 29, 2001, became effective on September 1, 2002. The law addresses both reproductive health and reproductive rights in a very

cautious way. It attempts to protect the legitimate rights and interests of citizens but makes no mention of the word 'reproductive rights' (Article 1, Article 4).[4]

The law emphasises women's health in its General Provisions and aims at improving women's health and status through education, and by providing jobs (Article 3 in Chapter 1).[5] It takes reproductive health as a priority in certain specific ways: for example, it calls for special labour protection, including assistance and compensation, for women during pregnancy and childbirth and when they are breastfeeding (Article 26). The law articulates the right of couples who practise family planning to receive, free of charge, the basic items of technical service specified by the State (Article 21). It also stresses that the Government should not, at any level, hurt the rights and interests of citizens in performing their administrative duties.[6]

The new law prohibits discrimination against women and maltreatment of women who give birth to female children and women who are infertile and bans discrimination against and maltreatment and abandonment of female infants (Article 22 in Chapter 3), and requires not only wives but also husbands to bear the responsibility of family planning (Article 17).

Reproductive health education is also emphasised. For example, the law requires schools to provide sex education (Article 13 in Chapter 2), and requires the State to create conditions for educating citizens and enabling them to select safe, effective and appropriate contraceptive measures that guarantee the safety of people who undergo surgical sterilisation (Article 33). In many ways therefore, this law works as a key instrument to improve women's reproductive health in China.

## The Role of Donors and Civil Society Actors

NGOs, women's health groups, trade unions, professional councils and social movements have made significant contributions in helping the Government of China to prepare for ICPD and the policy changes that followed. Among those who have been involved are: the Chinese All Women's Association, UNFPA, UNICEF, WHO, the World Bank, and others. China's non-governmental organisations, civic societies, community offices, and private institutions have played a major role in the population and family planning programmes. Non-governmental organisations such as the National Women's Association, the National Communist Youth League, and the National Trade Union have participated in the planning, implementation, monitoring and evaluation of the population and poverty alleviation programmes. A good partnership between NGOs and the Government has developed as a result.

China's largest non-governmental organisation in family planning - the China Family Planning Association - has been working through its over 80 million volunteers at the grassroots levels on the dissemination of knowledge on reproductive health and family planning as well as on agricultural production techniques to women in the reproductive age group. The Population Association of China has worked with academic institutions in the systematic study of China's population development trends and strategies and has provided valuable information for decision-making and implementation of China's population programme.

Other social organisations, civic societies and private enterprises have actively developed various poverty-alleviation projects such as the Hope Project, the Spring Bud Program, the Young Volunteers Teaching and Poverty Alleviation Relay Program, and so on. The National Women's Association has set up many poverty alleviation stations and households, the have conducted literacy and technical

training for women with such needs, provided them with small loans and assisted them in various labour-exporting and poverty alleviation projects.

According to a study on the role of civil society[7] in China, civil society organisations (CSOs) see themselves more as complementing and partnering with government and the reported collaboration is more in implementation and less in policy-making. According to government respondents, they expected more from CSOs in terms of innovations, acting as intermediaries between the community and the government, and creating community acceptance.

China has had excellent cooperation with various international organisations such as the United Nations Population Fund (UNFPA), the World Health Organisation, the United Nations International Children's Fund (UNICEF), the World Bank, the International Planned Parenthood Federation, the Japanese Organisation for International Cooperation in Family Planning, the Ford Foundation, and the Centre for Appropriate Technology in Reproductive Health. The areas of cooperation cover the quality of care services and informed choices on reproductive health and family planning, the reproductive health of adolescents, HIV/AIDS prevention, gender equity, and the safety and reliability of contraceptive methods and their improvement.

For example, UNICEF cooperated with the Chinese Government in launching an international programme to improve the women and children's health in China. During 1996-1998, UNICEF provided assistance to 600 counties to decrease infant mortality, and maternal mortality and to improve child nutrition. During 1999-2000, UNICEF selected 40 counties from a total of 600 to strengthen the management of the public health network at village, township and county levels. This programme is very successful in enhancing children's health and development in poor areas through effective management and providing basic public health services.

Such collaborative programmes have achieved their functions of exploration, guidance and demonstration and made possible the implementation of the goals set by the ICPD Programme of Action in China. The Chinese Government has strengthened its South-South cooperation with developing countries: in 1997, China joined the Population and Development Partnership and has had highly effective cooperation with the Partnership in terms of personnel training, experience sharing, programme cooperation, and product exchanges.

## Assessing Progress in Achieving ICPD Goals and Objectives

In 1994, China signed the ICPD document and in the subsequent two decades, it has attempted to achieve the goals set by the POA. China promised to reach the following goals in related areas:

### Reduction of Infant and Child Mortality

'... Countries should strive to reduce their infant and under-five mortality rates by one third, or to 50 and 70 per 1,000 live births, respectively, whichever is less, by the year 2000, with appropriate adaptation to the particular situation of each country. By 2005, countries with intermediate mortality levels should aim to achieve an infant mortality rate below 50 deaths per 1,000 live births and an under-five mortality rate below 60 deaths per 1,000 live births. By 2015, all countries should aim to achieve an infant mortality rate below 35 per 1,000 live births and an under-five mortality rate below 45 per 1,000. Countries that achieve these levels earlier should strive to lower them further.' [para. 8.16]

### Reduction of Maternal Mortality

'Countries should strive to effect significant reductions in maternal mortality by the year 2015: a reduction in maternal mortality by one half of the 1990 levels by the year 2000 and a further one half by 2015. The realisation of these goals will have different implications for countries with different 1990 levels of maternal mortality. Countries with intermediate levels of mortality should aim to achieve by the year 2005 a maternal mortality rate below 100 per 100,000 live births and by the year 2015 a maternal mortality rate below 60 per 100,000 live births. Countries with the highest levels of maternal mortality should aim to achieve by 2005 a maternal mortality rate below 125 per 100,000 live births and by 2015 a maternal mortality rate below 75 per 100,000 live births. However, all countries should reduce maternal morbidity and mortality to levels where they no longer constitute a public health problem. Disparities in maternal mortality within countries and between geographical regions, socio-economic and ethnic groups should be narrowed.' [para. 8.21]

### Access to Reproductive and Sexual Health Services Including Family Planning

'All countries should strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015. Reproductive health care in the context of primary health care should, inter alia, include: family-planning counselling, information, education, communication and services; education and services for pre-natal care, safe delivery and post-natal care; prevention and appropriate treatment of infertility; abortion as specified in paragraph 8.25, including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood. Referral for family-planning services and further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases, including HIV/AIDS should always be available, as required. Active discouragement of harmful practices, such as female genital mutilation, should also be an integral component of primary health care, including reproductive health-care programmes.' [para. 7.6]

On the basis of its own experiences as well as more advanced international experiences, the Government of China has, since ICPD, made many important decisions on the issue of population and development, taking into consideration national conditions. It has also formulated guidelines, policies and measures that are beneficial for economic and social development and population development.

