Health-Seeking Behavior of Rural-to-urban Migrant Women regarding Sexual Health in Pearl River Delta, China: Linkages between Individual Behavior, Formal and Informal Institutions and Policy Change

Dissertation

Zur Erlangung eines
Doktors der Politikwissenschaft (Dr. rer. pol)

Vorgelegt
am Fachbereich Politik und Sozialwissenschaften
der Freien Universität Berlin

vorgelegt von
Yuan Yuan-Ihle

Berlin 2017

Erstgutachterin: Prof. Dr. Bettina Gransow

Zweitgutachterin: Prof. Dr. Catherine Ruth Levy

Tag der Disputation: 17. Juli 2017

Abstract

The present thesis addresses the health-seeking behaviors of rural-to-urban migrant women in Guangzhou City and Shenzhen City in Pearl River Delta, China, with regard to their sexual health, as well as the governmental policies related to migrants' sexual health. This study applies a qualitative research method using primary data gathered through 54 semi-structured interviews with migrant women and 14 expert/stakeholder interviews. Drawing on approaches from new institutionalism, the analysis focuses on the linkage between individual behaviors and formal and informal institutions. Regarding the connection between individual and institution the existing theoretical approaches concentrate on political and economic elites. This thesis seeks to expand these approaches to individuals who are not in a position of power. Moreover, this thesis seeks to expand the spectrum of informal institutions in new institutionalism. Unlike previous analysis focusing on informal institutions in association with individuals in power, such as clientelism and factionalism, this thesis identifies and analyzes informal institutions embedded in the society and comprised of individuals outside the power structure ("non-dominant individuals"), such as tradition and ideas.

Four main research questions are addressed in this thesis:

1) Which formal and informal institutions influence non-dominant individuals' behaviors and how do they do so?
2) How do informal institutions, through their impact on non-dominant individuals, further influence the effectiveness of formal institutions?
3) How does a formal institution change?
4) How does an informal institution change and how does the change of an informal institution influence the change of a formal institution?

Regarding the first question, this study shows that health-seeking behaviors evolve from individuals' rational calculated decision-making and the composite results of self-evaluation and reaction to the institutional context in which they live. Not only formal institutions, but also informal institutions may influence rural-to-urban migrant women's health-seeking behaviors. Patriarchal tradition, gender inequality, discrimination and prejudices against sex work and the tradition of postpartum care - practicing *doing the month* are identified as the informal institutions that affect migrant women's health-seeking behaviors. Social networking is not regarded as an informal institution according to the definition of informal institution used in this thesis. Instead, it is an informal

organization that plays a significant role in migrant women's approaches to health-related information. With regard to the second research question I draw on the analytical framework developed by Gretchen Helmke and Steven Levitsky to classify the identified informal institutions/organizations into accommodating, competing and substitutive institutions, and discuss their influence on policy effectiveness and policy change. Regarding the third research question on policy change I draw on the theory of incremental policy change developed initially by Kathleen Thelen and Wolfgang Streeck and analyze the policies related to migrant women's health-seeking behaviors. The analysis reveals that policy change is always path-dependent and incremental, and a policy change depends on how political decision-makers face externally-changing environments and act. Further, I develop the five patterns of institutional change identified by Thelen and Streeck, arguing that the process of policy change may be unidirectional or bidirectional. With regard to the last research question this study shows that informal institutions, as "codes of behaviors" embedded in the culture, are persistent. The change of informal institutions is incremental and only when the majority of community members accepts the new "codes of behaviors" can a change take place in the informal institution. Due to the dominant role of political elites in China's political power structure, only when the political elites also embrace the new "codes of behaviors" can the change of an informal institution further influence the political decision-making processes that may in turn lead to policy changes.

Zusammenfassung

Die vorliegende Arbeit befasst sich mit dem gesundheitsbezogenen Verhalten der Land-Stadt-Migrantinnen in Guangzhou und Shenzhen im Pearl Fluss Delta, China im Hinblick auf ihre sexuelle Gesundheit sowie der relevanten öffentlichen Politik. Diese Studie wendet eine qualitative Forschungsmethode an und benutzt die primären Daten, die mit 54 semi-structured Interviews mit Migrantenfrauen und 14 Experten/Stakeholder-Interviews erhoben wurden. Auf der Grundlage von Ansätzen des neuen Institutionalismus fokusiert die Analyse auf die Verknüpfung von individuellen Verhalten und formalen und informellen Institutionen. In Bezug auf den Zusammenhang zwischen Individuum und Institution konzentrieren sich die bestehenden theoretischen Ansätze auf politische und wirtschaftliche Eliten. Diese Arbeit versucht, diese Ansätze auf Individuen zu erweitern, die nicht an der Macht stehen. Darüber hinaus baut diese Arbeit das Spektrum zu informellen Institutionen im neuen Institutionalismus aus. Im Gegensatz zu früheren Analysen, die sich auf informelle Institutionen in Verbindung mit Individuen an der Macht, z.B. Klientelismus und Fraktionalismus, konzentrieren, identifiziert und analysiert diese Arbeit informelle Institutionen, die in die Gesellschaft eingebettet sind und aus Individuen außerhalb der Machtstruktur ("nicht-dominante Individuen") bestehen, z.B. Traditionen und Ideen.

Diese Arbeit widmet sich der Antworten der vier Hauptforschungsfragen:
1) Welche formale und informelle Institutionen beeinflussen das individuelle Verhalten nicht-dominanter Individuen und wie geschieht dies?
2) Wie beeinflussen informelle Institutionen durch ihre Wirkungen auf das Verhalten nicht-dominanter Individuen die Wirksamkeit formaler Institutionen?
3) Wie kommt ein Wandel einer formalen Institution zustande?
4) Wie kommt ein Wandel einer informalen Institution zustande und wie kann der Wandel einer informelle Institution Wandel einer formalen Institution beeinflussen?

