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Gender issues in the transition to a market based system in China

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China had a long history of feudal and then semi-colonial and semi-feudal society before the foundation of the People's Republic of China (PRC) in 1949. Women in China experienced two waves of emancipation significant for moving towards gender equity. One occurred in 1898–1911 when the Reform Movement and the Revolution banned feet binding among women, promoted education for females and advocated equal rights for men and women in political affairs. The second was the upsurge of women's participation in social production and political life in the New China after 1949 while polygamy ended and prostitution was eliminated (Du Jie & Nazneen Kanji 2003). The Government led by the Chinese Communist Party solemnly declared that women had equal rights with men in all political, economical, cultural, educational and health aspects. These rights were formally entitled in the Constitution of PRC, under which the Marriage Law of 1950, the Election Law of 1953 and other legislations further entrenched specific rights of women. The All China Women's Federation (ACWF) network covered all villages and production units. The proportion of women representatives in the first National People's Congress was 11.9 % in 1954 and increased to 22.6 % in 1975 of the forth Congress (Ding Juan 2006).

From the late 1970s on, China initiated economic reform and open policy, and commenced the transition from planning economy to a market based system. This resulted in a persistent economic growth, remarkable infrastructure development and prosperity as well as substantial changes in social structure, norms and hierarchy. Unintended policy issues related to gender equity brought about by the transition include:

– The collapse of rural collective economy based on the people's commune system turned families to a household-based agricultural production pattern, which largely depends on traditional farming and labor forces; and the gradual closure or downsizing of state-owned enterprises left a large number of unemployed workers;
– Decentralized power and responsibilities from the Central Government to local ones with a slow development of fiscal transfer and public finance systems increased economical and social disparities between urban and rural, eastern coastal and western inland regions;
– When social welfare built into previous commune system and public employer units disappeared, the majority of the population was exposed to uncertainties of future retired life, risks of unpredictable expense of diseases and pressure of ever increasing costs of housing, education and living, as they were rarely covered by any social insurance schemes which were undeveloped in China.
– Access to basic health care, education and other public services became dependent on individual ability to pay when a fee-for-service system was introduced as a palliative measure for sustaining providers, while the government withdrew from the areas due to financial constraints. The poor and disadvantaged groups received less benefit from subsidized social services and inequity was increased.
– Urbanization and migration of rural population to cities for temporary jobs not only provided positive opportunities for cash income, technique learning and culture exchange but also had negative effects on disease transmission such as STDs and HIV/AIDS.

Gender and health

The overall health status of the population in China has been notably improved since the foundation of the People's Republic of China. The maternal mortality rate has been decreased from about 1500/100 000 live birth in 1949 to 48.3/100 000 in 2004, infant mortality reduced from 200‰

to 21.5‰ in the same period, and the average life expectancy at birth increased from 35 years in 1949 to 71.4 year in 2000 (MOH 2006). However, as a country with a population of more than 1.3 billion these average figures concealed big disparities among geographical regions and social groups. Although health inequity in China mainly exists between urban and rural, rich and poor populations, the gender inequity in health and related issues should not be neglected.

Imbalanced sex ratio is an increasingly public concern.
In 1950 the sex ratio of boys to girls was 103 at birth (normal range is 103 to 107). It increased to 108.5 in 1982 by the third census, 110.9 in 1987 by a survey among 1 % of population, 111.14 in 1990 of the forth census, and 119.92 in 2000 by the fifth census (Xie Zhenming 2006). In the four worst provinces it even exceeded 130 (Xinhuanet 2004). There was a tradition of boy preference in China, as males were entitled to priority rights of family inheritance and the obligation of supporting parents. This patriarchy remnant was coupled with strong needs for labor force in farming on household land leased from government and lack of insurance for aged life.

Rising HIV/AIDS transmission in women.
The latest study on the HIV/AIDS epidemic in China by the Ministry of Health, UNAIDS and WHO estimated that by the end of 2005 the accumulated number of HIV infections was 650000 (ranged from 540000 to 760000), with approximately 70000 newly infected in 2005 (Miao Wei 2006). It was mainly transmitted by intravenous drug misuse and increasingly through sexual intercourse. The study also warned that HIV was spreading from high risk groups to the general population. The proportion of females out of the total number of reported HIV infections increased from 15.3 % in 1998 to 32.3 % in 2004, while that of males decreased from 84.7 % to 67.7 % (HIV/AIDS Prevention Office 2004).