ICPD goals apart, China has also progressed in making achievements after 1999, ICPD+5. It participated in all major international conferences and conventions linked to SRHR issues, including the Millennium Summit in September 2000. China has followed up with successful related programmes, such as the national polio eradication effort and the National Programme of Action (NPA) for women and children. Efforts by the Chinese Government and civil society groups are currently under way to monitor progress toward achieving the ICPD goals, especially in: 1) reduction in child mortality, 2) improvements in maternal health, and 3) combating HIV/AIDS, malaria and other diseases.

In what follows, this essay looks at changes and progress in achieving ICPD goals on the basis of the three key indicator frameworks developed.

## Gender Equality, Social Equality and Equity

Gender equity, social equality and equity mean ensuring equal access for all to social and economic opportunities. Gender equity and social equity are singled out as focus areas of ICPD. After ICPD, China took on board the task of developing a policy on improving gender equality and development and these issues were addressed in a government report presented at the 2002 UN Asia Pacific Population Conference in Bangkok. The report concluded that the social status of women has greatly improved after ICPD in terms of their participation in political affairs (for example, in local elections and the percentage of female representatives in the National People's Congress), and in terms of the proportion of women who have received education at different levels. As well, female labour force participation rates and employment structures, maternal and child health care institutions, women's status in marriage and in the household, have also seen improvement. The report also highlighted factors that militate against further improvement of women's social status, such as limited material resources to support women's development programmes, traditional biases towards females, and inequality in educational opportunities for women, and domestic violence. However, there is no mention of other, newer forms of discrimination towards women that have become evident as China makes the transition to a market economy. These include a high proportion of female laid-off workers, a rise in the number of sex workers and increasing numbers of female drug users.

### Country Status

Because the statistical system of China is not gender-sensitive, it is hard to get the essential or critical indicators that are desegregated by gender. This study, however, attempts to use a combination of different indicators to measure the situation of gender equality in China.

As has been mentioned earlier, Chinese women are today active participants in a wide range of political affairs. According to the Common Country Assessment,[8] he sex distribution of heads of government departments at the provincial level (female to male) increased from 10:90 in 1988 to 17:83 in 2000. At the prefecture and municipality levels this figure (female to male) went up from 11:89 in 1988 to 21:79 in 2000. And at the county level (female to male) it increased from 7:93 in 1988 to 14:86 in 2000. For heads of government departments at the town and neighbourhood levels, the figure (female to male) increased from 6:94 in 1988 to 11:89 in 2000 (CAA 2003). In 1995-2000, in the local election of the people's representatives, the participation rate was 73.4 percent for women, which closely matched the rate of 77.6 percent for men. At the Ninth National People's Congress in 1998, there were 650 female representatives, and this figure accounted for 21.8 percent of the total representatives. At the Ninth National People's Political Consultative Conference, there were 341 female delegates, accounting for 15.5 percent of the total. These facts provide evidence that China has become one of the countries where there is a high level of women's participation in politics although the country still has a long way to go before it can be said to have equal participation of men and women.

Although the data above show that, compared with men, more women take the role of heads of government departments at provincial, prefecture, municipality and county levels, women's political participation in China has seen some erosion at both the state and village levels. The sex distribution of seats of heads of government departments at the state level dropped from 19:81 in 1988 to 17:83 in 2000. At the 16th Party Congress in November 2002, five women were elected to the Central Committee of the Communist Party representing 2.5 percent of the

total of 198 seats, a decline from the figure of four percent that was achieved at the last Congress in 1997. At the village level, about 60 to 70 percent of the villages and townships have at least one woman in the decision-making body,[9] but this is still far from the target of at least one woman in each village government set by the National Programme for the Development of Chinese Women 1995-2000.

The proportion of women who have received education at different levels has been increasing and the education level of women has also improved. Comparing 1990 and 2000, among women aged 18-64, the illiteracy rate has dropped from 30.1 percent to 11.1 percent. The average increase of the years of education for women is higher than for men, though in absolute levels men continue to outperform women with respect to education. The average years of women attending school was 6.1 years in 2000, which is 1.4 years more than that in 1990, and the difference between women and men was 1.5 years in 2000 instead of 1.9 years in 1990. In 2000, the primary school enrolment ratio of Chinese girls of school going age was 99.1 percent. In general colleges and universities, the proportion of female students increased from 35.4 percent in 1995 to 41.0 percent in 2000.

The employment rate of females has increased to 46.0 percent in 2000 from 45.7 percent in 1995, a ratio that is high and stable and is located within an employment structure that is reasonable. The proportion of female professional and technical workers was 22.8 percent of the total workers, a 5.4 percentage point increase over that of 1990.[10]

The life expectancy of women in China increased from 70.47 years in 1990 to 73.33 years in 2000, while that of men increased from 66.84 years in 1990 to 69.63 in 2000. However, the increase in women's life expectancy in the nineties became slower than that in the eighties. The life expectancy of women in China almost reaches life expectancy figures of women in developed countries. The growth curve of the Chinese girl child has reached the standard of WHO. While domestic violence continues to draw public attention, it remains an area on which statistical information is hard to find.

### National Level Laws and Policies, and Service Delivery

The Chinese Government has made considerable effort to improve women's social status and has made positive progress after ICPD in 1994 and the Fourth World Conference on Women, held in Beijing in 1995. China has been active in the formulation of conventions and resolutions on women's rights and gender equity. The major international conventions and documents including the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), the Convention of Children's Rights, the Beijing Platform for Action and other plans of action are well known in China. The Government has also prepared the China Women's Development Programme (1995-2000 and 2000-2010) and has thus integrated the goal of women's development into the national social and economic development plans.

The Constitution of China clearly stipulates that women enjoy rights equal to men in political, economical, cultural, social and family life. During the past ten years, on the basis of existing laws and regulations, the Chinese Government has used existing laws as a base to enact other laws and regulations for the protection of women such as the Law that Guarantees the Rights of Women and Children, the Mother and Infant Health Care Act, and the Population and Family Planning Law. Moreover the Marriage Law was revised and the legal protection of women's rights was further enhanced.

The Chinese Government has also paid special attention to creating and strengthening the environment for the adoption of new legislation and the enforcement of existing laws to protect women's rights. They have worked hard to achieve the ultimate goal of a society free from violence and prejudice against women and girls, and to reduce gender disparities in China's grassroots governance and national politics.

The law on population and family planning in China, which was promulgated on September 1, 2002, prohibited sex selective abortion and the discrimination and abuse of women who are sterile or unable to bear a son.

The new Marriage Law of the People's Republic of China addresses the issue of domestic violence. Article 3 of this new law prohibits domestic violence. Victims of domestic violence have the right to seek help from the local government and the local public security department and court (Article 43). Family members who violate this law shall be subject to legal sanctions if the victim sues (Article 45).

