Equality, Quality and Accountability in Sexual and Reproductive Health and Rights: China Case Study

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1. Introduction

After the founding of the People's Republic of China in 1949, maternal and child health (MCH) was within a few years put on the agenda of the Chinese Government. In the early 1970s, family planning programs were launched throughout the country. Since the early 1980s, "to implement family planning, control population growth and improve the life quality of the population" became a basic state policy, which was enshrined in the Constitution promulgated in 1982. Since the 1970s, the two national networks of MCH and Family Planning have long addressed sexual and reproductive health services, through joint or complementary actions, in collaboration with other agencies (Information Office of the State Council, 1995).

Prior to the mid-1990s, China harshly implemented a strict population control policy. A top-down approach focused on controlling the birth-rate and emphasised the quantitative demographic goals and birth quotes. A system of "one-vote veto" was initiated and the performance of the local 'head' of the Party and the government would be voted against if they failed to meet their population control targets. During the high tides of the family planning campaign, local family planning staff resorted to violence, coercion and other abuses, including forced abortions, sterilisation, IUD insertion, and even tearing down houses or confiscations in some places in the countryside (Xie and Tang, 2008:6).

Not surprisingly, equality, quality and accountability (EQA) in sexual and reproductive health and rights (SRHR) has seldom been considered seriously. For instance, every expectant mother needed a birth permit, otherwise her child was not entitled to state preferential medical, food, housing and educational benefits, and extra allocations of land in rural areas (Conly and Camp, 1992:23). In rural areas, married women were regularly inspected to check if they were pregnant, even well into their 40s and 50s. To achieve demographic targets, local family planning staff developed some measures such as to insert IUDs for couples who had had their first child and to perform sterilisation for those who had had a second child. A woman who had given birth to unlicensed children might suffer forced abortions, even late-term abortions, and sterilisations as well as escalating financial penalties known as the "social compensation/upbringing fee" (Conly and Camp, 1992: 8-9; Xie, 2011: 6). The priority of population control apparently often overrode respect for women's and men's needs, rights, and dignity (Xie and Tang, 2008: 2-3).

Following the International Conference on Population and Development (ICPD) in 1994 and its path-breaking outcome document, Program of Action (PoA), which was described as a "paradigm shift" in population policy because of its overarching human rights frame and emphasis on the interconnections of sexual and reproductive health, gender equality, women's empowerment, and poverty reduction; China gradually started to reform population and development polices. Led by the State Family Planning Commission established in 1984, *a*

holistic approach to addressing *SRHR* was strengthened. The quality of care (QOC) campaign became a catalyst to translate some new international concepts into practices.

Despite great progress over the past 25 years, gaps in SRHR between the most advantaged and least advantaged populations remain. The convergence of globalisation, urbanisation, large-scale migration, along with the influences of mass media, have reshaped the demographic landscape, as well as opportunities and perils for sexual and reproductive health among Chinese people, particularly marginalised groups.[2] So far, a large percentage of the population remains vulnerable and excluded from access to quality sexual and reproductive health services. They include the left-behind women in poor rural areas, rural-urban migrants, and particularly sexually active young people.[3]

Since the early 1990s, China has actively engaged in global health governance. The Chinese Government has aligned its 13th Five-Year Plan with the 2030 Sustainable Development Goals (SDGs). Health has become an explicit priority with the approval of the Healthy China 2030 Planning Outline launched in October 2016. This strategic plan, with its focus on social equity and justice, offers a rare opportunity to make a difference in promoting a healthy life for all. It demonstrates the Government's tremendous political will in investing in health and fulfilling the SDGs.

Meanwhile, the Chinese Government kicked off the two-child policy nationwide at the end of 2015. More women of advanced age have been seeking to have their second child, which is associated with a range of adverse pregnancy outcomes. As indicated by official data, there was an increase in the maternal mortality rate in rural areas, which rose from 20 per 100,000 live births in 2016 to 21.1 per 100,000 live births in 2017 (National Bureau of Statistics, 2018). In 2017, the number of live births born in the hospital was 17.58 million, and the percentage of second child accounted for 51% (National Health Commission, 2018). In 2016, pregnant women with high risks accounted for 24.7% (National Commission on Health and Family Planning and China Population and Development Research Center, 2018:253). Safe motherhood and postpartum contraception thus became a new challenge for improving availability, accessibility and quality of reproductive health care.

It is timely to take account of EQA in monitoring the progress, identifying gaps and improving the delivery of services. However, there has been little scholarly literature linking these three dimensions in SRHR. We know even less about their intersections in the real world.

[2] Since the 1980s China has experienced rapid urbanisation, with the proportion of urban residents increasing from 21.1 per cent in 1982 to 59.6 percent in 2018 (National Bureau of Statistics, 2019). Along with urbanisation, China has witnessed a large-scale internal migration from rural to urban areas, from the western and central to the eastern regions over the past four decades. By end of 2017, there were a total of 287 million rural migrants, accounting for more than one-fifth of the total population, with migrant women accounting for more than one third (34.4%) of them. Notably, more than half of them (50.5%) were the new generation of migrant workers born after 1980（National Bureau of Statistics, 2018a）

[3] According to China's sixth census in 2010, China has approximately 300 million young people aged 10-24, more than one fifth of the total population. An increasing number of vulnerable youth population is exposed to a variety of reproductive health risks, including unsafe sex, unplanned pregnancies, sexually transmitted infections including HIV/AIDS, and gender-based violence. Severe inequalities have been embedded also in the shortage and unequal distribution of human and financial resources for their reproductive health.

Reproductive health policies and practices urgently require a thorough analysis of these key factors.

This case study seeks to fill the gap by examining the state of EQA in SRHR in China. It tries to answer the following three questions applying EQA framework: (1) What have been the changes in SRHR related laws and policies over time? (2) What has been achieved and what are the major challenges? and (3) How can China deal with the gaps? Drawing on available official statistics, population-based studies and academic work, this case study scrutinises the realities of EQA in China since the mid-1990s beyond the political rhetoric.

This case study primarily focuses on maternal and child health and family planning policies and practice in China, the two priority issues that have topped the government agenda. There is adequate data and evidence for the in-depth analysis.

2. The Key Trend of Law and Policy Development – Benchmark Status

Over the past two decades, the Chinese Government has made significant strides towards putting in place a framework of laws and policies in accordance with international frameworks on SRHR. This evolution is mainly due to two driving forces: (1) to meet the commitments made at ICPD, Beijing Platform for Action at 4th World Conference on Women and other internationally agreed standards; and (2) to respond to the emerging challenges in population and social development.

2.1.Legislative Frameworks

Immediately after the ICPD, the Law on Maternal and Infant Health Care was issued in October 1994 (revised in 2009 and 2017). Ever since then, promoting SRHR has been put at the centre of China's vigorous efforts.