In Bezug auf die erste Frage zeigt diese Studie, dass das gesundheitsbezogene Verhalten sich von den rationelle kalkulierte Entscheidungen der Individuen und das Ergebnissen ihrer Selbstevaluation und Reaktion auf den institutionellen Kontext, in dem sie leben, entwickelt. Nicht nur formale Institutionen, sondern auch informelle Institutionen können das gesundheitsbezogene Verhalten der Land-Stadt Migrantinnen beeinflussen. Patriarchalische Tradition, Geschlechterungleichheit, Diskriminierung und Vorurteile gegen Sexarbeit und die Tradition der postpartalen Versorgung – „die Praktizierung des

Monats“ (*doing the month*) werden als informelle Institutionen, die das gesundheitsbezogene Verhalten der Migrantinnen beeinflussen, identifiziert. Ein soziales Netzwerk gilt nicht als eine informelle Institution nach der Definition der informellen Institution, die in dieser Arbeit verwendet wird. Stattdessen ist es eine informelle Organisation, die eine wichtige Rolle bei Suchen nach gesundheitsbezogene Informationen der Migrantinnen spielt. Im Hinblick auf die zweite Forschungsfrage greife ich auf das von Gretchen Helmke und Steven Levitsky entwickelte analytische Rahmenwerk zurück, um die identifizierten informellen Institutionen/Organisationen in akkommodierende, konkurrierende, und substituierende Institutionen zu klassifizieren und ihren Einfluss auf die Politikwirksamkeit und den Politikwandel zu diskutieren. Um die dritte Forschungsfrage zu beantworten knüpfe ich an die Theorie des inkrementellem Politikwandels an, die ursprünglich von Kathleen Thelen und Wolfgang Streeck entwickelt wurden, und analysiere die Politik im Zusammenhang mit dem gesundheitsbezogenen Verhalten der Migrantinnen. Die Analyse zeigt, dass ein Politikwandel immer pfadabhängig und inkrementell ist und ein Politikwandel davon abhängt, wie die politischen Entscheidungsträger mit von außen wechselnden Umgebungen konfrontiert werden und handeln. Weiterhin entwickle ich die fünf Muster des institutionellen Wandels, die von Thelen und Streeck identifiziert wurden und argumentiere, dass ein Prozess eines Politikwandels unidirektional oder bidirektional sein kann. Im Hinblick auf die letzte Forschungsfrage zeigt diese Studie, dass informelle Institutionen, die als "Verhaltenskodex" in einer Kultur eingebettet sind, persistent sind. Der Wandel einer informellen Institution ist inkrementell. Nur wenn die Mehrheit der Mitglieder einer Gemeinschaft die neuen "Verhaltensregeln" akzeptiert, kann eine Veränderung in einer informellen Institution stattfinden. Aufgrund der dominierenden Rolle der politischen Eliten in der politischen Machtstruktur Chinas, kann ein Wandel einer informellen Institution die politischen Entscheidungsprozesse beeinflussen, die zu einem Politikwandel führen, nur stattfinden wenn die politischen Eliten die neuen "Verhaltensregeln" auch umarmen.

TABLE OF CONTENTS

CHAPTER 1 1

INTRODUCTION: INSTITUTIONS AND INDIVIDUAL BEHAVIOR – TWO SIDES OF ONE COIN IN CHINA'S TRANSITIONAL ERA 1

1.1 Clarifying the core terms 14

1.2 Rural-to-urban migration against the backdrop of economic reform and urbanization and the influence of the *hukou* system..18

1.3 The influence of individuals on policy: different roles of dominant and non-dominant individuals in present China 21

1.4 Reviewing of previous research and concretizing of research objectives 25

CHAPTER 2 33

THEORETICAL FRAMEWORK: THE NEW INSTITUTIONALISM AS ANALYTICAL TOOL 33

2.1 Definition of institution: formal and informal institutions and their interaction regarding individual's behavior 34

2.2 The influence of institution on individual's behavior 36

2.3 The influences of informal institutions on policy effectiveness 37

2.4 Approaches to understanding policy change 40

2.4.1 Path dependence 41

2.4.2 Mechanisms of incremental institutional change 43

2.4.2.1 The "*conversion* > *layering*" pattern..44

2.4.2.2 The "*drift*>*exhaustion*>*displacement*" pattern..45

CHAPTER 3 47

RESEARCH METHOD, SOURCES OF RESEARCH MATERIALS AND METHOD OF ANALYSIS 47

3.1 Qualitative research method 47

3.2 Data gathering: semi-structured interviews and expert/stakeholder interviews 48

3.3 Method of analysis..53

CHAPTER 4 55

EMPIRICAL CONTEXT AND ANALYSIS: FINDINGS OF THE CASE STUDIES 55

4.1 Introduction of the two target groups: migrant women living in urban villages in Guangzhou and female sex workers in Shenzhen 55

4.2 Case study 1: Sexual health and *health-seeking behaviors* of migrant women living in urban villages...65
4.2.1 Identified health problems, health care needs and demands, and *health-seeking behaviors* 66
4.2.1.1 Sexual health problems: gynecological diseases, STDs, unexpected pregnancy and induced abortion..66
4.2.1.2 *Healthcare-seeking behaviors* in cases of contracting gynecological diseases, STDs and facing unexpected pregnancy 68
4.2.1.3 Needs of sexual health education 74
4.2.1.4 Demands of maternity care and *care-seeking behaviors* in case of giving birth 75
4.2.2 Formal institutional factors influencing migrant women's *health-seeking behaviors* 78
4.2.2.1 Community-based healthcare facilities and services..79
4.2.2.1.1 Large public hospitals 79
4.2.2.1.2 Community health care service centers and community health care service stations 82
4.2.2.1.3 Family Planning Service Stations 86
4.2.2.1.4 Private health facilities...87
4.2.2.1.5 Health facilities financed and run by public-private-partnership 91
4.2.2.2 Medical insurance and maternity insurance 91
4.2.2.3 Family planning policy and birth control targeting rural-to-urban migrants...............95
4.2.3 Informal institutional factors influencing migrant women's *health-seeking behaviors*....100
4.2.3.1 Persistence and change of son preference 101
4.2.3.2 Practices of "doing the month" 104
4.2.4 Conclusion...107

4.3 Case study 2: Sexual health and *health-seeking behaviors* of FSWs in Shenzhen....109
4.3.1 Identified problems and risks with regard to sexual health and *health-seeking behaviors* 109
4.3.1.1 Physical harm 109
4.3.1.2 Gynecological diseases, STDs and HIV/AIDS, unexpected pregnancy, and low condom usage..111
4.3.1.3 Mental health problems..113
4.3.1.4 Drug use 116
4.3.1.5 Approaches to sexual health knowledge and *healthcare-seeking* behaviors 117
4.3.1.6 Mobility of FSWs and their clients, and the risk of spreading STDs and HIV/AIDS 121
4.3.1.6.1 Mobility of FSWs...121
4.3.1.6.1.1 Geographical mobility between working places and hometowns 122
4.3.1.6.1.2 Geographical mobility between different working sites within sex industry 125
4.3.1.6.1.3 Social mobility: vertical vocational shifts within sex industry 127
4.3.1.6.2 Mobility of FSWs' clients 129
4.3.1.6.2.1 Mobility of clients from Hong Kong 129
4.3.1.6.2.2 Rural-to-urban male migrants as FSWs' clients..130
4.3.1.6.3 The risk of STDs/AIDS transmission related to mobility of FSWs and their clients...131
4.3.2 Formal institutional factors influencing FSWs' *health-seeking behaviors*.......................132
4.3.2.1 Policies of prostitution control 132
4.3.2.1.1 Transformation of policies of prostitution control since 1979 132
4.3.2.1.1.1 Provisions of prostitution control..132
4.3.2.1.1.2 Police-led "strike hard" campaigns and policy implementation at local level