Significant efforts have been made to spread awareness of the rights of the girl child. A rights-based approach has been employed to promote the enforcement of laws and policies, and to make education accessible and compulsory to all, for example. This is especially important in underdeveloped areas where the disparities between boys and girls in terms of schooling and learning achievements are significant. The rights-based approach, particularly in poor and ethnic minority areas, can encourage educational content that is relevant, thus enhancing female students' interests in education; such an approach can also help to raise questions with young students about practices that reinforce gender inequity. Raising awareness of equal opportunities among women and men encourages more girl children to take part in higher education.

China started to implement its Programme on Chinese Children's Development in the 1990s. This was followed in 1992 by the Programme on Chinese Children's Development (2001-2005). The programme covered the goals on children's development specified in ICPD, and included in the Millennium Development Goals (MDGs) and other UN conventions. It also paid special attention to the development of the girl child, including her rights, the nutrition and health care of girl children as well as their education. In March 2003, the National Population and Family Planning Commission of China cooperated with UNICEF to launch a special programme to protect the rights of the girl child. The 'care about the girl child' activity includes advocacy on gender equality; a guide to technology and services to improve the health of newborns and mothers, and especially to decrease the mortality of the girl child. It encourages protection of girl children and forbids the use of sex selective abortions.

### Comments

China is a country with a long history and the influence of gender-based discrimination embedded in its traditional culture remains strong. Even with the increase in government efforts to popularise principles of female equity, many girls and women remain vulnerable from birth, throughout their schooling and into the workforce and old age. While gender inequalities with respect to political participation and education are being lowered, they are far from eliminated.

Growing urbanisation and modernisation, as well as the growth of a market economy, have made for new developments in relation to gender-based

discrimination. For example, women now have to work more on agriculture as compared with men. This feminisation of agriculture is mainly due to the exodus of large numbers of men from rural areas to cities to seek employment. Women are prevented by traditional male-oriented cultural values from access to and control over such resources as land, credit, technology, information and training. This situation is compounded by insufficient legal protection for women to contract land and other resources in rural areas. In the industrial sector, women face more difficulties than men in gaining promotions. In many cases they are the first to be laid off and often have to take work outside the social protection of a regulated formal market. Limited employment opportunities and pressure to send money home can lead young women into the sex industry, which has increased dramatically in the last twenty years. All sectors, especially agriculture and industry, are experiencing drastic change after China's WTO entry in December 2001. In this transition, rural and urban women are and will continue to be deeply affected by State owned enterprise (SOE) reform, decentralisation of financing for public goods and services to lower-level governments, as well as the erosion of employment security and social protection systems.

Privatisation of State owned factories has created millions of laid-off workers, a disproportionate number of whom are women. The Chinese Government works very hard to improve women's social status and has made great progress in this, but discrimination against women continues to exist, even in the employment policies. For example, according to the early retirement policy for women, they are obliged to retire at age 55, five years earlier than men.

Issues related to the girl child also need more attention. Parental preference for boys is supported by modern medical technologies that reliably identify the sex of foetuses and make abortions possible. The result is a sex ratio at birth which is increasingly in favour of boys. According to the 2000 census, 116.9 Chinese boys were born for every 100 girls in 2000 -- up from an already alarming sex ratio at birth of 111.3 boys in 1990 (the normal sex ratio is around 103-107). The sex ratio between girls and boys (ages 0-4) was 100 to 120, which means that the ratio at birth increases in the first few years of life.

Although the percentage of girls in primary school has increased in recent years, their dropout rates are higher than for boys. Teenage girls become more useful as labour in households, so many families fail to enrol them in senior school. While female students comprised 48 percent of the primary school population and 47 percent in secondary schools in 1999, this decreased to 40 percent for college and only 32 percent for doctoral programmes. The female illiteracy rate also has been consistently higher than that of males. About 70 percent of China's 140 million estimated illiterates are women, and they are mostly concentrated in the economically underdeveloped rural regions.

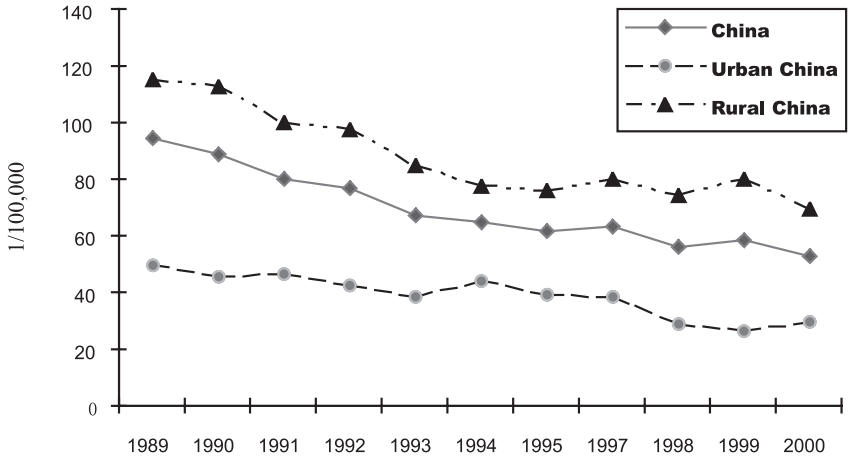
## Maternal Mortality, Safe Motherhood and Abortion

Although the national report cited above had no special section on maternal mortality and safe motherhood, it did mention maternal mortality in the section on mortality, morbidity and poverty. The Government reported that maternal mortality dropped from 89 per 100,000 in 1990 to 53 per 100,000 in 2000, and the figure for rural China dropped from 112.5 per 100,000 in 1990 to 69.6 per 100,000 in 2000. The national report did not highlight the national policy and advocacy on safe motherhood. The report did, however, say that the number of abortions in 2001 was 53 percent less than that in 1990, although the number of abortions among adolescents was seen to be rising.

## Country Status

The maternal mortality rate (MMR) of China has dropped from 89 per 100,000 in 1990 to 53 in 2000, and further declined to 43.2 per 100,000 in 2002.[11] The decline of MMR was guaranteed by both the improvement in health services and the decline in fertility levels (Figure 1).

