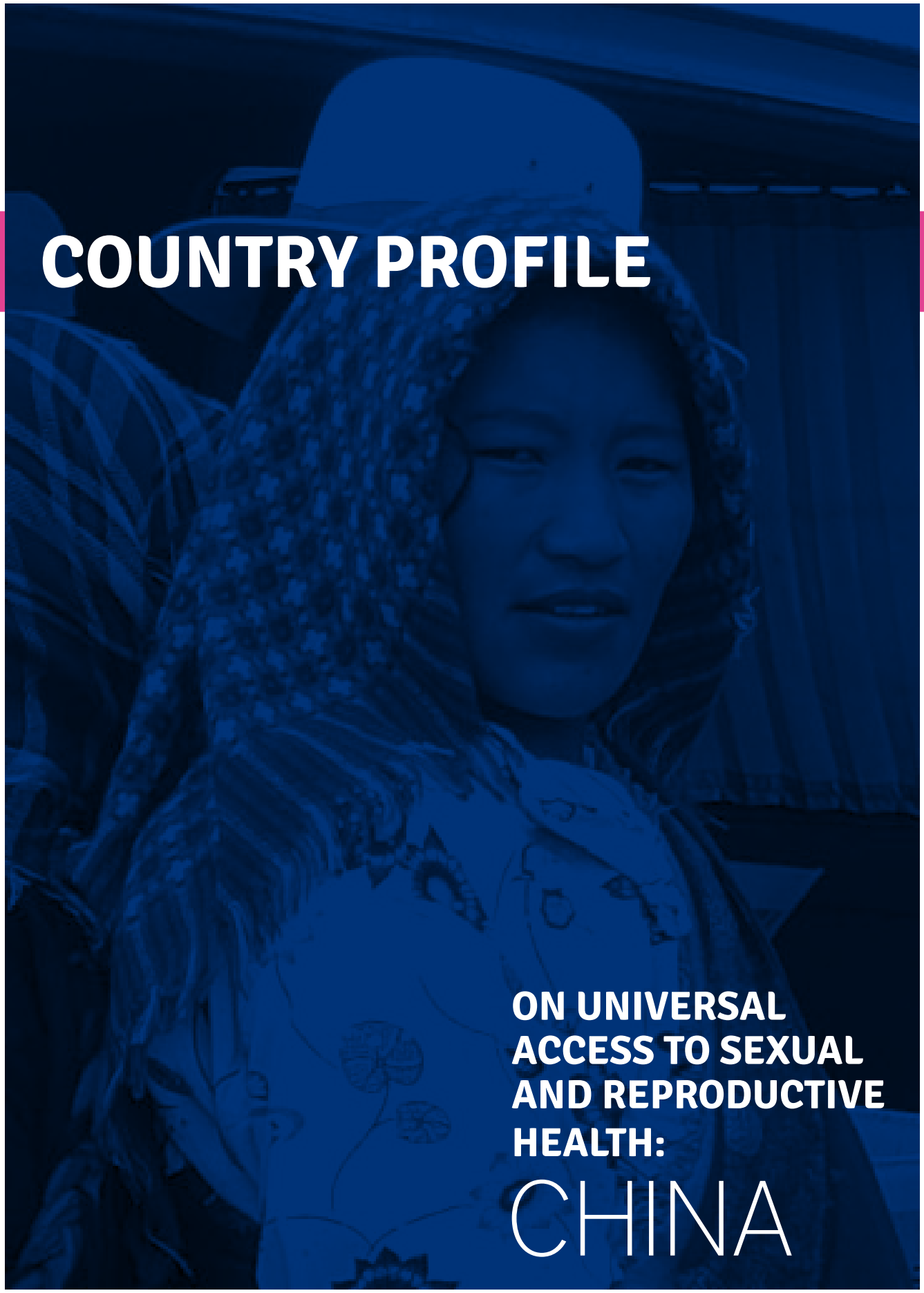


COUNTRY PROFILE

ON UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH:

CHINA

This project is funded by the European Union

With co-funding support from Sida

YHDRA

arrow

SRHR for ALL

Introduction

China is the world's most populous country with a total population of 1.354 billion[1] people by the end of 2012. China's population continues to increase steadily even as the population growth rate has reduced at 4.95 per 1,000 people in 2012 down from 11.21 per 1,000 people in 1994.

Concurrent with China's ever-increasing population is a fast growing economy accompanied by rapid socio-economic changes that bring in a host of challenges in ensuring comprehensive sexual and reproductive health (SRH) information, education, and services to its general populace.

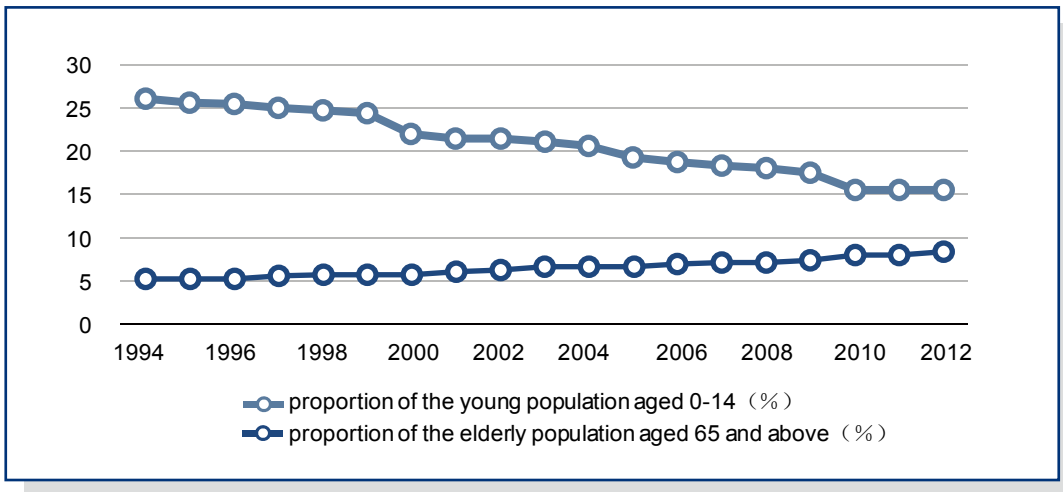
Providing adequate healthcare, including SRH services, to its more than one billion people, has long been a great concern for China. Since 1994, when the country signed the International Conference on Population and Development (ICPD) Programme of Action, China has put in efforts to improve the sexual and reproductive health and rights (SRHR) of individuals and has achieved observable results and outcomes.

The total fertility rate of women in China fell below the replacement level in the early 1990s and kept declining to about 1.6 at present,[2] an indication that China has transitioned into the group of low fertility countries. At the same time, the sex ratio of the population has been increasing, from 104.51 in 1994 to 106.74 in 2000.

Government measures and public involvement in campaigns such as "caring for girls" and "rewards for families for having girls," however, have resulted in the sex ratio to drop to 105.13 in 2012. Sex ratio at birth (SRB) has started to reverse, but only to a very limited extent and is still far from the globally accepted range. In 2012, SRB in China was at a high 117.7. [3]

In the last two decades, the age structure of the population in China has experienced drastic changes. The proportion of population aged 0-14 declined continuously from 26% in 1994 to 16.46% in 2012, while the elderly population aged 65 and above went up steadily from 6.36% in 1994 to 9.39% in 2012 (see Figure 1). This means China has entered into an aging society and an increasing elderly population can bring great challenges to the country's social security system, commerce, industry, and healthcare services.