....139
4.3.2.2 Policies towards NGO activities promoting STDs and HIV/AIDS prevention.........141
4.3.2.2.1 Transformation of NGO status in China 141
4.3.2.2.2 NGOs' activities regarding prevention of STDs and HIV/AIDS and the case of the "AIDS CARE" project in Shenzhen...144
4.3.2.3 Influences of governmental policies on FSWs' *health-seeking behaviors* 147
4.3.3 Informal institutional factors influencing FSWs' *health-seeking behaviors*....................150
4.3.3.1 Patriarchy, gender inequality, discrimination and prejudices 150
4.3.3.2 The system of *face*..152
4.3.3.3 FSWs' social network within sex industry 156
4.3.3.3.1 Trust for managers of prostitution sites..156
4.3.3.3.2 Relationships with other FSWs..158
4.3.3.3.3 Relationships with boyfriends..159
4.3.4 Conclusion...162

CHAPTER 5 164

ANALYSES AND ANSWERING THE RESEARCH QUESTIONS ON MIGRANT WOMEN'S *HEALTH-SEEKING BEHAVIORS* AND CHANGES OF FORMAL AND INFORMAL INSTITUTIONS.. 164

5.1 Understanding migrant women's health-seeking behaviors: rational calculated decision-making under restriction by formal and informal institutions 164
5.1.1 Care-seeking behaviors of those facing sex-related illnesses and abortion.....................165
5.1.2 Care-seeking behaviors regarding fertility and maternity care..168
5.1.3 Condom usage for contraception and prevention of STDs and HIV/AIDS.....................170

5.2 Understanding the impacts of informal institutions on effectiveness and change of policy 171

5.3 Understanding policy change: path dependent incremental change..........................177
5.3.1 The family planning and birth control policy: a case of "*conversion> layering*" or "*conversion> layering> replacing*"? 178
5.3.2 Prostitution control policies and the policy of NGO-regulation: combined "*conversion>layering*" cases 181
5.3.2.1 The change of the policies of prostitution control 181
5.3.2.2 Change in policies for prevention of STDs and HIV/AIDS, targeting the population in the sex industry, and the change of policy concerning NGO regulation in the face of preventing STDs and HIV/AIDS 185
5.3.3 The policy change of urban community-based health service provision: a "*drift>exhaustion>displacement*" case 186
5.3.4 Developing the theory of incremental policy change: the unidirectional and bidirectional pathways of incremental policy change...189

5.4 Understanding of incremental change of informal institutions and its impact on policy change...190

CHAPTER 6 194

SUMMARY AND RESEARCH LIMITATIONS 194

REFERENCES... 197

APPENDIX I. INTERVIEW LIST 230

APPENDIX II. GUIDELINE FOR SEMI-STRUCTURED INTERVIEWS WITH MIGRANTS IN URBAN VILLAGES 236

APPENDIX III. GUIDELINE FOR SEMI-STRUCTURED INTERVIEWS WITH FEMALE SEX WORKERS.. 241

APPENDIX IV. GUIDELINE FOR INTERVIEWS WITH LOCAL VILLAGERS AND/OR EMPLOYEES IN ADMINISTRATIVE DEPARTMENTS OF URBAN VILLAGES 243

APPENDIX V. GUIDELINE FOR INTERVIEWS WITH DOCTORS OF MEDICAL FACILITIES.. 246

APPENDIX VI. GUIDELINE FOR EXPERT INTERVIEW WITH EMPLOYEES OF “AIDS CARE” 250

APPENDIX VII. CODING TREE FOR EVALUATION OF THE INTERVIEWS WITH MIGRANTS LIVING IN URBAN VILLAGES IN GUANGZHOU 251

APPENDIX VIII. CODING TREE FOR EVALUATION OF THE INTERVIEWS WITH FEMALE SEX WORKERS IN SHENZHEN... 253

LIST OF ILLUSTRATIONS

MAPS

Map 1: Location of the Pearl River Delta....................10
Map 2: Cities in the Pearl River Delta....................10

TABLES

Table 1: Possible impacts of informal institution on formal institution....................37
Table 2: Categories of FSWs in present-day China....................64
Table 3: Current provisions regarding penalties and measures to individuals and organizations involving in prostitution....................137
Table 4: Impacts of informal institutions/organizations on policy effectiveness and change 172

PHOTOS

Photo 1: Multi-story buildings with rent apartments in Xian Village....................56
Photo 2: A migrant woman in front of a bulletin board advertising rental information in Tangxia Village....................56
Photo 3: FSWs in front of a KTV in SW District, Shenzhen 65
Photo 4: A private clinic in Shipai Villages....................89
Photo 5: A vehicle that provides pick-up service for patients in Tangxia Village 91
Photo 6: Regulation on reporting cases of violating the family planning policy in Kengkou Village....................98
Photo 7: "Shame parade" of offenders involved in prostitution in FT District, Shenzhen in December 2006....................140
Photo 8: An alleged FSW was identifying the crime scene in Dongguan in July 2010 ..140

ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
CCP	Chinese Communist Party
CHCSC	Community Health Care Service Center
CHCSS	Community Health Care Service Station
FPRS	Family Production Responsibility System
FPSS	Family Planning Service Station
FSW	Female sex worker
GDP	Gross domestic product
HIV	Human immunodeficiency virus
MOCA	Ministry of Civil Affairs
NGO	Non-governmental organisation
NPO	Non-profit organization
PRC	People's Republic of China
PRD	Pearl River Delta
RCMS	Rural cooperative medical system
RTI	Reproductive tract infection
SARS	Severe Acute Respiratory Syndrome
SMF	Social Maintenance Fees
STD	Sexually transmitted diseases
SZIPFP	Shenzhen Institute of Population and Family Plan
NCMI	New rural cooperative medical insurance
UEMI	Urban employees' medical insurance
URMI	Urban resident's medical insurance
UV	Urban village
WHO	World Health Organisation

CHAPTER 1

Introduction: institutions and individual behavior – two sides of one coin in China's transitional era

The research focus of this thesis is the People's Republic of China (PRC) in the latest transitional era, namely the period from the beginning of economic reforms and implementation of "open door" policies in the late 1970s to the present. Owing to economic reforms and policies of increased openness, China has witnessed a remarkable economic growth and fundamental social and political change. This large-scale transformation has attracted increasing scholarly interest. In political science, a particular research focus has been on the role of institutions, addressing the question of how institutions shape China in this burgeoning period.