**Figure 1. Maternal Mortality in China, 1989-2000**




**Source: China Health Statistic Yearbook, 2002**

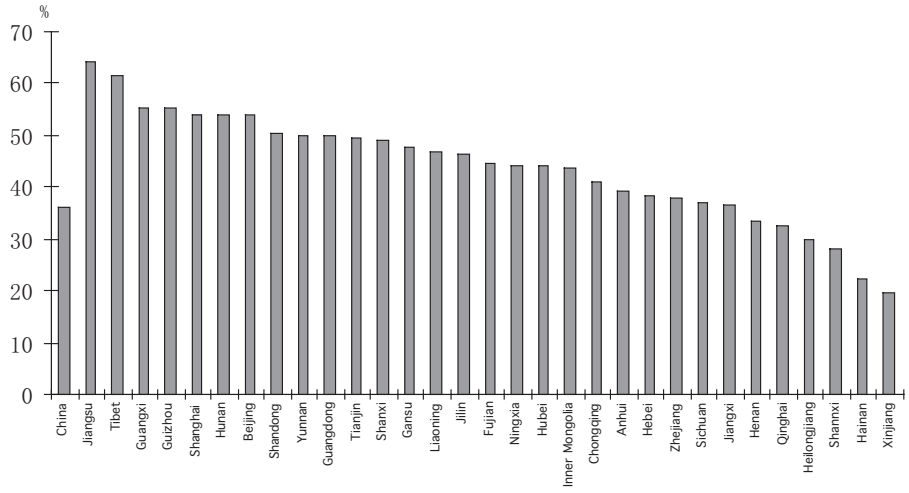
The prenatal examination rate rose to 90 percent in 2001 from 69 percent in 1990, the rate of aseptic delivery rose to 96 percent in 2000 from 94 percent in 1990, the rate of clinic delivery rose to 76 percent in 2001 and 78.8 percent in 2002 from 50.6 per cent in 1990, the rate of hospital delivery increased to 73 percent in 2000 from 45 percent in 1990.[12]

Since the 1990's, China's fertility level has been declining. The total fertility rate dropped to 1.80 children per woman in 2001 from 2.29 children in 1990. The crude birth rate and the rate of natural increase decreased to 13.38 per 1,000 and 6.95 per 1,000 respectively in 2001 from 21.06 per 1,000 and 14.39 per 1,000 in 1990 respectively.[13]

The decline of fertility and the changing attitude towards marriage and childbearing are directly related. Since 1990, Chinese women's average age at first marriage has been fluctuating between 21.9 years and 22.8 years with the figure being at 22.6 years in 2000. The average age of childbirth has been fluctuating between 25.1 years and 25.5 years during 1991-2000 with a figure of 25.5 years in 2000. The age of the first parity birth has been fluctuating between 23.2 and 24.1 years with 24.1 years in 2000.

As an aspect of safe motherhood, child mortality dropped dramatically. Reported infant mortality dropped from 50 per 1,000 live births in 1990 to 32 in 2000 (Figure 2), neonatal mortality dropped from 33.1 per 1,000 live births in 1991 to 21.4 per 1,000 live births in 2001, and under five mortality dropped from 61.0 per 1,000 live births in 1991 to 35.9 per 1,000 live births in 2001

**Figure 2. The percentage of decrease of IMR in Mainland China, 1990-2000**




**Source: China Health Statistic Yearbook, 2002**

The number of abortions in 2001 was 53 percent less than in 1990, abortion rates showed a steady decline by 30 to 40 percent in the period 1991-2000, and are now lower than in most Asian countries. This decline reflects the Government's increasing commitment to family planning with access to reliable quality of care and counselling (emergency contraception), as specified at the International Conference on Population and Development (ICPD) in 1994.

### National Level Laws and Policies, and Service Delivery

The National Working Committee on Children and Women (NWCCW), the Ministry of Health (MOH), and the National Population and Family Planning Commission of China (NPFPC) as well as other government departments have been working hard on improving the health status of women in China. During 2000-2001, the central and local governments invested 20 billion Chinese Yuan (approximately 2.4 billion US dollars) in Ren Min Bi to implement the programme on decreasing maternal mortality and eliminating tetanus in the newborn in 12 provinces in west China (this programme was conducted jointly by NWCCW and MOH). The programme was continued in 2004 and will now cover more areas.

NPFPC has been working on improving maternal health through providing reproductive services, such as pre-birth examinations, and fertility decline has also contributed to safe motherhood through reducing the risk of pregnancy. In 1999, 81 percent of the prefectures, 90 percent of the counties and 88 percent of the townships had already established family planning service stations and there were 502,000 family planning service professionals. This service network provides not only clinical services of contraception, fertility regulation and reproductive health, but also face-to-face counselling, health care consultations, and expert lectures. It also disseminates publicity and education materials and contraceptive supplies. These health promotion activities are helpful for safe motherhood and in preventing maternal mortality, especially in rural areas.

In China, abortion is legal and available to all women who want it for any reason.[14] Unsafe abortion is not a key issue. The NPFPC has put contraception as a priority in fertility regulation, and they provide emergency contraception services nationwide. The high contraceptive prevalence rate guarantees the decline of the incidence of induced abortions among Chinese women.

### Comments

The national figures given above do not reflect the considerable variation between urban and rural, eastern and western provinces. In the eastern provinces and major cities, economic growth led to improved medical services for women and good access to emergency obstetric care (EOC). This has resulted in contraceptive prevalence rates (CPR) and maternal mortality rates (MMR) that are at developed country levels. In 2000, the MMR in Shanghai was 9.6 per 100,000 live births, while in Tibet and Xinjiang it was 466 and 161, respectively. In 2002, the MMR was 19.7 per 100,000 live births in the coastal region, while it was 53.8 per 100,000 live births in inland China and as high as 71.6 per 100,000 live births in remote areas. In 2002, the maternal mortality rate was 22.3 per 100,000 in urban China while the MMR was 58.2 per 100,000 in rural areas. The child mortality rate also showed regional disparity - the child mortality rate in rural China is twice the rate in urban China. Women in the western provinces, especially in rural areas, have limited access to EOC and deliver at home, often without the presence of a skilled health worker.

Many girls have no access to health services and suffer gender-based negligence by their parents. This results in malnutrition and disproportionately low levels of health. The health insurance cover currently offered includes reproductive health care, for example abortion, STDs and other related diseases, but only a small part of the population is covered and most rural women and workers in the private/informal sector do not have such cover. That leaves more than 70 percent of women with no insurance cover at all.

## Promoting and Protecting Sexual Health and Rights, Safe Contraception, Preventing and Treating HIV/AIDS and Reproductive Cancer

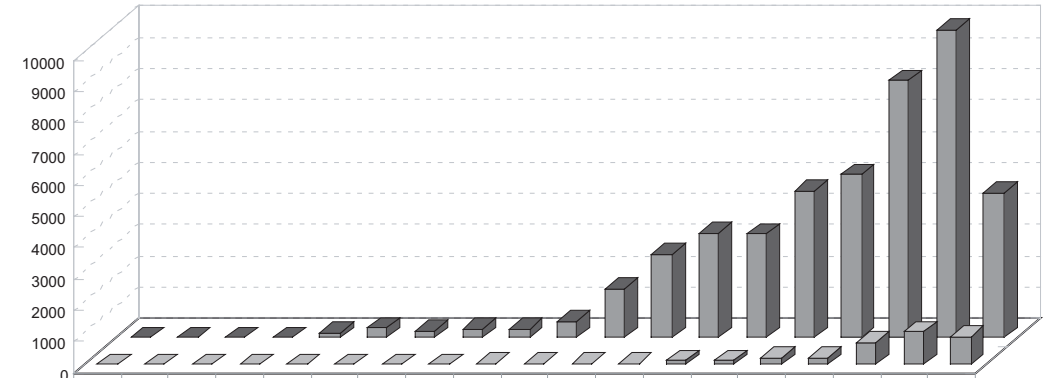
The government report addresses the issues of sexual health, contraception and HIV/AIDS, but makes no mention of issues such as sexual rights and reproductive cancer. It pays more attention to reproductive health, but only mentions sexual health in terms of sex health education in response to adolescent reproductive health issues. According to the report, contraceptive prevalence is quite high in China, at around 83 percent in the 1990s.While the proportion of users of irreversible methods, such as male and female sterilisation, has started to decline, that of users of reversible methods, such as intra-uterine devices, has risen. User-controlled methods such as condoms etc. have also increased. The Chinese Government introduced methods of informed choice of contraceptives to enable people to enjoy a better quality of care and family planning service. The government report pays special attention to HIV/AIDS and it discusses the situation and trends of HIV/AIDS in China, national actions on HIV/AIDS prevention, HIV/AIDS among adolescents, as well as the goals of the HIV/AIDS prevention programme.