At the start of the 21st century, a host of new laws and regulations were promulgated. In December 2001, the Population and Family Planning Law was passed. For the first time, a national law adopted key ICPD principles. It addressed the topics of women's status, male participation, sexual health education and the establishment of a social-support system, etc. Its Article 3 reads: "the population and family planning programs shall be combined with the efforts to offer more opportunities for women to access to education and employment, improve their health and promote their status." Article 13 provides: "schools shall conduct education on physiological health, puberty or sexual health among pupils in a planned way appropriate to the characteristics of the receivers" and Article 17 stipulates: "both husband and wife bear equal responsibility for family planning."

It defines eight legitimate rights and interests, including the rights of access to family planning and reproductive health information and education, the right of access to contraceptive methods and reproductive health care services and the right of informed choice of safe, effective and appropriate contraceptive services. For example, Article 19 provides that: "the State creates the conditions to ensure individual citizens knowingly choose safe, effective, and appropriate contraceptive methods" and Article 34 states: "persons providing family planning technical services shall give guidance to citizens who practice family planning in choosing the safe, effective and appropriate contraceptive methods."

Other laws and regulations also play a pivotal role in shaping reproductive health and rights policy and practices. For instance, the Regulation on Administration of Technical Services for Family Planning was passed in 2001, with the improvement of reproductive health being stressed. The Law on the Protection of the Rights and Interests of Women promulgated in 1992 was amended in 2005 and 2018. It strengthens the commitments to promoting maternal and child health care and improving women's reproductive health. At the end of 2015, the Anti-domestic Violence Law was passed prohibiting any form of domestic violence.

In response to the challenges of swift demographic shifts, the amended Population and Family Planning Law passed in December 2015 allows for all married couples to have two children. The law reaffirms promoting informed choice, providing safe, effective and appropriate contraceptive services to people of reproductive years and improving equity and accessibility.

Another notable challenge in the Chinese Government's agenda for health and development is how to equalise basic pubic services to meet the needs of marginalised and disadvantaged groups. Given that the segmented urban-rural hukou registration system prevented migrants from accessing the same basic public services as urban residents in terms of reproductive health services, in 2009 the State Council promulgated the Regulations on the Work of Family Planning among the Migrant Population. This regulation promises to guide reproductive-aged couples among migrants to choose safe, effective and appropriate contraceptive methods and to provide basic family planning technical services to them free of charge. This regulation is of particular importance for targeting the large, vulnerable group of rural–urban migrants.

The above frameworks, along with some special laws and regulations, seem to lay the legal foundations for improving related policies on SRHR.

2.2.Policy Trajectories

Prior to the promulgation of Population and Family Planning Law in 2001, the Central Committee of the Communist Party of China (CPC) and State Council issued A Decision on Strengthening Population and Family Planning Work and Stabilising a Low Fertility Rate in 2000. It reiterates the stringent target of stabilising a low fertility rate, meanwhile promises to promote quality of care universally, focusing on technical services and informed choice of contraceptive methods. It also emphasises prohibition of all forms of coercion and to uphold citizens' reproductive health and rights. In 2006, two institutions again jointly issued A Decision on Fully Strengthening Population and Family Planning Work and Addressing Population Issues in an Integrated Manner. Both regulations make clear that it is essential to deal with the population issue in an integrated way, highlighting people-centred development.

Universal access to essential health services has been continuously stressed in policy framework on health (China Institute of Reform and Development and UNDP China, 2008; Deng et al., 2014). To narrow the gaps in public services between rural and urban, rich and poor areas, and among different social groups, the Opinion on Promoting Gradual Equalisation of Basic Public Services was enacted in 2009, which underscored maternal and child health care. Its key principles were again echoed in the Outline of Healthy China 2030 Plan approved in 2016. This strategic plan reiterates its commitments to universal access to affordable and quality medical health services for all throughout the life course. Vulnerable groups, such as

adolescents, women of reproductive years and rural–urban migrants, were singled out as the focus of interventions. In response to the Outline, the Action Plan of Maternal and Child Safety (2018-2020） was released by the National Health Commission in 2018.

Sexual and reproductive health has also become one of the national priorities of women's policies. To implement the Beijing Platform for Action adopted in 1995, the Chinese Government has successively released three versions of the Program for the Development of Chinese Women (1996-2000, 2001-2010, and 2011-2020). Taking the latest one as an example, the program aims to promote gender equality in seven areas, including health. The program sets some ambitious goals for SRHR such as increasing women's access to quality essential medical services throughout the life cycle; reducing the maternal mortality ratio (MMR) to less than 20 per 100,000 live births; closing the MMR gap between urban and rural areas; controlling HIV/AIDS and STD infections among women, and protecting women's rights for making informed contraceptive choices, etc.

In sum, the milestone conference of ICPD in 1994 and 4th World Conference on Women in 1995 ushered in a raft of progressive legislation and policies related to SRHR in China. Since then, the Chinese Government has made tremendous political commitments to invest in reproductive health, fight against inequality and inequity and leave no one behind. More recently, reproductive health has been emphasised in the chief national development strategies, such as the Thirtieth Five-Year Plan for National Economic and Social Development (2016-2020). The legal and policy frameworks, in turn, provide a solid foundation for continuous progress in the field. Although it is too early to assess the outcomes of the recent policy shift, it has, undoubtedly, paved the way towards achieving the 2030 Sustainable Development Goals.

3. EQA in SRHR: Progress and Challenges

Despite positive legal and policy frameworks that enable EQA, great challenges and gaps remain. Based upon the available data, we will examine how the laws and policies have been implemented and the evolution of EQA on the ground. We will also identify challenges and opportunities of addressing EQA in the SRH services and policies.

3.1. Equality Profile

Since the early 1990s, China has achieved remarkable progress in advancing equality and equity in SRHR. The Chinese Government has made great efforts in achieving the MDG and SDG targets to increase access to reproductive health services by all throughout their life cycle, and to reduce urban-rural, regional and subgroup health inequalities (Ministry of Foreign Affairs and United Nations System in China, 2015; United Nations Children's Fund, National Working Committee on Children and Women and National Bureau of Statistics, 2018). The improvement of maternal health is just one of the telling stories.

China's MMR has decreased significantly over the past quarter of a century. As illustrated in in Figure 1, the MMR dropped from 88.9 maternal deaths per 100,000 live births in 1990 to 22 maternal deaths per 100,000 live births in 2014, down by more than 60 percent, thereby attaining the MDGs of "reducing maternal mortality rate by three quarters from the 1990 level by 2015" ahead of schedule. China has also basically achieved the target of universal access to

reproductive health (Ministry of Foreign Affairs and United Nations System in China, 2015). By the end of 2017, the MMR further dropped to 19.6 per 100,000 live births.