Figure 1: Proportion of the elderly and young population



Source: From the website of National Bureau of Statistic http://data.stats.gov.cn

1. Includes the population of Mainland China; excludes Taiwan Province, Hong Kong SAR, and Macau SAR. In this report, demographic data without special notes all refer to those in Mainland China, which, unless otherwise noted, are cited from the website of National Bureau of Statistics (NBS) of the People's Republic of China: http://data.stats.gov.cn.

2. Country Report on Population and Development of China, September 2013, page 8.

3. Country Report on Population and Development of China, September 2013.

China is witnessing a significant increase of rural-to-urban internal migration (WHO, 2013), with 51% of the population living in urban areas (WHO, 2013). What was once a predominantly "rural China" is transforming into an "urban China." According to the 6th National Population Census, migrants in China totaled 221 million in 2010.[4] The proportion of migrants in total population grew from 9.2 percent in 2000 to 16.5 % in 2010.[5] The huge and increasing number of migrants brings great challenges and pressure to basic public services and social management due to the constraints of household registration management, land administration, social security, financial and taxation systems, and administrative regulations.

Facing all these challenges, the Government of China has set the goal of universal access to basic health services by 2020, and has increased input into the health sector since 2003 (see figure 2). In 2011, General Government Expenditure on Health consists 56 percent of the Total Health Expenditure (THE). The proportion of the Out-of-Pocket Expenditure reduced to 35 percent in 2011 from 60 percent in 2001. [6]

However, there is still a long way to go for China to realize universal access to SRH services due to demographic changes, disparity of various groups, and socio-cultural dynamics. This paper examines SRH services in China including contraception, maternal health, adolescent and young people's SRH, HIV/AIDS, and SRH services at different levels of healthcare to show the challenges China is facing and advocate for active responses respectively.

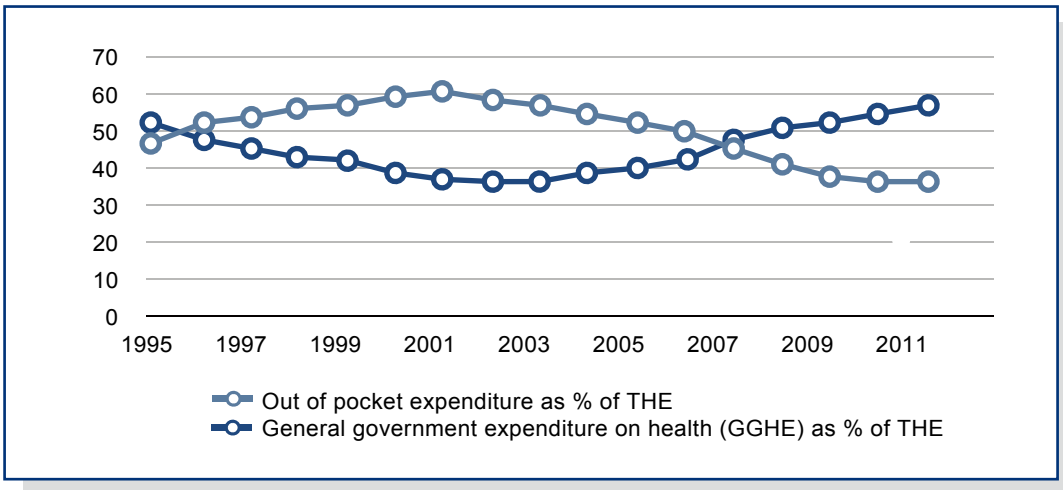
Status of SRH Services in China

The ICPD Programme of Action urges governments to ensure the provision of the full range of comprehensive SRH information, education, and services through the primary healthcare system to all individuals using a human rights framework.

Paragraph 7.6 of the ICPD Programme of Action notes that reproductive health services through primary healthcare should include:

- family planning counseling, information, education, communication, services, and referral;
- education and services for prenatal care;
- safe delivery and post-natal care;
- complications arising from pregnancy;
- treatment of infertility;
- prevention and management of consequences and complications of abortion;
- treatment of reproductive tract infections, sexually transmitted diseases, and other reproductive health conditions;
- information, education and counseling on human sexuality;
- breast cancer and cancers of reproductive system; and sexually transmitted infection including HIV/AIDS.

Figure 2: Health Financing



Source: WHO National Health Accounts Database. http://apps.who.int/nha/database/PreDataExplorer.aspx?r=1&d=1

4. The definition of migrants here is in accordance with that used in the population census, referring to the population whose residences are inconsistent with the addresses indicated on their household registrations and have been away from their household registered localities for more than 6 months, but excluding the population within the urban jurisdiction whose current residences are different from those indicated on the household registrations (according to the census, in 2010 the population within the urban jurisdiction whose current residences are different from those indicated on household registration totaled 39.96 million).

5. The data related to migrants are from "The People's Republic of China Country Report on Population and Development", written by National Health and Family Planning Commission (NHFPC) of China, September 2013.

6. WHO National Health Accounts Database. Retrieved from http://apps.who.int/nha/database/PreDataExplorer.aspx?r=1&d=1.

Progress made in the above areas towards the realization of SRH services in China is discussed below. Key indicators include contraception, maternal health, adolescent and young people's SRH, HIV/AIDS and SRH services at different levels of healthcare.

Contraception

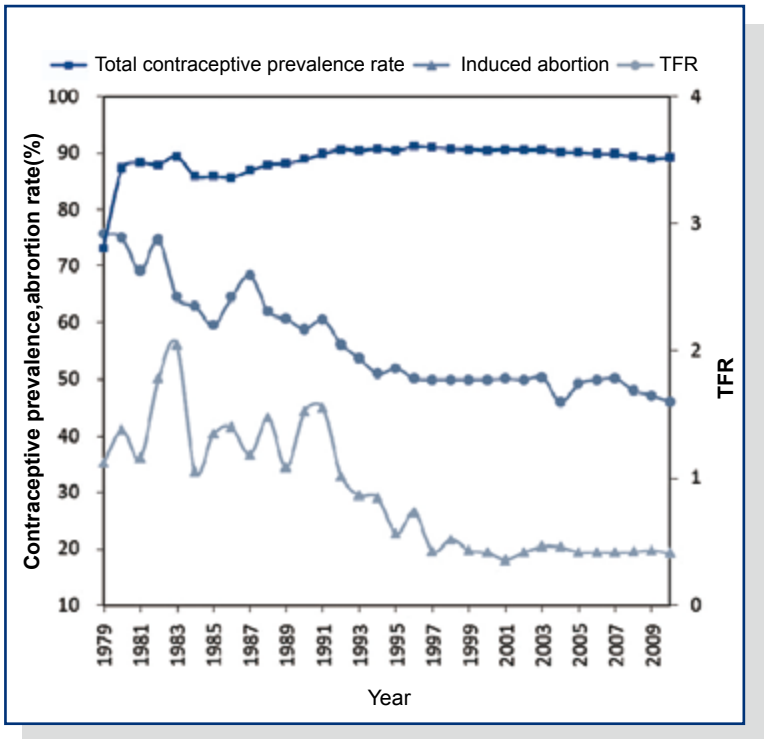
The right to decide the number and spacing of children is enshrined in international agreements, and the provision of contraception is critical to achieve this right. This section discusses

- Total fertility rate (TFR), which is "an indirect indicator of good or poor reproductive health;" a high total fertility rate (more than five births) puts women at high risk;
- Contraceptive prevalence rate (CPR), which serves as a proxy measure to assess reproductive health service, assuming there is no coercion for acceptance of birth control through government policy; and
- Unmet need for contraception, which is also a proxy measure for access to reproductive health services as well as for assessing the gap between women's reproductive intentions and actual reproductive behavior.[7]

Total Fertility Rate

Although there was some fluctuation, TFR has decreased drastically since the family planning program and policies in the early 1970s.[8] In 1970, the TFR in China was 5.74.[9] In 1983, it dropped to 2.42,[10] and in 2007-2008, it was 1.47.[11] This increasing trend of TFR parallels with an increasing CPR, which is directly influenced by the family planning policy and services in China (see Figure 3).