The approaches of new institutionalism are increasingly employed in political science to explain transitional social and political contexts. The new institutionalism has made two notable contributions to political analysis: 1) the attempt to link the individual/actors'[1] behavior/action[2] and institutions and to understand their mutual and reciprocal interaction, and 2) the introduction of the concepts of formal and informal institutions into institutional analysis. New institutionalism argues that institutions matter because they shape the behaviors of individuals. Concurrently, individuals' behaviors may influence the development of institutions. New institutionalism understands institutions as "… the formal or informal procedures, routines, norms and conventions embedded in the organizational structure of the polity or political economy" (Hall and Taylor

[1] In the present thesis, I use the term *individual* as the overarching working term because my research focuses on rural-to-urban migrant individuals. In China's authoritarian political regime they are de facto outside the power structure and should not be defined as active "actors" according to the definition in previous political research based on democratic contexts (also see Subchapter 1.3). I understand *individuals* as those who have exogenously determined preferences and are able to make decisions in a strategic way. In some parts of this thesis *individual* and *actor* are used interchangeably or are referred to as individual(s)/actor(s), especially where quotations are used.

[2] *Behavior* is used as the overarching working term in this thesis. However, I do not interpret *behavior* as individuals' unconscious acts. Instead, I understand *behavior* as an individual's conscious purpose-oriented decision(s). The term *health-seeking behavior* is explained in detail in Subchapter 1.1.

1996:938). *Formal institutions* refer to the formal rules, regulations, guidelines, and laws of political and economic systems, whereas *informal institutions* refer to the norms, conventions, values, and beliefs that guide individuals' choices in an institutional setting. The core of new institutionalist analysis, as stated above, is that institutions (both formal and informal) are important insofar as they affect the behaviors of individuals within the institutional framework (Young 2011:131).

One approach in this regard that must be specifically noted here is the "actor-centered institutionalism" developed by Mayntz and Scharpf (1995), as it bridges both the system and individual/actor spectrums, often studied separately in previous research. For example, a new institutionalist approach was used by Solinger (1999) to examine change in three institutions in China: the *hukou*[3] system, the urban bureaucracies and the system of planning and rationing; the study showed how the population from rural areas was originally kept out of the cities and how they later survived in the urban areas. Young's study (2011) also focuses on the change in the *hukou* system. This study regards the *hukou* system as a formal institution and attempts to determine how rural residents conduct informal practices to adopt the institutional setting because of the modification of the *hukou* system. A case study by Feng (2011) conducted in Jiahe County in Hunan Province identifies the interactions among three groups of actors: government officials, urban developers and evicted residents, showing the impact of these interactions on the implementation of the policy of urban housing demolition and relocation. Focusing on the interaction between governmental officials and enterprises, Han's (2003) and Zhang's (2003) studies exam the local-level transformation of China's stock system and food provision system, respectively.

With regard to the role of informal institutions and the impacts of individuals' behaviors on formal institutions, researchers of China's politics have often put their focus on the interaction of political individuals/actors and their personal networks. For example, the study by Heilmann (2000) comparing the economic reforms in China and Russia reveals that the personal network established based on clientelism has led to rent-seeking actions, corruption of politicians and informal processes of economic reform. Dittmer and Wu's study (1995) focuses on the impact of factionalism in the Chinese Communist Party (CCP) and shows how the personal network between the party cadres based on kinship relations, school connections, and co-worker relationships impacts the

[3] The *hukou* system and its influence on China's rural-to-urban migration are elaborated in Subchapter 1.2.

power constellation within the CCP.

Research gaps can be found within these previous studies. With regard to the role of informal institutions linking individuals' behaviors, the majority of previous studies focuses on "insiders"/"herrschende Eliten" (dominant elites) (Köllner 2012:7), specifically political elites (e.g. officials in Han's (2003) and Zhang's (2003) studies, party members in Heilmann (2000) and Dittmer and Wu's studies (1995) and enterprises in Feng's study (2011)). However, individuals being involved and acting in an institutional setting are not limited to dominant elites. Non-dominant individuals, such as normal citizens, should also be taken into account in institutional analysis, particularly when it comes to the issue of effectiveness. Institutional effectiveness is at the heart of institutionalist theories. What institutionalists interest is the level of engagement of individuals in a society with economic activities. Therefore, institutional effectiveness is the quality of economic and social organizations that makes individuals or groups of individuals willing to participate in economic activities (Huang 2011:5). With regard to this point, North and Thomas note that an effective institutional arrangement is to "create an incentive to channel individual economic effort into activities" (1973:1).

In China, due to the autocratic regime, non-dominant individuals can hardly act directly on the transformation of formal institutions. However, non-dominant individuals participate in socio-economic activities and are the targets of institutional arrangements. How non-dominant individuals act/behave is related to institutional effectiveness and should not be ignored in an institutional analysis. Some previous studies, such as Solingen's (1999) and Young's (2011) studies on the *hukou* system and Feng's (2011) study on the policy of housing demolition and relocation delve into the behaviors of non-dominant individuals, i.e. rural residents (in Solingen's and Young's studies) and urban evicted residents (in Feng's study). However, these studies lack a clear identification of informal institutions that influence individuals' behaviors. For example, Young's study (2011) investigates how rural residents deal with the changing *hukou* system. The author summarizes these rural residents' strategies as "informal practices" without addressing the question of what informal institutions actually influence the residents' decision-making in choosing and implementing these strategies.

Moreover, I argue that the spectrum of informal institutions should be expanded. Informal institutions that were identified in previous political science research are limited to clientelism and factionalism that causes clientelistic,

patronage-related, factional relationships and the behavioral structures of political and economic elites (e.g. Dittmer and Wu 1995, Heilmann 2000, Isaacs 2011). Are there other informal institutions involved in the transitional social and political setting? In particular, with regard to non-dominant individuals and their behaviors as relates to institutional effectiveness, as argued above, the question should be answered: ***Which formal and informal institutions influence non-dominant individuals' behaviors and how do they do so?***

Whereas there is a large number of studies using institutionalist theories to analyze international and regional cases, the development of theories addressing why and how institutions change has lagged behind. Addressing the reason for institutional change, the dominant theories developed in previous studies include the assumption that institutions are path-dependent and remain stable, or in a state of "equilibrium" (Pierson 2000:252). Only when a "punctuated equilibrium" occurs does a change of the old institutions take place. The concept of *punctuated equilibrium* is well developed in the work by Baumgartner and Jones (1991, 1993, 2009), for example. Instead of regarding institutional change as an incremental process, punctuated equilibrium focuses on the impact of sudden events on institutions. More precisely, the punctuated equilibrium model argues that although most institutions remain relatively stable for a long period, the stability can be broken by a sudden exogenous event that leads to major institutional change. Such sudden events, which may include a war or a social or financial crisis for instance, have been called by other scholars a *critical juncture* (Gorges 2001, Capoccia and Kelemen 2007) or *conjuncture* (Wilsford 1994). According to Capoccia and Kelemen (2007:348), *critical junctures* are "relatively short periods of time during which there is a substantially heightened probability that actors' choices will affect the outcome of interest." Gorges (2001:138) notes that *critical junctures* "are usually crises for an existing institution and they present leaders with an opportunity to enact new plans and realize new ideas by embedding them in the institutions they establish." In sum, critical junctures provide the opportunities for actors/individuals to make the decision to change, because during that brief period of time, actors/individuals face a broader range of feasible options, so the option of choice will likely have a significant impact on subsequent outcomes.