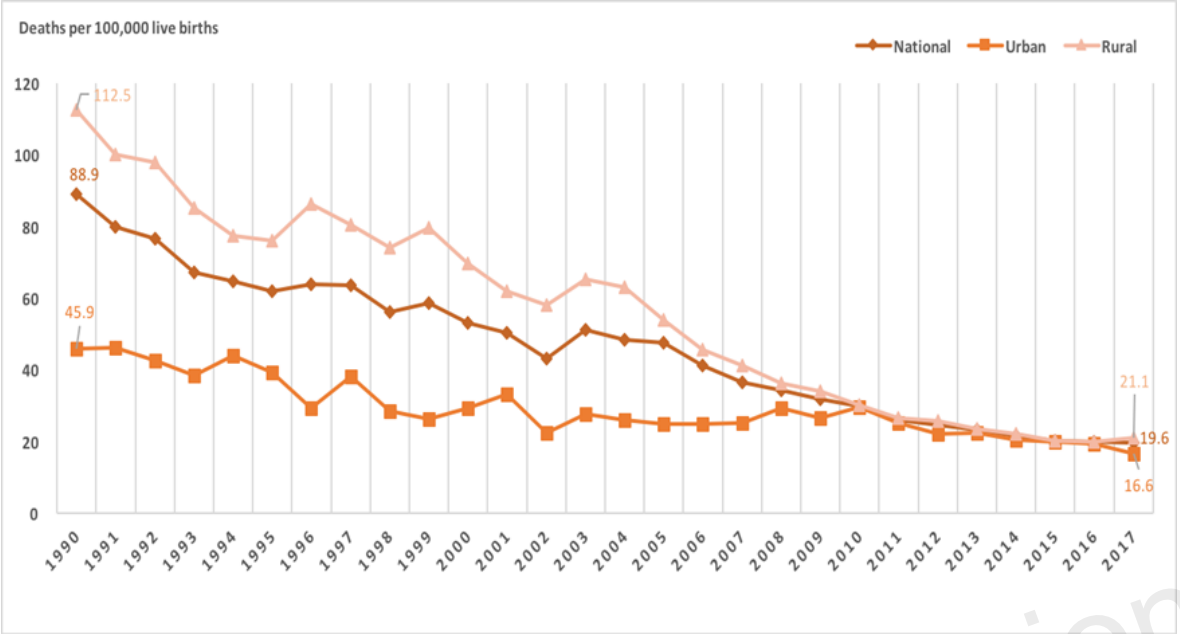

Figure 1: Trends in Maternal Mortality Rate by Urban/Rural Division 1990-2017
Source: National Commission on Health and Family Planning and China Population and Development Research Centre (2018: 250) and National Health Commission (2018:217)

Meanwhile, there has been a steady decrease in the disparities of MMR between rural and urban areas. In 1990, women living in rural areas had a much higher maternal mortality ratio (112.5), compared with their urban counterpart（45.9). Even in 2005, the MMR in rural areas was almost 2.15 times that of urban areas. Since then, urban-rural disparities have been narrowing and the gap between the two has almost disappeared. This was due primarily to a dramatic drop in rural maternal mortality and simultaneously a surprising lack of improvement in urban maternal mortality (You, 2014). The MMR was, respectively, 19.5 and 20.0 per 100,000 live births in urban and rural areas in 2016, with the urban-rural difference being almost negligible.

Similarly, the MMR in under-developed provinces in western China show greater and more rapid progress than that in more developed eastern provinces. As shown in Figure 2, the MMR fell from 21.2, 52.1 and 114.9 per 100,000 live births in 2000, respectively, to 13.5, 21.2 and 26.9 per 100,000 live births in 2016 in Eastern, Central and Western China.

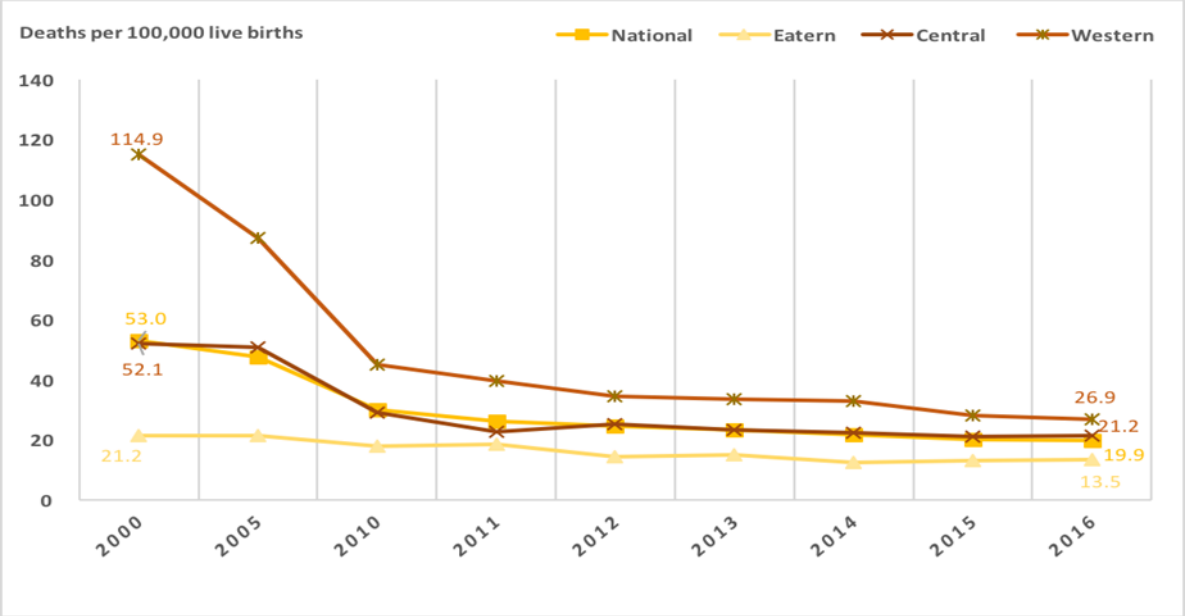

Figure 2: Trends in Maternal Mortality by Region 2000-2016
Source: National Bureau of Statistics (2017:26)

How did this happen and what has been done to address the gaps and tackle the inequality in SRHR? We will only outline some key drivers behind the continuous progress.

Firstly, the declining trend of MMR has resulted largely from China's societal and economic development over the past four decades with rapid economic growth performance and impressive progress in rural poverty reduction. By 2015, China had achieved the MDG targets of halving the proportion of people in poverty. Meanwhile, we also witness the demographic shift, such as rural-urban migration and decreased fertility rate. Some preferential public policies, such as the strict implementation of one-child policy from the 1980s to 2015, with increasing contraceptive use, contributed to the dramatic drop of MMR. The total fertility rate (TFR) fell below the replacement level of 2.1 between 1990 and 1995 as a consequence and has remained at a low level ever since, making China one of the low-fertility countries of the world.

