

# An Ongoing Journey

- Review of ICPD + 25 in China



China Population and Development  
Research Center (CPDRC)



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# FOREWORD

The International Conference on Population and Development (ICPD), convened in 1994 in Cairo, marked a historic moment in international population and development, and its Programme of Action (PoA), adopted by 179 Governments, represented a paradigm shift for population and development, moving the focus away from population targets and to the needs, aspirations, and reproductive rights of women and men. Global 5-year reviews conducted have reaffirmed that ICPD principles contributed to progress on the Millennium Development Goals (MDGs) and were embedded in the latest international development commitment — the 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs).

China, represented by a huge delegation from the then State Family Planning Commission (SFPC) and many other relevant departments, attended the Conference and has since acted on many of the recommendations in the PoA in the areas of sexual and reproductive health and rights (SRHR), gender equality, adolescent and youth reproductive health, and population and development. Over the years, China has made good progress in attaining most of the ICPD goals, supported by its continuous economic growth and Government's commitment to place population and development at the center of its planning and development initiatives.

The measures taken to reap the potential of its youthful population have been widely accepted as part of China's success and have contributed significantly to the country's social and economic development. China's experience over the past four decades, including particularly the 25 years since ICPD, shows that implementing ICPD principles yields enormous benefits for national development by providing universal access to sexual and reproductive health and rights, family planning services, and women's and youth empowerment.

The year 2019 represents a milestone in the ICPD agenda — this is the 25th year after its endorsement, and an excellent occasion to review its implementation at the national level. The present ICPD review for China is the first since the adoption of the 2030 Agenda for Sustainable Development, and serves as an evidence-based examination of the implementation of the ICPD PoA in China since 1994; it focuses on the achievements, shortfalls, and contributions to the SDGs in China with respect to the UNFPA mandate areas of sexual and reproductive health, youth, gender equality, and population and development.

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# INTRODUCTION

The year 2019 marks the 25<sup>th</sup> anniversary of the International Conference on Population and Development (ICPD), which was held in Cairo, Egypt in September 1994. This historic Conference was a milestone in redefining the connections between population and sustainable development. The Programme of Action (PoA) adopted at the ICPD calls for a human-centered approach in addressing population issues, particularly in terms of reproductive health and reproductive rights. The principles of the PoA/ICPD are explicitly embedded in the Millennium Development Goals (MDGs) and recognized as closely linked with the realization of the Sustainable Development Goals (SDGs) adopted later by the United Nations.

Since then tremendous changes, both socioeconomically and demographically, have occurred around the world, including in China. As the 25th anniversary of the ICPD approaches, it is valuable for China to have a sound appraisal of the Program of Action generated by ICPD and to document progress since the 15th-anniversary review in 2009 (NBS 2009).

The present review is the first to be conducted since the adoption of 2030 Agenda for Sustainable Development; it examines the implementation of the PoA/ICPD in China since 1994 and its contributions to the achievement of the SDGs in China in the areas of population and development, gender equality, and health improvement.

The review report is written in three parts.

- Part one focuses on the changes in the population and family planning programme in China. Special attention is paid to the call for “Two Reorientations” in family planning as a response to ICPD, the quality of care (QoC) pilot, fertility policy, and the role of international collaborations, particularly the long-term collaboration between China and UNFPA.
- Part two presents the approaches and achievements over the past 25 years with respect to the PoA/ICPD in the areas of population and development, gender equality, and health improvement.
- Part three discusses the path ahead and emerging issues such as low fertility and women’s empowerment, rapid ageing and the labor market, speedy urbanization and massive migration, as well as family planning and reproductive health under the scenario of below-replacement fertility, and their implications for South-South cooperation.

# PART ONE: CHINA'S RESPONSE TO ICPD

## 1. China's participation in the ICPD

As a member of the United Nations (UN) and UN Security Council, China was an active participant of the ICPD in 1994. China was represented by a huge delegation from the various government departments headed by the then State Councilor and Minister of State Family Planning Commission (SFPC) Mme. Peng Peiyun. China also attended the month-long PrepCom in New York in April, 1994 concerning the draft PoA, as well as the NGO Forum held in Cairo in parallel with the ICPD.

The PoA adopted at the ICPD calls for addressing population issues with a broader concept of reproductive health and reproductive rights. It also urges a client-centered, service-oriented, user-friendly, rights-based, and gender-sensitive approach to family planning programmes.

The ICPD exposed China to the concepts of reproductive health and reproductive rights; subsequently, the Fourth World Conference on Women, held in Beijing in 1995, exposed China even more directly to the concepts of women's rights, interests, and empowerment. The 25-year journey of ICPD implementation in China started with reflections on how ICPD principles could be transformed into programmes and can get into operation in the given context of China. International perspectives on reproductive health, such as frameworks on quality of care (Bruce 1990), were introduced

to China (Gu et al. 1996). To learn more about how ICPD principles were implemented in other countries, an SFPC delegation visited India in March 1998 to share experiences and concerns in programme reorientation with Indian counterparts (IIHMR et al. 1999), particularly after that country's announcement to adopt a target-free approach in its family planning programme.

The 25-year journey of ICPD implementation in China involves two dimensions: reforms of the family-planning programme focusing on quality of care and relaxation of fertility policy in the evolving national context.

## 2. Prelude to family-planning programme reforms

Immediately after the ICPD, and at the beginning of the ninth Five-Year Plan period (1996-2000), the Government in late 1995 issued an official call known as "Two Reorientations" of the family-planning programme in both its guiding ideology and implementation approach. These reorientations included a shift from demographic targets to client-centered approaches, and from a narrow focus on contraceptive prevalence to integration with objectives on reproductive health and women's empowerment (Peng 1995)<sup>1</sup>.

Pilots along the lines of these two reorientations were then carried out in selected sites of China. In early 1998, the SFPC elaborated on its goal for family-planning programme

reorientation, specifying that, with the successful demonstration of the innovative pilot in selected counties and districts by the year 2000, the client-centered and quality-focused approach to family planning would gradually be expanded over the country as a whole, and the reorientation of the programme would be realized nationwide by the year 2010 (Peng 1998).

### 3. Introduction of quality-of-care approach

As a concrete measure to implement the PoA/ICPD and the two reorientations, a pilot project was initiated to introduce the quality-of-care approach into China's family-planning programme. This pilot was intended to demonstrate the feasibility of the innovation in line with the principles of the PoA/ICPD, and received international assistance from the Ford Foundation, UNFPA, the Population Council, the University of Michigan, and the International Council on Management of Population Programmes (ICOMP), among others.

The goal of the pilot project was to demonstrate that realigning the family-planning programme

with people's interests and needs was possible and desirable, and would not result in an increased number of births (Kaufman 2006).

**Pilot.** In the pilot areas, the concept of quality of care became gradually but widely accepted by programme managers and service providers. The six elements of quality of care<sup>2</sup> were posted in many clinics as guidance for service provision. Birth quotas and targets were totally abandoned, the requirement for a birth permit prior to pregnancy was removed, and couples were able to decide their own timing for childbearing. The parity-specific policy on contraceptive use was discontinued and replaced with the informed choice of contraceptive methods.

For a thorough review of the experiences of the first 6 SFPC pilots<sup>3</sup> in the first three years of the pilot (1995-1998), a field assessment employing a qualitative methodology (Simmons et al. 1997) was carried out in late 1998 by an interdisciplinary team consisting of Chinese and international specialists (Zhang et al. 1999).

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1. The official text of the call for "Two Reorientations(两个转变)" is as follows: "The family planning programme in China must make two reorientations in both its guiding ideology and programme approach, i.e., from a narrow focus on family planning alone to closely integrating it with economic and social development, and addressing population issues in a comprehensive manner; and from implementing the programme primarily relying on social constraints to gradually institutionalizing a mechanism to integrate rewards-driven with social constraints along with a coordinated IEC, comprehensive services, and scientific management" (Peng 1995).

2. The "six elements of quality of care (优质服务六要素)" include providing adequate choice of contraceptive methods, introducing knowledge of contraceptive methods, competent technical skills, good interpersonal relationships, thorough follow-up services, and multifunctional reproductive health services (Bruce 1990).

3. The first six SFPC pilots on QoC, initiated in 1995, include Nong'an County of Jilin Province, Liaoyang County of Liaoning Province, Jimo City of Shandong Province, Yandu County of Jiangsu Province, Deqing County of Zhejiang Province, and Luwan District of Shanghai. The next five SFPC pilots on QoC experiment, initiated in 1997, include Xuanwu District of Beijing, Heping District of Tianjin, Xuanwu District of Nanjing, Zhuzhou City of Hunan Province, Liuyang County of Hunan Province.

Local people who were involved in the pilot — including family planning programme managers, service providers, clients and government leaders — were convinced that quality of care was the best approach to implement the programme. The results of the pilot project were tangible, convincing, and apparently sustainable. The pilot demonstrated the feasibility of a service-oriented approach to the programme in the context of China. With this new approach, not only did the programme become more widely accepted, leading to greater impact and better demographic outcomes, but more importantly it provided better services to clients and protected their health and rights.

**Scaling-up.** While the QoC experiment started with a low profile, the progress it made was gradually becoming known throughout the country. Hundreds of family-planning managers and service providers from all over the country poured into the pilot counties and districts seeking more information for their reference. More and more areas became interested and subsequently initiated their own local pilots with a quality-of-care approach. The number of rural counties and urban districts that have started their own quality-of-care pilots totaled 200 in early 1998, 300 in late 1998, more than 500 in early 1999, and more than 800 by 2000.

From the very beginning, the pilot project was built on the principle of sustainability and scalability (Simmons et al. 2007). In July 2000, the SFPC proposed overall promotion of quality of care in the national family-planning programme, which marked the beginning of a

comprehensive, top-down development stage for the QoC project. In June 2002, the SFPC officially introduced the “National Quality Service Advanced County Creation Activity.” At the end of 2003, after a special evaluation, 99 advanced counties were recommended as the first batch of state-level quality service advanced counties. By the end of 2013, a total of 1,818 counties, districts and cities had been assessed and rewarded as national Advanced Units for QoC, accounting for about 63 percent of the 2,853 county-level units in total. Provinces and cities also assessed more advanced units at the local level. The quality-of-care approach to family planning and reproductive health services basically achieved full coverage throughout China.

As summarized recently, “the pilot project conducted by the State Family Planning Commission of China in a few select areas was a response to the 1994 International Conference on Population and Development in Cairo, as well as to a range of social and economic changes in China. To achieve quality of care, the pilot project adopted a client-centered approach to refocus China’s family planning efforts on client needs and rights, informed choice of contraceptives, and the provision of better-quality services. After nearly ten years of trials, the successful experiences of the pilot project served as the basis of a family planning programme reform rolled out nationwide” (Xie 2018, also see Kaufman et al. 2006).

The QoC initiative (Xie 2011) was later selected as one of the 10 cases of Innovative Experiences in the PPD/UNFPA/UNDP publication (PPD

2011). It was stated that the “China case study is in many ways an illustration of the basic need to strengthen the quality of care in family planning services, as called for in the Programme of Action of the ICPD.” And it “demonstrates that, by reorienting the focus, upgrading services and improving facilities, the country succeeded not only in attaining low and stable fertility levels but also in generating among the people an improved awareness of reproductive rights and benefits, an improved relationship between clients and service providers, and an improved image of the family planning programme” (PPD 2011: 15-16). The QoC initiative also received great interest from international media, such as the *Wall Street Journal*<sup>4</sup>.

Many people involved in the pilot have deeply regarded it as the most significant experience of their personal careers associated with family planning programmes. A collection of their personal stories has been recently assembled, with the title *Efforts in Memory: Quality of Care Initiative in China’s Family Planning Programme* and will soon be published (Xie et al. forthcoming).

#### 4. Adjustment of fertility policy

Announced in 1980, China’s so-called one-child-per-couple policy<sup>5</sup> was formulated in the

wake of the Cultural Revolution (1966-76) as an emergency measure to slow down population growth and to facilitate the quick recovery of the national economy (Peng 1997).

China’s fertility policy varied across different regions and population groups. Despite local variations and exemptions, the one-child policy remained a core element of China’s fertility policy. Should all couples under various policy regimes follow the local fertility policies fully, more than 60 percent of all Chinese couples would end up with only one child. It was estimated that the overall average fertility targeted by the fertility policies for China as a whole would be 1.47 at the end of the 1990s (Gu et al. 2007).

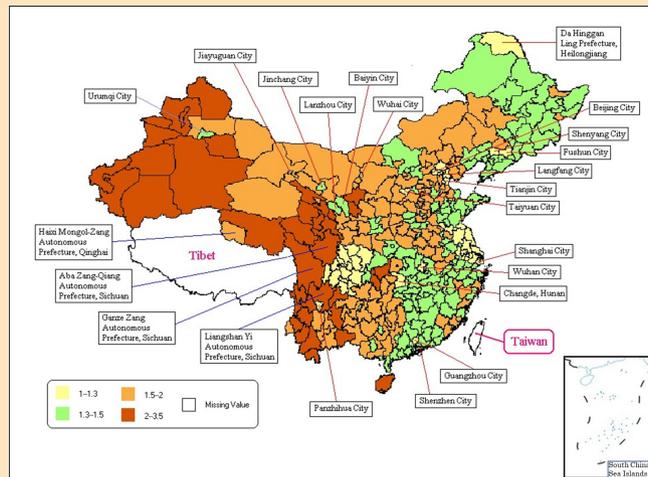
With more reform of the family-planning programme, particularly the success in introducing the quality-of-care approach, it became increasingly viable to consider relaxing the fertility policy on birth restriction. As reported (Xie and Tang 2011), by the early 21<sup>st</sup> century nine provincial governments had abolished the birth spacing requirement; 29 provinces allowed rural couples who were both the only child in their families to have a second child; six provinces allowed rural couples to have a second child as long as one spouse was an only child.