Although the concept of the critical juncture is widely applied in the explanation of institutional change, there are also some studies concluding that sudden exogenous shock does not necessarily result in institutional change (Pierson

2004). I also argue that sudden external events have little relevance to the change of institutional setting in China in the transitional period because since the late 1970s China has witnessed neither a war, nor radical social or political unrest. The tentative political reform movement from 1987 to 1989 could be regarded as an unexpected blow to China's political establishment. However, the stake-out situation dimmed soon after the CCP, led by Deng Xiaoping, suppressed the pro-reform student movement. No punctuated equilibrium/critical juncture causing institutional change in China's transitional period occurred.

The other well-developed theoretical approach to explain institutional change is the five mechanisms of incremental institutions initiated by historical institutionalists Wolfgang Streeck and Kathleen Thelen (2005) and improved upon by later researchers (e.g. Hacker 2004, Boas 2007, Thatcher and Coen 2008):. These five mechanisms are *displacement, layering, drift, conversion, and exhaustion*. These researchers use path dependence to analyze incremental institutional change, while holding a somewhat flexible attitude about the line between institutional stability and institutional change. In this sense, the mechanisms of incremental institutional change are complementary approaches to path dependence, allowing a more precise explanation of path-dependent institutional change by providing different narratives and typologies.

The five mechanisms of incremental institutional change have been applied by researchers for case studies and comparative studies of institutional changes. These studies include, for example, Weishaupt's research (2008) on the labor market in integrating Europe, Thatcher's study (2007) on market internationalization and national economic institutions, comparing policy change in Germany, the Great Britain, Italy and France (2007), Heemskert's research (2007) on the decline of the corporate community in the Netherlands with regard to the role of the network of the business elites, and Stiller's study (2010) on welfare state reform in Germany, revealing how politicians and policy ideas transformed the old welfare system. In all these previous studies, the patterns of incremental institutional changes were applied to analyze the social and political settings in Western, particularly European, countries with well-developed democratic and stable political systems. The following questions can be raised in this context: ***Are these five mechanisms also suitable for explaining institutional change in the rest of the world, such as in transformation-period China? Can this theoretical framework be further developed?*** Moreover, previous studies have focused on the

question of how informal institutions impact the change of formal institutions, whereas few of them address the dynamic of change within informal institutions. To fill this research gap I also raise the following questions: ***How does an informal institution change, and how does the change of an informal institution influence the change of a formal institution?***

To answer these research questions I decided to conduct an empirical study focusing on the health-seeking behaviors of rural-to-urban migrant women in the southern Chinese cities of Guangzhou and Shenzhen in the Pearl River Delta (PRD). Along with the remarkable economic growth and rapid urbanization, the large-scale "migrant tide" (*mingong chao,* 民工潮) is a consequence of the economic reforms and open door policies, embodied by the enormous number of rural laborers that have poured into cities to seek jobs (Zhou 1995, Luan 2004, Wei 2015). Since the first rural-to-urban migration began in the mid-1980s, the Chinese government's attitude towards migration has been "double-edged" (Gransow and Zhou 2010:1). The government has tried to sustain migrants' contribution to the country's economic growth. Simultaneously, migrants' access to urban facilities and welfare are deliberately restricted through a series of polices rooted in the *hukou* system. Facing the contradictory results of these double-edged policies, since 2006 China's government has begun to rethink its attitude towards migrants and to institute policy changes aimed at the integration of rural-to-urban migrants in the cities (Gransow and Zhou 2010:1).

As discussed above, non-dominant individuals' behaviors should not be neglected in an institutional analysis. Rural-to-urban migrants are among the non-dominant individuals in China's political arena and they are the targets significantly influenced by governmental policies. This thesis uses a new institutionalist definition of formal institutions and considers governmental policies as formal institutions. Hence, focusing on the behaviors of rural-to-urban migrants allows me to gain deeper insight into the impacts of governmental policies on individuals. Through examining how migrants behave in the institutional setting constructed through implementation of governmental policies, I am able to compare the aims and results of policies and examine the effectiveness of policy implementation. Moreover, the rural-to-urban migrant population links China's rural inland where they originate and the cities as their migration destination. Migrants are rural residents, as they hold a rural *hukou*, while they are also de facto urban residents because they work and live in cities and conduct most of their activities there.

Because of these two characteristics, rural-to-urban migrants are uniquely suited for a study of institutional analysis. Focusing on rural-to-urban migrants opens up an opportunity to identify informal institutions embedded in China's rural society, and also to look at how these informal institutions evolve as they 'migrate' from rural to urban areas with their carriers-migrants and how do they influence the effectiveness of policy implementation manifested by their impact on migrants' behaviors.

The focus of the present thesis is migrant women's behaviors regarding their sexual health. Discussions of governmental policies also concentrate on policies related to migrants' sexual health. The reason for choosing this research focus is that due to the phenomenon of migration in China, research on migrant-related concerns, including health issues, is increasing. However, research on migrant health issues is dominated by epidemiological studies aimed at identifying concrete health risks (e.g. diseases) that migrants face, and among these, studies on migrants' sexual health are rare. There is abundant research addressing policies related to migration in China. However, the majority of these studies focuses on policies regulating migration, and few of them address concrete, migrant-related issues such as wages, working conditions, education and housing. Studies on policies related to migrants' sexual health are extremely rare. Moreover, health, especially sexual health, is a very private and even embarrassing issue compared to other topics. Therefore, an empirical study on sexual health is often a challenge for researchers. I argue, however, that exactly because of its nature of high privacy sexual health is a good intersection for researchers to look at the informal factors which impact individuals' decision-making. Because sexual health is often related to intersexual relations, it also helps the researchers avoid or at least minimize the bias of focusing only on one sex among the target population, and it provides the opportunity for deeper insight into the issue of gender equality.

The gender issue is also an explanation of my decision to separate migrant women from the general rural-to-urban migrant population and focus on migrant women's sexual-health-related behaviors. It must also be pointed out that the lack of studies on migrant women is incongruous with the reality that women have become a significant component of the migrant population (Lin 2013:30). In labor-intensive industries and the service sector (e.g. hotels and restaurants), the number of female migrant employees has even exceeded that of male employees (cf. Pun 2005, Zhu, Batisse et al. 2009). With regard to sexual health, migrant women face

the risk of gynecological diseases and they are as vulnerable to sexual-transmitted diseases (STDs) as men. Migrant women are also in need of maternity care and face physical and physiological burdens in the event of unexpected pregnancy, which men do not encounter in the same way. Thus, I argue that in order to a gain insight into the issue of migrants' sexual health as comprehensively as possible, it is necessary to focus the research on migrant women. The present thesis analyzes how and why migrant women conduct certain behaviors when they face or perceive risks of diseases related to sexual health, when they are in need of childbirth-related care, and when they face unexpected pregnancy. To maintain descriptive coherence I use *health-seeking behaviors* as the overarching the term to represent these behaviors. More precise explanations of what falls under this term are provided in a separate chapter.