### Country Status

The Contraception Prevalence Rate (CPR) in 2001 was 87 percent for married women of childbearing age and was above 90 percent for women aged 30-44. The two most common methods of contraception in 2001 were the intrauterine device (IUD) at 45 percent, and female sterilisation at 38 percent. Compared with the contraceptive use in 1992, the proportion of the users of irreversible methods such as male and female sterilisation has started to decline while the users of reversible methods such as the intrauterine devices has risen. The user-controlled methods such as condoms etc., have also risen and are becoming more widely known although condom use is still low at five percent in 2001. Condoms are not used

in China as protection against HIV/AIDS but for contraceptive use. Thus couples who are sterilised or those who make use of IUDs, do not use condoms.

**Figure 3. Reported AIDs/HIV Cases in China, 1985-2003**

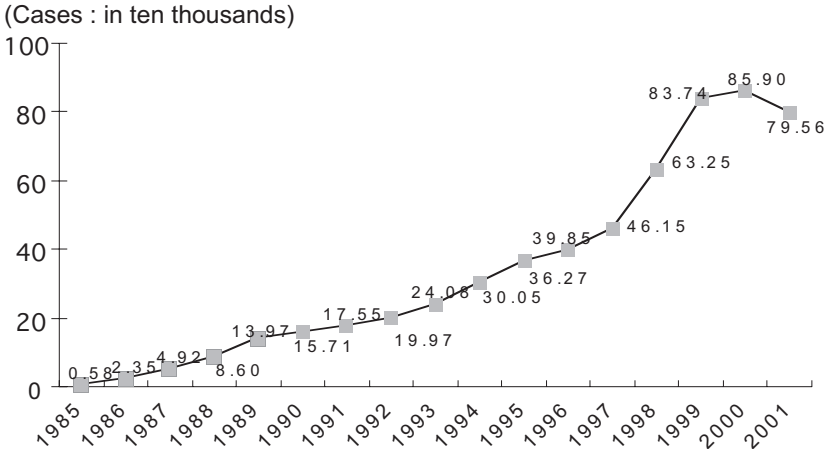



| | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS | 1 | 0 | 2 | 0 | 0 | 2 | 3 | 5 | 23 | 29 | 52 | 38 | 126 | 136 | 230 | 233 | 714 | 1045 | 910 |
| HIV(+) | 5 | 1 | 9 | 7 | 171 | 299 | 216 | 261 | 274 | 531 | 1567 | 2649 | 3343 | 3306 | 4677 | 5201 | 8219 | 9824 | 4624 |

The first AIDS patient was reported in 1985, and the number of HIV/AIDS patients grew rapidly in the eighties (Figure 3). According to a survey conducted by the Chinese Centre for Disease Control, there were 840 thousand HIV and 80 thousand AIDS patients in 2003, much more than the number reported by MOH.

China has set up HIV/AIDS observation sites since 1995. The observation site system has developed to include 194 sites at country level and to cover all 31 province units in mainland China, which includes 72 STD clinics, 4 under-ground whorehouses, 49 drug-use sites, 11 long-distance driver sites, 18 pregnant/lying-in women sites, and one site for homosexuals. Among the AIDS patients in 2001, almost half were drug users, using injections (49.4 percent), nearly one-fifth were blood donators (18.2 percent). STIs/STDs increase the risk of HIV/AIDS infection. Reported STD cases have increased dramatically in the 1990s, especially after 1997 (Figure 4).

**Figure 4. Reported STD Cases in China, 1985-2001**



## National Level Laws and Policies, and Service Delivery

Since the 1994 International Conference on Population and Development, the Chinese Government has earnestly implemented the ICPD Programme of Action. The Government emphasises that the implementation of the family planning work must focus on such regular work as publicity and education and birth control. Family planning must be integrated with such programmes as economic development, helping people to become prosperous, and building the civilised happy family. The Government has also pushed for changes in the thinking and approaches used in family planning work and expanded the quality of care in the family planning and reproductive health programmes.

The reform and innovation in China's family planning programme have brought about changes in the population programmes: from the control of population size to the promotion of health and at the same time to stabilisation of low fertility level and improvements in population quality. The working methods have moved from family planning management to family planning services that embody management. The scope of services has expanded from family planning to reproductive health that includes family planning. Clients who receive services have been increased, from only married women of childbearing age to all people of reproductive age, including men and adolescents.

In one concrete step to initiate changes in family planning thinking and working methods, the Government started (in 1995) a pilot project on the quality of care services in family planning in 11 counties/districts in the eastern part of China. Some other provinces, autonomous regions and municipalities have also started their own pilot studies at the same time. By the end of 2000, more than 800 counties, or about one third of the Chinese counties had participated in the quality of care services testing. In 2001, the Government started another comprehensive reform pilot project in the family planning programme in some districts. Through the joint efforts of local people, government officials and service technicians, the pilot projects have achieved good and notable results.

The pilot areas have gradually introduced methods of informed choice of contraceptives that enable people to have the right to information, choices, and decision-making. The Government provided free basic family planning services to couples and created notable changes in the pattern of contraceptive uses. In 2000, the Government began to initiate three major projects including the 'informed choice in contraceptive uses project', the 'reproductive tract infection (RTI) intervention project' and the project for 'birth defect intervention'. These projects have guided the pilot areas to carry out birth control services, screening, treatment and prevention of reproductive tract infections for women and birth defect intervention in an integrated manner. Project activities have stimulated the development of the basic studies on reproductive health, the wider application of new technologies, and the study of reproductive health interventions. Resources have also been mobilised from different sectors of society and have enhanced local family planning services and their technical capability and have been welcomed by local people. In order to satisfy people's needs in reproductive health, family planning and health departments have jointly started programmes to provide maternal health services.

The State Council issued a Regulation on Family Planning Technical Services Management in June 2001, and promulgated the law on population and family planning on September 1, 2002. Both the regulation and law clearly state that the reproductive right of citizens, including the right of informed choice in the use of contraceptives and the right to receive free basic services should be

protected. The regulation also guarantees the safety of people receiving family planning services. In order to effectively implement it, provincial, autonomous regions and municipal governments have begun to strengthen their capacities for delivery of family planning services, and have developed technical standards for these, trained more technical services personnel, purchased more reproductive health instruments and facilities, and established a family planning/reproductive health service network that covers all provinces, regions, counties, townships and villages.