Disparity in reproductive health.
In general, women in China suffered higher illness prevalence, felt less healthy and are exposed to more reproductive health risks. The third national health survey indicated that in 2003 the two-week's disease prevalence was 155.8‰ in women and 130.4‰ in men (MOH 2005). The second survey on China women's social status revealed that women in both urban and rural areas felt less healthy than men with a self-judgment method. Women in lagging regions had very limited access to health care which in turn put them at much higher health risks. For instance, in 2004 only 38.9 % of pregnant women in Guizhou Province delivered their babies in hospitals, while the institution delivery rate was 99.5 % in Beijing and 99.4 % in Shanghai. The maternal mortality rate of Guizhou in the same year was 95.4/100000 live birth as compared with 18/100000 in Beijing and 10.8/100000 in Shanghai (Jiang Xiuhua 2006). Females in China bore most of responsibilities in family planning. In 2003 there were 254 million married child-bearing age couples, 90.48 % of them adopted contraceptive methods, 78.73 % by women (intrauterine devices, sterilization, pills, etc.) and 11.75 % by men (sterilization and condom).

Limited gender awareness in health planning and services.
In China the health planning is featured with top-down and segmented approaches. Officials have limited awareness and understanding of gender issues. Women have a weak voice and little chance to participate in health planning and health policy development. For instance, the high prevalence of reproductive tract infections among women, particularly those living in the countryside, has been unrevealed and largely ignored until the late 1990s when some special studies carried out in the area, as the suffered women seldom seek health care due to cultural and/or financial constraints. So far in the health statistics system most data are aggregated without adequate gender information, and gender sensitive indicators have not been well used for health planning, monitoring and evaluation.

One illustrative example

Dafang County of Guizhou Province is located in western China. It has a township called Liulong Township with 27136 residents. Most villagers are poor and living on traditional and lean agriculture in the mountains. In 1999 their average annual income was 158 US dollars. About 20 % of them belong to minority groups, and the illiterate rate among people above the age 15 was 18 % (26.4 % in women and 9.9 % in men). Their two-week's illness prevalence in 1999 was 124‰ in men and 162‰ in women. In the same year only 15.2 % of pregnant women gave birth at hospitals while others delivered babies at home without attendance by trained health workers. There were two maternal deaths and 13 infant deaths in 1999 in the Township. Women suffering from reproductive tract infections (RTIs) deemed themselves as unfortunate and did not seek health care due to a sense of shame or lack of money. Most health workers at the village and township health center could not diagnose and treat RTIs.
From June 2000 to June 2004, the Foreign Loan Office, Ministry of Health organized a pilot reproductive health improvement project in Liulong and other townships in Dafang County with funds from Ford Foundation and

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governments. The project was aimed at safer motherhood, prevention and treatment of RTIs, promoting males and females' participation in reproductive health and improving basic services by training health workers and introducing clinical protocols. Local women's groups and family planning institutes were mobilized to work together with health staff.

The project was carried out as part of the efforts vindicating women's rights. The joint project team identified 68 households as demonstration families to link with communities, organized 108 study groups of women and men as peer education facilities to change community gender prejudice, and trained staff at township health center and village clinics to provide free diagnosis and treatment on RTIs, established fast track for the referral of maternity women to township health center or county hospital with community assistance, and provided free hospital delivery attendance. A sense of gender perspective was also established among local government officials and health mangers through training and local situation analysis.

By 2003 the hospital delivery rate increased to 58.7 % in Liulong Township, infant deaths reduced to 4 and no maternal death since 2000. The utilization rate of the township health center's beds increased from 18.07 % in 1999 to 64.5 % in 2003, mostly for maternal care. A follow up study (Dafang County 2005) in Liulong and other townships indicated that 90.5 % of surveyed villagers in project townships understood the importance of prenatal care (in contrast to 51.8 % in non-project townships), 69.8 % of them considered that prenatal visits should be accompanied by husband, 87.8 % understood the benefits of breast feeding, 64.3 % correctly knew the ways of HIV transmission and 87.1 % understood RTIs prevention, in contrast to 20.4 % and 28.9 % respectively in non-project townships.