In order to unite the interfaces of individual behavior and formal and informal institutions regarding policy effectiveness and institutional change I draw on the theories of new institutionalism, which, as discussed above, attempt to understand the mutual and reciprocal interactions between individual behaviors and institutions, providing a confluence of the two without placing excessive strain on either of them. To understand migrant women's health-seeking behaviors, I combine the approaches of rational-choice institutionalism and sociological institutionalism, and assume that individuals have exogenously determined preferences and goals, whereas their behaviors are influenced by both formal and informal institutions. These institutions are identified in present thesis. I regard governmental policies and the institutional setting based on policy implementation as formal institutions, and traditions, customs and ideas as informal institutions. I then draw on the framework developed by Helmke and Levitsky (2004) to analyze the impacts of informal institutions on policy effectiveness. In order to understand policy changes, I first draw upon the approaches developed by historical institutionalists, especially Pierson (2000), to shed light on the characteristics of *path dependence* in policy change. Then, I make use of the mechanisms of incremental institutional change introduced by Thelen and her co-authors (Thelen and Steinmo 1992, Thelen 2003). By combining the single mechanisms, I develop new ways to examine policy change that can be applied for further policy analysis. Finally, I provide my own interpretation regarding how informal institutions change and how the change of informal institutions influences policy change.

The empirical research for this thesis was conducted in Guangzhou from

November 2007 to January 2008 and December 2008 and in Shenzhen from September to October 2009. Guangzhou and Shenzhen are two megacities in the PRD in Guangdong Province. I follow Zhou by using a narrow geographical definition of PRD.[4] PRD is located on the southeastern coast of China in the low-lying alluvial plain surrounding the Pearl River estuary, which in administrative terms belongs to Guangdong Province and contains the cities of Guangzhou, Foshan, Zhongshan, Dongguan, Shenzhen, Zhuhai, Jiangmen and Huizhou, as well as the counties Panyu, Nanhai, Shunde, Doumen, Shanshui, Gaoming, Kaiping, Xinhui, Taishan, Enping, Baoan, Zengcheng, Hushan, Huaxian, with a total area of 25,300 km^2 (Zhou 2005:40) (cf. Map 1 and Map 2, page. 10).

As the first zone where China's economic reform was launched, PRD is one of the most economically dynamic regions in China. By the year 2012, although PRD had only 4.2% of China's total population, it provided 9.3% of China's gross domestic product and 26.7% of export value (Statistics Bureau of Guangdong Province and Survey Office of the National Bureau of Statistics in Guangdong 2013:589-591). Owing to the large amount of foreign capital invested in PRD, which represented 19% of China's total amount of foreign investments by the year 2012, and the booming domestic private enterprises since the end of the 1990s, PRD has become one of the most important manufacturing bases in the world, and provides substantial work opportunities for rural-to-urban laborers in labor-intensive industries and, as a later consequence, the service sector. As governmental statistics show, by the year 2012 PRD had absorbed 19.8 percent of China's total internal migrant population (National Bureau of Statistics of China 2013).

Guangzhou and Shenzhen are the two main megacities in PRD and have enormous rural-to-urban migrant populations. Also known to many English speakers as Canton, Guangzhou is the capital of Guangdong province and has the fastest development rate of gross domestic product (GDP) and the largest population in the PRD. According to Guangzhou's municipal government, the city had a population of around 16.7 million by the year 2013, half of which was comprised by the rural-to-urban population. The total number of migrants was even slightly higher than that of permanent residents (by about 50,000) (Guangzhou Daily 2014).

Shenzhen was China's the first special economic zone, developed in 1980,

[4] According to a wider definition, PRD refers to Guangdong Province plus Hong Kong and Macao special administration zone. The corresponding term to this definition is Pan-PRD.

and is located at the border with Hong Kong. As a special economic zone, Shenzhen has benefited from preferential policies. By adjoining Hong Kong, it enjoys the beneficial effects of Hong Kong's economic growth, especially in the export-oriented manufacturing sector. By the year 2012, Shenzhen had contributed the most exports in the PRD, a total of 271.4 billion US dollars (Statistics Bureau of Guangdong Province and Survey Office of the National Bureau of Statistics in Guangdong 2013:596). Shenzhen city is a region of only 1953 km^2, but it witnessed the most rapid urbanization and population expansion in China. Due to the rapid urbanization and industrialization, Shenzhen has become the largest city in China in terms of migration, containing a migrant population of 15.3 million by the end of 2012, which was five times greater than the population of permanent residents (Qu 2013).

Map 1: Location of the Pearl River Delta (source: Hong Kong Trade Development Council 2005)

Map 2: Cities in the Pearl River Delta (source: Hong Kong Environmental Protection Department 2015)

In Guangzhou, the research focus was migrant women living in urban villages, a new type of migrant settlement that has emerged due to urbanization in China's big cities (cf. Subchapter 4.1). In Shenzhen, the target group of the empirical study was female sex workers (FSWs) with a migration background, who work in brothels, barbershops or other recreational sites. The reason for choosing these two groups is linked with the previous research project entitled "Informal Migrant Communities and Health Strategies in Urban Villages of Pearl River Delta, China" (Phase 1) and its follow-up project "Internal and International Migrant Communities in the Pearl River Delta, China - Linking Informal Migration Dynamics, Global Change and Urban Health" (Phase 2) (PRD 3).[5] I took part in the PRD 3 project as a research assistant and the project also initiated my research interests in the present thesis.