China has also been greatly concerned about STDs and AIDS. The committee on AIDS prevention was established under the State Council in February 2004, and will make key policies and plans related to AIDS prevention. Some of the new policies include free treatment, free testing without ID, free mother-baby block, free education to AIDS orphans and social assistance to AIDS patients.

The sexual and reproductive health rights of adolescents have also drawn the attention of the Chinese Government. Twenty six percent of China's population is made up of young people between the ages of 10-24. Their reproductive health problems and needs have become increasingly noticeable. The proportion of young people who accept premarital sex is increasing, as are premarital sexual activities.

The Government has introduced adolescent health and population education as a part of formal education and has specified the roles and responsibilities of concerned governmental departments for student health care in this regard. The Population and Family Planning Law of the People's Republic of China enacted on 1 September 2002 stipulates clearly that 'the physiological hygiene education, the adolescent education or sex health education shall be carried out in schools in a planned, appropriate and audience-specific way.' About 50 percent of the rural middle and high schools and 90 percent of the urban middle and high schools and universities now offer adolescent health education courses. The national medium and long-term plans on HIV/AIDS control has made adolescent sexual and reproductive health programme a part of its important goals. Adolescent health education outreach and service programmes have been implemented in some provinces.

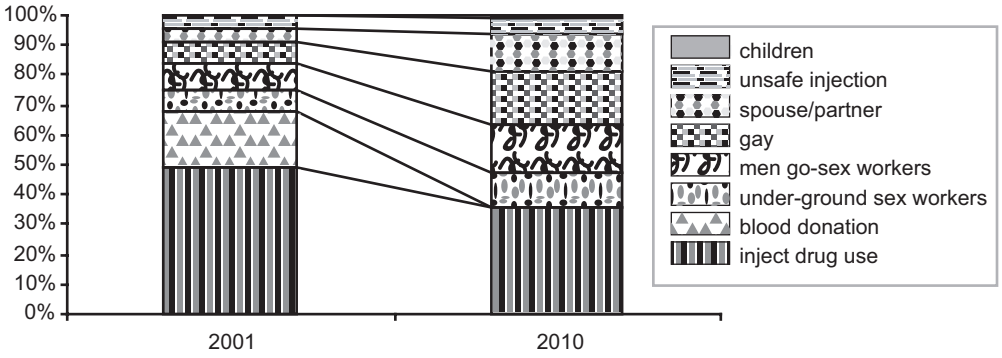
The mass media and the Internet have been drawn into the dissemination of information and knowledge on a range of issues to do with sexual health. In addition, seminars, training workshops, exhibitions and summer camps serve as useful spaces to raise awareness of issues relating to sexual health and rights. Outside of schools, youth clinics, health service centres and youth hotlines help to spread the message. Condoms are easily available and accessible to young people, and condom vending machines can now be found in university campuses.

In 2002, the China Association of Science launched an advocacy programme aimed at the high-risk population and adolescents. In 2003, the Ministry of Education published the 'Outline of Education on AIDS for Students in Primary and Secondary School' to help adolescents live a healthy life and to teach them about AIDS prevention. In 2003, the China Association of Science, Ministry of Education and Ministry of Health launched an advocacy initiative titled 'Knowledge, Prevention and Care—Knowledge of AIDS for Adolescents' which extended to 31 provinces.

## Comments

The prevalence of sexually transmitted infections (STI) and HIV/AIDS will be a major issue of concern for China in the future. Experts estimate that there will be over 10 million HIV cases by the year 2010, and the proportion of spouse/sex partners will increase (Figure 5).

**Figure 5. Structure of HIV (%), 2001 and 2010**




The low rate of condom use exposes high-risk populations to STI, including HIV/AIDS. Women and adolescents are especially vulnerable to infections. Because women in particular are often unable to negotiate with men for safer sex, the spread of HIV/AIDS has accelerated among them. The male to female ratio of HIV infections has increased from 9:1 in 1990-95 to 7:1 in 1996-97 to 5:1 in 1998-99 to 4:1 in 2000 to 3.4:1 in 2002.

Adolescents present a high-risk group for HIV/AIDS. National data on the adolescent sexual and reproductive health status and needs are hard to come by. Data on reproductive health knowledge, attitudes, and behaviour of unmarried people have not been collected in any national demographic and health surveys. Their absence has hindered effective policy formulation, advocacy, programme designs and performance evaluation for reproductive health interventions.

# Main Implementation Barriers and Facilitating Factors

## Barriers

Among the barriers to implementation of ICPD goals, health system reform remains a key issue in China. Despite success in some key health indicators, the process of reform reveals some worrying trends. Since the early 1990s, mortality rates have increased in some poor areas. The rate of improvement in health-related indicators in the 1990s has slowed compared to advances made in the 1970s and 1980s. This slowdown in health status, in an overall climate of rapid economic growth, can be attributed to several factors, particularly a shift of health financing from a collective system to that of a market-oriented system.

Although the reform of the health system is meant to improve the efficiency of the health sector, the decentralisation of public health funding has led to the breakdown of basic health services in poor rural areas. Reduced public funding has forced hospitals to rely increasingly on revenue from patients who are able to pay. As a result, income from drugs and high-technology equipment has become very important. To control provider-induced costs and raise effectiveness in this area, hospitals must now separate drug prescriptions from drug sales along with new measures to control capital investment in excessively used high-technology diagnostic equipment.

The dramatic changes that occurred in health financing between 1978 and 1993 are reflected in the decline of the Rural Cooperative Medical System (RCMS). By 1981, RCMS coverage was about 48 percent and in 1993 it was only about 7 percent. As prepayment coverage levels declined, health system efficiency suffered even as the unit costs of services escalated. The October 2002 State Council Resolution has provided funds from the central and local governments and individuals to re-establish a version of the RCMS, especially the health care network in poor areas.

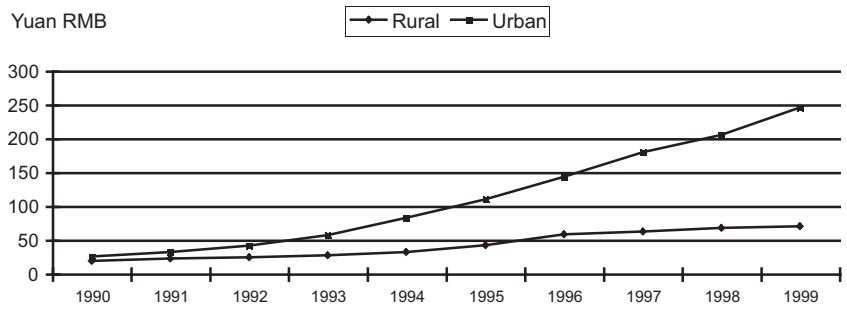
At the village, township and county levels, the system has been consolidated for reasons of administrative efficiency at county level. Private clinics have been allowed to offer health services in many areas. Due to the RCMS collapse, many village and township health facilities have been forced to reduce services, and combine these into 'hospital groups', or just to close down.

