

**Health Vulnerability among
Temporary Migrants in Urban China**

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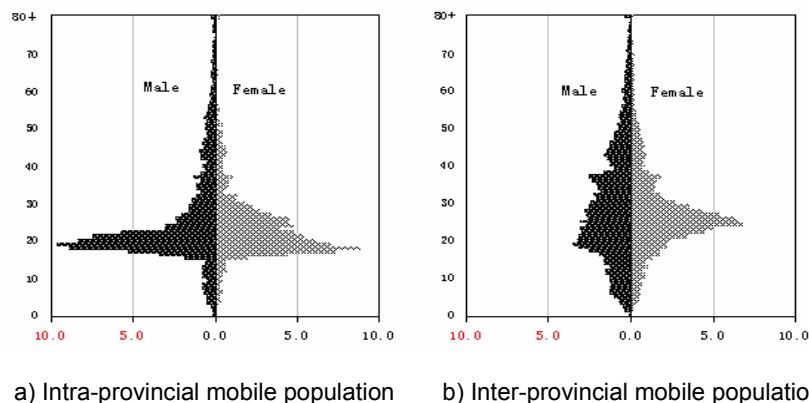
1 Background

China had about 79 million people migrated during 1995~2000, including intra-province and inter-province move (Liang and Ma, 2004). Most of the migrants left their rural home and work in cities temporarily. Since China has a strict household registration system that identifies a person as either urban residence or rural residence, the rural identification put migrants in a much more disadvantaged position in urban society. Attracted by better job opportunity and more income in cities, rural to urban migration has been increasing each year disregard the unfavorable working and living conditions. Meanwhile, the “marginalized” life of rural migrants has been one of the most concerned issues in the process of urbanization in China.

Most of migrants are in ages 15~39, 75.3% female and 69.2% male are in the age group (National Bureau of Statistics, 2005), and about half of them are women. Figure 1 shows the age pattern of migrants, and the different sex distribution by age and migration status, that is, more young women in their twenties had migrated to other province.

Figure 1 Age and sex distribution of migration in China, 1995-2000 (%)

Source: Population Report for 2003, NPFPC



The specific age structure and special social-economic context in the destination make the migrants paid higher health costs and facing higher health risks while they make contributions to the destination area. The problem in terms of living condition, health insurance and benefits, and public health service for migrants are more serious when there is any erupt of epidemics and dangerous infectious diseases, such as SARS in 2003 and HIV/AIDS in the recent years.

Although the labor force mobility started in China about two decades ago, there is a lack of systematic health risk assessment among the mobile population, and the health issues of temporary migrants have not been paid attention until very recent years. Information and publications from research related to migrant’s health are scarce.

This paper will review the status of some key health issues such as HIV/AIDS, occupational safety and health at workplace, infectious disease, and reproductive health among migrants from limited data. We will also analyze the possible determinants and

consequences of different health risks among different migrants, discuss related policy issues, identify the gaps and make recommendations for further research.

The data and information for this research are mainly from the existing literatures, research reports, and available statistics.

2 An Analytical Framework

The analytical framework of the research is to establish a relationship between four sets of causal variables and migrants in sub-groups. The variables affect health risks and health outcomes of migrants either directly or indirectly, and some of them are also inter-correlated. There are factors relate to government/public policy, employer, health sector, community, and individual migrant, as listed below, may have some effect on the health of migrants.

- **Government:** public policies, social welfare and social security system, public service system, community development and housing;
- **Employer:** work site safety, living condition of dorms, worker's insurance, women worker's maternal and reproductive health benefit;
- **Health sector:** health/disease control network, service coverage and approaches, as well as affordability and accessibility of the services;
- **Community:** living condition and environment of the community where migrants are major residence, popular practice of peers, support and communication network;
- **Individual:** social-demographic characteristics (age, sex, marital status, education attainment, occupation, income, living arrangement, et al.), social support, health awareness, health knowledge, health believes, health behavior and help seeking behavior.

We assume that the variables play different roles in increasing/decreasing different health risks on sub-groups of migrants differently. Therefore, improvement of some variables will lower certain health risks effectively in some sub-groups but not for the others since there are different needs among different groups. The policy implication from such analysis is to better identify interventions that can have a largest impact on majority of people in a certain group under a specified context, that is, to pin point the right target.

3 Health Vulnerability of Migrants

The health risks regarding HIV/AIDS infection, reproductive health, infectious disease, as well as occupational safety and health at workplace will be discussed in this section, separately. The vulnerability of different sub-groups of migrants to different health problems will be identified.