Figure 3. Total contraceptive prevalence rates, induced abortion rates (%) of married women of reproductive age (20–49 years) and TFR in China, 1979–2010.



Source: Wang, C. (2012). History of the Chinese Family Planning Program. p. 566.

7. *An Advocate's Guide: Strategic Indicators for Universal Access to Sexual and Reproductive Health and Rights: http://www.arrow.org.my/publications/AdvocateGuide_Final_RN_Web.20131127.pdf.*
8. *Wang, Cuntong. 2012. "History of the Chinese family planning program: 1970-2010." Contraception. 85:563-569.*
9. *UN Department of Economic and Social Affairs, Population Division publishes World Fertility Data. World Fertility Data. 2012. Retrieved from: http://www.un.org/esa/population/publications/WFD2012/MainFrame.html.*
10. *National Population and Family Planning Commission of P.R.China (NPFPC). Family planning and demographic yearbook. 2010. Beijing: China Population Publishing House, 2011.*
11. *UN Department of Economic and Social Affairs, Population Division publishes World Fertility Data. World Fertility Data. 2012. Retrieved from: http://www.un.org/esa/population/publications/WFD2012/MainFrame.html.*

Contraceptive Prevalence Rate

CPR has increased since 1979 as a result of China's national family planning policy and the available services.[12] The widespread use of long-term contraceptive methods was the core strategy. As a result, the CPR increased dramatically from 13.47% in 1979 to 87.2% in 1980, and achieved the world's highest levels with 89.4% in 1983. However, the campaign had a difficult time due to the conflict with traditional ideas that more children bring more happiness, especially in China's vast rural areas. The mandatory population policy was modified first in April 1984, with the mass campaigns ultimately being halted. The CPR decreased to 85.82 % in 1984. However, with the central government consistently promoting long-term contraceptives, the prevalence of contraceptive use gradually increased. In 2010, it rose to 89.2 % (see Figure 3).

The responsibility of contraception mainly lies on women although CPR of different contraception methods may vary at different periods.[13] Contraceptive methods for women in China mainly include female sterilization (26.6% in 2010), IUD (48.15% in 2010), and oral contraception (0.98% in 2010). The prevalence rate of these methods constitutes the main part of the total CPR. Those used by men mainly include male sterilization (15.44% in 2010), and condoms (9.32% in 2010). However, there were large regional differences in the prevalence of different contraception methods, from western regions to central and eastern regions and from rural to urban areas, due to social, cultural, and economic reasons. For instance, in 2010, the prevalence rate of male sterilization was higher in rural areas (9.99%) than in urban areas (0.21%), and it was higher in western regions (9.44%) compared to central (4.45%) and eastern regions (1.41%). The prevalence rate of condoms in 2010 was higher in urban areas (17.43%) than in rural areas (1.21%).It was also higher in eastern regions (16.44%) than in central (10.45%) and western regions (1.07%).[14]

Several studies highlight that women are usually scared to request condom use in their committed relationships because the condom is perceived as a symbol of women's promiscuity, distrust, and infidelity and that a condom is only appropriate in non-exclusive relationships. (Cook, 2011; Kacanek, Dennis, & Sahin-Hodoglugil, 2012; McMillan & Worth, 2011; Smith, 2007). China's One Child Policy, implemented in 1979, restricted couples from having more children (see Box 1). Beginning in the late 1970s, this large-scale national family planning campaign has assigned Chinese married women as the target group for contraception to rapidly reduce the population growth in a short period (Wang, 2012a). During the time of exponential population growth, almost every married woman after delivering one or two babies must adopt one kind of long-acting contraceptive method based on the policy of birth control (The State Council Information Office of the People's Republic of China, 1995). By 2010, the overall prevalence rate of long-term contraception reached 79.85% nationwide. While IUD and female sterilization accounted for about 80% of contraceptive use, condom use only made up less than 10% (Wang, 2012b). Thus, in the Chinese context, the policy requirement makes women more responsible for long-term contraception. In this case, additional condom use is not necessarily linked to birth control but implies certain symbolic meaning of safety in a relationship. This divergence puts men outside the obligation for either birth control or sexually transmitted infections at the same time that it leaves women with limited bargaining power over condom use as additional or alternative form of contraception.

Unmet Need for Contraception

According to the National Surveys on Family Planning in China, women's unmet need for contraception is very low, and has decreased steadily since the ICPD. In 1992, the unmet need for contraception was 3.3%.[15] In 1997, the rate dropped to 2.7%,[16] while in 2001, the rate was only 2.3%.[17]

Among some sub-populations, there are still unmet needs which should not be ignored, and efforts should be made to improve universal access to contraception. Some researches even claim a higher unmet need for contraception for many sub-populations. A study on unintended

12. *Wang C. 2012. Trends in contraceptive use and determinants of choice in China: 1980–2010. Contraception. 85 (6).*
13. *See Cuntong Wang's paper "Trends in contraceptive use and determinants of choice in China: 1980-2010" (2012b) to see the historical change of different methods.*
14. *Data from Wang, C. (2012b).*
15. *Data pertains to never-married women of reproductive age, excluding women who are not using a method of contraception due to being separated, sterile, ill, breastfeeding or pregnant, or trying to get pregnant. Data from 1992 National Fertility Sampling Survey. United Nations, Department of Economic and Social Affairs, Population Division (2012). World Contraceptive Use 2012. (POP/DB/CP/Rev2012). Retrieved from: http://www.gsjsw.gov.cn/html/zgrksjtj/10_14_19_688.html.*
16. *Excluding women who are not using a method of contraception due to being separated, sterile, ill, breastfeeding or pregnant, or trying to get pregnant. Data from 1997 National Demographic and Reproductive Health Survey. United Nations, Department of Economic and Social Affairs, Population Division. 2012. World Contraceptive Use 2012. (POP/DB/CP/Rev2012). Retrieved from: http://www.gsjsw.gov.cn/html/zgrksjtj/10_14_19_688.html.*
17. *Excluding women who are not using a method of contraception due to being separated, sterile, ill, breastfeeding or pregnant, or trying to get pregnant. Data from 2001 National Family Planning and Reproductive Health Survey. United Nations, Department of Economic and Social Affairs, Population Division. 2012. World Contraceptive Use 2012. (POP/DB/CP/Rev2012). Retrieved from: http://www.gsjsw.gov.cn/html/zgrksjtj/10_14_19_688.html.*

Box 1: China's One Child Policy

The One Child Policy of China was first introduced by the central government in 1979 to curb the rapid growth of the population. After its establishment, it has remained for over 30 years. It is not a unified rule for all citizens. The policy only limits most urban Han Chinese couples to one child. Most people living in rural areas and ethnic minorities are allowed to have two or three children.

Over the last 30 years, it is estimated the policy has resulted in a reduction of some 400 million people in China. However, the policy has also been blamed for generating a number of social problems. China's labor force, at about 940 million, decreased by 3.45 million year on year until 2012, marking the first "absolute decrease." The labor force is estimated to have decrease by about 29 million over the current decade. Meanwhile, the country's growing elderly population aged 60 and over, which currently accounts for 14.3% of the total population, is predicted to exceed one third of the population by 2050.