Defined functions for urban health services and the development of urban health centres have begun to improve system efficiency, but urban health continues to be hospital-centred in large cities with eastern coastal provinces having much better health services than the rest of the country. China's rapidly aging population requires increased community health services and reduced levels of hospital-based care if greater cost-effectiveness is to be achieved by the urban health system. Regional planning is required to improve the efficiency and coordinated management of services and resources.

As the result of health system reform and the decentralisation of public health funding, Government sources accounted for 15 percent of total health expenditures in 1999, down from 25 percent in 1990 and 36 percent in 1980. The Government's share of health expenditure in China at present is very low compared to other countries. Private household sources accounted for 59 percent in 1999, up from 37 percent in 1990 and 23 percent in 1980. Social insurance and others accounted for 26 percent in 1999, down from 38 percent in 1990 and 41 percent in 1980.

Health sector reform leaves rural residents, especially poor people, in a situation of considerably reduced access to health services. Figure 6 shows the health expenditure per capita of rural and urban residents in China. As it demonstrates, the gap of health expenditure between urban and rural people became large in 1990s.

**Figure 6. Health expenditure per capita 1990-1999, China**



### Facilitating Factors

China's stable political system and reliable legal structures and institutions provide a very good environment for both economic and social development and human rights protection. The National People's Congress (NPC) is China's fundamental political system, and it is the highest organ of State power. NPC is gaining an increasingly important role in the political arena. The use of the law is being expanded daily. The political framework and legal system guarantee gender equality, women's rights, sexual rights and the health of China's population.

Important progress has been made in the legislative arena. In March 1999, the NPC adopted a constitutional amendment that introduced the following sentence at the beginning of Article 5 of the Constitution: 'The People's Republic of China shall practise ruling the country according to law, and shall construct a socialist rule-of-law state.' A new law on family planning and population was passed in late 2001 and became effective on September 1, 2002. The law brings the Government's longstanding family-planning policy that has been in effect for two decades into legal status. This change prevents abuses in family-planning enforcement. China's first draft civil code was submitted to the NPC Standing Committee for preliminary reading in December 2002. The draft, which promotes equity, fairness and good faith, is fundamentally a law about civil rights. For the first time, private property receives the same protection as State-owned property. The draft code contains clear provisions to protect an individual's privacy and the right of human dignity concerning her or his name, image, reputation, credit and security.

## Challenges and Recommendations to Government

### The Prevalence of HIV/AIDS

HIV/AIDS is spreading rapidly in China. Sharing of needles by drug users, inadequate controls on blood collection and supply, a growth in commercial sex, changes in the sexual behaviour of young people and unsafe medical practices are fuelling its spread. The disease has now entered the mainstream community in China through sexual contact. The Chinese Government has declared: '(i) If the AIDS epidemic is not dealt with efficiently by the year 2010 there is a likelihood of more than 10 million people being infected with HIV in China.' If that becomes the case, the disease could become a major obstacle to achieving the goals of ICPD.

Challenges related to HIV/AIDS include: 1) low political commitment in many provinces, counties and cities; 2) inadequate information, education and communication; 3) poverty, lack of education and access among HIV-infected individuals; 4) high rates of sexually transmitted infection; 5) lack of access to and use of condoms; 6) the vulnerability of young people; 7) voluntary counselling and testing (VCT) the general non-availability and expense of services and drugs for treating HIV/AIDS.

### Gender Equity

Owing to the traditional bias against females, women cannot participate fully in the decision-making process in community affairs. Gender inequality remains a barrier in the acquisition of contracted farmlands as sex discrimination does in employment in public enterprises. Females are more vulnerable to unemployment

during the economy transformation phase and therefore face an increasing risk of poverty and must endure more physical and psychological pressures. In addition, the tradition of son preference at birth still lies deep in the people's mind. Inequalities in educational opportunities still exist for women, especially in the countryside and impoverished areas where the level of female education is distinctively lower than that of males. Rural female illiteracy is 13.6 percent and that is 9.6 percentage points higher than that of males. In the impoverished rural areas, maternal and childcare facilities are rather inadequate and women's awareness of health services is insufficient. The hospital delivery rate is low, and both the maternal mortality rate and the infant mortality rate run high. Malnutrition of both women and children in the impoverished rural areas is apparently higher than in the more developed areas.

In addition, domestic violence has been considered trivial and was therefore neglected. Worse still, most domestic violence victims are subjected to the traditional dictum that they 'should not wash their dirty linen in public' and should silently endure their suffering alone. Even with the increase in Government efforts to popularise principles of gender equity, many girls and women remain vulnerable from birth, throughout their schooling and into the workforce and old age.

### Population Growth

Population growth will continue for a considerable length of time, with an annual net increase of over 10 million in the next decade or so, and this will exert great pressure on the economy, on social resources, the environment and on development as a whole, and will be an obstacle to the realisation of sexual and reproductive rights. With a huge population base, even a very low fertility rate will lead to a rapid increase in the population annually in China. Faced with this pressure, the Chinese Government has had to continue to maintain the low fertility rate and cannot satisfy individual reproductive rights. With the decline of the fertility rate and longer life expectancy, China's population is also rapidly aging and it is important that the rights of the elderly are not ignored.

## Conclusion

China has made great progress in implementation of ICPD commitments in the past ten years, although research shows that there are gaps between ICPD goals and the achievements of China in some fields. The National Population and Family Planning Committee is the key department of the Chinese Government tasked with taking charge of the implementation of the PoA  However, other government departments and NGOs also need to follow the recommendations and goals set by the ICPD PoA, and the Beijing Platform for Action as well as the Millennium Development Goals.

China's transition from a plan-oriented economy to a market-oriented economy, and the processes of decentralisation and privatisation that have accompanied it, have had both positive and negative results. While the concept of sexual and reproductive health and rights has been promoted a lot, progress in implementation leaves much to be desired.

Gender equity is a complicated issue in China. The Chinese Government has put a very high value to gender equity since the founding of the People's Republic in 1949, but even with the increase in government efforts to popularise principles

of gender equity, there are many girls and women who remain vulnerable from birth, throughout their schooling, within the workforce and even in old age. Added to these are the relatively recent phenomena such as the high sex ratio at birth, and trafficking in women and girls.

Regional disparities in public health services have drawn some attention. People in China's western region, for example, suffered more than others from the breakdown of the three-tier public health network. As a result, the Chinese Government has decided to invest more health resources in rural areas and western China to provide better health services to the low-income population.

