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CHINA'S MIGRANT WOMEN AND THEIR REPRODUCTIVE HEALTH NEEDS

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At the beginning of this decade, there were 175 million international migrants worldwide. China however, had 150 million migrants travelling within its borders. Almost half of those are women. Their number shows the need not to overlook internal movements; their experiences also suggest that similar issues may affect reproductive health in both the internal, and international, migrant community.

Migration is nothing new for Chinese women who, on marriage, have traditionally had to move to their husband's family home and become part of the husband's family. The novelty today is that women are moving for a range of economic and social reasons, and often doing so independently.

Who are these women?

Predominantly rural, more than 80 per cent are aged between 20 and 40. The majority have no more than junior high school education. They may seek jobs within their own province or travel right across China. They work in factories, especially if they are young and single; in service industries; and as traders or small business operators, especially if they are married, when they often work with their husbands. They save a large proportion of their income and send remittances back to their families; they also revisit or return to those families quite frequently.

They may live in dormitories (especially if they are factory workers) or in cramped, shared substandard accommodation or makeshift shanties, often illegal. With their darker skins and unintelligible local dialects they are all too visible on the streets. The resident population tends to regard them with suspicion or contempt.

The single girl.

Although their earnings are extremely important to their families as well as themselves, some studies suggest that young single women migrate as much for the

stimulus of city life, and to avoid the drudgery of peasant existence, as for the income. Many acquire a boyfriend, and they are less likely than their stay at home equivalents to marry the first boyfriend, and more likely to choose their husbands without family intervention.

The majority are tolerant about premarital sex – and there is growing evidence that this is not an attitude consequent on migration but one shared by younger rural women generally. There is also quite widespread approval for the provision of contraception to the unmarried. Perhaps a quarter of the migrants have some sexual experience, according to one survey at least. However, few have any real knowledge of contraception and among those who had been sexually active, a third had already been pregnant and had abortions. Their knowledge about STDs and HIV/AIDS is even more limited, especially when it comes to how to prevent or reduce exposure to those diseases.

Programmes of sex education and services for unmarried young people remain extremely limited in China, where many policymakers have been unable to grasp, let alone accept and address, rapid changes in sexual behaviour. The difficulties inherent in reaching young migrants mean that they are even more likely to miss out.

Marriage and children.

Despite early fears that migrants would attempt to avoid registering, or otherwise being officially noticed, in their new places of residence so as to avoid the family planning regulations, there is increasing evidence that migrant couples are in fact having somewhat fewer children than other rural families. One possible explanation is the housing situation; it is not uncommon to find two couples sharing a single roomed flat. Another is that until recently there was no automatic provision by the cities for schooling for migrant children. If accepted into a school, the child's family has to pay 'endorsement fees' which even at primary school are unaffordable for many. For secondary education they may amount to 2-3 years of the family's total income. Most migrant children instead go to private migrant schools, whose quality is generally poor.

A further reason may be that migrant couples are seldom in the types of employment which provides maternity leave or health insurance. Many, as already mentioned, are self-employed. A hospital-based study in Shanghai found that only 7 per cent of migrant mothers, compared to three quarters of local women, had some

insurance cover towards perinatal care. Almost half of the migrant women had no prior antenatal visits before arriving for delivery. As several other studies have also found, they avoided the health services partly because they saw themselves as having lower social status than residents, and hence feared being treated rudely or with arrogance; partly because of the cost; but- more fundamentally – because they thought the services just a way of extracting money. ‘I am very healthy; they probably just want to collect money again’ said one while others thought Shanghai women were ‘sissies’ for needing antenatal care. But all pregnancy outcome indicators for the migrants were worse, and they had twice the number of still births as local residents.

The women largely prefer to go home to their husband’s family to give birth – 90 per cent in one survey did so – they work as long as circumstances permit and then return to the village for delivery. As a result, they very often miss out on routine antenatal care at either place. Government efforts to improve quality of care in rural maternity services through a comprehensive schedule of antenatal visits have included the provision of information and education to those women who are, or are hoping to be, pregnant; less has been done to educate the wider community, especially husbands and parents in law, as well as adolescent unmarried girls, that such antenatal monitoring has real value.

Another indication that financial constraints are not the only, or primary, problem in reproductive health care is the high level of caesarean births. In one survey of migrant mothers, two out of five had delivered by caesarean operation. Apparently, given the government policy on limiting pregnancy, many couples even in not particularly wealthy rural areas are opting for such births because they are believed to offer the safest outcome for the foetus

When it comes to contraception, migrant women seem more knowledgeable about the different types of contraceptive available, and more likely to express dissatisfaction with the method they are currently using. But one survey found them no more likely than other women to know about possible side effects of the different methods, and some 40 per cent of them, like their non-migrant sisters, would not go to a doctor if they had a contraceptive problem.

Exposure to city living may, however, have provided these women with some insights which may improve the health of their children. One survey noted that on return to their villages, migrant women were critical of the local standards of hygiene.

Impact on women's status

It is well known that women's reproductive health is entwined with a number of issues of women's status and women's development. Migration will have consequences – intended or otherwise – which are bound to affect these relationships. For example, factories are increasingly demanding workers with better education, and this may help to ensure that girls reach higher levels of schooling. Alternatively, for some families, the immediate prospects of a daughter's remittances may be too tempting.

Rural Chinese women complain that their work, both on the farm and in the household, goes unrecognised, is taken for granted. Remittances from a migrant job, however, are much more likely to be recognised as a tangible contribution to the family's wellbeing. On this measure alone, women's status has already begun to change. It is perhaps not surprising that migrant women are less likely to report son-preference than are rural dwellers. But, nevertheless, the children of those migrant women actually have a higher sex ratio than their village counterparts: the result of easier access to illegal ultrasound examination for sex selection and consequent abortion.

Young women who have escaped the drudgery and boredom of life on the farm may be reluctant to return – especially where that return is to a husband's family in which she is expected to be the submissive daughter-in-law. Chinese migrant men apparently still feel closely bound to their home villages, to which they can return when unemployed or ill, and in which they have a permanent stake; women are more inclined to want to settle in the cities. And urban living, exposing them to new ideas and offering them more scope for independent choices and behaviour, will change their outlook and their lives in ways which are unforeseeable.

These young women migrants are already becoming more independent in their choice of a spouse, which may further shift the balance within Chinese families towards the couple as a unit. With greater expectations of love and closeness within a marriage, however, the chances of marital breakdown can also rise. And a more couple-centred family may also threaten not only the power, but the ability to command services, of older family members. Indeed, in some cases the aged relatives

are already forced to bring up a second generation of children, sent back to the village by migrant parents who cannot afford a city education for them.

Conclusion.

Migrant women's reproductive health needs are affected by the knowledge and beliefs they bring with them from their homes, as well as those they acquire at their destination. Their poor social status and often questionable residence standing make them reluctant to access many services and compounds the difficulties of providing targeted services to them. Such targeted services are frequently minimal, and of low priority, in any case. Migrant mobility often results in their falling between two stools, with responsibility for their care unclear and any services uncoordinated.

In China, UNFPA has underwritten a number of small research projects exploring some of these issues and helping to inform local and national governments so that appropriate strategies to address these can be developed. Other donor programmes too can ensure that the needs of migrant women are not overlooked. And further research into related aspects of migrant well-being, such as how to provide better housing and education, also needs to be explored if their health is to be improved..