Another side effect of the one-child policy is gender imbalance. Chinese parents' preference for sons led to the abortion of female fetuses due to the policy. About 118 boys are born for every 100 girls in 2012, higher than the normal ratio of 103 to 107 boys for every 100 girls. Millions of Chinese men will be unable to find wives in 2030.

Given these side effects, the Communist Party of China (CPC) made a significant decision in November 2013 to loosen this decades-long population controlling policy. The new policy allows urban couples to have two children if one of them is an only child, while adhering to providing informed family planning services for all citizens.

Source: Xinhuanet. "China to ease one-child policy." Issued on 15 November 2013. Retrieved from: http://news.xinhuanet.com/english/china/2013-11/15/c_132891920.htm. Accessed on 23 June, 2014.

pregnancy and induced abortion among unmarried women indicates a large amount of unmet need for reproductive health services for women prior to marriage.[18] Another research that studied 2,513 female rural-to-urban migrants aged 18-29 years in 2008 reported unmet need for contraception by 36.8% and 51.2% of the respondents in Qingdao and Guangzhou, respectively.[19] These studies reveal that services are needed to meet the needs of vulnerable women such as unmarried women and female rural-to-urban migrants.

Maternal health

Preventable maternal deaths violate women's right to life, health, equality, and non-discrimination. The denial of quality care and the right of women to enjoy the benefits of scientific progress that affect their SRH is integral to attain improved maternal health. The ICPD Programme of Action urges the governments to strive to significantly reduce maternal mortality by 2015. This section looks at key indicators pertaining to women's health:

- Maternal mortality ratio (MMR), which is a reflection of how safe child delivery is for the woman;
- Perinatal mortality rate (PMR), which is a good indicator of both status of maternal health and nutrition and quality of obstetric care;
- Infant mortality rate (IMR) which is a reflection of optimal maternal health, nutrition, and care during delivery;
- Proportion of births attended by skilled birth attendants, which helps understand the extent to which governments have invested in developing human resources necessary for ensuring safe delivery and prevention of maternal deaths;
- Availability of basic and comprehensive emergency obstetric care (EmoC) to ensure safe delivery and prevention of maternal deaths; and
- Antenatal care coverage (ANC), which is an indicator of women's access to healthcare services.

18. *Xu Qian, et al. "Unintended pregnancy and induced abortion among unmarried women in China: a systematic review." BMC Health Services Research. 2004.*
19. *Peter Decat et al. 2011. "Determinants of unmet need for contraception among Chinese migrants: A worksite-based survey." The European Journal of Contraception and Reproductive Health Care. 16 (1).*

Maternal Mortality Ratio

Maternal and child health (MCH) became a government priority of the Health Ministry since the ICPD. In the past decades, the national MMR has kept falling markedly, and women health status has improved remarkably. However, regional disparities remain with maternal mortality higher in the western regions compared to the central and eastern regions. The MMR in the eastern, central, and western parts of China were 17.8/100,000, 29.1/100,000 and 45.1/100,000, respectively in 2010.[20] Despite progress, there still exists disparity between rural (25.6/100,000 live births) and urban (22.2/100,000 live births) areas. Maternal mortality among migrant women is also relatively higher.[21] About 69% of maternal deaths are a result of obstetric hemorrhage, amniotic fluid embolism, and hypertensive disorders in pregnancy, pregnancy associated with cardiac diseases, venous thrombosis, and pulmonary embolism.

China's MMR has steadily dropped over the last two decades. In 1995, the ratio was 84 per 100,000 living births. It dropped to 45 in 2005. In recent years, the data showed that the ratio further dropped to 37 per 100,000 living births in 2010,[22] 26.1 in 2011,[23] and 24.5 in 2012.[24]

To further reduce MMR, improvements in the MCH system and service network especially at the local level, in poverty stricken areas, remote mountainous areas, and ethnic minority areas are needed. Adequate training and recognition of services of midwives are some key interventions in reducing regional disparities in MMR.

Perinatal Mortality Rate

There is no nationally available data about PMR in China. According to comparative data for countries available from WHO sources, the estimated perinatal mortality rates, early neonatal mortality rates, and neonatal mortality rates of China were 35, 16, and 21 per 1000 births, respectively in 2000 and 31, 14, and 18 per 1000 births respectively in 2004. [25]

Infant Mortality Rate

Since the founding of the People's Republic of China, Chinese children's health status has improved remarkably. Infant mortality and under-five mortality rate continued to decline. Relative indicators in the UN MDGs have been reached ahead of schedule, and children's growth and development have improved.[26] IMR in China has decreased dramatically. In 1995, the IMR was 37.7 per 1000 live births. This dropped to 20.2 per 1000 live births in 2005, and more dramatically, the latest data in 2012 showed the rate decreased to only 12.1 per 1000 live births.[27]

Proportion of Births Attended by Skilled Birth Attendants

The proportion of births attended by skilled birth attendants has been high and has steadily increased. In 1995, the proportion was 89.3%, while in 2005, it reached 97.5%. By 2010, 99.6% of births are attended by skilled birth attendants. [28]

Availability of Basic and Comprehensive Emergency Obstetric Care

Data on the availability of essential and comprehensive emergency obstetric services are not routinely collected or published in China. However, there are some data about this at study and projects levels. For example, a study conducted in seven rural counties and townships in Shanxi Province showed that basic EmOC facilities are not adequate and township hospitals should be upgraded to provide birthing services. Three counties were below the recommended minimum number[29] of BEmOC facilities (4 per 500,000 population) and the other four counties had more than four BEmOC facilities. However, the number of comprehensive EmOC facilities was adequate in all the counties, following the recommended minimum of 1 per 500,000 people in 6 of 7 counties. The details of the availability of EmOC services by county are presented in Figure 4 (Gao and Barclay 2010).

20. *Ministry of Health PRC. Report on Women and Children's Health Development in China. (2001). Ministry of Health. Contract No. 2.*
21. *China's progress towards the Millennium Development Goals 2013 report.*
22. *The official United Nations site for the MDG indicators Retrieved from: http://mdgs.un.org/unsd/mdg/Data.aspx.*
23. *White paper on medical and health services in China.: The national health and family planning commission of the People's Republic of China. 2012. Retrieved from: http://www.moh.gov.cn/mohzcfgs/s7847/201301/6fbe5f5264d84e03960eb72dbd752d05.shtml.*
24. *Statistical bulletin health and family planning development 2012 in China. 2013.*
25. *WHO. Neonatal and Perinatal Mortality: Country, Regional and Global Estimates. 2007.*
26. *Ministry of Health PRC. Report on Women and Children's Health Development in China. 2011. Ministry of Health. Contract No. 2.*
27. *The official United Nations site for the MDG indicators. Retrieved from: http://mdgs.un.org/unsd/mdg/Data.aspx.*
28. *The official United Nations site for the MDG indicators. Retrieved from: http://mdgs.un.org/unsd/mdg/Data.aspx*
29. *UNICEF/WHO/UNFPA. Guidelines for monitoring the availability and use of obstetric services. UNICEF, New York. 1997.*

Table 1: Availability of emergency obstetric care (EmOC) services in 7 counties in Shanxi Province in 2005

County	DX	FS	NW	PD	HG	XY	ZZ	Total
Population	200 000	250 000	158 000	320 000	283 000	248 000	350 000	1 809 000
Live births	1619	1815	1732	2480	3449	1812	2349	15 256
Facility delivery rate (%)	59.9	52.0	53.2	99.6	81.8	94.9	92.6	78.8
No. of facilities providing CEmOC	1	3	3	3	3	4	3	20
CEmOC per 500 000	2.5	6.0	9.5	4.7	5.3	8.1	4.3	5.5
No. of township hospitals	11	13	14	12	23	11	10	94
Township hospitals providing BEmOC (%)	0.0	30.8	50.0	8.3	13.0	27.3	20.0	21.3
BEmOC per 500 000	0.0	8.0	22.2	3.1	1.8	6.0	4.3	5.5

Source: MCH Annual Reports of 7 counties and interviews with MCH health workers during March to November 2006.