Secondly, universal health coverage (UHC) has become a powerful tool of providing basic health services for all, especially to the poorest and most vulnerable people. By 2015, basic medical insurances for urban employees and residents and the New Cooperative Medical Scheme (NCMS) launched in 2003 for rural residents, have covered almost all Chinese citizens. In the context of a new round of reform of the medical and healthcare system launched in 2009, the System of Equalisation of Basic Public Health Services has been implemented involving two kinds of schemes: basic public health programs and major public health programs. MCH was incorporated into the former, including five antenatal check-ups and two postnatal visits for all pregnant women free of charge. Other maternity care, such as hospital delivery for rural pregnant women, screening and treating breast cancers and cervical cancers among rural women, and prevention of mother-to-infant transmission of HIV/AIDS, was integrated into the latter. The types of services covered have expanded from the original nine categories to

fourteen in 2017, including free contraception. These interventions have greatly reduced out-of-pocket expenditure for impoverished families.

Thirdly, focused interventions have played a pivotal role, which will be elaborated in detail in the accountability section of in this case study.

Fourthly, as shown in the following section of quality, a three-tier network of maternal and child healthcare, established gradually since the 1950s, has been consistently improved throughout the country.

Fifthly, ongoing progress in gender equality and women's empowerment enables women to have greater control over their reproductive lives. Since the economic reform, rural women have performed an increasing share of on-farm and off-farm work in the countryside. Currently, more than one third of rural migrants are women.

Despite this great progress in China as a whole, significant disparities in MMR remain in different regions and provinces, with a similar pattern observed in rural and urban areas. As shown in Figure 3, the MMR in 2017 ranged from less than 10 per 100,000 live births in coastal provinces, about 15 per 100,000 live births in central provinces to above 25 per 100,000 live births in some western provinces. Additionally, there has been a consistently high MMR among migrant women, who often have limited access to high-quality health care.

Figure 3: Maternal Mortality Ratio by Province in 2017
Source: United Nations Children's Fund, National Working Committee on Children and Women and National Bureau of Statistics (2018: 49)

The patterns of maternal mortality differ greatly between high- and low-income provinces and regions and across different groups. In 1990, there were 15.3 maternal deaths per 100,000 live births in Shanghai, whereas this figure was as high as 715.8 maternal deaths per 100,000 live births in Tibet. The corresponding figures in 2000 were, respectively, 9.6 and 466.3 maternal deaths per 100,000 live births in Shanghai and Tibet (Zhuang and Zhang, 2003: 136). In 2016 the gap between the province with the lowest rate, Jiangsu (2.2) and the one with the highest, Tibet (109.9) was nearly 50 times greater (National Commission on Health and Family Planning and China Population and Development Research Centre, 2018:258). As seen from Figure 2, in 2016, MMR in western China was almost twice that of eastern China.

The disparities in maternal survival and health undoubtedly reflect the wide urban-rural and the east-centre-west divide of income and wealth and corresponding human development. China's reform and opening up to the outside world policy have led to serious socio-economic inequalities between rural and urban residents and among residents living in eastern, central and western regions. For example, the ratio between per capita income of urban and rural residents remained high at 2.7 across country in 2017 (United Nations Children's Fund, National Working Committee on Children and Women and National Bureau of Statistics, 2018:28). At the same time, with the reduction and privatisation of public health services, access to reproductive health care has largely depended on the levels of individual income and wealth. The out-of-pocket expenditure once reached a peak of 60 per cent in 2001. It dropped to below 30 per cent in 2015 for the first time and to 28.8 per cent in 2017 (United Nations Children's Fund, National Working Committee on Children and Women and National Bureau of Statistics, 2018: 48).

3.2. Quality Profile

After the ICPD, the concept and practices of quality of care (QOC) were introduced to China. The six fundamental elements of QOC landmark framework in family planning proposed by Judith Bruce (1990), have been incorporated in the provision of sexual and reproductive health services ever since. The six components include: choice of methods, information given to clients, technical competence, interpersonal relations, follow-up and continuity mechanisms and the appropriate constellation of services. Both MCH and family planning systems began to be involved in improving access and quality of reproductive services.

In the field of MCH, a three-tier network of maternal and child healthcare initiated in the 1950s has continuously been improved across the country. By the end of 2016, there were 3,063 MCH institutions, 757 maternity hospitals, and 370,000 gynaecologists, obstetricians, paediatricians, and assistants. In 2016, the Chinese Government invested RMB 2.9 billion to support the construction of 247 city-and county-level maternal and child healthcare institutions. Full-time and part-time maternal and child health workers were available in 34,000 community health centres (stations), 37,000 town and township health centres and 640,000 village clinics (State Council Information Office, 2017). As a result, the coverage of MCH services has steadily increased.

Since the early 1990s, a continuum of care, from pre-pregnancy to postnatal stages, has been implemented on a large scale. Antenatal care, the hospital delivery, emergency obstetric

services and postnatal visits, among others, remarkably improved (see Figure 4). For instance, prenatal checkup rate rose markedly from 69.7% in 1990 to 95% in 2010, and 96.5% in 2017. The hospital delivery rate substantially increased from 50.6 % in 1990 to 99.2% in 2010, and 99.9 % in 2017. Between 2009 and 2013, on average, pregnant women took up 6.3 antenatal visits (7.4 visits for urban women and 5.4 visits for rural ones), vis-à-vis five minimal antenatal visits required by the systematic maternal care management (United Nations Children's Fund, National Working Committee on Children and Women and National Bureau of Statistics, 2018: 46).