The PRD 3 was a sub-project of Priority Program 1233 of the German Research Foundation, entitled "Megacities-Megachallenge: Informal Dynamics of Global Change."[6] The research purpose of PRD 3 in Phase 1 was to provide general insight into various issues related to migrants' health (e.g. health problems that migrants face and their coping strategies). For this purpose, urban villages were chosen for conducting the field work. Urban villages are favorable residential locations for rural-to-urban migrants, and migrants from different regions of origin and from different professions can easily be approached there. Health risks, including those caused by the environmental situation in urban villages were also addressed in Phase 1. Migrant residents (males and females) living in urban villages in Guangzhou were interviewed during Phase 1. The findings in Phase 1 revealed significant differences between migrant men and women regarding their sexual health problems and behaviors that they engage in to cope with these problems. Phase 2 focused on special high-risk migrant populations. Along with migrant factory workers who face the risk of working accidents and work-related diseases, FSWs with a migration background were identified as the other high-risk group because of sexual health risks, especially STDs, due to their high level of

[5] The research team of the sub-project PRD 3 was built by researchers from the Free University of Berlin and the University of Cologne, guided by Prof. Dr. Bettina Gransow, who is also the first supervisor of this thesis, and Prof. Dr. Frauke Kraas. One of other PhD theses, also based on the PRD 3, was written by Tabea Bork-Hüffer in the discipline of geography. The emphases in that thesis were on the impact of structural factors on health-seeking actions of migrants, as well as the interaction and power relationships between different types of corporate and primary agents that influence the health care system in China. (cf. the publication based on Mrs. Bork-Hüffer's thesis (2012))

[6] The Priority Program 1233 was an interdisciplinary project based on comparative studies in two areas encompassing megacities - PRD in China and Dhaka in Bangladesh. The project was intended to gain a deepened understanding of the connection between the megaurban processes and the mutual forms and effects of global change, as well as the reorganization of spatial, social and institutional relationships in the megacities.

mobility and their role as a bridge population for the spread of STDs. Hence, FSWs in Shenzhen were chosen as one of the research emphases in Phase 2. For the purpose of this thesis I used the data gathered through interviews with migrant women living in urban villages in Guangzhou during Phase 1 and with FSWs in Shenzhen in Phase 2.

In sum, the main research aim of the present thesis is to understand the mutual influence of non-dominant individuals' behaviors, the effectiveness of policies (formal institutions) and change of formal and informal institutions in China's transitional political and social context. The guiding questions and sub-questions are as follows:

➢ Guiding research questions:

1) Which formal and informal institutions influence non-dominant individuals' behaviors and how do they do so?

2) How do informal institutions, through their impact on non-dominant individuals, further influence the effectiveness of formal institutions?

3) How does a formal institution change?

4) How does an informal institution change and how does the change of an informal institution influence the change of a formal institution?

➢ The following research sub-questions are used to approach the main research questions with regard to migrant women's health-seeking behaviors based on the case studies in Guangzhou and Shenzhen:

1) Which health-seeking behaviors do migrant women engage in when they face health problems or when they are in need of care with regard to their sexual health?

2) Which governmental policies influence migrant women's health-seeking behaviors and how?

3) Which informal institutions embedded in Chinese society, such as traditions, customs and ideas, influence migrant women's health-seeking behaviors and further influence the implementation of governmental policies regarding migrants' sexual health, and how do they do so?

4) How do governmental policies regarding migrants' sexual health change?

5) How do informal institutions concerning migrant women's sexual health change and how do changes in traditions, customs and ideas impact the change of governmental policies?

With regard to the structure of this thesis, Subchapter 1.1 is devoted to clarification of the core terms. Among these are terms related to *health-seeking behaviors*, including *health*, *sex*, *sexuality* and *policy*. In this subchapter I also explain why I use *sexual health* instead of *reproductive health* and define the term *health-seeking behavior*. Subchapter 1.2 describes the connection between rural-to-urban migration and the *hukou* system. The *hukou* system is one of the most crucial components of the institutional setting in China and should not be ignored by any socio-political study of modern China. Subchapter 1.3 gives a brief introduction to the political power constellation as concerns the roles played by various individuals in political decision-making. My goal in doing so is to provide a brief overview of the autocratic nature of China's political setting, which, in my opinion, is important for understanding the unequal roles of dominant and non-dominant individuals in China with regard to political decision-making. Subchapter 1.4 provides a brief review of the previous literature on migrant women's sexual health and health-seeking behaviors and policy change related to migrants' sexual health. After reviewing the previous literature and identifying its limitations, gaps and obstacles, I concretize my own research objectives based on the research questions listed above. Chapter 2 encompasses the approaches of new institutionalism that I draw on as analytical tools. Chapter 3 introduces the methodology applied, including why a qualitative research method was selected (3.1), and how research data were collected (3.2) and analyzed (3.3). Chapter 4 presents the findings of the empirical research, providing further discussion regarding migrant women living in urban villages in Guangzhou and FSWs in Shenzhen. The original research questions are answered in Chapter 5, drawing on new institutionalist approaches. A final summary of the overall thesis and the research limitations are presented in Chapter 6.

1.1 Clarifying the core terms

Health

The term *health* is defined by the World Health Organization (WHO) as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity”. (World Health Organisation (a)) In the Chinese language, *health* (*jiankang* 健康) is defined more narrowly as “the normal functioning of all the physical mechanisms of the person, without any disease or deficiency,” while the wider definition of WHO tends to be used more frequently in China. (Jeffreys and Huang 2009:154)

Sex and sexuality

The term *sex* (*xing* 性) has two common definitions. First, it refers to the biological characteristics that tend to define humans as female or male, but not in a mutually exclusive way, as there are individuals who possess both. Second, in many languages (as in the Chinese language), it is often used to mean “*sexual activity*” (*xingxingwei* 性行为). In the context of sexual health discussion, WHO prefers to use the former definition (World Health Organisation (b)). Another term that needs to be differentiated with *sex* is *sexuality*. WHO defines *sexuality* as “a central aspect of humanity and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction,” which is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles, and relationships. (Glasier, Gülmezoglu et al. 2006:1597) Compared with the term *sex, sexuality* deals with broader, more complex and multidisciplinary dimensions, as “it is affected by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious, and spiritual factors.” (Glasier, Gülmezoglu et al. 2006:1597)

Reproductive health and sexual health

The differentiation between *reproductive health* and *sexual health* is vague, and these two terms are often interchangeable. At the International Conference on Population and Development in Cairo in 1994, the term *reproductive health* (*shengzhi jiankang* 生殖健康) was defined as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all

matters relating to the reproductive system and to its functions and processes." *Reproductive health* therefore implies that "people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. … (R)eproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems." (Glasier, Gülmezoglu et al. 2006:1597) *Reproductive health* is a new phrase in the Chinese health lexicon and the WHO definition is so far adopted. (cf. Zhang 2011)

The term *sexual health* has overlapping meanings with *reproductive health*. Moreover, it is more often to be used when it comes to topics related to life and personal relations, as it "requires a positive and respectful approach to sexuality and sexual relationships, and the possibility of having pleasurable and safe sexual experiences that are free of coercion, discrimination, and violence." (Glasier, Gülmezoglu et al. 2006:1597) Also, s*exual health* is specifically used in the discussion of HIV/AIDS and STD prevention. (Glasier, Gülmezoglu et al. 2006:1595).