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4. Please refer to a length report on the reform, “Parental Discretion, China Tries Easing Once-Brutal Approach to Family Planning, As Population Growth Slows, The ‘Womb Police’ Yield to Ms. Liu’s Gentler Way. Is a ‘Two-Child’ Policy Next?“, published in the front page of *The Wall Street Journal* on February 2, 2001 (Chang 2001).

5. In fact, as a later part of this report explains, the one-child-per-couple policy is only a general description of China’s family planning policy, which is factually more complicated than the one-child-per-couple policy in China (see Gu et al. 2007 for details). This report uses this customary statement here.

**Figure 1. Distribution of Prefectures by Fertility Policy by the End of the 1990s<sup>6</sup>**



Source: Gu, Baochang, Wang Feng, Zhigang Guo, and Erli Zhang. 2007. "China's Local and National Fertility Policies at the End of the Twentieth Century," *Population and Development Review* 33 (1): 129-147.

Notes: Tibet and Taiwan are not included in the analysis due to unavailability of relevant data.

At the same time, the demographic situation was changing dramatically, with fertility dropping to below replacement level for the first time since the early 1990s, and population growth slowed downward (to be discussed in more detail in part two of this report). As succinctly stated by President Xi, "China's demographic structure is obviously characterized by a high level of ageing and a shrinking young population, the fertility desire of the childbearing age population is obviously reduced, and the total fertility rate of women is

obviously below replacement level" (Xi 2015).

Despite continuing debates and concerns, the Government nevertheless decided in November 2013 to initiate a partial change to the one-child policy by allowing couples with one spouse being a single child to have a second child. This measure was taken with caution, because of the fear of possibly creating a new baby boom. On the contrary, however, the gradual implementation of the new policy in 2014 over various parts of the country failed to produce a tangible impact on fertility levels. Surprisingly, "among the estimated more than 11 million couples who are eligible to have a second child under the new rule, only 1.69 million had applied

as of end August (2015), accounting for 15.4 percent of such couples" (Xi 2015). The tepid response from eligible couples triggered off another policy debate, whether the Government should allow all couples to have two children, and even the removal of official birth restriction altogether. In October 2015, the Government decided that all couples would be allowed to have two children. The announcement of the new policy marked the official ending of the 35-year one-child policy in China (Wang et al.

6. Given the variation in fertility policies by region and sub-population as discussed in detail in Gu et al. (2007), indicators are used to measure fertility as the fertility policy is targeted to achieve assuming that everyone living in the given region gave birth strictly following the local fertility policy. This measure was not the real fertility level but was used to explain variations across regions and groups in terms of fertility policy.

2013; Wang et al. 2016; Attane 2016a; Scarping 2018).

New opportunities have arisen with the introduction of the conditional two-child policy in 2013 and the universal two-child policy in 2015, as well as the merging of the National Population and Family Planning Commission (NPFPC) and the Ministry of Health (MOH) into the National Health and Family Planning Commission (NHFPC) in 2013 and subsequently the National Health Commission (NHC) in 2016. The Government has integrated reproductive health and family planning services into the public health service system, and doubled its efforts to improve the social support system for family development and healthy ageing. A series of special reproductive health and contraceptive services have been provided in response to the adjustment of fertility policy.

## 5. International collaborations

While the reform of the family-planning programme was largely home-grown rather than donor-driven, it has nevertheless received extensive assistance from a variety of international organizations and foundations. The longest-standing and strongest support has been from the United Nations Population Fund (UNFPA). The year 2019 marks the 40th anniversary of the collaboration between China and UNFPA, as well as the 25th anniversary of the implementation of ICPD principles. Reproductive health and rights have always been prioritized in the cooperative agenda between UNFPA and the Government of China.

Below are listed some highlights of UNFPA's work to assist China in implementing the ICPD:

- **Rights-based policy-making using research on changing population dynamics:** Since the mid-1990s, UNFPA has, through a combination of capacity building, evidence generation, and policy advocacy, provided support to rights-based population and development planning and sexual and reproductive health and rights (SRHR)-related policy design and implementation. This has included continuous support for population research and national capacity to generate and utilize disaggregated population data.
- **Rights-based, client-centered family planning and sexual and reproductive health services:** From 2000 onwards, UNFPA supported the Government of China in transitioning from an administrative family planning approach to an integrated client-oriented reproductive health approach. This entailed a progressively expanding effort by the NPFPC (and later NHC) to institute informed choice-centered quality-of-care training and standards for family planning and reproductive health service providers across the country. The decline in the number of abortions and the broadening of the contraceptive method mix in China in recent years can be partly attributed to this programmatic upgrade.
- **Integration of family planning with maternal and child-health services:** In the years immediately after the ICPD, UNFPA partnered with UNICEF and WHO to help the

Government of China implement a massive grassroots training programme to integrate family planning with maternal and child-health services. Nearly half a million doctors at the township and village levels across 27 provinces were provided with the necessary skills to deliver integrated maternal and child-health and family planning care.

- **Youth empowerment:** In 1998, UNFPA was the first UN agency to support national partners in the field of reproductive health and family planning; this included support especially to China's largest non-governmental organization, the China Family Planning Association (CFPA), to address the sexual and reproductive health needs of Chinese youth. By empowering young people via peer education and the creation of a national network of university-based clubs, thousands of Chinese youth were enabled to reach millions of their peers with life-saving sexual and reproductive health information and counseling.
- **Gender equality:** UNFPA has contributed to the increasing normalization of China's skewed sex ratio at birth by supporting provincial government-led community mobilization efforts to change norms of son preference. UNFPA has also supported evidence-based advocacy and policy dialogue to foster increased attention to gender-based violence (GBV), including a more robust and systematic health-system response.

- **Global and South-South cooperation:** South-South Cooperation became part of the UNFPA country programme of cooperation with China in 1999, represented by the establishment of three South-South Centers of Excellence in the area of reproductive health in Nanjing, Shanghai, and Chengdu. In May 2017, the Population and Development South-South Cooperation Center of Excellence was launched at the China Population and Development Research Center, with support from UNFPA and the National Health and Family Planning Commission. The Centre of Excellence has become an important platform to promote South-South and Triangular Cooperation in population and development under the Belt and Road Initiative through such activities as technical exchange meetings and training workshops.

UNFPA support to the QoC pilot is a relevant example. The fourth cycle of the China/UNFPA collaboration project (1998-2002) focused on reproductive health and family planning services in 32 selected counties in 22 provinces in central and western China. The 32 counties involved in this project were spread geographically over the country, primarily in rural areas with relatively unfavorable socioeconomic conditions. The initiative catalyzed the lifting of births targets and quotas at the county level, eliminating birth permits for first birth, and added strong monitoring and impact evaluation mechanisms.

Given this success, the China/UNFPA RH/FP project can be replicated in other areas with similar conditions. It is feasible to make the

family-planning programme effective, even in terms of demographic outcomes, using the ICPD-recommended approach as an alternative to the traditional administrative measures in the implementation of the programme (Gu 2004). This approach was not only continued but further strengthened in the fifth cycle of China/UNFPA cooperation (2003-2005) and the sixth cycle (2006-2010) of the UNFPA Country Programme in China (Xie and Tang 2011). An external evaluation carried out in 2014 showed that this collaboration between UNFPA and China had a positive impact (UNFPA 2015).

UNFPA has always been a strong advocate for reproductive health and reproductive rights in China. An example of this work was the joint organization of the Third Fertility Policy Symposium, under the title "Facing the Future of Population Research in China," held in Shanghai in December 2014 in partnership with the Center for Population and Development Policy Studies of Fudan University. Over 50 demographers from 30 research institutes in China and abroad participated in the symposium, reviewing the achievements and efforts made to promote adjustments to the fertility policy in China since 2000. Based on observations on the implementation of the two-child policy for one-side-single families, and in-depth discussions on population dynamics that China was facing, the participants called for further relaxation of China's fertility policy. Mr. Arie Hoekman, then UNFPA's Representative to China, noted in his speech: "UNFPA is pleased to note the policy change in November of 2013 where couples are now allowed to have a second child if one of the partners or spouses

is a single child. It is hoped that this signals the beginning of further policy change aimed at guaranteeing universal access to sexual and reproductive health and reproductive rights of the Chinese people. This would be in line with the principles and Programme of Action of the International Conference on Population and Development (ICPD) that 179 countries, including China, agreed to in Cairo in 1994." Based on the discussion, a recommendation letter on policy change, the third in a series, titled "Adopting a two-child policy and removing all the birth restrictions" was produced, and was later submitted to and acknowledged by top decision-makers and ushered in the announcement of the two-child policy for all couples in late 2015.

In short, ICPD implementation in China initially focused on improving family planning services to reorient the programme from a demographic targets-driven approach to a client-centered approach, with the provision of informed contraceptive choices and quality of care. China launched an innovative pilot strategy in a few sites, focusing on quality of SRH and family planning care before scaling up nationwide. The strategy gradually extended to fertility-policy adjustment and the official end the one-child policy, which had been in effect for 35 years. Programme implementation continued to evolve in scope and approach nationwide.

# PART TWO: MAJOR APPROACHES AND ACHIEVEMENTS IN CHINA SINCE ICPD

Tremendous changes have taken place in almost every aspect of Chinese society over the 25 years since ICPD in 1994. This part of the report reviews the major achievements in socioeconomic development in China and discusses how these achievements were secured in line with the PoA/ICPD, particularly in the three UNFPA mandate areas of population and development, gender equality, and health improvement.

## 1. Population and development

With its total population of 1.39 billion at the end of 2018, China remains a developing country with the largest population in the world. As a result of the people-centered development process, China has recorded improvements in livelihoods and progress in social development, building on rapid economic development since the reform drive in 1978. Meanwhile, China's population trends have shifted to fertility

**Figure 2. Population Change in China: 1949-2018**



Sources:

(1) Data for 1949-2008 came from NBS. 2008. China Compendium of Statistics: 1949-2008. Department of Comprehensive Statistics of National Economy. Beijing: China Statistics Press.

(2) Data for 2009-2017 from NBS. 2018. China Statistical Yearbook 2018, Beijing: China Statistics Press.

(3) Data for 2018 from NBS. National Economy and Society Developed Statistical Bulletin 2018.

[http://www.stats.gov.cn/tjsj/zxfb/201902/t20190228\\_1651265.html](http://www.stats.gov.cn/tjsj/zxfb/201902/t20190228_1651265.html).

decline and population ageing, following global demographic trends. The population age structure has been changing remarkably, with a reduction in the youth population aged 0-14 and growth in the elderly population aged 65 and above. With the population peak looming large in the near future, population structural issues have become a salient priority for China.

### **1.1 Demographic dividend and economic development**

China's demographic dividend is widely considered to have had a positive impact on the country's economic miracle over the past decades. With the implementation of family-planning programmes, China has undergone demographic change more rapidly than most industrial economies. Demographic transition lasted about 30 years, from the early 1970s to the beginning of the 21st century, which led to a large and growing labor force, creating a favorable demographic window of opportunity. The abundant labor force aged 15-64 increased from 559 million in 1978 to 889 million in 2000, accompanied by a fast-declining dependency ratio. The annual rate of increase of the labor force was much higher than that of the total population. This demographic opportunity has been successfully leveraged by a set of social and economic policies.

Under the guidance of the reform and opening-up strategy, various economic and social policies built on basic national conditions were gradually developed, facilitating the demographic dividend. These policies include the free flow of the labor force, development of labor-intensive industries, reforms to the

system of employment and entrepreneurship, promotion of equal labor opportunity for men and women, implementation of the Healthy China Initiative, and the strategy for invigorating China through science education. The peaceful international environment and the globalization process also helped pave the way for economic development (Yuan and Gao 2018).

With the combination of reforms and opening to the outside world, China has become a model country for leveraging the demographic dividend and creating an economic miracle (Yuan and Gao 2018).

### **1.2 Low fertility and the coming negative population growth**

By the early 1990s, China's fertility had fallen to a level below replacement. Data from several Chinese censuses repeatedly showed a very low total fertility rate (TFR), from 1.22 in 2000, to 1.18 in 2010, and 1.05 in 2015. This decline triggered heated debates and questions about data quality and the actual fertility level. With an eye to possible statistical errors and under-reporting, many studies have been carried out with various alternative data sources and methods. In recent decades, the adjusted total fertility rates were from 1.3 to 1.6, except for 2016 and 2017, when the TFR was slightly above 1.6, but still far below replacement level (Wang and Wang 2019).