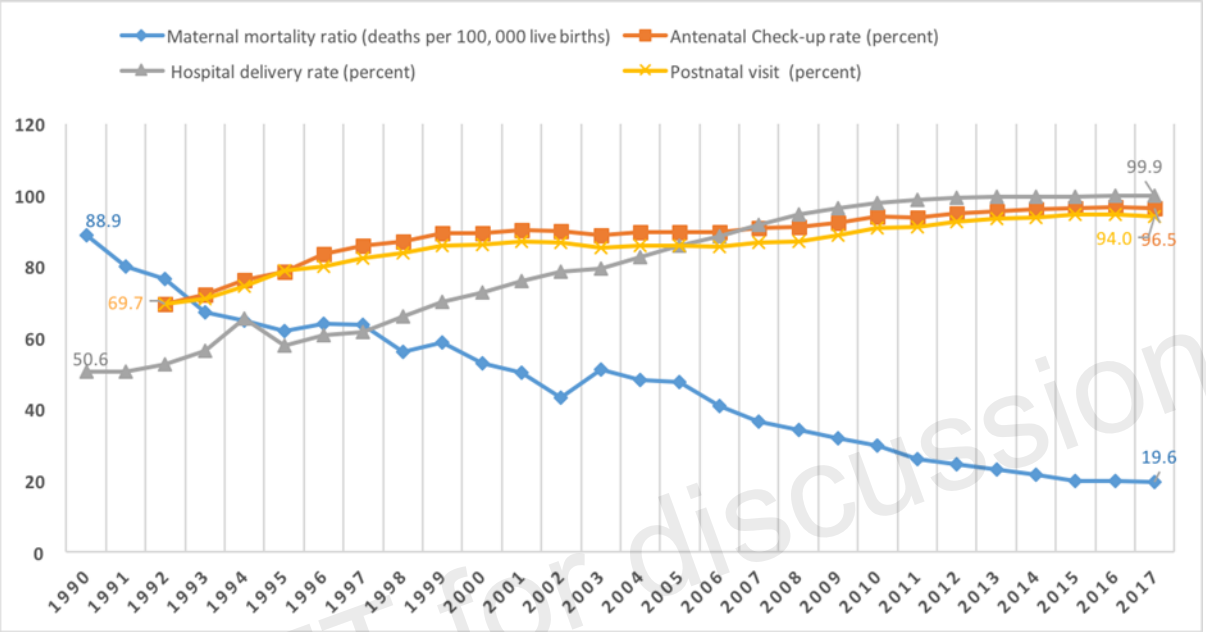

Figure 4: Maternal Mortality Ratio and Maternal Health Interventions
Source: National Commission on Health and Family Planning and China Population and Development Research Center (2018: 250) and National Health Commission (2018:219; 220)

Meanwhile, a wide variety of maternal and newborn interventions have been promoted, with QOC being emphasised. For instance, China immediately responded to the Baby-Friendly Hospital Initiative (BFHI) launched in 1991 by UNICEF and WHO the same year. By 1994, approximately three thousand facilities had been awarded Baby-Friendly status (Yan, 1996:8). Not only are numbers of mothers breastfeeding their infants growing, but privacy, informed choices and user-friendliness are considered seriously in maternity services. Notably, a demonstration project of QOC in Maternal and Child Health began to be implemented in 2013. In order to improve the quality and level of maternal and child health services, the National Health Commission released the Action Plan of Maternal and Child Safety (2018-2020) in 2018, which focuses on the following five areas: to prevent the risks during pregnancy, to treat and cure emergency and severe cases, to improve quality and safety, to enhance professional capacity building and to deliver convenient and high quality services.

In spite of significant improvements, coverage of maternal care interventions varies within and between provinces and across the continuum of prenatal to postnatal care. For instance, China has achieved a near-universal coverage of hospital delivery at the national level, yet the disaggregating data shows that less than 80 percent of pregnant women delivered in hospital in

39 counties in the western areas in 2015 (United Nations Children's Fund, National Working Committee on Children and Women and National Bureau of Statistics, 2018: 48). Limited access to the continuum of basic care reflects different levels of socioeconomic development current in China, which is also an issue of equality.

Following the ICPD, a comprehensive reform on the family planning work was launched. The State Family Planning Commission (SFPC) announced "two reorientations" in family planning work in October 1995. One reorientation was the shift from treating family planning in isolation to linking it closely with economic and social development, dealing with population issues via comprehensive measures. Another one was the shift from a social control-oriented approach to a combination of interventions targeting social control and incentives, which integrate publicity and education with services and management (Xie, 2011: 1; Peng, 1996).

The "san wei zhu" (three priorities) and "san jie he" (three combinations) launched at the end of the 1980s became two powerful instruments. The former refers to the practice of pursuing family planning primarily through administrative means and campaigns that must be replaced by efforts of publicity and education, contraception and regular work. The latter means that family planning in rural areas should combine with "developing economy, helping peasants to become better off through hard work, and building progressive and happy families" (Information Office of the State Council, 2015). The scope of family planning has gradually expanded to include QOC, clients' informed choice of contraceptive methods, and some new priorities such as birth defects, RTIs and the HIV/AIDS epidemic (Zhang, 2008; Xie and Tang, 2008).

Since the mid-1990s, the improvement of the QOC in family planning services has become one of the key priorities. In order to attain the "two reorientations", the SFPC decided in 1995 to initiate QOC projects in five counties, in five provinces and one of the districts in Shanghai. These aimed at exploring best practices to ensure family planning goals were met with high quality care. In 1997, the pilot project was scaled up to eleven counties and districts (Xie and Tang, 2008: 13-17). In 2002, the SFPC launched a campaign of Constructing National Advanced Units of Quality of Care in Family Planning, with the intention of scaling up the successful experiences and working pattern of the pilot project to the whole country. By 2013, 1,818 national advanced units have been established, accounting for over 63.7 percent of the units at the county level (2,853) across the nation while eastern China has basically achieved full coverage of high-quality services (Xie, 2016). In the context of the two-child policy, a new campaign around Constructing National Advanced Units of Quality of Care in Family Planning was initiated in 2016.

Since the QOC project started, a comprehensive package of interventions has been launched. The SFPC initially defined the QOC in reproductive health services as "people-centred, need-based and contraception-focused". The initial QOC project set a powerful example for subsequent movement. The quality of care approach has reframed the reform of family planning from population quota-centric to the clients' need-driven. The core of QOC in family planning service has long targeted the standardised technical services, including the improvement of provider motivation and equipment, as well as quality IUD and sterilisation contraceptive services. Consequently, the QOC movement enhanced the communication

capability of service providers, offered more choices of contraceptives to the married population of childbearing age and allowed them to make informed choice of contraceptives.

Moreover, the QOC project has emphasised clients' rights, empowerment and the quality of client-provider interactions. The users' rights promoted by the International Planned Parenthood Federation were introduced into China (Gu, et al., 1996). It is underscored by the clients' satisfaction with "ten rights" in family planning.[4]

As Kaufman pointed out, the QOC became a symbol of advanced family planning work (Kaufman, 2012). The incremental changes in the QOC movement consequently led to a silent revolution in population policy. The contraceptive prevalence rate among married women of reproductive age was over 88% in 1990 and 88.6% in 2011. With the relaxation of the family planning policy, it dropped gradually from 87.9% in 2012 to 80.6% in 2017 (Zhuang and Zhang, 2003:154; Zhuang and Han, 2012: 208-209; National Health Commission, 2018:223).