After the 2008 Wenchuan earthquake and the 2010 Yushu earthquake disaster, the United Nations Population Fund (UNFPA) started working with the Government of China on promoting the Minimum Initial Service Package (MISP) for SRH in crisis situations,[30] including the provision of personal hygiene/dignity kits for women in reproductive ages and emergency reproductive health kits to increase their basic sanitary needs and maternal health situations for those vulnerable women in affected areas, developing a National Procurement Guideline on Reproductive Health Kits in emergency situations, and capacity building for the maternal and child health and Red Cross service providers on the MISP implementation. This project trained the maternal and child health professionals from all the provinces of China in 2009.[31]

Antenatal Care Coverage

The antenatal care coverage was reasonably high in China. Percentage of antenatal care coverage with at least one visit was 78.7% in 1995, 89.8% in 2005[32] and 95.0% in 2012.[33] No country level data are available for the antenatal care coverage for at least four visits. Data are available only at the provincial and project levels.

Postpartum/Postnatal Care within 48 hours of Delivery by a Skilled Health Provider

Although the coverage of postpartum/postnatal care within 48 hours of delivery by a skilled health provider is not available in China, official statistics showed that the postnatal care rate is 86.0% in 2005[34] and 92.6% in 2012.[35] The rates cover all home visits after the birth within seven days, 28 days, and 42 days under the regulations and standards of the Ministry of Health.[36] Moreover, given the 99.2% hospital births rate,[37] we can estimate that the coverage of postpartum/postnatal care within 48 hours of delivery by a skilled health provider should be seen as quite reasonable.

Adolescent and Young People's Sexual and Reproductive Health

The ICPD Programme of Action urges governments to address adolescents' SRH issues, including unwanted pregnancy, unsafe abortion, and sexually transmitted infection including HIV/AIDS. It also calls for the reduction in adolescent pregnancies. This section looks at indicators of adolescent birth rate and the availability of range of adolescent SRH services irrespective of marital status in China. These indicators are reflective of the status of adolescent SRHR in the country.

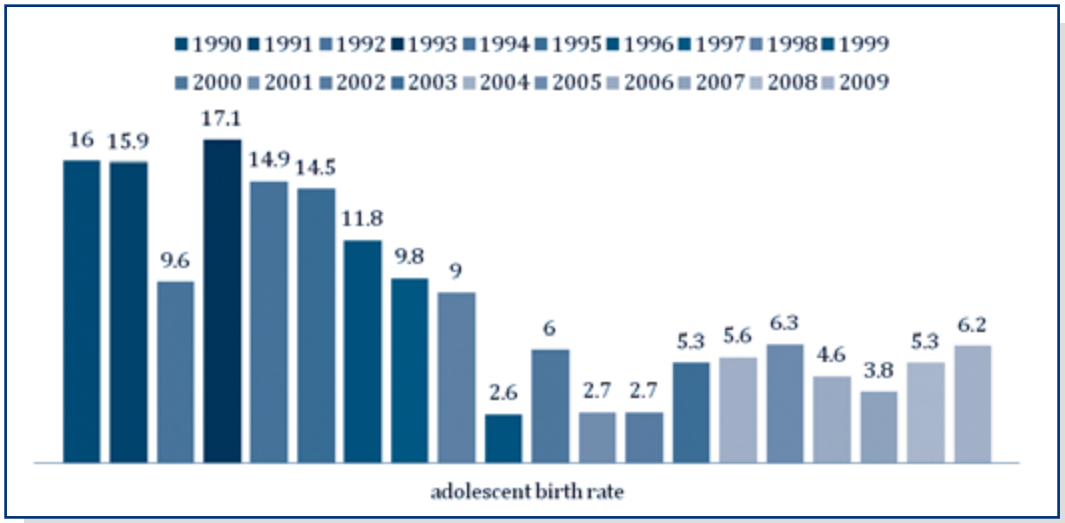
Adolescent birth rate

Young motherhood affects both mother and child and is an important indicator of adolescent reproductive health and reproductive rights.

Between 1990 and 2009, the adolescent birth rate in China appeared to be fluctuating but generally declining. In 1990, the rate was 16 per thousand and rose to 17.1 per thousand in 1993. Since then, it has gradually decreased with a bottom level of 2.6 per thousand in 1999. The latest data in 2009 indicates that the adolescent birth rate was 6.2 per thousand[38] (see Figure 5). In 2010, according to UNFPA, this rate was 6 per thousand (UNFPA, 2013).

30. *UNFPA. Reproductive health policy advocacy. Available from: http://unfpa.cn/zh/page/10.*
31. *The Ministry of Health/United Nations Population Fund. Basic reproductive health service pack emergency training course. 2009. Retrieved from: http://www.chinawch.org.cn/rdxw/200902/t20090212_63882.html.*
32. *Statistical bulletin of health and family planning development 2012 inChina. 2006. National Population and Family Planning Commission.*
33. *The official United Nations site for the MDG indicators. Available from: http://mdgs.un.org/unsd/mdg/Data.aspx*
34. *Statistical bulletin of health and family planning development 2005 in China.2006. National Population and Family Planning Commission.*
35. *Statistical bulletin of health and family planning development 2012 inChina. 2006. National Population and Family Planning Commission.*
36. *Regulations of maternal health care in China. 2011. Ministry of Health.*
37. *Statistical bulletin of health and family planning development 2012 in China. 2013. National Population and Family Planning Commission.*
38. *The Millennium Development Goal database provides data for UN Member countries at: http://mdgs.un.org/unsd/mi/wiki/5-3-Contraceptive-prevalencerate.Ashx.*

Figure 4: Adolescent Birth Rate in China (1990-2009) (‰)



Source: ARROW

Availability and Range of Adolescent Sexual and Reproductive Health Services

Currently, there is no separate center or health delivery facility specializing in adolescent SRH in the healthcare system. However, according to several relevant policies[39] and action plans, efforts of providing SRH services to young people are underway, especially in the areas of health education, HIV, and violence prevention.

Some NGOs have initiated creative pilot projects, recognizing the pressing need to offer youth-friendly services for young people at multiple levels. For example, since the late 1990s, the Chinese Family Planning Association (CFPA) has launched a cooperative project on promoting SRH of Chinese adolescent in 14 cities. This project has conducted school-based as well as outreach activities for both in-school and marginalized young people to obtain essential information and life skills training. In addition, it has functioned as a secondary or tertiary referral system to promote youth-friendly healthcare. Around 2000 public and private health delivery facilities have been involved at multiple levels to provide health counseling, contraception, and safe abortion services for more than 170,000 of young people in China (Hu & Liu, 2011).

Another successful example is the "You and Me Youth Health Service Centre" developed by the Marie Stopes International China in five metropolis. Focusing on young people's needs and rights, these centers highly conform to the framework of youth-friendly services, including convenient working hours and location, non-judgmental, and confidential procedures, as well as free services for young people in need (Guo, Liu, & Xiao, 2010).