China's fertility will likely remain at a low level in the near future due to a variety of socioeconomic factors. The latest survey data on national fertility status in 2017 revealed the top reasons for the low fertility levels, including:

weakened childbearing desire, particularly among the younger generations even after the fertility policy was relaxed to allow two children per couple; the economic burden of having another child; difficulties in child care; and tension between career development and childbearing (He et al. 2018).

A key demographic factor is that the age at first-marriage and the age at first-childbearing have both risen. Recent survey reveals that the average age at first marriage for females was 26.3 in 2016 (He et al. 2018), 3.5 years higher than that in 1990 (NBS 2010). Compare this to figures from 2006, when the female age at first marriage in urban areas was 24.6, 1.8 years higher than that in rural areas. The urban-rural gap in age at first marriage was as small as 1.3 years in 2016 (He et al. 2018). The average age at first-childbearing for females was 26.9 in 2016 (He et al. 2018), 3.4 years higher than in 1995 (Zhang and Hou 2016).

Associated with the lasting low fertility rates, the population in China has experienced a declining growth and will soon see a negative growth if the current trend persists, which would have complex social and economic implications. It is estimated that the total population will likely peak at 1.43 billion in the future, regardless of the elimination of birth restrictions, which will be followed by population reduction starting approximately before 2030 (Wang and Wang 2019). By 2050, the total population will likely be reduced to 1.32 billion, a reduction of roughly 100 million from the peak.

Along with the negative growth of the total population, the newly-born population will likely decrease year by year, from above 15 million by 2020, down to 11 million by 2050, a reduction of about one-third less than the figure at present (Wang and Wang 2019). According to the annual report of national statistics, for the year 2018 the birth rate was 10.94 per thousand, the death rate was 7.13 per thousand, and the natural increase rate was 3.81 per thousand.

<b>Population Statistics for 2018</b>	
• Population at Year-end	1.39 (billion)
• Number of Births	15.23 (million)
• Number of Deaths	9.93 (million)
• Birth Rate	10.94 ‰
• Death Rate	7.13 ‰
• Rate of Natural Increase	3.81 ‰
- NBS. <i>National Economy and Society Development Statistical Bulletin 2018.</i>	

### **1.3 The reduction of the labor force and rapid population ageing**

During the period from 1995 to 2018, the age structure of China’s population underwent drastic changes. The labor force aged 15-59 started to decline in 2010; it was 910.7 million in 2018 (NBS 2019c) and will decline to 800 million by 2035, and to 670 million in 2050. The proportion of the population aged 0-14 declined continuously from 26.7 percent in 1995 to 16.9 percent in 2018, and that of the working-age population aged 15-59 rose steadily from 63.1 percent in 1995 to 65.3 percent in 2018 (NBS 1996a; 2019c). Such changes in age structure have kept reducing the total dependency ratio of China’s population

from 48.8 percent in 1995 to 40.4 percent in 2018, i.e., 40.4 dependent children and seniors for every 100 working-age population (NBS 1996a; 2018a; 2019c). The median age of the labor force will grow from 39.4 years in 1995 to 42.7 years in 2018.

China became an ageing society at the turn of the century and will retain this status for the rest of the 21<sup>st</sup> century. In 2000, the population aged 60 and above was 130 million, accounting for only 10.5 percent of the total population, while the population aged 65 and above was 88.2 million, accounting for 7.0 percent of the total population (NBS 2000). By the end of 2018, however, the population aged 60 and above had reached 249 million, or 17.9 percent of the total population, while the population aged 65 and above was 167 million, or 11.9 percent of the total population. The elderly population will increase further in the coming decades. It is estimated that the population aged 60 and above will reach 326 million in 2035, accounting for 22.8 percent of the total population, and be over 300 million in 2050, accounting for 29.3 percent of the total population (He 2018), which would make China one of the oldest countries in the world at that time.

China has developed strategies to respond proactively to population ageing and to prepare for the future demands that would arise with the fast increase in the size of the elderly population in the next three decades. More than 20 strategies and plans have been developed since 2013 to address different aspects of population ageing, including integrating elderly care with medical services, developing old-

age programmes and industries, promoting the social participation of elderly people, and reducing the burden of child care on young couples in order to boost fertility.

#### **1.4 Speedy urbanization and massive migration**

China's urbanization has developed rapidly in recent years. In 2011, China's urban population accounted for over 50 percent of the total population, indicating the end of an era dominated by rural society. The urbanization rate in China has been rising steadily, with nearly 60 percent of the population now living in cities, 23.8 percentage points higher than that in 2000, and up by 1.3 percentage points per annum on average. The National New-Type of Urbanization Plan (2014-2020) requires the inclusion of the migrant population in planning for the social and economic development of destination areas, and promotes the orderly resettlement to towns and cities of qualified populations from the agricultural sector. It stipulates that the population transferred from agriculture be eligible for the same basic public services as local urban residents, and that efforts be made to establish and improve the citizenship mechanism of the transferred agricultural population and ensure equal access to education for the children of migrant workers. In 2014, two significant documents, namely "Opinions on Furthering the Work of Serving Migrant Workers" and "Opinions on Further Promoting the Reform of the Household Registration System," were released by the Chinese government to address the challenges of rapid urbanization.

Meanwhile, the Chinese government attaches great significance to enhancing urban service capacity and quality, improving living environments in urban areas, and upgrading the quality of life for urban citizens. In 2017, the per capita road area and public park green area in cities reached 16.1m<sup>2</sup> and 14.0m<sup>2</sup> respectively, which is 2.6 and 3.8 times greater than in 2000. Urban tap water prevalence and the rate of wastewater disposal reached 98.3 percent and 94.5 percent respectively, which is 34.4 and 60.2 percentage points higher than in 2000 (NBS 2018a; 2019b). Meanwhile, the urban public services register constant enhancement in terms of system development and service quality.

China now has the largest domestic migrant population in the world. In 2018, the flow of internal migration was well above 240 million, either migrating from rural to urban areas or between cities. The Chinese government has been promoting full coverage of basic public services, especially to ensure migrants enjoy the same public services and social welfare in health, education, housing, and social insurance as local residents. Since 2006, a nationwide programme has been launched to promote the social integration of migrants and provide them with equal access to basic public health services, including free contraceptives and health counseling services. The initiation and implementation of “Action Plan of Health Education and Health Promotion among Migrants (2016-2020)” in major migrant destinations nationwide mobilized social resources and enabled relevant activities by enterprises, schools, residential communities, and civil society organizations.

The coverage of basic public health and family planning services among migrant populations expanded from 80.5 percent in 2014 to 87.4 percent in 2017. The immunization rate of migrant children has been above 90 percent. To understand the basic situation and emerging needs of migrants, the Government has conducted a dynamic survey of migrants each year since 2010, with a sample size of 180,000 people. A report on China’s migrant population development, based on survey results, has been published annually.

As more international talents, students, businessmen, and tourists come to China, more Chinese people have been traveling internationally for economic reasons or as tourists in recent years, with an increasing number of visitors to “Belt & Road” countries. China became a member of International Organization for Migration (IOM) in 2016. A new government department, the State Immigration Administration, was established under the Ministry of Public Security in 2018 to meet the needs of increasing international travel and migration to and from China.

### **1.5 Poverty reduction**

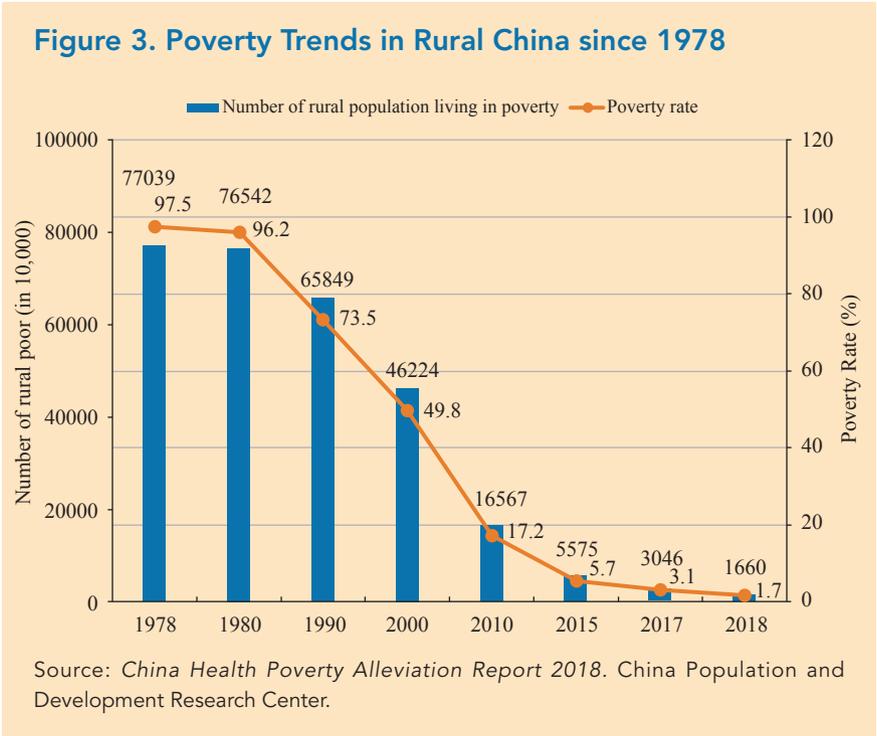
China has made significant progress in alleviating and eradicating poverty during the last twenty-five years. Since putting forward the targeted poverty-alleviation strategy in 2013, China has greatly increased its budget for poverty relief and encouraged society to help in these efforts. The self-development capacity of poverty-affected areas has been steadily enhanced.

China has largely eliminated absolute poverty, and is meeting the food and clothing needs of its almost 1.4 billion people. A welfare system covers urban residents by providing basic living allowances to families under poverty line since 1997. China’s Human Development Index (HDI) score rose from 0.541 in 1994, just barely above the low human development floor, to 0.752 in 2017, very close to high human development (UNDP 2018). The rural poverty headcount ratio dropped from 7.7 percent in 1994 to 1.7 percent in 2018. Evaluated against the international poverty line, the number of people living on less than USD 1.90 per day was 0.7 percent in 2015.

The rural population in poverty declined from 82.5 million in 2013 to about 16.6 million in 2018 with a poverty line of per capita net income CNY 2,300 per year (2010 constant price)(NBS 2018a). Several hundred million Chinese have been lifted out of poverty during a quarter-century, truly a historic achievement.

The Chinese government gives priority to meeting

the basic living needs of rural poor populations, and to ensuring they have access to food, clothing, compulsory education, basic medical services, and housing. In 2019, by strengthening poverty alleviation and infrastructure development efforts in areas of extreme poverty like the “three regions and three prefectures,”<sup>8</sup> a reduction of over 10 million in the rural poor population has been targeted. The Government is determined to reach the goal of eliminating absolute poverty nationwide by the year 2020, which goal was established by the 19<sup>th</sup> National Congress of the Communist Party of China in October 2017.



7. The World Bank has updated the international poverty line to USD 1.90 a day (in 2011 prices) since 2015. The previous line was USD 1.25 a day in 2005 prices. Poverty headcount ratio at USD 1.90 a day is the percentage of the population living on less than USD 1.90 a day at 2011 international prices.

8. The “Three Regions (三区)” refers to the Tibet Autonomous Region, the four prefectures in southern part of Xinjiang Autonomous Region and the Tibetan areas in the four provinces of Qinghai, Yunnan, Gansu, and Sichuan. The “Three Prefectures (三州)” refers to the Linxia Prefecture in Gansu Province, Liangshan Prefecture in Sichuan Province, and Nujiang Prefecture in Yunnan Province. These are the areas of greatest extreme poverty at the national level.

## 2. Health improvement

The Government of China takes health issues as a high priority and announced on October 25, 2016 a strategic framework to improve the health of all in “Outline of Healthy China 2030 Plan” (hereafter Healthy China 2030). The Outline sets goals and targets for key health indicators to be reached by 2030, such as maternal mortality and mortality under age 5. The Government has developed the basic medical and healthcare system and aims to achieve universal primary health care coverage — including essential reproductive healthcare services in such areas as family planning and maternal and child health — by the year 2020. This is to be achieved by continuously improving the medical service system. China continues to reform the coordinated medical

services, medical insurance, and pharmaceutical industry, and has raised the level of government subsidies for rural and non-working urban residents’ basic medical insurance and the reimbursement rate of serious illness insurance.

The proportion of health expenditure covered by the government’s budget to total health expenses gradually increased from 19.4 percent in 1994 to 28.9 percent in 2017, and individual expenditure decreased from 44.0 percent to 28.8 percent during the same period. Medical and health services also continue to be improved. Nationwide, beds in hospitals and health centers have increased from 2.36 per thousand people in 1994 to 5.72 per thousand people in 2017; and the number of medical practitioners per thousand people rose from 1.57 in 1994 to 2.44 in 2017 (NBS 2001; 2018a).

### **Box 1. The Development of China's Health in 2018**

According to the “Statistical Bulletin on China’s Health in 2018” published in May 2019 (NHC 2019b), the average life expectancy of Chinese residents has increased from 76.7 years in 2017 to 77.0 years in 2018. The maternal mortality rate has dropped from 19.6 per 100,000 in 2017 to 18.3 per 100,000 in 2018, and the infant mortality rate has decreased from 6.8 percent in 2017 to 6.1 percent in 2018.