The QOC in family planning services have contributed to people's choice of the most appropriate contraceptive method in terms of its safety, effectiveness, availability (including accessibility and affordability), and acceptability. A variety of contraceptive options are now available in China and all of the major contraceptive methods are available without cost for married people. Due primarily to the QOC interventions, as shown in Table 1, condom use increased significantly from 3.68 in 1990 to 18.04 in 2017. At the same time, male and female fertilisation dropped from 11.79 and 37.45 percent to 3.32 (male) and 24.93 (female) percent. Dual protection from the simultaneous risk for HIV and other STDs was considered by contraception users. Since the mid-1990s, informed choice of contraceptive methods, as an essential guiding principle in family planning services might be an important contributor to the rise of condom use. In Beijing, condom use accounted for 80.77% of all contraceptive methods. Its impacts will become more pronounced over time.

Table 1: Contraceptive Methods Used by Married People of Childbearing Age (1990-2017) (%)

Year	Vasectomy	Tubal Ligation	IUDs	Implant	Pill	Condom	Drug	Others
1990	11.79	37.45	40.61	--	5.0	3.68	0.85	0.62
1995	10.57	39.92	41.65	0.31	2.92	3.76	0.52	0.34
2000	8.88	37.60	46.32	0.36	2.14	4.23	0.30	0.17
2005	6.98	33.84	50.57	0.35	1.54	6.31	0.24	0.17
2010	5.19	30.78	53.50	0.29	0.96	8.89	0.18	0.22
2017	3.32	24.93	52.18	0.19	0.82	18.04	0.15	0.37

Source: Zhuang and Zhang (2003:154); Zhuang and Han (2012: 208-209); National Health Commission (2018:223)

Although QOC itself is a means to reduce inequality, notable gaps and challenges remain. For example, because of gender norms and bias, the burden of birth control has long fallen largely on women. Since its inception in the early 1970s, the use of modern contraception was much

[4] The ten user's rights include the right to information, choice, safety, comfort, privacy, confidentiality, access, continual use, respect and expression.

higher among women than that among men. As shown in Table1, in 2017, IUD use still represented 52.2 percent of total contraceptive use and female sterilisation 24.9 percent. Despite an increasing proportion of controllable and reversible contraceptives, long-term contraceptives used by women remain the most popular ones in most parts of China, perpetuating a long-discredited concept that family planning is merely the business of women of childbearing years. Notably, in 2017, there were 181,000 cases of male sterilisation surgery, in contrast to 1.68 million cases of female sterilisation and 8.48 million cases of IUD insertions throughout the year (National Commission on Health and Family Planning and China Population and Development Center 2018:214). The feminisation of contraception places a huge burden of birth control, along with its risks, on women.

Method-specific contraceptive prevalence varies substantially by provinces. As seen below, the four contraceptive methods of male and female sterilisation, IUD and condom use account for 98.47% of all methods used. IUDs are the most prevalent method of contraception for women, with the highest percentage being 82.37% in Jilin province and lowest 16.82% in Beijing in 2017. Tubal ligation, a permanent type of female sterilisation, was the second most popular type of birth control method in China. After assessment indicators for long-acting reversible contraception (IUDs) were cancelled, increasing numbers of women have stopped using this contraceptive method. Variation in condom use between provinces was even greater, ranging from 80.99 percent in Beijing to 3.18 percent in Shanxi. Although sterilisation and IUD are highly effective at preventing pregnancy, they do not protect against STDs, including HIV.

In addition, increasing condom use leads to a high rate of contraceptive failure and unwanted pregnancies. China has one of the world's most liberal abortion laws. Women, married or unmarried, have legal access to early termination of pregnancy. It is widely reported that there are more than 1,300 million cases of induced abortions annually in China and approximately half of the abortions occur among youth under the age of 25 (Hu, 2015). The lack of post-abortion contraceptive counselling in abortion services is common. All of the above, shed light on the lack of adequate protection mechanisms and on the existing gaps in policies and programs to address this challenge.

Table 2: Five Provinces with the Highest and Lowest Percentage of the Four Most Popular Contraceptive Methods Used by Married People of Childbearing Age in 2017 (%)

Tubal Ligation		IUDs		Vasectomy		Condom	
Highest	Lowest	Highest	Lowest	Highest	Lowest	Highest	Lowest
Gansu	Beijing	Jilin	Beijing	Henan	Liaoning	Beijing	Shanxi
(53.61)	(0.44)	(82.37)	(16.82)	(11.27)	(0.00)	(80.77)	(3.18)
Guizhou	Chongqing	Heilongjiang	Guangdong	Guizhou	Jilin	Tianjin	Henan
(50.72)	(1.27)	(80.97)	(23.10)	(10.58)	(0.01)	(52.60)	(5.21)
Jiangxi	Liaoning	Liaoning	Tibet	Guangxi	Ningxia	Shanghai	Gansu
(43.78)	(1.77)	(79.59)	(24.33)	(7.63)	(0.01)	(51.19)	(5.54)
Fujian	Sichuan	Xinjiang	Guizhou	Guangdong	Beijing	Zhejiang	Guizhou
(39.58)	(2.24)	(75.76)	(32.29)	(5.88)	(0.02)	(35.93)	(6.00)
Henan	Shanghai	Sichuan	Jiangxi	Shandong	Tibet	Guangdong	Yunnan
(39.37)	(2.70)	(75.64)	(33.68)	(5.56)	(0.02)	(34.75)	(7.03)

Source: National Commission on Health and Family Planning and China Population and Development Research Center (2018: 217-218)

Serious challenges persist in delivering quality services, sustainably and fairly, to some social groups most in need. For example, there are considerable challenges in meeting the SRHR needs of unmarried young people (Hu, 2015). A national survey unveils there was a significant gap in meeting the needs of unmarried people. 22.4 percent of youth aged 15-24 had sexual intercourse, and 9.4 percent for those aged 15-19. Only 4.4 percent of youth were well-informed about reproductive health and merely 14.4% percent had the accurate HIV prevention knowledge. More than half (53.9%) did not use any contraceptive methods when they had their first sexual intercourse. In addition, among sexually active female youth, 21.3 percent had experienced unplanned pregnancies, with 86 percent resorting to abortion and 4.9% of this group of youth undergoing multiple abortions. Notably, 59 per cent of counselling needs and 54 per cent of service needs in reproductive health were not met. The major reasons include: "feel embarrassed", "perceived it is not serious" and "afraid of being humiliated". In terms of the choice of health facilities, they cited the "level of quality of medical service", followed by "protection of privacy" (Zheng and Chen el at., 2010).