Specifically with respect to psychosocial counseling, there is a considerable unmet need in China. In Beijing, very few health institutes are capable of providing psychosocial counseling for adolescents (Li, Han, & Wu, 2009). In Hubei province, less than 30% of school or clinics have set up counseling services for adolescent (Dai et al., 2005). A national survey in 2009 revealed that 39.1% young people aged 15 to 24 had self-reported need for counseling but only 40.8% of them actually utilized counseling services (Yang, Han, Tan, Chen, & Chen, 2011). Another investigation also confirmed that indeed, only 20% adolescents in China have accessed psychosocial counseling and most of them prefer hotline services (Zheng et al., 2010).

Through the Chinese healthcare system at provincial, county, and township levels, almost all types of reproductive health services (e.g., contraception, HIV/STI prevention and treatment, and maternal healthcare) are committed to serving adolescents regardless of their marital status. However, in reality, the utilization of such services among adolescents is very low largely due to the unfriendly attitudes of health providers, lack of confidentiality and privacy, unaffordable prices, inconvenient location, and socio-cultural intolerance towards the sexual behaviors of unmarried people (Dai et al., 2005; Hu & Liu, 2011; Zheng et al., 2010). Most young people prefer to obtain information, contraception and treatment from pharmacies and private clinics, or

39. *For instances, the Law of the People's Republic of China on Population and Family Planning, the Law of the People's Republic of China on the Protection of Minors, and the Action Plan for Reducing and Preventing the Spread of HIV/AIDS (2001-2005).*

rely on self-controllable methods (e.g., safe period contraception, withdrawal) (Zheng et al., 2010).

In 2008, the Ministry of Education issued the Outline of the Guide of Health Education in Middle and Primary Schools. Based on the statement of the outline, sexual health education has become a formal part of health education that should be provided for all middle and primary students. However, with all its best intentions, the content of the program concerning sexuality and sexual health fails to deliver the message clearly without raising the fear factor and it has not addressed the essential elements of comprehensive sexuality education (CSE), such as gender, sexual rights, and diversity. Experienced and qualified health educators are also significantly insufficient for carrying out CSE. Out-of-school youth have more difficulties to access sexual education (Hu & Liu, 2011). The internet and books become top two resources of acquiring sexual information for Chinese young people (Durex China, 2011). With this large gap between the principles of CSE and the actual health information that Chinese young people received from either health professionals or teachers, many efforts in the future should be directed to designing and promoting the CSE curriculum in China.

HIV/AIDS

The ICPD Programme of Action urges governments to prevent, reduce the spread of, and minimize the impact of HIV infection; and ensure that HIV infected individuals have adequate medical care and are not discriminated against. In this section we look at indicators of HIV prevalence and burden as well as availability of services for HIV/AIDS.

Prevalence and burden

Although the overall prevalence rate of HIV/AIDS among the adult population in China is relatively low, the absolute number of people living with HIV is high. China's HIV epidemic can be characterized by an outbreak of infection among injection-drug-using population (146 cases) in the border areas of Yunnan Province in 1989 (Ma, Li, & Zhang, 1990), followed by a rapid spread from rural to urban areas via sharing non-sterile needles to sexual transmission, from most at risk groups to the general population, and from border areas to inland China. Another unique attribute of transmission was an explosive spread among commercial plasma donors in the mid-1990s (He & Detels, 2005; Wu, Rou, & Cui, 2004).

The epidemic of HIV/AIDS in China has gone through three phases (Wu et al. (2004): the initial phase (1985-1989), the spreading phase (1990-1994), and the expansion phase (1995-present). At the end of 2005, HIV prevalence in some provinces, such as Yunnan, Henan, and Xinjiang, has become "generalized epidemic" as the prevalence rates surpassed 1% among pregnant women and persons who receive premarital and clinical HIV testing. In the same year, sexual transmission accounted for more infections (49.8%), which is over injecting drug use (48.6%) (Gill, Huang, & Lu, 2007: vi).

Beginning in 1995, China has significantly advanced its HIV surveillance. The national comprehensive surveillance was introduced in 1999, which contains eliciting epidemiologic, serologic, and behavioral information, and covers six population groups at higher risk (i.e., commercial sex workers, STD clinic attendees, injection drug users, long-distance transport workers, men who have sex with men or MSM, and adolescent students). By the end of 2011, the Ministry of Health, UNAIDS and WHO estimated that there were 780,000 people living with HIV/AIDS in China, and the positive female accounted for 28.6%. The number of new infections has dropped by almost 30%, down to estimated 48,000 from the estimated 70,000 in 2005 (Ministry of Health of RPC, UNAIDS, & WHO, 2011: 4).

Based on the national report in 2012, percentages of young people aged 15-24 who are living with HIV in 2010 is 0.05% (27/52641), and is 0.05% in 2011(28/52601).[40] This overall ratio seems low, but HIV infection among young students is very alarming in recent years. According to the latest data reported by the government, HIV infection among students is constantly increasing. The percentage of young students aged 15-24 living with HIV significantly increased from 0.9% in 2008 to 1.7% in 2012 (Xinhua News, 2013). The majority of students living with HIV are young MSM. In addition to this alarming epidemic distribution, data showed that during 2000-2011, new HIV cases in the 50+ age group increased noticeably on account of unprotected sex. The proportion of total cases in the 50-64 age group increased from 1.6% to 13.8%, and the proportion of total cases in the 65+ age group increased from 0.34% to 7.3% respectively (Ministry of Health of the PRC. 2012: 27).

The percentage of sex workers living with HIV in 2011 remained at 0.3% (522/204614) as in 2010 (565/198883) (Ministry of Health of the PRC, 2012: 15). The proportion of HIV positive persons among sex workers decreased by half than that at the peak of epidemic in 2000 (see Figure 6). The HIV prevalence among MSM has significantly increased however. The percentage of MSM living with HIV in 2010 was 5.7% (1948/34009), which

40. *National HIV Sentinel Surveillance Results.*

rose to 6.3% (2343/37094) in 2011, considerably higher than the 1.8% of the national prevalence estimated for 2004-2005. It is equally worrisome for women, as the number of HIV infected women has also distinctively increased in China. One study reviewed that in 1992, HIV prevalence among male was much higher than female (10.8:1), but new infections in 1995 tend to quickly spread among women with an increased male-female ratio of 5.9:1 (Sun & Mao, 1997). In 2000, 1,008 women were identified as newly reported HIV positive and then increased to 15,389 in 2004. By 2007, 10,890 women were newly infected with HIV. [41]