In 2018, the total number of national medical treatments in medical and health institutions reached 8.31 billion, an increase of 130 million (1.6%) over the previous year. Residents went to medical and health institutions for an average of 6.0 visits per person. The number of medical treatments in township hospitals and community health service centers (stations) reached 1.92 billion, an increase of 40 million from 2017. It accounted for 23.1 percent of total medical treatments, and the proportion increased by 0.1 percentage points over 2017.

At the end of 2018, the total number of health workers nationwide reached 12.3 million, an increase of 551,000 (4.7%) over the previous year. There were 2.59 (assistant) physician practitioners per 1,000 people, 2.94 registered nurses per 1,000 people, 2.22 general practitioners per 10,000 people, and 6.34 professionals in public health institutions per 10,000 people.

The total national health expenditure in 2018 reached CNY 5,799.83 billion, accounting for 6.4 percent of GDP. Of this total, government health expenditures accounted for 28.3 percent, social health expenditures accounted for 43.0 percent, and personal health expenditures for 28.7 percent. The total health expenditure per capita was CNY 4,148.1.

By the end of 2018, 45.4 percent of the public hospitals at the second level and above had carried out appointment diagnosis and treatment, 90.8 percent had clinical pathway management, 52.9 percent had telemedicine services, 85.8 percent participated in mutual recognition at the same level, and 70.9 percent had high-quality nursing services.

In 1996 life expectancy was 70.80 years, and by 2015 it had increased 5.54 years to 76.34 years (NBS 2018a), and further to 76.7 years in 2017 and 77.0 years in 2018 (NHC 2019b).

**Table 1. China's Health Expenses and Structure**

Year	1990	1994	2000	2005	2010	2015	2017
Total Health Expenses (CNY 100 million)	747	1761	4587	8660	19980	40975	52598
Government Health Expenditures	187	342	710	1553	5732	12475	15206
Social Health Expenditures*	293	645	1172	2586	7197	16507	22259
Individual Health Expenditures	267	774	2705	4521	7051	11993	15134
Structure of Health Expenses (%)	100	100	100	100	100	100	100
Government Health Expenditures	25.1	19.4	15.5	17.9	28.7	30.5	28.9
Social Health Expenditures	39.2	36.6	25.6	29.9	36.0	40.3	42.3
Individual Health Expenditures	35.7	44.0	59.0	52.2	35.3	29.3	28.8
Proportion of Health Expenditure to GDP (%)	4.0	3.6	4.6	4.6	4.8	6.0	6.4
Per Capita Health Expenses (CNY)	65	147	362	662	1490	2981	3784

Source: NBS. 2018. *China Statistical Yearbook 2018*. <http://www.stats.gov.cn/tjsj/ndsj/2018/indexch.htm>.

\* Social health expenditure refers to the capital investments on health by various social sectors, excluding those by the Government, which includes such expenditures as those by the social medical security, commercial health insurance, medical expenditures by society, social donations and assistance, and revenue from administrative and institutional fees.

## 2.1 Maternal and child health

China regards maternal and child health as an integral part of the fundamental public health services and major public service projects. In 2002, the Implementation Programme for Carrying out the National Programme of Action for Child Development in China (2001-2010) and the National Programme of Action for Women's Development in China (2001-2010) were issued, which proposed a number of maternal and children's health targets, such as improving the health of newborn babies, ensuring safe delivery for pregnant women, reducing infant and child mortality under the age of five, improving children's nutrition status and healthy growth, strengthening education on children's health, guaranteeing women's access to basic health services, and improving the living environment. It pointed out that maternal and child health is an important responsibility of government at all levels.

A new round of healthcare reform was initiated in 2009, and has included important public health service projects such as allowances for rural women during hospitalization and child delivery, screening for breast cancer and cervical cancer for rural women, and nutritional improvement for children in poor areas; these were implemented for the purpose of addressing safety issues impacting the health of women and children. With allowances provided to 37.62 million rural women for hospital

delivery of children and 222.35 million eligible-age rural women screened for cervical cancer and 3.15 million for breast cancer, the project achieved marked results between 2009 and 2012.

After the fertility policy was adjusted in 2016 to allow for a second child, there emerged a rapid increase in the number of high-risk pregnancies among older women. To respond to this emerging challenge, China has initiated a national scheme called the "Five Regulations for Maternal and Infant Safety,"<sup>9</sup> which focuses on preventing and reducing maternal and infant mortality. In remote rural areas, efforts have been made to improve knowledge on reproductive health and maternal and child health in a way that villagers can easily understand. Hospital delivery is strongly promoted. NHC also initiated the Action Plan for Safe Motherhood and Children (2018-2020) to reduce maternal health risks and safeguard maternal and child health.

The national basic public health service project and a variety of thematic projects have greatly improved maternal and child healthcare in China. In 2017 the pre-delivery checkup rate reached 96.5 percent and the hospital delivery rate of pregnant women reached 99.8 percent in China, much higher than the rates 25 years ago (NHC 2018). The mortality rate of newborns declined from 27.3 per 1,000 in 1995 to 3.9 per 1,000 in 2018 (NHC 2019a). Meanwhile, the

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9. The "Five Regulations for Maternal and Infant Safety (母婴安全五项制度)" refers to pregnancy risk prevention system, high-risk maternal project management system, critical and serious treatment system, death case reporting system, and interview notification system.

infant mortality rate went down from 36.4 per 1,000 in 1995 to 6.1 per 1,000 in 2018, and the mortality rate of children under 5 decreased from 44.5 per 1,000 in 1995 to 8.4 per 1,000 in 2018 (NHC 2019a, MOH 2005), respectively. All of these rates have declined faster than in the previous decade, enabling China to attain the relevant Millennium Development Goals (MDGs) ahead of time. Years of efforts have reduced China's maternal mortality rate from 80.0 per 100,000 in 1991 to 24.5 per 100,000 in 2012, down by more than 60 percent, thereby attaining ahead of schedule the MDG target of reducing the maternal mortality rate by three-quarters from the 1990 level by 2015. The maternal mortality rate declined further to 18.3 per 100,000 in 2018 (NHC 2019a). Children age

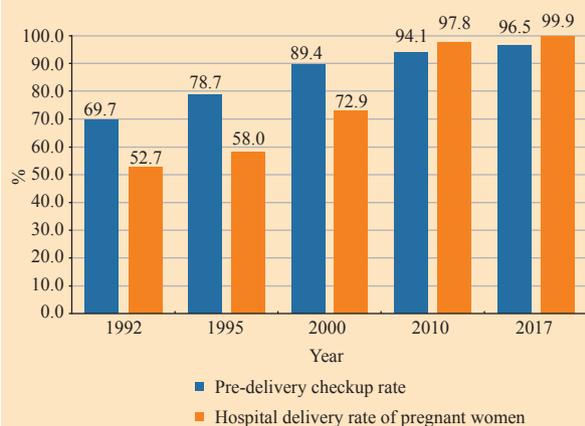
6 and under are almost fully covered by the national vaccination programme, and the rate of vaccination was above 95 percent in 2017.

## 2.2 Health-poverty alleviation

In June 2016, the Guiding Opinions on the Implementation of the Health Poverty Alleviation Project was jointly issued by 15 ministries including the former National Health and Family Planning Commission (NHFP) and the State Council Leading Group Office of Poverty Alleviation and Development.

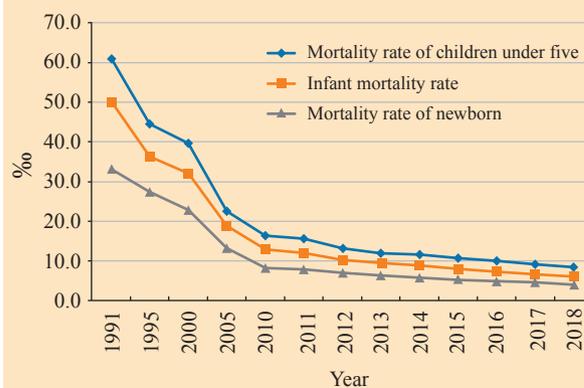
According to the rationale of medical and health services, health-poverty alleviation adheres to a scientific approach in determining whom to support, who is responsible for implementation

**Figure 4. Maternal and Child Health Care in China**



Source: *China Health Statistics Yearbook 2018*. National Health Commission. 2018. Beijing: Chinese Peking Union Medical College Press.

**Figure 5. Infant and Child Mortality Rates in China: 1991-2018**



Sources: (1) Data of 1991-2000 came from the Ministry of Health. *China Health Statistics Yearbook 2005*. Beijing: Chinese Peking Union Medical College Press. (2) Data of 2005-2017 came from the National Health Commission. *China Health Statistics Yearbook 2018*. Beijing: Chinese Peking Union Medical College Press. (3) Data of 2018 came from the National Health Commission. 2019. *China Women and Children Health Care Development Report (2019)*. Beijing.

and how, and how to assess an exit from poverty. In accordance with the requirements of ensuring access to sufficient food and clothing, compulsory education, basic health care, and safe housing for poor people (Two Assurances and Three Guarantees<sup>10</sup>), health-poverty alleviation focuses on the overall goal of safeguarding basic healthcare for the poor. Moreover, it also aims to realize the “Healthy China” and “Rural Vitalization” strategies by adopting the “Three Batches”<sup>11</sup> Action Plan that is designed to ensure that poor people have access to affordable and quality medical and health services.

Since the commencement of the Health Poverty Alleviation Project, local governments have centered on the goal of providing “guaranteed medical care” for poor people. The health-poverty alleviation policies and measures have taken effect.

As of the end of 2017, the State Council Leading Group Office of Poverty Alleviation had registered 9.81 million poor households affected by illness, with 28.56 million people living in such households. Among that number, 17.3 million people from 5.71 million illness-affected poor households had been lifted out of poverty, with the rate of poverty alleviation reaching 58.2 percent. The pace of lifting people out of poverty among the illness-stricken

poor households was basically the same as the overall pace of poverty alleviation among the poor households registered by the government (CPDRC 2019).

### **2.3 Sexual and reproductive health and reproductive rights**

Sexual and reproductive health and reproductive rights are at the heart of the ICPD Programme of Action. As discussed in Part One, China’s State Family Planning Commission (SFPC) responded to the ICPD in 1995 by issuing an official call for “Two Reorientations” as a prelude to family-planning programme reform in China. From then on, the Chinese government has implemented a series of national policies, programmes, and strategic plans in the areas of family planning and reproductive health, pushing forward major changes in these areas.

In 2001, the Law on Population and Family Planning and the Regulations on Management of Family Planning Technical Services were officially promulgated, and incorporated the concepts of “human-centered and human development” in a holistic manner, including reproductive health, informed choice and quality of care. The law has promoted family planning programmes at all levels nationwide, and markedly built up the capacity for the standard provision of family planning and reproductive health services.

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10. The “Two Assurances (两不愁)” means ensuring food and clothing. And the “Three Guarantees (三保障)” means compulsory education, basic medical care, and housing security to be guaranteed.

11. The “Three Batches (三个一批)” means that on the basis of the approval work of poverty caused by illness and poverty reversion due to illness, and in accordance with the requirements of “one batch of centralized treatment for serious diseases, one batch of contracted service management for chronic diseases, and one batch of guarantee for the relief of serious diseases”, the organization will carry out classified and batch treatment for the poor population suffering from serious diseases and chronic diseases to implement the health-poverty alleviation.

Maternal and child healthcare services have been incorporated into basic public health services as also discussed in section 2.1 above. In 2001, the implementation plans for China's National Programme for Children's Development 2001-2010 and China's National Programme for Development of Women 2001-2010 were released, which put forward multiple targets such as better health quality of newborns, ensuring safe child-delivery for women, reducing infant and under-5 mortality rates, safeguarding women's access to basic health services, and improving women's health status.

In 2009, the Opinion on Promoting Gradual Equalization of Basic Public Services made it clear that vaccination and child and maternal healthcare are all items of national basic public health services, and the Opinion also listed significant public-health service items including hospital deliveries for rural pregnant women, pre-pregnancy and early-pregnancy supplementation of folic acid for rural women to prevent neural tube defects, screening for breast and cervical cancers among rural women, and prevention of mother-to-infant transmission of HIV/AIDS, syphilis, and hepatitis B.

The capacity-building of service providers has also been a persistent focus of China's sexual and reproductive health programme. A nationwide initiative has been made to develop a group of licensed consultants who are willing and qualified to serve the people, capable in good communication and skilled in providing services. The Government has organized corresponding national qualification

examinations to ensure the supply of better skilled family planning/reproductive health service providers. These licensed consultants have made great contributions in assisting couples of reproductive age to make informed choices about contraceptive methods.

The gender perspective has been introduced into the service provision process, particularly focusing on male participation and couple's joint decision-making on family planning and family development.

One of China's main approaches in ensuring the quality of care is to build the national norms for standardized and client-centered services. The Government has introduced and implemented 33 indicators for supervising and evaluating the quality of care.

In remote rural areas, efforts have been made to improve knowledge on reproductive health and maternal and child health in a way that villagers can easily accept and understand. Hospital delivery is strongly promoted.