To address the multi-dimensional disadvantages and marginalisation, requires the multi-pronged approach that pays attention to both equality and quality. So far, the efforts targeting other sexually active groups, such as rural migrants, sex workers and college students, who are at a particular disadvantage to access reproductive health services, have been fragmented and unsystematic. Even sexually active college students may have limited knowledge of and access to reproductive health information and services, let alone the marginalised youth group. Indeed, there is a great deal of heterogeneity in offering sexual education across China. Some current sexual education programs have tended to focus too narrowly and have missed the opportunities to deliver a broader set of interventions at the primarily and secondary levels (Hu, 2015; UNESCO & Shanghai Institute on Planned Parenthood Research, et al., 2018). All these reflect the inequality and inadequacies in the availability or delivery of care, or structural barriers that prevent marginalised people from utilizing the care they need.

3.3. Accountability

The following analysis focuses on some core elements of accountability for SRHR, including government's commitments at the global and domestic level, the mechanism of implementing domestic laws and policies, the financing for SRH services and the collaboration with multiple partners, among others.

(1) China has actively participated in global governance and in particular global health governance. In response to the Plan of Action for Implementing the World Declaration on the Survival, Protection and Development of Children in the 1990s adopted at the World Summit for Children in 1990, the State Council approved the Program for the Development of Chinese Children in 1992. One of the seven major goals of the Plan of Action is by year 2000 to have reduced maternal mortality rates to half that of the 1990 rate. As mentioned above, the two landmark international conferences held in the mid-1990s, marked an obvious shift from a vigorous pursuit of birth control towards a people-centred approach to population and development. China is a signatory to the Program of Action of the International Conference on Population and Development (ICPD) held in Cairo in 1994. The hosting of the Fourth World Conference on Women in Beijing the following year further promoted a broader development agenda.

Since 2000, the Millennium Development Goals (MDGs) became a critical mechanism for accountability at the national level. It provided unparalleled opportunities for the Chinese government to build commitments. By 2015, a total of six of China's progress reports towards the Millennium Development Goals were released. These reports review the implementation of the MDG agenda, its structural obstacles and challenges, including many facets of reproductive health. Since reproductive health was identified as one of the most critical unfulfilled challenges, China's national strategy recently responded to its endorsed Sustainable Development Goals (SDGs), accelerating progress on meeting the needs of the most vulnerable and least reached marginalised population. The SDGs provide further impetus to accelerate action towards reproductive health goals.

(2) Updating and amending laws and policies is an important mechanism to translate high-level aspirations and commitments into measurable actions. For instance, the Outline of Healthy China 2030 Plan was approved in October 2016 to implement the country's commitment to the UN 2030 Agenda for Sustainable Development. The Plan set an ambitious national goal of reducing MMR to 18.0 per 100,000 live births in 2020 and 12.0 in 2030.

In order to improve the maternal health over the years, the Chinese Government has launched some powerful and innovative programs and invested resources to implement the prenatal check-ups and postnatal care services and provide emergency obstetric care and family planning services. It demonstrates that putting in place the right policies can make striking differences in reducing the gaps, improving accessibility for the poorest and marginalised populations.

In 2000, the National Working Committee on Women and Children, Ministry of Finance and Ministry of Health jointly launched a widely noted program entitled Reducing Maternal Mortality and Eliminating Neonatal Tetanus that initially covered only 378 poverty-stricken

counties in 12 provinces, autonomous regions and municipalities in central and western China. By 2008, it had expanded to 1,200 poor counties in 22 provinces in central and western China for the benefit of 460 million people (Ministry of Foreign Affairs and United Nations System in China, 2015:46).

Notably, there are some life-saving interventions. A *Green Channel* system to ensure timely referral and first-aid was formulated. By the end of 2014, 2191 *Healthy Fast Vehicles for Mothers*[5] had been sent out to more than 1000 counties/districts all over the country, benefiting over 39 million persons (Ministry of Foreign Affairs and United Nations System in China, 2015: 51). The MCH monitoring and emergency response capability has continuously strengthened. In 2015, the monitoring network covered 140 million people in 334 districts and counties, which has become the largest MCH monitoring network in the world (Ministry of Foreign Affairs and United Nations System in China, 2015: 51). In rural areas in western China, numerous preventable deaths of mothers and newborns at home have been averted with improved transportation and infrastructure.

However, the progress is slow and uneven, facing new gaps and challenge. Some of the national legal provisions are not sufficiently concrete to provide a cause for action, resulting in a lack of accountability. The package of incentives and disincentives relating to childbirth remain. The fine still applies for breaching the new two child policy. In addition, whilst laws were passed by the National People's Congress' Standing Committee, the formulation of actionable guidelines has been left to the provinces. Each province and administrative region formulate its own family planning and MCH regulations as well as other supporting policies. The implementation of national and sectorial policies thus often depends on or is determined locally. The diffusion of responsibility may lead to a lack of action around creating new programs to improve quality and equality. It would seem that the implementation of the law and policy frameworks rely heavily on the local authority, its initiative, financing and capacity. This is probably one of the major reasons for significant variations in the MMR among provinces. A coherent and coordinated monitoring and evaluation mechanism is needed. This shows once again that equality, quality and accountability are interdependent, and the accountability problem cannot be solved without improving equality and quality.

(3) There have been tremendous increases in government's financial investments for sexual and reproductive health services, particularly for maternal health in rural areas of central and western regions. From 2009 to 2013 only, a total of RMB 2.52 billion Chinese yuan (about 360 million US dollars) was invested in the program of Reducing Maternal Mortality and Eliminating Neonatal Tetanus initiated in 2000, covering 2,297 counties and benefiting 830 million people. In addition, a subsidised hospital delivery program was launched for rural

[5] *Healthy Fast Vehicles for Mothers* is a program initiated by the China Women's Development Foundation in July 2003. It raises funds to purchase medical vehicles and donate them to county-level maternal and child health centres in poor, remote and ethnic minority areas. This program is jointly implemented by local women's federations and local hospital. The mobile medical vehicles offer the health services such as screening and physical examination, as well as used as ambulance and transportation bringing women to hospitals. It also plays the role of health and service platform for training of health personnel.

pregnant women in 2009, which by 2015 had benefited 47.278 million people (Ministry of Foreign Affairs and United Nations System in China, 2015:50-51).

Usually, the central government provides funds for these programs and local governments provide matching funds. For instance, the rising hospital delivery rates were financially supported not only by NCMS, but also by specific local or regional programs.

In 2008 the Ministry of Health launched a Subsidy Program on Maternal Hospital Delivery in Central and Western China, which provided a subsidy for pregnant women who delivered in hospitals in 2,297 counties in central and western China and by 2009 it had covered the whole area. In 2014, 9.74 million rural women benefitted from this subsidy program and delivered in hospital. All these efforts reflect strong political commitments and willingness to invest in the SRHR for vulnerable and hard to reach populations.