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## Abbreviations / Acronyms

| | |
|---|---|
| AIDS | Acquired Immunodeficiency Syndrome |
| ARROW | Asian-Pacific Resource & Research Centre for Women |
| CCA | Common Country Assessment |
| CCP | Chinese Communist Party |
| CEDAW | Covenant on the Elimination of Discrimination against Women |
| CPPCC | Chinese People's Political Consultative Congress |
| CPR | Contraceptive Prevalence Rate |
| CSO | Civil Society Organisation |
| GDP | Gross Domestic Product |
| HDI | Human Development Index |
| HIV | Human Immunodeficiency Virus |
| ICPD | International Conference on Population and Development |
| IUD | Intrauterine Device |
| MDG | Millennium Development Goal |
| MMR | Maternal Mortality Rate |
| MOH | Ministry of Health |
| NER | Net Enrolment Rate |
| NGO | Non-Governmental Organisation |
| NPA | National Programme of Action |
| NPC | National People's Congress |
| NWCCW | National Working Committee for Women and Children |
| PRC | People's Republic of China |
| RCMS | Rural Cooperative Medical System |
| RMB | Renminbi |
| SFPCC | State Family Planning Commission of China |
| SRHR | Sexual and Reproductive Health and Rights |
| STDs | Sexually Transmitted Diseases |
| STI | Sexually Transmitted Infection |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations International Children's Fund |
| US$ | US Dollars |
| WHO | World Health Organisation |
| WTO | World Trade Organisation |

# Annexures

## List of interviewees

| Name | Position | Title |
|---|---|---|
| Liu Bohong | Chinese Association of Women's Studies | Vice-General-Secretary |
| Wan Yan | Division of Women, National Working Committee of Children and Women | Deputy Director |
| Ma Yinan | Centre of Women's Studies, Peking University | Professor |
| Liu Bing | UNICEF, Beijing office | Programme Officer |
| Mu Guangzong | Institute of Population Studies, Ren Min University | Professor |
| Tian Xueyuan | Chinese Association of Population | Vice President |
| Wang Junqing | China Family Planning Association | Deputy Executive Director |
| Yang Shenwan | Committee of Education, Science, Culture and Health, National People's Congress | Deputy Director |
| Qiao Jie | Department of Gynaecology and Obstetrics, No. 3 Hospital of Peking University | Obstetrician |

## Participants in Focus Group Discussions

FIRST FGD

| Name | Position | Title |
|---|---|---|
| Zheng Xiaoying | Centre for Population, Health and Development, Peking University | Director, Professor |
| Pang Lihua | Centre for Population, Health and Development, Peking University | Assistant Professor |
| Wu Junqing | Institute of Family Planning, Shang Hai | Professor |
| Chen Gong | Centre for Population, Health and Development, Peking University | Deputy Director, Associate Professor |
| Zhou Yanqun | Xin Hua News Agency | Senior Reporter |
| Mu Guangzong | School of Social logy and Population, Ren Min University | Professor |
| Qian Mingyi | Department of Psychology, Peking University | Professor |
| Zhang Lei | Institute of Population Research, Peking University | Research Assistant |
| Liu Jufen | Institute of Population Research, Peking University | Research Assistant |
| Wang Linhong | Chinese Women Health Service Centre | Professor |
| Ding Hui | Beijing Maternity Hospital | Doctor |

SECOND FGD

| Name | Position | Title |
|---|---|---|
| Zheng Xiaoying | Centre for Population, Health and Development, Peking University | Director, Professor |
| Pang Lihua | Centre for Population, Health and Development, Peking University | Assistant Professor |
| Du Fengqin | Hospital of Peking University | Doctor |
| Song Xinming | Institute of Population Research, Peking University | Associate Professor |
| Cheng Jiapeng | Centre for Population, Health and Development, Peking University | Ph. D Scholar |
| Jiying | Institute of Population Research, Peking University | Research Assistant |
| Zeng Guang | Centre for Disease Control and Prevention, China | Professor |
| Zhang Ting | Capital Children Health Centre | Professor |
| Ma Dongling | Chinese Women's Society | Research Fellow |
| Qiao Jie | Department of Gynaecology and Obstetrics, No. 3 Hospital of Peking University | Obstetrician |

## Team Members

| Name | Position | Title |
|---|---|---|
| Zheng Xiaoying | Centre for Population, Health and Development, Peking University | Director, Professor |
| Pang Lihua | Centre for Population, Health and Development, Peking University | Associate Professor |
| Wu Junqing | Institute of Family Planning, Shanghai | Professor |
| Chen Gong | Centre for Population, Health and Development, Peking University | Associate Professor |
| Song Xinming | Centre for Population, Health and Development, Peking University | Associate Professor |
| Cheng Jiapeng | Centre for Population, Health and Development, Peking University | Research Fellow |
| Zhang Lei | Centre for Population, Health and Development, Peking University | Research Assistant |
| Hu Chenghua | Centre for Population, Health and Development, Peking University | Research Assistant |
| Jiying | Centre for Population, Health and Development, Peking University | Research Assistant |
| Liu Jufen | Centre for Population, Health and Development, Peking University | Research Assistant |
| Fan Xianghua | Centre for Population, Health and Development, Peking University | Research Assistant |
| Wang Haitao | Centre for Population, Health and Development, Peking University | Research Assistant |

## Notes

[1] National Family Planning Committee. 1995. Programme on Family Planning (1995-2000).

[2] The Great Leap Forward refers to a period in China when Chairman Mao conducted some special policies to catch up with developed countries - like the United States, Britain and the Soviet Union - within a couple of years.

[3] The Cultural Revolution refers to the ten years from 1966-1976 when China experienced a terrible backslide in both economy and culture because of the wrong policies.

[4] In Article 1, The Law is enacted, in accordance with the Constitution, for the purpose of bringing about a coordinated development between population on the one side and the economy, society, resources and environment on the other, promoting family planning, protecting the legitimate rights and interests of citizens, enhancing happiness of families, and contributing to prosperity of a nation and progress of the society.

[5] Article 3, The population and family planning programmes shall be combined with the effort to offer more opportunity for women to receive education and get employed, improve women's health, and elevate their status.

[6] Article 4, When promoting family planning, the people's governments at all levels and their staff members shall perform their administrative duties strictly in accordance with law, and enforce the law in a civil manner, and they may not infringe upon the legitimate rights and interests of citizens.

[7] Research Team of "CSOs Role in RH Programmes". 2002. Enhancing Civil Society Role in Reproductive Health Programmes in China.

[8] UN Country Team in China. 2003. Updated Common Country Assessment.

[9] Decision-making body usually includes seven persons at the township level, and five persons at the village level.

[10] National Report of the People's Republic of China to the Fifth Asian and Pacific Population Conference. 2002

[11] MOH. 2003. The Statistic Year Book on Health.

[12] NPFPC. National Report of the People's Republic of China to the Fifth Asian and Pacific Population Conference. 2002.

[13] National Statistic Bureau. 2003. China Population Statistic Year Book.

[14] The cost of an abortion depends on the level of the hospital, varying from 20-30 Yuan in RMB around $2-3 in township hospitals to 100-150 Yuan ($20) in high-level hospitals. It is not expensive compared with different income levels.