### ***2.3.1 The change in contraceptive mix***

In 2017, there were 268.2 million married women of childbearing age in China (NBS 2018c). Over 80.6 percent of them have adopted contraceptive methods, keeping China's contraceptive prevalence rate at a fairly high level (NHC 2018).

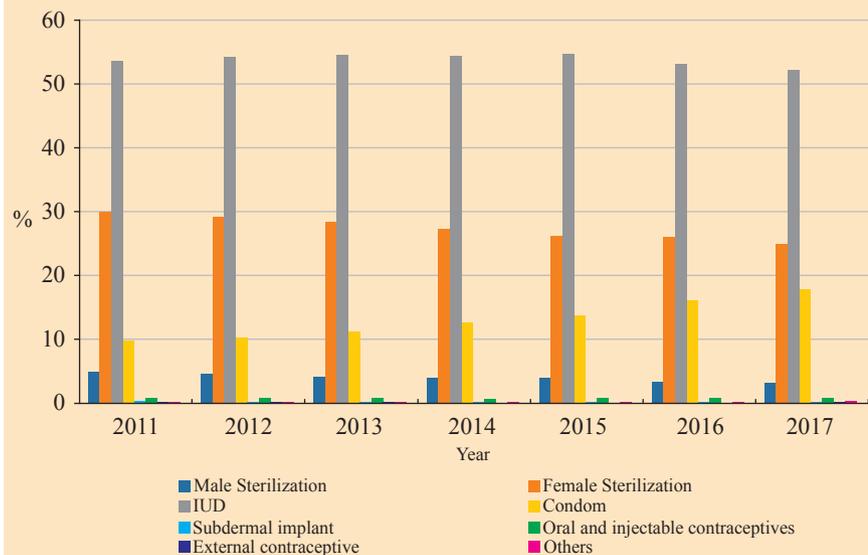
With the "Two Reorientations" of family planning programme since 1995 and the spread of quality of care, education, information, and family planning services have been widely

available to people of reproductive age. Women of childbearing age, in particular, are exposed to some new practices and concepts in improved family-planning, such as informed choice of contraceptive methods, client-centered services, and reproductive health rights. Therefore, family planning boosts the decision-making capacity of Chinese women, especially rural women (Hardee et al. 2004). Significant change has also taken place in the contraceptive mix for couples of reproductive age, as seen in the marked increase in the proportions of condom and IUD users and the use of self-controlled and reversible contraceptives. Public satisfaction with contraceptive services has enjoyed year-on-year improvement.

In 1992, the percentage of couples of reproductive age who underwent sterilization (including vasectomy and tubal ligation) and an IUD insertion were 53.46 percent and 40.12 percent, respectively, which accounted for over 93 percent of all married women of reproductive age interviewed (Jiang 1996). In 2006, the percentage using sterilization had dropped to 39.7 percent, while the proportion of those using an IUD had risen to 51.35 percent, and condom users accounted for 6.8 percent (CASS 2007). In 2017, the percentage of married couples of reproductive

age who had undergone sterilization had dropped further to 28.2 percent, and the percentage using an IUD first rose and then dropped to 52.2 percent, while condom users accounted for 18 percent. During the period 2011-2017, the use of subdermal implant and oral and injectable contraceptives remained at relatively low levels between 0.2-0.3 percent and 0.8-0.9 percent, respectively (NHFPC and CPDRC, 2018).

**Figure 6. The Proportions of Contraceptive Methods Use in China: 2011-2017**



Source: National Health and Family Planning Commission and China Population and Development Research Center. *Population and Family Planning Data Sheet 2017*. Department of Family Planning. Beijing: China Population Publishing House.

### 2.3.2 Sexually transmitted diseases

HIV/AIDS prevention and control programme has received high attention from the Government and the whole society. In line with China's Medium- to Long-Term Plan for Prevention and Control of HIV/AIDS (1998-2010), and the Chinese Action Plan for HIV/

AIDS Prevention and Control (updated every five years since 2001), the Chinese government has reinforced publicity and education on HIV/AIDS prevention. Money from the central government for the special fund for HIV/AIDS prevention and control totaled CNY 4.8 billion in 2017. The HIV/AIDS morbidity ratio has been reduced by 57 percent, achieving the target of a 30 percent reduction by the end of 2015 from the 2010 levels, set by the Action Plan (2010-2015).

In 2002, China started to pilot the prevention of mother-to-child transmission of HIV/AIDS in 8 counties in 5 provinces. The Regulations on Prevention and Control of HIV/AIDS promulgated in 2006 specifies the Government's responsibilities for HIV/AIDS prevention and control at all levels, as well as the rights and obligations of those living with HIV/AIDS. In addition, governments at all levels in China have implemented the policy of "4 Frees and 1 Care."<sup>12</sup>

In 2009, further reform of the health system included prevention of mother-to-child transmission of HIV/AIDS as a major public health service item; a pilot project has been expanded to include 453 counties. In 2017,

mother-to-child transmission of HIV has been controlled to 5.5 percent, and blood transmission has been virtually eliminated with nearly zero case reports.

As a whole, there is a low spread of HIV/AIDS in China. HIV prevalence among drug users has been significantly reduced by comprehensive interventions. The incidence of HIV infection among rehabilitated drug users has declined from 0.2 percent in 2012 to 0.03 percent in 2017. People living with HIV or AIDS numbered 759 thousand by the end of 2017, compared to 780 thousand at the end of 2011. In 2017, the reported cases of HIV/AIDS were 134,512, about 77 percent male, mainly ages 25-40 and the elderly, and most of whom work in agriculture or domestic service or are unemployed. More than 80 percent of people living with HIV/AIDS currently receive anti-HIV therapy. Case fatality has declined year after year and voluntary HIV testing and screening capacity is now available nationwide (Zheng 2018).

#### **2.4 Young people's sexual and reproductive health and rights**

Young people's sexual and reproductive health and rights constitute an important component of China's health programme. In China, many

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12. The "4 Frees (四免)" are free anti-virus drugs and exposure to anti-virus treatment for HIV/AIDS patients who are rural residents or urban residents in economic hardship without participation in basic medical insurance; free counseling services and preliminary screening of HIV virus antibody for those voluntarily receiving HIV/AIDS counseling and virus testing; free provision of drugs blocking mother-to-infant transmission and infant test agents to pregnant women affected by HIV/AIDS; and free compulsory education for orphans of HIV/AIDS patients. "1 Care (一关怀)" refers to government care for treatment of people living with HIV/AIDS and HIV/AIDS patients, i.e., including HIV/AIDS patients and their families living in economic hardship in the scope of government subsidies and provide them with living allowances according to relevant social relief policies; and supporting people living with HIV/AIDS and HIV/AIDS patients to engage in income-generating activities as they are able.

laws and regulations adopted or revised after 1994 have included articles on young people's rights to health and development, including the Constitution revised in 1993, the Law on Maternal and Child Health issued in 1994, the Criminal Law revised in 1997, the Law on Preventing Crime of Minors issued in 1999, the Marriage Law revised in 2001, the Population and Family Planning Law adopted in 2001, the Law on Protecting the Rights and Interests of Women revised in 2005, the Law on Protection of Minors revised in 2006 and the Compulsory Education Law revised in 2006. For example, the Law on Protection of Minors includes prohibition of sexual harassment against minors in the national law for the first time, and Article 19 of that law states that it is schools' obligation to provide life-skills education, psychological-health education, and puberty education that are commensurate with their maturity level.

China has attached growing significance to HIV/AIDS prevention and treatment for young people in its laws, regulations, and policies, in consideration of the HIV risk and vulnerability of youth. The National Programme of Action for Child Development in China (2001-2010 and 2011-2020) promulgated in 2001 and 2011, respectively, and the National Action Plan on Human Rights 2009-2010 adopted in 2009 combine to create a favorable policy environment for safeguarding young people's sexual and reproductive health. In 2008, the Ministry of Education released Guidelines for Health Education at Primary and Secondary Schools, stipulating that puberty health shall be a major component of primary and secondary school health education.

Regarding young people's sexual and reproductive health as an important work area, the Government organizes adolescent-health education and service projects. Peer education, participatory activities, and life-skills training have increased the knowledge of adolescents in and outside school about sexual and reproductive health and enhanced their ability to prevent sexually transmitted infections and HIV/AIDS. At the same time, the role of Chinese non-governmental organizations such as the China Family Planning Association (CFPA) and Chinese offices of relevant international organizations are fully utilized. They have provided sexual and reproductive health education and services to young people and thereby safeguarded adolescents' rights to access reproductive health education and services.

#### **2.4.1 Knowledge, attitude and behavior**

The puberty of young people in China starts at an earlier age today than 25 years ago. The age of menarche has declined from 13.26 years in 1995 (Chinese Student Physical and Health Research Group, CSPHRG 1996) to 12.07 years in 2014 (CSPHRG 2016), while the age at first marriage has risen from 23.6 years in 1995 to more than 26 years in 2017 (NBS 2010). The marriage age of women continues to rise year by year, particularly in large cities. As the exposure time to sex prior to marriage has increased from about 10 to about 14 years, people's attitude towards premarital and extramarital sex has become more tolerant.

In 2018, a survey of 5,338 youths aged 15-24 in Beijing-Shanghai-Guangdong about

premarital sex was carried out. Compared with 1999 and 2004, young males' recognition of "chastity before marriage" dropped by 5.7 and 0.4 percentage points respectively, while girls' decreased by 10.3 and 9.3 percentage points. At the same time, young people's acceptance of "having sex with engagement," "having sex with love," and "having sex without love" all increased significantly, with acceptance among boys tending to be higher than that among girls. Young people's attitude towards adolescent pregnancy is becoming more and more tolerant (Yang 2018).

Among young people, the age at sexual debut is trending downwards, with pre-marital sex and cohabitation becoming more widespread. Sexual experience is becoming more common among older young people, men, students in vocational secondary schools, migrants, and young people in single-parent or divorced families.

A survey conducted at a university in Guangzhou from 2015 to 2016 shows that, among the 1,305 respondents aged 15-24, the average age of first sexual activity is 18.5 years. 6.3 percent of college students admitted to having sex and 56.6 percent of college students used contraceptive methods during their first sexual activity (Ma et al. 2018). Another survey conducted in Ningbo, Zhejiang Province from 2012-2014 shows that among the 1,346 off-campus young people aged 15-24, 44 percent admitted having had sex, 32.1 percent used condoms for the first time and 35.3 percent used condoms for the most recent sexual encounter (Jiang, Zhang and Zhang 2016).

While the birth rate of girls aged 15-19 over the last decade has remained low, i.e., under 6 per 1,000, it rose to 8.49 per 1,000 in 2017 (NBS 2018b).

However, unmet contraceptive needs still exist among young people. As contraceptive services mainly target married couples of childbearing ages, young people's access to sexual and reproductive health services is still restricted. At present, there are more than 9.63 million cases of induced abortions annually (NHC 2018), of which a great proportion is by adolescent girls. In some large cities, induced abortions by unmarried women have already exceeded that of married women.

For example, from August 2015 to July 2016, a hospital in Ningbo, Zhejiang Province received 1,638 cases of induced abortions to young people, with an average age of 21.83 ( $\pm$  3.67) years, including 3 cases (0.18%) at age 15, 183 cases at age 16-19 (11.17%), and 1,452 cases (88.65%) at age 20-24. Unintended pregnancies among young people were attributed to non-use of contraception or contraceptive failure (Ji et al. 2019).

Unmet contraceptive needs among adolescents may lead to an increase in the numbers of HIV infections as well. By the end of October 2015, China had reported 9,152 cases of HIV infection among students aged 15-24, and the number of young students infected with HIV was increasing steadily and rapidly year by year. For example, the number of cases from January to October 2015 increased by 27.8 percent compared with the same period in 2014 (Wang et al. 2017).

### **2.4.2 RH information and service among youths**

After the Guidelines for Health Education at Primary and Secondary Schools were released by the Ministry of Education in 2008, sexual and reproductive health education was scaled up among youths in secondary school and higher education institutions, covering more than 80 percent of cities and counties across the country by 2017.

Non-governmental organizations have played a positive role in the promotion of youth SRH in schools, communities, and clinics. Since the late 1990s, the China Family Planning Association (CFPA) has implemented a number of pilot projects in collaboration with UNFPA, the International Planned Parenthood Federation (IPPF), the Bill Gates Foundation, and others. The best known is the international cooperative project to promote the reproductive health of Chinese youth, implemented jointly with the Programme for Appropriate Technology in Health (PATH). Experiences of youth SRH programmes have been scaled up to more areas, benefiting millions of young people since being launched in 1998.

Since 1995, peer education on youth SRH has also expanded across the country, mostly via young volunteers in colleges and middle schools. A number of international and civil-society organizations have conducted peer education among university and middle-school students, factory workers, and migrant workers, including on topics such as values, relationship ethics, pre-marital sex and unwanted pregnancy, condom use, and HIV/AIDS prevention. By

focusing on changing behaviors and improving life skills, peer education has been welcomed by youths because of its equality, openness, and participatory orientation.