The successful experience of the pilot project in Liulong and other townships of Dafang County in improving reproductive health were disseminated to other counties by Guizhou Province. And the World Bank and DFID of the UK Government sent experts to review the case, and recommended including the strategy into the second phase of a large scale basic health services project in China which covered 46 mission populations in 10 provinces. Many counties have adopted the reproductive health improvement approaches from 2003 to their local situations.

Key messages related to gender issues

The policy issues of gender and health equity in the transition to a market based system in China attracted the attention of the Government. The People's Congress and the Government of China have taken legislative, political and financial measures to protect the rights of women, rectify market failure and distortion in social services, and assure that all men and women and disadvantaged groups can equally enjoy the benefits of reform and economic growth. The notions of balanced economical and social development and building up a harmonious society advocated in recent years by political leaders are framing new social norms and facilitating justice. The following important actions have been taken in China to address gender and health equity issues.

In 1992 the People's Congress issued the China Women's Rights Protection Act. It was the first law focusing on women's basic rights. In 1993 China set up a National Working Committee on Women & Children headed by a Vice-Premier. It consisted of 33 member ministries and acted as the highest coordination mechanism on women and children affairs. In 1995 the State Council issued China Women Development Guidelines (1995–2000) aiming at facilitating gender equality and women's development. It was renewed in 2001 for the period of 2001–2010. In March 2003 the National Rural Land Contract Law took effect which reaffirmed equal rights of rural women in land contract disregarding their marriage status (Tan Lin & Jiang Yongping 2006). Then a historical change took place in 2004 that the Government exempted agricultural tax for all farmers.

Since the forth World Women Conference in 1995 China attached great importance to reproductive health. The quality care of family planning took a women's health and needs centered approach, promoted informed selection of contraceptives and participation of males. A number of reproductive health studies in the country which provided evidence for policy development on gender issues and women's health. From 2004 a new policy was implemented to provide government subsidies to rural couples for life who are over 60 years and have only one child or two girls. The policy is being institutionalized and scaled up. In the same year the national poverty reduction program included female chronic illness prevalence and the rate of girls' drop-out from primary and middle schools as two of the eight poverty alleviation indicators, which promoted better targeting of assistance to poor women and girls.

In order to improve health equity the Government started to re-establish the cooperative medical system (New CMS) in rural areas from 2003. It is a preliminary insurance scheme to protect farmers from financial risks of catastrophic diseases. At present each resident contributes 10 RMB (about 1.5 dollars) per year, and gets 40 RMB subsidies from the central and local governments. The funds are pooled at county level for partial reimbursement of in-patient care and substantial out-patient costs. By the end of March 2006 the scheme covered 374 million people, more than 50 % of the total rural

population. It is spreading to cover all rural habitants by 2010. Also from 2003 the Government initiated a national medical financial assistance program to assist the poor in access to basic health care. Funds provided by the central and local governments are used to exempt premium of the poor for New CMS enrolment, and increase the proportion of their reimbursement of medial costs. By the end of 2005 about 11.1 million farmers benefited from the program.

Furthermore, the Ministry of Health initiated a national program to reduce maternal mortality and eliminate neonatal tetanus since 2000 in collaboration with UNICEF. By the end of 2005 the program has covered 1 000 poverty rural counties in 22 provinces. It strengthened the capacity of county, township and village health institutes in obstetric and prenatal care, subsidized hospital delivery of poor women, and mobilized communities to support maternity care. As HIV/AIDS has become a priority concern in China, the Government set up a National HIV/AIDS Prevention and Control Committee at the State Council, issued HIV/AIDS Prevention and Control Ordinance and China Action Plan on Control and Prevention of HIV/AIDS (2006–2010), and furnished a large amount of resources for massive health education, promotion of condom use, voluntary anonymous blood tests and free treatment for AIDS patients including infected pregnant women. It recognized that HIV/AIDS will remain one of the major health challenges in China and more efforts are being made jointly with international agencies.

The transition of China from planning economy to a market based system since 1978 has brought profound social changes and economic growth. It caused a number of policy issues and challenges in gender and health equity as well as provided opportunities for women's development and health reforms. China is making great efforts to address these issues and heading to a harmonious society with more equity and justice.

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