HIV/AIDS infection

According to the recent report on HIV/AIDS epidemic in China, more than 80% of people live with HIV/AIDS were found between ages of 20-39. Early cases of HIV/AIDS were reported among returned labour migrants from abroad. Those who go out in very young

age, single, and unaware of risks, they are usually less likely to practice self-protection. For example, it is reported that relatively more cases of HIV infection were found among returned labour migrants who used drugs in Yanbian, Jilin (Cui, et al., 2002), and more than half of HIV/AIDS cases in Jilin were found in Yanbian². According to information reported by Guangdong and Sichuan that most HIV/AIDS cases found among farmers and unemployed people, some of them had cross-provincial migration experience (Li, et al., 2002; Liang, et al., 2003).

Sexual intercourse is another way of HIV/AIDS infection due to unprotected sex. Different living arrangement may lead to vulnerability in different ways. Large factories and hotels usually provide dorms for employees with certain management regulations and full time dorm managers. Regulations usually include not allow visitors stay overnight in the dorm, close dorm gate in the late night, et al. It would be impossible to have out of wedlock sex relationship or use drug in such places. Possible vulnerability to HIV/AIDS among general migrant population should be in those who are not living with their peers and out of the eyes of their own society, as well as those who are self employed.

Risks of HIV/AIDS infection is also related to the status of employment. Commercial sexual relationship is increasing in recent years, but the illegal status of sex industry put women in a helpless situation for health care service and necessary screening, therefore they have a higher risk of STI/HIV infection (Wu, et al., 1997). It has become a major barrier in HIV/AIDS prevention. An investigation report said that most sex workers in some cities are unmarried and from rural area, and the age of the group is younger, while the investigation revealed that sex workers from rural and with a lower education are more likely to be infected by STI/HIV (www.chain.net.cn).

A study by Sun et al. (2002) in Heilongjina found that out of 393 women migratory workers in the service sector of several cities, 59.8% of them had multiple sex partners and only 34.4% of them used condoms. Freedom of movement and removal of traditional constraints changed some youth's behaviour, especially sexual behaviour.

Spouses or sex partners of migrants also worth attention in HIV/AIDS prevention program, since they are usually less aware of health risks but may have a higher probability of infection. It is found that rural women who suffered STDs infected by their husband returned from migration trip. However, it is a common believe among rural women that if one were loyal to one's partner, she would be safe from HIV infection (Zheng and Xie, 2004). Similar misinformation and misunderstanding were found by other studies also.

A research found that workplace based education/training on AIDS prevention is effective in improving knowledge of young migrant workers, after participatory training about HIV/AIDS prevention, knowledge improve and attitude change among young unmarried participants were observed significantly (China Youth Reproductive Health Project, 2005). However the coverage of such training is very limited.

A multi-country study on the issues of migration and HIV vulnerability has been done

² Information provided by Yanbian Family Planning Department.

to review the situation in seven Asian countries including China, focusing on cross-border mobility (UNDP and APMRN, 2004). The study found that although government and civil society have responded to address the issue among migrants, the effort is far from enough. Meanwhile, relative information is scarce and a better understanding about the situation is still needed.

Reproductive health

Migrant's reproductive health, especially for women and children, has been the increasingly studied in urban China in recent years, but knowledge gaps still exist.

Reproductive health related problems and risks among migrants mainly are:

- **Safe sex and unmet needs** of contraception service including counseling among unmarried youth. It is found that premarital sex among young migrants is not rare, however, it is more likely unprotected due to lack of awareness, lack of knowledge, lack of information, or hesitation to use service (Lou, et al., 2001; Zheng, et al., 2001; Zheng, 2002). There is a higher risk resulted from unprotected sex, unwanted pregnancy and childbearing.
- **Induced abortion and post-abortion care.** As a consequence of unsafe sex or contraceptive failure, induced abortion and post-abortion care has not been adequately addressed, especially among young unmarried workers. Although both local residence and migrants have induced abortion in family planning clinics or hospitals, it is found that migrant women are more likely to have abortion in younger age and later pregnancy, and there is often no family planning benefit and paid leave for migrant workers.
- **Benefit and rights of women workers.** Protection in workplace for pregnant women and violation to women's reproductive rights and benefits, such as most enterprises do not cover maternal insurance, some enterprises even stated in contract that no pregnancy allowed during the employment period (Jiang, 2004; Tan and Song, 2004). Employers often do not offer paid maternal leave with job and seniority guaranteed, neither provide any insurance for antenatal care and child delivery for migrant workers.
- **Prevention and treatment to reproductive tract infection (RTI)** and other gynecological diseases. Studies in Beijing and Shanghai, and conducted by different groups, found that migrant women have a higher prevalence of RTI and lower rate of regular gynecology check-up (Chen and Zheng, 2001; Lan, et al., 2004).
- **Immunization of children.** Community-based studies found that migrant children had a much lower immunization rate than local children (Xu, et al, 2000; Shan, 2000), it is lowest among the children of peddlers, only 25% (Guo, et al., 2000), while the immunization rate for local children is about 100%. The main reasons are (1) parents lack of information and less aware of the service; (2) frequently changing of residence place makes immunization registration and service delivery very difficult.