CFPA has been working on sexual and reproductive health and rights among adolescents by developing curricula and training school teachers and peer educators for more than a decade. China Youth Network (CYN), which focuses on advocacy for the sexual and reproductive health and rights of people aged 10-24 years, has conducted peer education and related activities in universities since 2004. The network now covers 112 city/county administrative units, and activities had been carried out in 257 universities by the end of 2017.

The CFPA has cooperated with several international organizations and relevant government departments to carry out the “Youth Sexual and Reproductive Health (SRH)” programme, which provides SRH education and services to young people aged 10-24. Its main objectives include raising young people’s awareness of SRH rights; promoting their capacity for a healthy lifestyle; improving the accessibility of high-quality and youth-friendly SRH services; creating a supportive environment at all levels; and strengthening the ability of Family Planning Associations to advocate for, implement, and evaluate youth programmes.

After years of exploration and practice, the Youth SRH programme has formed a unique “Conceptual framework for youth SRH behavioral intervention,” which identifies

three levels of work for adolescents, parents, and teachers, as well as corresponding work methods. It includes four components as outlined below.

- **Core concept:** The conceptual approach emphasizes “Life Skill Training,” rather than simply disseminating sexual knowledge; “Peer Education,” rather than imposing knowledge and ideas; and “Participatory Learning,” rather than giving lectures.
- **Team building:** Since 2009, the CFPA has launched “National Teacher Certification for SRH Education” and organized training for candidates. It has provided training to youth peer educators in youth-health summer camps. And with the support of UNFPA, CFPA has established the China Youth Network (CYN) in June 2004. As a volunteer organization, the CYN advocates SRH peer education for young people aged 10-24.
- **SRH education and services:** Its life-skills training benefited millions of students, soldiers, and young migrants. The programme organized “Youth Health College Trip,” and carried out peer-education activities in communities, military camps, and enterprises. It also established “Youth Health Clubs” to provide places for young people to acquire SRH knowledge and carry out peer education activities.
- **Exchange and cooperation:** Collaborations with counterparts and institutions in Taiwan, Hong Kong, and Macau have been developed over the years. CFPA has also strengthened its collaboration with and

initiated provision of technical support to other developing countries and regions.

### 3. Gender equality

The Chinese government has successively enacted or amended more than ten laws and regulations to address issues of women’s empowerment and gender equality, which have served as the legal basis for the protection of women’s development.

For example, it is clearly stipulated in the amendments to the Law of the People’s Republic of China on the Protection of Women’s Rights and Interests that “It is a basic state policy to realize equality between men and women. The state shall take necessary measures to gradually improve various systems for the protection of the rights and interests of women and to eliminate all kinds of discrimination against women.”

Since 1995, China has produced *National Development Outlines for the Development of Women* every ten years (the current one is the third, covering the period 2011-2020), and publishes the statistical report each year to monitor and review achievements and gaps in gender equality in the areas of health, education, economy, decision-making and management, social welfare, environment, and legal issues. In 2009, the Chinese government approved the *National Plan of Action for Human Rights* (2009-2010) with specific articles on the protection of rights for ethnic minorities, women, children, older persons, and persons with disabilities.

**Table 2. Main Monitoring Indicators of the National Plan of Action for the Development of Chinese Women: 2010-2017**

Year	2010	2017
<b>Women and Health</b>		
Maternal Mortality Rate (per 100,000)	30.0	19.6
Hospital delivery rate (%)	97.8	99.9
Gynecology Detection Rate (%)	28.8	24.2
<b>Women and Education</b>		
Higher Education Gross Enrollment Rate (%)	26.5	45.7
Gross Enrollment Rate for High School (%)	82.5	88.3
Proportion of Female Students among High School Students (%)	47.1	47.6
Compulsory Education Consolidation Rate (%)	91.1	93.8
Preschool Gross Enrollment Rate (%)	56.6	79.6
Number of Female Students in Preschool Education (million)	13.5	21.5
<b>Women and Economy</b>		
Proportion of Female Employees to Total Number of Employees (%)	44.7	43.5
Number of Female Employees in Urban Units (million)	48.6	65.5
Rural Poverty Headcount Ratio (%)	17.2	3.1
Proportion of Women in Extreme Poverty Who Have Received Assistance (%)	34.4	39.4
<b>Women's Participation in Decision-making and Management</b>		
Proportion of Female Representatives of the National People's Congress (%)	21.3	24.9
Proportion of Female Members on the Board of Directors of an Enterprise (%)	32.7	39.7
Proportion of Female Village Committee Members (%)	21.4	23.1
Proportion of Female Residents' Committee Members (%)	49.6	49.7
<b>Women and Social Welfare</b>		
Number of Women Participating in Maternity Insurance (million)	53.7	84.3
Number of Women Participating in Basic Medical Insurance (million)	189 (2011)	520
Number of Women Participating in Basic Pension Insurance (million)	352 (2016)	390
Number of Women Participating in Unemployment Insurance (million)	51.5	79.5
Number of Women Participating in Work Injury Insurance (million)	57.0	85.9
<b>Women and Environment</b>		
Park Green Areas (square meter per capita)	11.2	14.0
Treatment Rate of Domestic Sewage (%)	82.3	94.5
Coverage Rate of Rural Sanitary Toilet (%)	67.4	81.8
<b>Women and Legal Issues</b>		
Number of Legal Aid Agencies for Women	3592	4292
Number of Women Receiving Legal Aid (2011-2017) (million)		2.3
Number of Cases of Combating Trafficking in Women (2011-2017) (thousand)		16.0

Source: NBS. 2017. *The National Plan of Action for the Development of Chinese Women (2011-2020) Statistical Monitoring Report 2017*. [http://www.stats.gov.cn/tjsj/zxfb/201811/t20181109\\_1632537.html](http://www.stats.gov.cn/tjsj/zxfb/201811/t20181109_1632537.html).

## **Box 2. Legislation and Policy Measures Against Female Employment Discrimination**

In order to protect women's equal employment rights, China has formed a system of laws and regulations, including the Constitution, the Labor Law, the Law on the Protection of Women's Rights and Interests (new revision of 2005), the Employment Promotion Law, and the Labor Protection Regulations for Women Workers. These laws and regulations clearly stipulate the protection of women's equal employment rights, and gender discrimination in employment is not allowed.

The *National Plan of Action for the Development of Chinese Women (2001-2010)* and the subsequent plan (2011-2020) include the goal and content of eliminating gender discrimination in employment.

In February 2019, the Ministry of Human Resources and Social Security, the Ministry of Education, and other nine departments jointly issued the *Notice on Further Regulating Recruitment and Promoting Women's Employment*. The notice included detail on preventing gender discrimination in the recruitment process. "No gender exclusion (except for cases defined for female workers' taboos, etc.) or gender preference, should be allowed, and women's job hunting and refusal should not be restricted based on gender. The employing units are not allowed to ask about the situation of women's marriage and childbearing. The pregnancy test should not be used as a job entry medical examination item. The restriction on childbearing should not be used as a condition of employment, and the criteria for employment of women should not be differentiated." The notice also required the improvement of the judicial relief mechanism and strengthening of the supervision mechanism. The corresponding punishment for gender discrimination in employment by employers was specified.

### **3.1 The decline of abnormality in the sex ratio at birth (SRB)**

The normal sex ratio at birth (SRB) is 103-107 males born for every 100 females. China's SRB has been on the rise for more than three decades, and at one time this was one of the country's top challenges for population and development. The SRB in 1982 stood at 108.5, which was already above the normal range, and continued to rise, reaching 120.6 in 2008. This

abnormality of SRB, caused to a large extent by the emergence of prenatal sex-selection of the fetus, has intensified over the decades.

To address the abnormal SRB in recent decades, China has built a multi-level governance framework based on the "Care for Girls Campaign," and has made great progress in social development and public policies. Proactive public policies have included the

Population and Family Planning Law of 2001 and the Law on the Protection of Women's Rights and Interests, revised in 2005. In 2005, the Plan of Action on Caring for Girls and Comprehensive Management of the High Sex Ratio at Birth was issued by the General Office of the State Council on behalf of 12 government ministries, which spelled out the responsibilities of different departments. In 2006, the Decision on Fully Enhancing the Population and Family Planning Programme and Comprehensively Addressing Population Issues identified combating the high sex ratio at birth as a priority. In 2016, the regulation of National Health and Family Planning Commission, State Administration for Industry and Commerce and State Food and Drug Administration on Banning Illegal Fetal Sex Determination and Sex Selective Abortion was enacted, and was much more comprehensive than the regulation of 2002.

With all these efforts, the high sex ratio at birth has gone down since 2009, declining to 113.5 by 2015. Continued efforts to bring the SRB down to the natural level are still a priority.

Nevertheless, the consequences of the long-term gender imbalances have gradually become more prominent. The age pyramids are now increasingly skewed towards males among the younger generations, leading to a growing number of "missing girls" from

the demographic records. According to the estimates of UNFPA, the extent of prenatal sex selection and of excess deaths among young girls have already provided insights into the extent of this form of discrimination. This historically unprecedented development is leading to an irreversible demographic masculinization, or a gender-imbalanced society. This includes a widely cited scenario in which an estimated 30-60 million men, particular in rural areas, would face difficulties in finding a spouse. In the period of social transformation, the issues of gender imbalance are further intertwined with other social changes including marriage, low fertility, population ageing and migration, which are bound to influence the future over the next half a century.

**Figure 7. Sex Ratio at Birth in China: 1982-2015**



Source: National Health and Family Planning Commission and China Population and Development Research Center. *Population and Family Planning Data Sheet 2017*. Beijing: China Population Publishing House.

### 3.2 Education and the gender gap

In recent decades, China has been implementing a development strategy prioritizing education, which has continuously upgraded national educational attainment. With increasing input into education, government appropriation for education grew from CNY 141.1 billion (USD 20.2 billion) in 1995 to CNY 3.1 trillion (USD 448.5 billion) in 2016, of which public expenditure for education increased from CNY 102.8 billion (USD 14.7 billion) to CNY 2.8 trillion (USD 395.7 billion), with the proportion of government appropriation for education to total GDP rising from 2.4 percent in 1995 to 4.2 percent in 2016 (MOE 2006; 2018a).

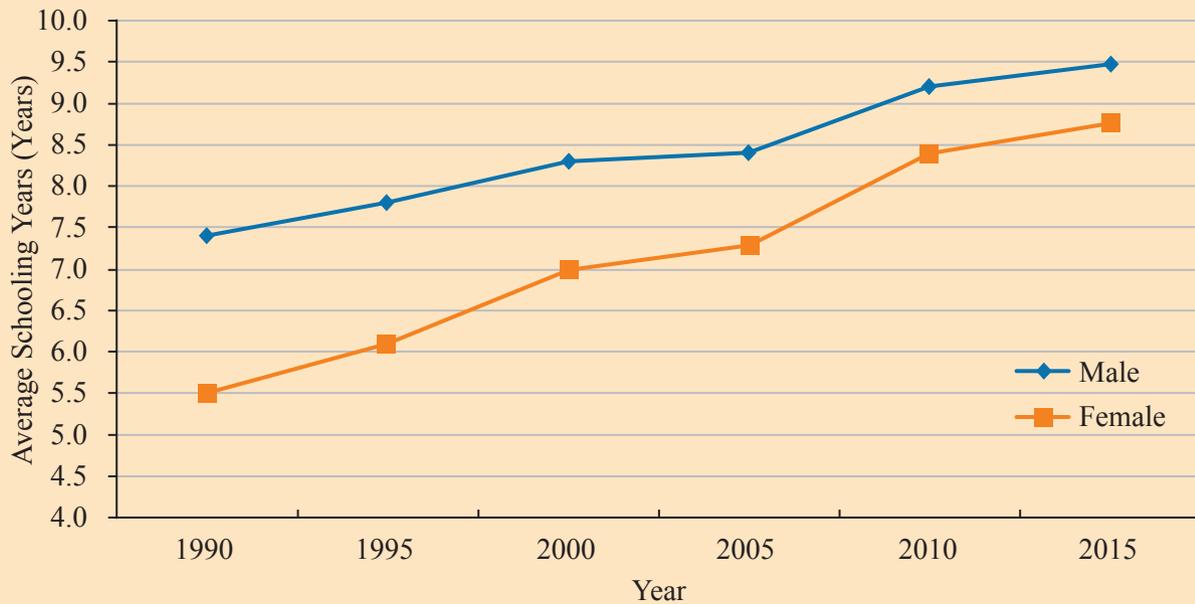
Remarkable achievements have been made in educational development, especially in rural areas. China allocated public education resources and increased input in primary education for the children of migrant workers and left-behind children. For example, in 2007, China implemented the policy of “Two Exempts and One Subsidy, i.e., all students can receive exemptions for tuition and miscellaneous fees and textbook fees, while poor rural students residing on campus can receive living allowances” for compulsory education; China expanded the policy nationwide in 2008 (NBS 2008). The policy has contributed significantly to shrinking gender inequality in educational attainments across regions, and between rural and urban areas.