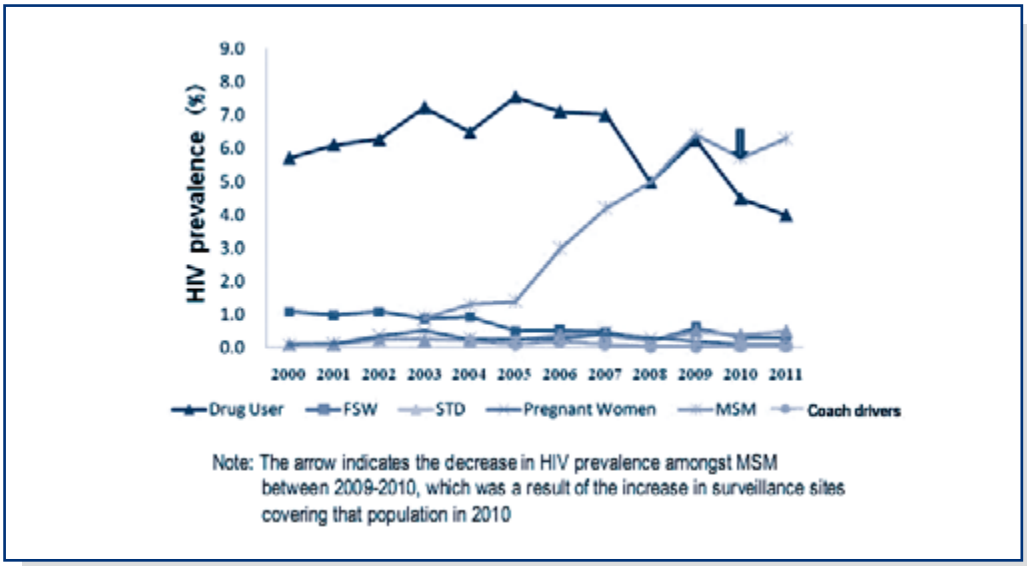
Availability of services for HIV/AIDS

The "Four Frees, One Care" policy issued in 2003 has led to fast expansion of HIV services around the country. The "Four Frees" refer to free HIV testing and counseling, free antiretroviral therapy, free services for prevention of new HIV infections among children, and free education for children orphaned by AIDS. And the "One Care" refers to care for people living with HIV. At the end of 2004, the first 15,000 AIDS patients received free treatment in nine provinces (Huang, Meng, & Qin, 2008). The policy was further enhanced by the adoption of "Five Expands, Six Strengthens" approach in recent three years. The "Five Expands" refer to expanding publicity and education coverage, monitoring and testing coverage, preventing mother to child transmission coverage , comprehensive intervention coverage, and coverage of ART. The "Six Strengthens" means to strengthen blood safety management, health insurance, care and support, rights protections, organizational leadership, and strengthening of response teams.

In 2011, China issued the "National Free Antiretroviral Treatment Handbook," revising the criteria for initiation of treatment and prioritizing testing for drug resistance in order to manage switching of drug regimens. Over 75% eligible AIDS outpatients were able to receive free treatment from nearby hospitals in 2011 (Ministry of Health of the PRC, 2012: 18). At the end of 2011, a total number of 3,142 ART providers were in place nationwide covering 2,082 counties (or districts) throughout the 31 provinces (and autonomous regions and municipalities). The total number of people who have received and are currently receiving treatment increased from 81,739 and 65,481 respectively in 2009 to 155,530 and 126,448 in 2011, respectively. There were 5,313 reported cases of pregnant women living with HIV in 2011, among which, 74.1% of them have received antiretroviral treatment to prevent mother-to-child transmission, an increase on the figure of 73.8% seen in 2010. [42]

In August 2013, the National Center for AIDS/STD Control and Prevention and China CDC launched a pilot project among 9 provinces to provide one-stop services for all AIDS outpatients, i.e., all

Figure 5: Changes and trends of HIV positive testing rates from China's HIV sentinel surveillance system, 2000-2011



Source: Ministry of Health the People's Republic of China: 2012 China AIDS Response Progress Report.

41. Data source: Report of China women's health on the tenth women national congress. http://www.china.com.cn/news/zhuanti/2008fndh/2008-11/05/content_16716620.htm.

42. Figures from this paragraph provided by the Ministry of Health of the PRC. 2012.

Box 2: Four Frees and One Care Policy

On World AIDS Day 2003, Jiabao Wen, the Prime Minister of China in that time, committed that the Chinese government would positively respond to the HIV/AIDS epidemic by implementing "Four Frees and One Care" policy. The Regulations on AIDS Prevention and Treatment, Article 44 and 45, specifically addressed that: the people's governments at the county level or above shall take the following measures on AIDS prevention and treatment, care, and succor:

- Provide free antiretroviral medicine to rural and urban AIDS patients with economic difficulties;
- Provide free or low-cost medicine to rural and urban HIV/AIDS patients who are in economic difficulties as treatment of their unfortunate infections;
- Provide free counseling and primary testing to people who volunteer to receive these services;
- Provide free counseling and treatment to HIV infected pregnant women for the purpose of preventing mother-to-child HIV/AIDS transmission; and
- Care for orphan or pre-mature children left by AIDS patient, especially those with economic difficulties, including low or free compulsory education and relevant costs.

The policy is considered an important turning point in China's history of AIDS response and has made far-reaching political and social impacts.

For more information, please refer to Decree of the State Council of the People's Republic of China No. 457: "Regulations on AIDS Prevention and Treatment" adopted at the 122nd Executive Meeting of the State Council on 18 January 2006, promulgated and considered effective as of 1 March 2006.

people living with HIV/AIDS are able to receive services of diagnosis, counseling, ART, and follow-up visits in one locally designated hospital.[43]

During the last two decades, China has made significant advances in HIV counseling and testing. The Voluntary Counseling and Testing Services (VCT) are made available at all levels of centers for disease control, general hospitals, STI clinics, and maternal healthcare hospitals, providing free services for all in-patients and out-patients. According to the national report in 2007, there were 4,293 delivery points of VCT throughout the country and more than 1 million people receive VCT services every year (State Council AIDS Working Committee Office & UN Theme Group on AIDS in China, 2007). In addition to the VCT, provider-initiated testing and counseling services have been widely promoted in healthcare system in order to actively expanding the coverage of HIV testing and counseling, and enhancing the effectiveness of HIV identification. By the end of 2011, 14,571 medical facilities nationwide had conducted 84,210,000 HIV tests, resulting in identification of 74,517 new HIV cases, 16.2% increase than previous year (Ministry of Health of the PRC, 2012).

While recognizing the Chinese government's efforts in preventing and controlling HIV/AIDS, we must be well aware that there are still quite a few difficulties and problems on the way forward. As injecting drug users, commercial sex workers, and MSM are identified as the most-at-risk population groups, both government and nongovernment organizations have conducted a wide range of behavior change intervention programs among these populations, including health education, condom promotion campaigns, and care services at entertainment places. Institutionalizing surveillance of these so-called high-risk populations based on epidemiological authority has powerfully dramatized the interpretation of HIV/AIDS. Highlighting 'risk' of these populations through tailored monitoring and intervention has converted them into "individuals who are a threat to others" (Lyttleton, 2000: 200). Others who are not directly identified as belonging to these risk groups have distanced themselves from them. Patton (2002) also pointed out that both epidemiological risk groups and topical thinking hamper effective HIV prevention, which lead people to ignore preventive advices by distancing oneself from certain groups and locations.

43. This information was obtained from the National Center for AIDS/STD Control and Prevention, China CDC.

Availability of SRH Services at Different Levels of Care

This section examines a set of indicators assessing the broad-based availability of a comprehensive set of SRH services, including

- Care level where SRH services are available;
- Categories of SRH services at different levels of care;
- Range of free services at service delivery in primary healthcare;
- Range of services in the Essential Services Package for Government-Sponsored Insurance;
- Proportion of deliveries in public and private health facilities,
- Proportion of women seeking antenatal care from health facilities; and
- Proportion of women seeking family planning services from health facilities.

Care Level Where SRH Services are Available

In China, most SRH services are offered in women and children's healthcare system. This was established in the early 1990s as one of the first public health service systems. It is a system with Chinese characteristics, independent from medical treatment and epidemic prevention systems. It takes maternal and child health professional institutions as the core, urban and rural primary healthcare facilities as the basis, and medium and large general healthcare facilities and related research and teaching institutions as the technical support.[44]

This system formed a three-tier network of women and children's health services at community (county in rural) health service facilities, township hospitals, and village clinic levels. In 2010, there were 3,025 maternal and child health institutions, 398 maternity hospitals, 72 children's hospitals, 33,000 community health service centers (stations), 38,000 township hospitals, and 648,000 village clinics. From 2005 to 2010, the number of practicing (assistant) doctors in obstetrics and gynecology and pediatrics grew from 224,000 to 360,000. The number of staff at maternal and child health institutions grew from 188,000 to 245,000. There are part-time and/or full-time staff in women and children's health at community health service facilities, township hospitals, and village clinics.[45]

Categories of SRH Services at Different Levels of Care

All levels of maternal and child health institutions are government-organized, not-for-profit, public institutions with a public health nature. They provide women and children with such public health services as health education, preventive healthcare, family planning counseling, and screening for common diseases of women and children and women and children's health information management at village, township, and county care level.