Researches found that the effect of similarity among young women who migrated to urban regarding health behavior and service use in reproductive health, for example,

migrated women have more knowledge about reproductive health and are more aware of health care than their counterparts stay in rural (Zheng and Xie, 2004), and it is found that migrant women are more aware of maternal health care and more likely to deliver baby in hospital (Ge, et al., 2004).

Meanwhile, it is also found a large gap between the service available and the need of both married and unmarried migrants regarding reproductive health/family planning in the destination, such as accessibility of contraceptives and availability of free service (Liu, et al. 2004). Another recent study found that although there are newly produced regulations and policies on reproductive health/family planning service to migrants, the existing urban system has difficulty to serve married migrant women effectively, let alone unmarried youth (Jiang, 2004).

Reproductive health, including maternal health is of specific importance in a woman's life course, and since most women workers are in the age of childbearing, it is an important issue to them. The State addressed maternal health issues of women workers in several regulations, such as "Regulation on women's benefit in workplace," which became active since 1988; "Regulation on jobs not appropriate for women workers" issued by Ministry of Labour and Social Security in 1990 listed jobs that are not appropriate for women who plan to get pregnant, currently pregnant, and in breastfeeding; in November 1993, a joint issued regulation by Ministry of Health, Ministry of Labour and Social Security, Ministry of Personnel, National Trade Union, and All China Women's Federation, "Regulation on the Health Care of Women Employees," defined more detailed requirements to women employee's maternal and antenatal health care benefits. However, how these regulations have been enforced, implemented, and monitored still needs more comprehensive and more specific assessment.

The 2000 Women's Status Survey of China revealed that 37.3% women respondents did not have paid maternity leave and pregnancy care from employers (National Bureau of Statistics, 2005).

Table 1 shows the related benefits reported by women survey respondents by the type of enterprises in a survey carried out by National Trade Union in 1999. Be aware that it is not a survey focuses on migrants especially, and often such a survey misses more small private enterprises, so the real situation for migrants should be worse.

As we understand so far, the state own and some other large companies and factories have relatively well-formed labor protection regulations for women. In these factories, female employees would be shift to the posts with less workload and with only dayshift, some factories have schedule and room for breastfeeding, some have day care center. However, it is not a popular practice in most private and small enterprises, most young women workers have to quite job after get pregnant, they usually back to their rural home to deliver baby without any benefit from employers, which means that all maternal costs are not covered by employers but the women and their family. The Government started to pay more attention to the issue recently. For example, Beijing Municipality Government is preparing a policy to enforce maternal insurance in the late of 2004. However, other aspects of reproductive health other than maternal health care also

deserve equal attention to.

Table 1 Labor safety of enterprises for women staff and workers, 1999 (%)

Type of enterprise	Regular gynae. check	Clinic & restroom for pregnant	Labor intensity for women	Work condition during period	Labor intensity for breastfeed	90 days paid maternity leave
State-owned	82.4	32.3	79.8	87.4	94.9	97.9
Collective-owned	66.9	22.9	72.2	80.7	91.6	95.2
Internal shareholding	77.8	3.8	60.0	77.8	89.3	96.6
Internal associated	66.7	66.7	100.0	100.0	100.0	100.0
Internal limited	91.9	45.5	89.7	89.7	100.0	100.0
Internal shareholding limited	77.8	40.9	92.0	92.3	96.7	100.0
Internal private	28.6	50.0	71.4	42.9	62.5	50.0
Internal other	33.3	33.3	100.0	100.0	100.0	66.7
Hong Kong, Macao, and Taiwan invested	87.5	42.9	100.0	100.0	100.0	87.5
Foreign invested	50.0	38.5	100.0	100.0	100.0	100.0
Institutions	80.7	33.2	63.4	68.2	93.2	98.6
Governmental agencies/organizations	100.0	31.2	-	-	100.0	100.0

Source: Sample survey on basic state of women staff and workers of National Trade Union. 1999. Referred from: National Bureau of Statistics. Women and Men in China: facts and figures 2004. China Statistics Press, 2005.

Infectious disease

Some infectious diseases were found more prevalent among migrants, mainly due to the poor hygiene and poor/crowded living conditions. Living arrangement, living conditions, and health behavior are found highly related to the incidence of infectious diseases. The poor living condition and unhealthy practices chronically harm the health of migrants and increase the chance of infection of certain diseases. For example, during the SARS crisis, the Beijing government enforced a construction company close to improve the living condition of workers (mostly dozens of young men living in a room with poor ventilation), as several SARS cases were found among workers working on the same construction site. It was reported that 184 SARS cases were found in 104 construction sites, as the epidemic under control in later May 2003, migrant workers made the largest proportion of newly founded cases (Caijing Magazine, 2003).