(4) The merging of the health and family planning department can help to enhance accessibility and quality of reproductive health services, particularly at the grassroots level. For a long time, family planning and MCH belonged to two different sectors. The SFPC established in 1981 was renamed the National Population and Family Planning Commission (NPFPC) in 2003. The NPFPC and the former Ministry of Health (MOH) merged into the National Health and Family Planning Commission (NHFPC) in March 2013 and was renamed the National Health Commission (NHC) in March 2018.

Further optimising and integrating the resources of maternal and child health care and family planning technical services is urgently needed. There were previously about 3,000 women and children healthcare facilities with 500,000 workers and 35,300 family planning service outlets nationwide. The family planning programs were enforced through its five-tier administrative network; including central, provincial, prefecture, county, township and village levels, with a wide service management network. It had the advantages of health communication, education and consulting. The work of family planning in China has emphasised birth control and management of fertility, focusing on married couples of childbearing age rather than improving the services. Therefore, the human resource allocation cannot fully meet the service needs. While health sectors have strong technical strength: health examination, diagnoses and treatment, it has been predominantly focusing on clinical treatment. This disease-centred medical system disadvantages prevention in health care, for instance, prioritising treatment over prevention, emphasising the successful outcome of pregnancy (i.e. maternal health care and delivery services) and neglecting abortion care and contraceptive services after abortion. The merging of the two agencies had provided the potential to better deliver comprehensive services.

(5) Multi-sectoral collaboration of government departments, international organisations and domestic NGOs and academia have played an important role in SRHR-related issues. Since UNFPA began to work in China in 1979, it has contributed substantially to improving SRHR by providing technical and funding support. For example, its fourth Country Program (1998-2003) focused on reproductive health and family planning services in 32 counties of 22 provinces in the less developed regions in central and western China. The fifth Country Program (2003-2005) extended the RH/FP program to 30 counties in 30 provinces. The sixth

Country Program (2006-2010) sought to further enhance the capacity of the pilot counties in providing quality client-centred reproductive health/family planning integrated services, as well as advocacy and services of HIV prevention among migrants and adolescents (Xie and Tang, 2008: 19-20). Under the seventh Country Program (2011-2015), UNFPA China cooperated with the related authorities to strengthen monitoring and evaluation of national reproductive health-related policies and worked with the national and provincial authorities to develop policy recommendations. It made efforts to advocate for the integration of sexual and reproductive health and prevention of gender-based violence issues into the national public health policy. UNFPA also focused on policy development on youth sexual and reproductive health.

Some international and domestic NGOs have also played a key role. Since 1998, the China Family Planning Association has been working with the UNFPA and PATH to implement a Youth Health Project. In the philanthropy sector, the Ford Foundation provides funding support for government agencies, academia and civil society groups to conduct research, capacity building and pilot projects in the areas of SRHR in promoting equality, including gender equality, and quality services. Marie Stopes International China has often been at the forefront of attempts to promote youth friendly services. China Family Planning Association, founded in 1980, is the largest non-profit, non-governmental organisation in the field of reproductive health and family planning (RH/FP), with its extensive network of over one million branches and 94 million members and volunteers all over the country.

4. Conclusion and Recommendations

In summary, from the perspective of EQA, reproductive health intervention in China has been both promising and disappointing. On the one hand, SRHR was making its way onto the broader legislative and policy agendas after ICPD 1994, with inequalities in some fields being narrowed and quality improved; whilst on the other hand, much effort still needs to be made to bridge the remaining gaps and to address the crucial issues as outlined below in this case study.

4.1.The Remaining Gaps

Although the State has taken a range of actions on some fronts, the laws and policies have been generally slow therefore unable to respond to the rights and needs of people's SRHR, especially those beyond reproductive age. For example, according to family planning law and policy, married women who are eligible for family planning can enjoy four free family planning technical services, including free removal of IUD, but the needs of women beyond childbearing age are neglected, such as comprehensive sexuality education for adolescents and young people, sexual and reproductive health services for elderly women, etc. There is also lack of clarity in policy on whether it is family planning technical service (meaning free of charge), or it is a general medical treatment, which should be covered by out-of-pocket expenses. According to a research by Professor Sun Xiaoming, the cost for removal of IUD ranges from 100 to 3000 yuan (about 15 to 430 US dollars). The research concludes that whether women beyond childbearing age can have access to this service or not would actually depend on "who pays the bill."

Laws and policies sometimes have biases built into them that advantage some groups while disadvantaging others. For instance, most policies do not contain any explicit reference to the rights of adolescents and youth. Article 21 of the new Population and Family Planning Law provides that married couples of reproductive ages who practice family planning shall receive, free of charge, the basic items of technical services specified by the State. Access to these basic items of technical services remain a privilege that has not yet been extended to adolescents and unmarried youth. In addition, older women were almost entirely missing from the SRHR related policy debate and consideration.

Progress in increasing access to the services that could make a difference to people's reproductive health is patchy and uneven. Some services, such as antenatal care and hospital delivery are more likely to be put in place than others, such as youth friendly services or eliminating sexual violence. Up to now, many facets of quality services are lacking. At the local level, the family planning programs have long been dominated by a narrow perspective that prioritises regulating rather than service delivery. Gender has not sufficiently been taken into consideration in policies and programs related to reproductive health including HIV/AIDS. Inter-sectoral coordination among implementing agencies is weak. In terms of improving EQA, much work needs to be done to respond to the long neglected and increasingly complex reproductive health challenges facing marginalised groups such as migrant women and adolescents.

The new two-child policy which was officially launched in January 2016 does not go far enough in terms of SRHR and gender equality. Rather than giving women and individuals the reproductive rights aligned with principle of ICPD, the amendment of Law on Population and Family Planning retains the article on punishment of couples for having more than two children. As long as the quotas and system of surveillance remain, women still could not fully enjoy their reproductive rights and bodily integrity. Furthermore, the policy does not integrate the gender perspective in a comprehensive manner. For example, there are special incentives and subsidies for families and households with only daughters. However, how effective this kind of policy would be in changing the attitude and behaviour of families in regard to son preference remains in doubt due to the lack of empirical evidence.

The obvious implication of this policy is labelling these families as weak and vulnerable and separating them from society, which may result in further exacerbating the gender-based bias, stigma and discrimination and reinforce the discriminatory son preference culture and patriarchal ideology. The original motivation for the adjustment of the family planning policy was not for advancing SRHR. Its rationale is to address the striking, imperative issues of demographic shift and disappearing population dividend, especially low fertility rates and aging. The new policy introduces tremendous new challenges in SRHR and gender equality, such as high-risk pregnancies and delivery, exclusion and discrimination against women in the job market, as well as the backlash discourse on gender and women's role. The implementation of the new family planning policy and its consequences for women, the health system and society yet need to be reviewed comprehensively to make it truly work for SRHR and gender equality.

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