In 2017, the nine-year compulsory education consolidation rate was 93.8 percent, that is, among the students enrolled in the first grade of primary school in 2010, 93.8 percent

completed middle school education in 2018, which was 89.7 percent in 2010 (MOE 2018b; The State Council of PRC 2011). The progress rate from middle school to high school increased from 50.3 percent in 1995 (MOE 2006) to 94.9 percent in 2017 (MOE 2018a), and a gross enrollment rate for tertiary education was 45.7 percent in 2017, which was 38.5 percentage points higher than the rate of 7.2 percent in 1995 (MOE 2006, 2018a). Thus, average national educational attainment has grown continuously.

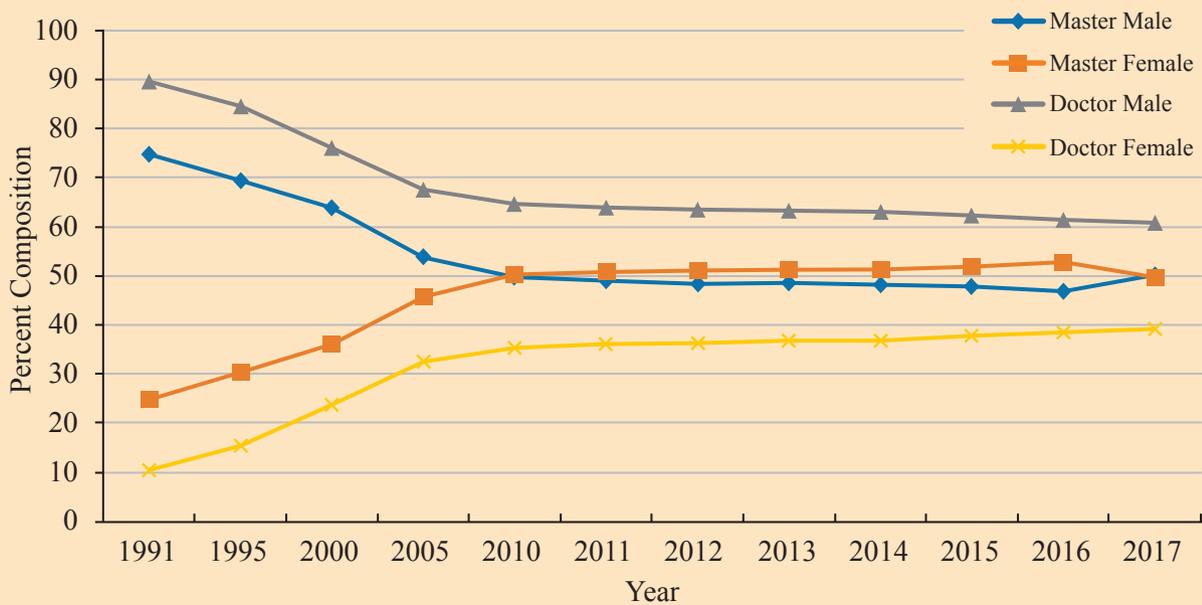
Meanwhile, the gender gap in education has been shrinking remarkably. The enrollment rates of 7-year-old boys and girls in 1990 were 77.82 percent and 73.66 percent, respectively. By the end of 2017, the net enrollment rate at primary schools had reached 99.9 percent for girls (NBS 2019a). Figure 9 shows that the gap between male and female postgraduate students had narrowed from 38.8 points in 1995 to 0.2 points in 2017. The gap between male and female doctoral candidates shrank from 69.0 points in 1995 to 21.5 points in 2017 (NBS 2012; Ministry of Education 2018a). The gender gap in higher education has reversed since 2010, with a higher proportion of young women age 16-21 enrolled in high school or higher education than men of the same age, and women outnumbering men in college, university, and graduate school in 2016. Despite this progress, gender bias still exists, a typical example of which is the unequal access to employment opportunities after graduation.

**Figure 8. China's Average Schooling Years by Gender: 1990-2015**



Source: NBS. *Tabulation on the Population Census of PRC (1990, 2000, 2010) & 1% Population Sample Survey Data (1995, 2005, 2015)*. Beijing: China Statistics Press.

**Figure 9. China's Gender Composition of Master and Doctoral Students, 1990-2017**



Sources: (1) Data of 1991-2000 came from NBS. 2012. *Women and Men in China—Facts and Figures (2012)*. Department of Social, Science and Technology, and Culture Statistics. (2) Data of 2005-2017 came from the Ministry of Education. *Educational Statistics Yearbook of China (2005-2017)*. Department of Development & Planning. Beijing: China Statistics Press.

### 3.3 Anti-domestic violence

According to the Third Survey on Chinese Women's Social Status, conducted in 2010 by the All-China Women's Federation (ACWF) and the National Bureau of Statistics, 24.9 percent of married women encountered violence in different forms, with physical violence reported by 6.4 percent of people interviewed (Liu, Song and Li 2013). A UNFPA-supported small-scale survey as part of the UN Multi-Country Study on Men and Violence conducted in 6 countries in Asia and the Pacific showed that 35 percent of women interviewed had experienced physical violence and 14 percent had experienced sexual violence during their lifetimes. Meanwhile, 44 percent of male respondents reported having perpetrated physical violence and 22 percent sexual violence (UNFPA 2013).

The Chinese government and women's organizations have allied with all stakeholders to combat domestic violence against women. With emphasis on the role of media in disclosing truth and guiding public opinion, China called for social attention via more vigorous publicity and advocacy efforts.

In 2008, the Opinions on Preventing and Putting a Stop to Domestic Violence was distributed jointly by several ministries, and specifies the division of duties among different departments in preventing and controlling domestic violence. Subsequently, 28 provinces have developed their local regulations or multi-sectoral joint documents on the prevention and reduction of domestic violence. Multi-sectoral cooperation has bolstered services to victims of domestic violence, and made active efforts

in intervention, research, and policy advocacy against domestic violence. For example, training on gender issues and anti-domestic violence have been conducted for the police, the procurator and the judiciary; training on awareness of gender equality and screening of violence has been carried out within the health sector; and shelters for women have been established in some areas.

In 2016, in a significant step forward from the traditional ideology that considers domestic violence a "family issue," the Anti-Domestic-Violence Law of the People's Republic of China took effect. With clear definitions of the legal interventions by the courts and the police, the law is more effective than previous legal attempts in protecting women, children, and the elderly, who are often victims of domestic violence. The awareness that "domestic violence is illegal" has spread among the general public after three years of advocacy and publicity of the law by the Government and civil society organizations such as the Women's Federation. Multi-sectoral efforts have been introduced to facilitate the law's enforcement and implementation.

# PART THREE: THE WAY FORWARD

The foregoing review demonstrated that China has made tremendous progress in implementing the principles of the PoA in its national context over the past 25 years since ICPD in Cairo in 1994. Still, the ICPD agenda remains unfinished in some respects and further efforts are required, particularly given the changing situation in China, as discussed below.

## 1. Low fertility and women's development

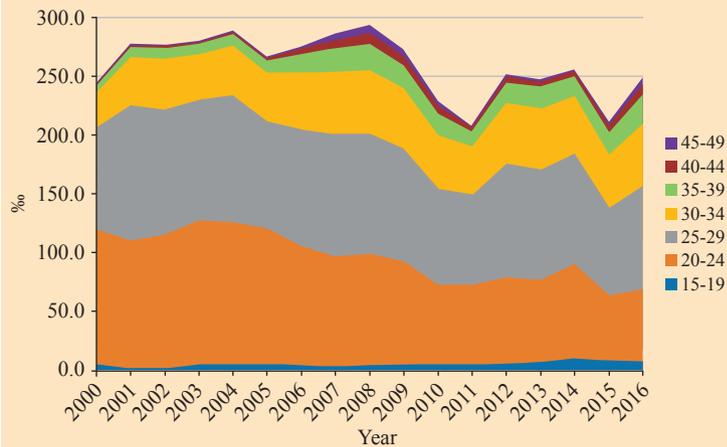
As discussed in Part Two, the rate of population growth in China has been declining rapidly, to the low level of 0.38 percent in 2018 (NBS 2019c). After reaching its peak around 2030, population growth will turn negative. The arrival of negative population growth will likely have profound implications for China's development, such as in the areas of labor productivity, longevity dividend, economic reforms, technological solutions, healthy and active ageing, and conditions for women and couples to realize their ideal family size. This section of the report will address some of these issues.

China's fertility fell to below replacement level since the early 1990s. As mentioned above in Part One, the Chinese government announced the fertility policy relaxation in the years 2013 and 2015, declaring the official end of the 35-year-old one-child fertility policy in China. Even after the relaxation of the fertility policy, the total fertility rate was still below 1.6, except for 2016 and 2017, when the TFR was slightly

above 1.6 (Wang and Wang 2019). Meanwhile, the newborn population increased from 15.92 million in 2010 to 17.86 million in 2016, and then declined to 17.23 million in 2017 and further down to 15.23 million in 2018, a marked reduction of 2 million births over a single year, with annual births falling to the lowest level since 1962.

The reduction in the newborn population has much to do with the dramatic drop in the population of women aged 20-29, from 114 million in 2010 to 95 million in 2018. The 2017 China Fertility Survey suggests that women's fertility desire dropped to 1.96 children, while women's intended number of children dropped to 1.75 (He et al. 2018). A decomposition analysis of changes in TFR with the annual survey data from NBS suggests that over the period of 2000-2015, fertility rates among those aged 20-29 years show a marked downward trend, indicating postponement in childbearing; fertility rates among those aged 30-39 years show some increase, indicating recuperation, particularly since 2013 as the effect of changes in the fertility policy set in. Overall, the decomposition analysis leads to the conclusion that strong postponement and weak recuperation in the childbearing behavior of Chinese women since 2000 may propel China's total fertility rate to a level far below the replacement level in the years to come (Gu and Hou 2018).

**Figure 10. Age-Specific Fertility Rates in China: 2000-2016**



Source: Gu and Hou. 2018. "Why is China's TFR so low? A decomposition analysis". Presented at *Fertility across Time and Space: Data and Research Advances*, Wittgenstein Center Conference 2018, 3rd Human Fertility Database Symposium. December 5-7. Vienna, Austria.

Chinese women are confronting the conflicts between family care and career development after the relaxation of the fertility policy, which impacts their fertility decisions significantly (Ji and Zheng 2018; Attane 2016b). Meanwhile, the heavy economic burden of childrearing has greatly weakened childbearing desire, particularly among the younger generations (Jin 2017). Participation in the labor force by Chinese women stood at 61.26 percent in 2018 (World Bank 2018), which is one of the highest national rates in the world, despite the fact that women remain the major bearers of household chores and care-providers for children and the elderly (Yang 2018). With the relaxation of fertility policy, more women have more than one child, likely putting them in even more disadvantaged positions in the labor market and making them less likely to participate in the labor force because of the "double taxes

of gender and motherhood" (Yang 2019). Thus, with fewer family members to share responsibilities with, and fewer family members to rely on, women, especially the ones with higher education or better career development potential, have no choice but to have fewer children than they may desire (Wang and Yang 2017). Neither the Government nor the society fully understands or is prepared for how these changes may impact women's lives and national development.

Families in China face the complex challenges of their changing size and structure over the last half-century. Low fertility has reduced family size, migration has changed the family structure, and the longer life expectancy of women and population ageing may result in more widowed elderly women.

With no comprehensive national family development policy, current basic public services and social policies concerning the family lag markedly behind actual needs. Notable gaps include the proper redistribution of income via the taxation system and support for family members caring for elders and children.

## 2. Healthy ageing and labor market

China's population is ageing at a historically rapid pace. Decades of continuous improvement in longevity and fertility far below replacement level have pushed China into an

era of accelerated ageing. These trends will turn China into one of the oldest countries in the world over the next two decades.

What might distinguish China from other ageing societies, as has frequently been noted, is the unpreparedness of China's socioeconomic infrastructure and social policies for its ageing population. By 2015, 25 percent of families had one person over age 65, an increase of 3 percentage points from 2010; and 9.27 percent of families had two persons over age 65, an increase of more than 3 percentage points from 2010 (Yang and Wang 2019).

With the rapid increase in the number of seniors in China, questions of how they can be supported and where that support will come from are becoming ever more pressing. The 2010 census reveals that 67.3 percent of the urban elderly have access to pensions as their main source of support, while another one-fourth of them have to rely on support from other family members. For the elderly in rural areas, however, pensions are virtually nonexistent (4.9 %). More than half of them (59 %) have to depend on support from other family members, while about one-third of them (28.5 %) have to continue working to survive (Gu 2016).

The trend of rapid ageing is irreversible, and it poses even greater challenges to rural sustainable development. With rapid industrialization and urbanization in China, millions of young and middle-aged workers have migrated from rural to urban areas, exacerbating population ageing in rural areas (Tong et al. 2014; Sun and Ji 2017). Rural

China saw the ratio of the population age 65 and above increase from 7.50 percent in 2000 to 10.06 percent in 2010. Villages in over 80 percent of counties had transitioned to ageing communities by 2010 (Guo et al. 2019).

There is a gender gap concerning sources of elderly support. Though the majority of urban elderly enjoy the availability of retirement pensions for support, the figure is even higher for elderly males, at 77 percent, but relatively lower for elderly females, at 58.6 percent. In rural areas, too, elderly females have to rely more on other family members for support (70.6%) than elderly males (46.4%). Elderly females in rural areas who are living longer than their male counterparts are more likely to become widowed, and hence will be doubly disadvantaged and more vulnerable (Gu 2016), especially when their adult children work or reside in cities (Ye 2018).