Malaria, hepatitis, typhoid fever, and respiratory infection were found with a higher incidence among migrants than the local stationary residents (Xie, 2000), due to the unclean and overcrowd living and working environment, as well as poor sanitary and unclean drinking water. Some rare disease such as measles was found in Guangdong

among migrants, presumably caused by children who did not have the immunization, and transmitted to adults later (Li, et al., 2001).

Occupational safety and health at workplace

Most of the employees of township enterprises are rural migrants, and often work for short-term contract or even without contract. From limited investigations and reports, the incidence of occupational disease among township enterprise employees was 15.8% in year 2002. About 83% of township enterprises were found unsafe factors in workplace, and 60% of township enterprises were found without any protective measures (Peng, 2004). Meanwhile, medical insurance and work injury insurance provided by employers are very limited. For example, only 45.6% women respondents in 2000 Women's Status Survey of China reported that they had medical insurance, and the percentage for work injury insurance is even lower, 29.7% (National Bureau of Statistics, 2005).

Rural migrant workers made majority of workplace death in year 2003, about 80% of deaths in mining, construction, and dangerous chemicals were migrant workers (China Youth, 2004). And it was found that more than 70% of enterprises in Pearl River Delta did not buy any insurance for their employees, according to the investigation result of a research team (Xie, 2004).

Women workers have a higher health risk caused by poor work environment in manufacture factories. For example, result from a survey among women workers in Pearl River Delta area shows that the major complains about workplace are noisy, poor ventilation, and dusty (Research Team of "Rural migrant women," 2000). Since women make more than 50% of foreign invested or joint invested factory workers³, and the proportion of such factories is increasing in China, the impact of occupational health and work safety will affect a large number of women workers.

4 Discussion

China has experienced a continues fast economic growth, the health issues of temporary migrants, who make a large contribution to the growth, have been found problematic. The issues have drawn an increasing attention from policy makers, public services, civil society organizations, and the public as well, since these health problems will

- Harmful to migrant's health or even life long health;
- Worsening the burden of rural since most of migrant workers go back to home after they were injured or seriously sick;
- Making an unsustainable way of using rural labor force (the workers with health problems will discontinue their job and replaced by new recruited workers)

The health issue of migrant is one of the basic rights and benefit of people, and it is part of human rights. The problems discussed earlier have an important impact on the health of migrant as well as the health of their family and children, some even have life long consequences, to impact on their quality of life.

³ Ministry of Labor and Social Security of China, 2002

Health issue is directly related to migrant's ability of labor participation and social participation. The practice of a large amount of industries and companies neglecting employee's health including reproductive health, not only harmful to the migrant's health, but also pass on the health burden to rural society. The migrant workers who are less healthy or women workers who get pregnant would be replaced by new and healthier migrants from rural, and the cost of maternal care and health care are totally paid by rural people, which enlarges the gap between urban and rural.

The public service systems in urban were designed within the context of planned economy, the services presumably only cover the residents with an urban household registration status, but not fit for the large amount of floating population in urban today. The existing health policy and health care service is no exemption. The public services related to health such as housing, transportation, medical and public health, disease control and prevention, and family planning are too weak to meet the need of floating population in urban.

Some governmental or nongovernmental activities have been carried out in factories to improve migrant's health status, such as improve working condition, eliminate hazardous materials, providing health and family planning service to women workers by local health professionals, providing maternal health care by service vans, and providing health promotion and education service in workplace. However, there are still obvious limitations of these activities. Firstly, the activity is often carried out by a single department of sector, there is a lack of integrated services with health, family planning, and social work combined effort, since a large part of health issues in floating population is actually social issue or gender issue, and they can hardly solved by one or two approaches or services. For example, the STI/HIV prevention is often a combined issue with gender and social problems, but some strategy and implementation have a disadvantage in consider gender issues, and also fail to consider the marginal status of the target group. Secondly, most activities are limited in service providing and education, but have not paid adequate attention to build up self-awareness and self-protection skill. Thirdly, most activities implemented are project based rather than regular and institutionalized, therefore the expandability and sustainability is of a big question. In consider the above limitations, the health issues of migrants are far from effectively solved.

Since the selectivity of migration, the migrants overall are relatively younger and healthier people. However, they are more vulnerable to specific health risks in certain context if they belong to some sub-groups. More specific and comprehensive researches are still needed to provide hard evidence to policy making and intervention.

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