They also carry out basic medical services closely related to women and children's health such as appropriate diagnosis and the treatment of common diseases among women and children, midwifery services, family planning services, and diagnosis and treatment of maternal complications at township and county levels of care.

The feature covers vast urban and rural areas, with roots at the primary level, and focusing on different work at different levels of responsibility, thereby providing women and children from birth to old age with a full range of healthcare services covering their entire life cycle.

Maternal healthcare, contraception, and HIV/STI prevention service are available at all levels of care. Gynecological services, screening for cervical and breast cancer, and safe abortion services for indications permitted by law can be provided at some secondary level of care and all the tertiary level of care.

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44. Report on Women and Children's Health Development in China. (2011). Ministry of Health. August, 2011.
45. Report on Women and Children's Health Development in China. (2011). Ministry of Health. August, 2011. Contract No. 2.
46. Some vaccines are free, but some are not.

Range of Free Services at Service Delivery in Primary Healthcare

Health education and consultation, prenatal care, postnatal care, and immunization[46] are available for free at the primary healthcare level. Contraceptive services, including IUDs insertion, abortion, and tubal ligation and vasoligation are free as well as family planning counseling for couples of reproductive age.

Range of Services in the Essential Services Package for Government-Sponsored Insurance

Rural individuals participating in the new cooperative medical system (NCMS) and urban individuals who participate in the system of medical insurance can avail a certain percentage of compensation in healthcare provided in outpatient or inpatient departments.

Proportion of Deliveries in Public and Private Health Facilities

In 2005, the proportion of deliveries in public and private health facilities is 85.9%,[47] which is 12.95% higher than that in 2000. In 2012, the proportion of deliveries in public and private health facilities is 99.2%, 0.5% higher than that in 2011.[48] However, there is still a little imbalance of this number in cities and rural areas. This proportion in city health facilities, which is 99.7%, is higher than that in rural health facilities, which is 98.8%[49] . The increased proportion of deliveries in public and private health facilities has contributed to lower MMR. MMR was 36.6 for every 100,000 women, which is 16.7 less than the ratio in 2000. It dropped most dramatically to 28.4 in 2012.

Proportion of Women Seeking Antenatal Care from Health Facilities

The proportion of women seeking antenatal care from public and private health facilities or providers was 95% in 2012.[50] In 2011, the proportion of women seeking antenatal care from public and private health facilities or providers was 93.7%, which is 4.81% higher than that in 2000 (88.89%). In 2005, the proportion of women seeking antenatal care from public and private health facilities or providers was 89.8%.[51]

Proportion of Women Seeking Family Planning Services from Health Facilities

The proportion of women seeking family planning services from a public (private) health facility or provider can be reflected in the contraception rate and the proportion of access to the free contraception pills and condoms. Data related to this proportion are based on the surveys conducted by National Population and Family Planning Commission in different years. In 1997, the proportion of comprehensive contraception is 83.8%, while 62.5% of married women have access to the free contraception service, and 28.6% women obtain contraceptive pills and condoms from stores.[52] The proportion of comprehensive contraception is 84.6%, and 58.8% of women had access to free contraception service in 2006.

47. *Statistical bulletin health and family planning development 2005 in China. 2006.*
48. *Statistical bulletin health and family planning development 2012 in China. 2013.*
49. *Statistical bulletin health and family planning development 2012 in China. 2013.*
50. *Statistical bulletin health and family planning development 2012 in China. 2013.*
51. *Statistical bulletin health and family planning development 2005 in China. 2006.*
52. *National population and Family Planning Commission of China. (1997). Statistical bulletin of sampling survey on demographic and reproductive health in China.*
53. *National Population and Family Planning Commission of China.(2006). Statistical bulletin of samplingf survey on demographic and family planning in China.*

Recommendations

China has achieved great success in improving general SRH services since 1995. However, realizing access to these services for the country's more than 1 billion people is still a great challenge. New problems arise, new vulnerable people emerge, disparity of various groups still exists and the gap between them is expanding, database for SRH services still do not fulfill the needs of all the people, and some health service mechanisms are not functioning well. To confront these challenges, we propose the following recommendations:

- Improve the database on family planning, especially launch or strengthen the sub-database on contraception, family planning, MCH to vulnerable populations, including migrants, adolescents, unmarried young people, and ethnic groups.
- Data collected and indicators used in SRH services should be consistent with international frameworks. For instance, antenatal care coverage rate should be broken down into at least two sub-groups, i.e., the rate of prenatal care with one visit and the rate of prenatal care with four visits.
- Ensure improved maternal health for all the women including migrant women, ethnic minority women, women in rural areas, and women living in regions with low access to these services.
- Design and promote the comprehensive sexuality education (CSE) curriculum based on Chinese contexts in the current education system, and provide outreach or community-based activities for out-of-school adolescents.
- Encourage and strengthen the collaboration between NGOs and government in China to addressing CSE for adolescents and youths to improve sexuality education for students from a gender and rights-based approach.
- Establish separate healthcare centers or integrate a specialized department in public health facilities in which youth-friendly reproductive health services are available for all young people regardless of their marital status, migrant status, gender identity, ethnicity, sexual orientation, and social background.
- Identify and address HIV vulnerability of young MSM and conduct interventions or provide quality of care.
- Understand the socio-cultural dynamics of HIV transmission among the aged population and address the issue with policy development and programming.
- Recognize and address "risk behavior" rather than "risk population" as the key in preventing HIV infections.
- Promote condom use widely and broadly in family planning strategies to encourage and advocate men's responsibility in contraception, and to address the unmet need to contraception of some sub-populations including internal migrants, adolescents, and young unmarried people in the future.
- Efforts should be put in place to address the disparities in maternal mortality between urban and rural areas, different regions and different population groups, particularly migrant women.

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About YHDRA

The Yunnan Health and Development Research Association (YHDRA), previously entitles the Yunnan Reproductive Health Research Association (YRHRA), was founded in March 1994. It is the first officially registered non-governmental academic organization focusing on multi-disciplinary reproductive health research in China. YHDRA is a centre for medical professionals and social scientists with 186 members from several dozens of colleges/ universities, scientific research institutes, family planning departments, health facilities and media.

YHDRA aims to promote a synergy between social sciences and medical sciences, conduct studies on social, cultural and economic factors that influence human health and development, carry out theoretical researches and social services related to health and development, and provide scientific evidence for decision-making bodies and community-based organizations.

Website: http://www.yhdra.org/
Office; 087165326379
FAX: 0871-65311542
Email: yhdra@sina.com

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Production Team

Authors: Rui Deng, Chaofang Yan, Yunmei Wu
Editors: Kaining Zhang, Yunmei Wu
English Editor: Cezar R. Tigno
Reviewer: Baochang Gu, Sai Jyothi Racherla, Maria Melinda Ando, Yukari Horii, P.Balasubramaniam
Template design: TM Ali Basir
Layout artist: Feihoe
Photographer: Huiqun Liu
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