As a response to the ageing situation, the Chinese government launched a series of unprecedented social welfare policy initiatives. These policy initiatives include the New Cooperative Medical System (NCMS) for the rural population in 2003, urban minimum wage in 2004, agricultural taxes abolition in 2006, and the new rural old-age security scheme in 2009. These endeavors have all resulted in changes in public in-kind and cash transfers, which have profound implications for intergenerational income redistribution.

During past decades, an abundant labor supply has contributed a great deal to China's economic growth. China had enjoyed a

favorable age structure of the population, supplying an enormous labor force to prompt the economic boom; other factors included reform and opening up in the past four decades. Following the lasting fertility decline, however, the labor supply has been changing — from reduction of the new-entry young labor force, to the ageing of the labor force, and finally to the shrinking of the labor force.

After several years of debate about the true extent of the labor shortage in China, the National Statistics Bureau concluded that, by 2012, the country had experienced a decline of the labor force (ages 15-59) by 3.45 million, a trend that is expected to continue until the end of the century. Even so, the negative impact of the decrease in the proportion of the working-age population on China's economic growth may be counterbalanced to some extent by the increase in the size of the total population (Tong and Wang 2017). Going forward, however, China would need to reorient its approach to economic development, shifting from relying heavily on cheap labor to improving productivity through education, health, and technological innovation.

### 3. Orderly migration and social integration

Population change is the result of the interplay between mortality, fertility, and migration. With both mortality and fertility declining to low levels and becoming less influential, population migration plays a more pivotal role in population demographics. The percentage of the population residing in urban areas has increased to over 58 percent, rising from a level at half

the world average in 1978 to 3 percentage points higher than the world average in 2017 (Li 2018; Wang 2019). This new situation poses huge challenges to the traditional perception of demographic dynamics.

For a long period, there existed a mindset that population demographics were determined primarily by fertility, and that understanding fertility was central to understanding the overall population situation. But this is no longer the case in China. Fertility has been less and less influential, while population movement has become the decisive factor dominating demographic trends. Without proper understanding of the trends in migration it would be even impossible to undertake any critical examination of other relevant demographic issues such as population growth, fertility trends, childbearing behavior, labor-force change, population ageing, and gender discrimination.

Migration is the main reason for the occurrence of negative population growth in some areas of China between 2000 and 2010, especially in some of the middle and west provinces such as Sichuan, Guizhou, and Hubei. As a further illustration of the central role of migration in China's population dynamics today, Shanghai, a city with negative growth of its *de jure* population since 1993, shows its *de facto* population becoming even younger, while Chongqing, a city located in southwest inland China has the highest proportion of the elderly among all the provinces in China, according to the 2010 census. The contrast between the two cities derives from their migration dynamics.

The huge inflow of young people into Shanghai “diluted” population ageing and increased the growth rate there; meanwhile, the large outflow of young people from western regions such as Chongqing has increased the rate of ageing there (Chen and Gu 2018). Over the period 2007-2017, Shanghai increased its population by 3.55 million, 78.5 percent of which growth was due to in-flow population.

The ageing situation is more acute in rural areas than in urban areas but fails to receive the attention it deserves. Large-scale youth population migration from rural areas is the main reason for China’s lagging urbanization of the elderly population, while the household registration system and dependence on agricultural land and the low level of social security are the major institutional factors (Lin 2018). Concerns over population ageing tend to focus on the urban elderly since it is often believed that rural fertility is likely to be higher and ageing is less serious an issue in rural areas than in urban ones. Due to the largely young floating population leaving the villages for cities and the generalized fertility decline, however, rural families not only have fewer children but also export most of their young adults to urban areas. The thousand-year-old tradition of old-age support by the next generation is no longer sustainable, and rural elders may not be able to rely on either own children or poorly developed social-security schemes.

Migration in China can be distinguished by whether it involves *hukou* (household registration) relocation, which is closely associated with urbanization. The lack of a

local urban *hukou* limits migrants’ and their families’ access to social services in their destination cities. Over the past few years, the Government has attached great importance to the urbanization of registered migrants. A new household registration system reform was launched in 2014. The difference of *hukou* status between rural and urban areas was the fundamental cause in limiting household migration. Moreover, migration to big cities is preferred by elites, while medium-size cities and small towns are less attractive to migrants (Hou 2017).

There are more than 220 million Chinese on the move, according to the 2010 census, and this figure can reasonably be expected to increase along with socioeconomic development, though migrants may not necessarily move to the largest cities. Very likely, internal migration will shift from the dominant rural-to-urban pattern to more diversified patterns including also urban-to-urban and urban-to-rural migration, which may call for more social policies and institutions to be adapted.

Moreover, the One Belt One Road Initiative recently proposed by the Chinese government may increase international migration in the years to come. Yiwu, for example, a small city in the center of Zhejiang province, is regarded by the United Nations and the World Bank as the world’s largest consumer-goods market. About 500,000 foreign businessmen work on trade in Yiwu every year. Over 13,000 foreigners from more than 100 countries and regions all over the world live in Yiwu. They initially come to Yiwu only for profitable trade, but then many

of them demand to reside in Yiwu and bring in their families and have their own communities and schools, all of which poses tremendous challenges to local infrastructure, government, and society (Gu 2018).

In the near future, China will likely maintain its rapid pace of urbanization. The urbanization rate will increase by one percentage point per year, and is expected to reach 70 percent by 2030, according to National Population and Development Plan (2016-2030). China will face many challenges from urbanization and population migration. Public policy would have to be more adaptable to demographic changes, so as to facilitate the conversion of rural populations to urban citizens. In order to ensure that everyone has the chance to pursue careers through hard work, more of the institutional barriers that block the social mobility of labor and talent need to be removed. To ensure harmonious labor relations, mechanisms should be improved for joint discussion and mediation involving government, trade unions, and employers.

#### **4. Reproductive health and family planning under low-fertility scenario**

For a long time in China and many developing countries, the driving force behind family-planning programmes has been demographic concerns, and such programmes were viewed as a means to reduce fertility, so as to slow down population growth, and facilitate economic development (Robinson and Ross 2007). With fertility at the level far below replacement for so long, and with the end of the one-child policy, the question arises whether the family planning

programme should be terminated or otherwise what is the mission for family planning program under sustained low fertility? For many in China who identify the family-planning programme with birth restriction or the one-child policy, the family-planning programme is no longer needed. For others, it is seen as the perfect opportunity for a more comprehensive family-planning programme that encompasses reproductive health and rights as stipulated in the PoA/ICPD and the SDGs, and with greater emphasis on client-centered, user-friendly, rights-based, and gender-sensitive approaches.

While the contraceptive prevalence rate among married women of childbearing age in China remains high, up to 83 percent since 2011, the contraceptive mix has changed significantly since the relaxation of fertility policy. For example, while IUD use has declined slightly, and sterilization has showed a dramatic decrease, the use of condoms has increased remarkably. In particular, condom use has increased significantly since late 2015, when the universal two-child policy was put in place. With the reduced uptake of long-term contraceptive methods and increased uptake of short-acting methods, the risk of induced abortion will tend to increase significantly (Zou et al. 2018).

As family planning services have traditionally been targeted at married couples of childbearing age, youth and unmarried persons often have limited access to sexual and reproductive health services. The younger cohorts tend to have a higher incidence of premarital pregnancy, especially among rural migrants and those with lower educational

attainment. Adolescent and unmarried persons still have unmet sexual and reproductive health needs (Li and Tian 2017). Also, it is hard for women in remote and poor areas to access basic maternal healthcare, and public health services tend to be less accessible to migrants, especially women, and adolescents who are more likely to have high unmet reproductive-health needs. Another acute reproductive-health issue is the withdrawal of IUDs for women at the age of menopause (Sun et al. 2014).

Abortion remains an issue to be better addressed in China. It is well known that frequent resort to abortions can be harmful to women physiologically and psychologically, and should be prevented and reduced by all means. With the relaxation of the fertility policy to allow for two children, abortions due to policy restrictions or sex-selection became less frequent, the total number of abortions in fact increased by one-third from 6 million during 2000-2013 to 9 million during 2014-2016, according to the government statistics (NHC 2018). One explanation for the increase in abortions is that it might be due to the merging of the two statistical systems of MCH and FPP. A more plausible explanatory factor is the higher incidence of contraceptive failure as more married women shifted to short-term methods, and higher levels of unprotected sexual activity among unmarried youth. In this regard, a high level of unmet needs for family planning among these sub-population groups is implicated.

Research has suggested that “as fertility transition progresses, the exercise of fertility control and the risk of unintended fertility both

increase,” and very likely “the proportion of pregnancies unplanned is highest in societies with the lowest desired family size” (Bongaarts and Casterline 2018). All in all, it is arguable that family planning programmes are in fact even more needed than ever before under the low-fertility scenario, and should not be abandoned but strengthened to provide quality services to meet the diversified reproductive health and family planning needs of the people.

## **5. Implications for South-South Cooperation (SSC)**

In 1994 the ICPD acknowledged, for the first time in history, that South-South Cooperation (SSC) is a key strategy and that it could play a catalytic role in the implementation of the PoA. The ICPD indeed laid the groundwork for SSC in population and development. It is recognized that population dynamics, sexual and reproductive health and rights and gender equality are at the core of sustainable development, and that SSC can contribute greatly to the achievement of the ICPD Agenda and the SDGs in developing countries (PPD 2019).

China is an active advocate and participant in SSC in the areas of population, family planning, and reproductive health. In November 1997, China joined the Partners in Population and Development (PPD). Since 2002, China has concluded and implemented MOUs on South-South Cooperation in the areas of population and reproductive health with the relevant government ministries of Pakistan, Thailand, Indonesia, Egypt, Ghana, Kenya, and Vietnam.

SSC leverages the wealth of intellectual and programmatic capacity of partner countries through the documentation and replication of best practices in population and sexual and reproductive health and rights (SRHR). As an example, the China-Africa Conference on Population and Development has been established in recent years to share the successes of developing countries in the field of population and reproductive health; the conference is held every year in China or an African country, with the latest and Third Conference held in Accra, Ghana in June 2019.

China established a South-South Cooperation Development Assistance Fund with a seed fund of USD 3 billion and, to help with roll-out, has enlisted Partners in Population and Development (PPD), a unique intergovernmental organization of SSC. Each year, China provides training for more than 400 senior officials and service providers in the population and reproductive health fields from other developing countries through PPD and other platforms.

The PPD China Programme Office established in May 2006 has made active efforts to conduct policy dialogues, sharing of experiences and information, personnel training, and exchanges of commodities and technologies. In November 2006, China and PPD signed an MOU (2006-2010) focusing on personnel training, capacity-building of reproductive health service centers, and donation of reproductive health commodity and medical equipment for other developing countries.

Since 2006, the Chinese government has provided reproductive health commodities

and medical equipment valued at more than USD 2 million to other developing countries. China has donated over USD 1 million worth of contraceptives and USD 600,000 worth of reproductive health medical equipment to other PPD member states.

China has also provided training programmes in China for over 50,000 people from other developing countries and sent over 7,000 young volunteers to other developing countries for skills transfer. Furthermore, in 2015, China committed to providing training to 120,000 people and 150,000 scholarships for citizens of other developing countries to receive training in China. China trained more than 1,300 senior government officials, programme managers, and health service providers from other developing countries between 2010 and 2019, and has become the largest training provider in the PPD network.

South-South Cooperation and foreign assistance in the areas of population and family planning are still new and in the process of gaining public understanding. Moreover, the sensitivity of family planning remains an obstacle to South-South Cooperation in population and family planning area. Thus, a demand-driven approach would be highly recommended and consistently followed. Meanwhile, UNFPA, as an international organization in the field of population and development with a huge global network, is well-placed to play an important role in the advancement of SSC around key ICPD Agenda issues with a view to institutionalize SSC as development cooperation approach.

# CONCLUDING REMARKS

This report is a review of China's experience over the last 25 years in response to the principles of the PoA adopted at the ICPD in Cairo, Egypt in 1994. The report discusses what has been achieved so far and what remains to be done in the years to come in China with regard to the PoA/ICPD agenda.

The review has demonstrated that China has experienced dramatic socioeconomic and demographic changes since ICPD in 1994. The rapid reduction of fertility and an abundant labor force created a favorable demographic window of opportunity for economic growth. China's experience over the past four decades, especially in the 25 years since ICPD, has revealed the huge impact that implementing ICPD principles can have on national development through universal access to sexual and reproductive health and rights, family planning services, and women's and youth empowerment.

Still, ICPD remains an unfinished business in many ways both in China and in other parts of the world, with attention to population and development challenges including low fertility, adolescent and youth SRH, aging, migration, urbanization, and strengthening the quality of SRH/FP services under a low fertility context, emerging as issues of high relevance in the period post ICPD+25 years. Besides, the unfinished agenda of ICPD requires greater attention to and investment in population groups left behind, including migrants, youth, people with disabilities, and older persons while the country moves ahead with the ICPD and sustainable development agenda. In short, despite all the success of the past, population issues remain significant and crucial to sustainable development. It is still an ongoing journey toward the final fulfillment of SDGs.

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