In this thesis I use *sexual health* instead of *reproductive health* as the overarching working term because the former holds wider conceptual meanings. More specifically, this thesis concerns rural-to-urban migrant women's sexual health in relation to the following factors: 1) Physiological well-being, which includes the needs/demands of sexual health-related services (e.g. medical counseling, access to health-related education and information) being met, as well as learning behaviors of dealing with and/or preventing disease related to sexual health and pregnancy/unexpected pregnancy and childbirth concerning antenatal, prenatal and postpartum care. 2) Psychological well-being, which refers particularly to migrant women's psychological burden as related to giving male offspring, postpartum depression, and FSWs' mental problems in association with unprotected sexual activities, worries about unexpected pregnancy, sterility, and STDs/HIV infections. Gender relationship is regarded as a crucial factor that

influences migrant women's sexual health, and gender discrimination and inequalities are revealed during the coming discussion on sex-selective abortion, bargaining of condom use between FSWs and their male sexual partners, and sexual violence that they face.

Health-seeking behavior

Another core working term that needs conceptualization in this thesis is *health-seeking behavior*. Following Tipping and Segall (1995), there are two aspects of this term, and a distinction must be made between *healthcare-seeking behavior* (*qiuyi xingwei* 求医行为) and *health-seeking behaviors* (*baojian xingwei* 保健行为).

As to *healthcare-seeking behaviors*, it emphasizes the "end point," namely a person's act of seeking 'health care," with two main focuses: The first approach looks at the processes and pathways through which a care-seeking act is conducted. One of the studies in this concern, for example, is Bedri's research in Sudan on abnormal vaginal discharge (2001). This study identifies stages where decisions have been made regarding adoption of modern medical care and four "sub pathways" followed by women, ranging from immediate pursuit of modern medical care to complete denial of medical service. The other approach to *healthcare-seeking behaviors* addresses the question: what facilities and health services will be used to deal with health problems, and what influences the different behaviors people exhibit in relation to their health. Studies examine the act of seeking health care in various contexts, demonstrating that the decision to use a particular medical channel, for example visiting traditional healers instead of modern medical care providers (Ahmed, Sobhan et al. 2001), is influenced by a variety of socio-economic variables, including: sex, age, the social status of women, the type of illness, access to services and perceived quality of the service. (Tipping and Segall 1995) These barriers/determinants can be categorized under the divisions of geographical, social, economic, cultural, and organizational factors, which can be further placed into three key spheres of influence: formal, infrastructure and informal. (MacKian, Bedri et al. 2004:138-139)

Studies best categorized with Tipping and Segall's approach to *health-seeking behaviors* are strongly rooted in psychology. Like studies of *healthcare-seeking behaviors*, *health-seeking behaviors* also convey an evolving mix of social, personal, cultural, and experiential factors that influence a person's decisions in

relation to their health. However, they focus on the act of "healthy choices" in either lifestyle or use of medical care, attempting actions before the individual becomes ill, to prevent illness or retain health.

Summarily, the difference between the focus of *healthcare-seeking behavior* and *health-seeking behavior* is that while the former is conceptualized as a sequence of remedial actions taken to rectify perceived ill-health, the latter is responding expressly to a perspective of affirmative, health-promoting behaviors, or more specifically, actions needed to prevent ill-health. (cf. MacKian 2003:4-7)

I use *health-seeking behavior* as the overarching working term in this thesis, which in fact covers the conceptual meanings of both *healthcare-seeking behavior* and *health-seeking behavior* discussed above, namely remedial actions to deal with illness/diseases and preventive behaviors/actions that are taken in order to keep somebody healthy. More specifically, discussions in this thesis on rural-to-urban migrant women's sexual health examine 1) their actions with the realization that they have caught certain sexual health-related illness/diseases (e.g. gynecological diseases and STDs) or when they are in need of certain care regarding sexual health (e.g. prenatal medical counseling, medical check-ups, and care during childbirth), and 2) their actions to prevent potential sexual health-related illness/diseases (e.g. gynecological diseases and STDs) or unexpected health situations (e.g. unexpected pregnancy).

In this thesis I use the term *health-seeking behavior* as the overarching working term but I regard an individual as an active decision-maker who is able to make a decision in relation to their health. Before a decision is made, the individual will evaluate the extent of a particular health problem that already exists or is going to occur. At the same time, the individual will evaluate the social and economic resources that can be used to deal with the problem, and the potential benefits or losses when they undertake certain actions. Regardless of whether the evaluation is comprehensive enough, or the decision is effective enough, to overcome the health problem or to improve the individual's health, the decision must be rational, rather than a simple reaction to the problem or outcome of certain habits. The individual rationality is further discussed in Chapter 2, in which I elaborate the theoretical framework of the thesis. It must be pointed out that the focus of present thesis is not the process of decision-making, namely not the "cognitive process" (MacKian 2003:8). In other words, I don't ask questions, such as, how the health-related problem is perceived, or how the social and economic resources are evaluated.

Instead, I look into the social context that affects the decision-making process, and try to indentify the factors that influence individuals' decisions in relation to their sexual health.

Policy

Combining the definitions of health policy of Buse et al (2005:6) and Leichter (1979:6-7), I define the term *policy* as a series of goal-oriented actions or inactions of authoritative individuals/actors, namely the dominant political elites/political decision-makers which mentioned above. According to Buse et al, "actors" who make policies as policy makers include governments, parties, businesses or individuals. (Leichter 1979:6-7) In this thesis, *policy* refers merely to policy adopted by governments, namely governmental/public policy. More precisely, *policy* is whatever political elites choose to do or not do. Both achievement and failure to decide or act upon a particular issue constitute *policy*. Public policy embraces "legislative enactments, including budgets, executive and administrative orders and decisions, judicial decisions, and the like. … Health policy is assumed to a set of governments' action or inaction affect the set of institutions, organizations, services and funding arrangements of the health system." (Buse, Mays et al. 2005:6) Because I argue that migrants' health is also influenced by many determinants outside the health system, *policies* in my purview also include those regarding outside health system issues and having an indirect impact on migrants' health (e.g. policy against commercial sex, which indirectly influences FSWs' health behaviors).

1.2 Rural-to-urban migration against the backdrop of economic reform and urbanization and the influence of the *hukou* system

The purpose of this subchapter is to provide background information about China's rural-to-urban migration, explaining how it emerged against the backdrop of economic reform and urbanization. Here I also explain the linkage between migration and the *hukou* system, which is one of the significant components of China's institutional structure with regard to rural-to-urban migrants' status in

China’s cities, as well as the provision of social welfare.

This massive rural-to-urban migration in China is derived from the push-out force in rural areas and simultaneously, a draw-in force from urban areas. In rural areas, the Family Production Responsibility System (FPRS) was implemented in the late 1970s and early 1980s. The FPRS contracts farmland to individual households and allows them to keep their surplus harvest and net profits as long as they meet the crop quotas for their collective unit. In 1993, the government abolished the grain rationing system, and since then, the prices of agricultural products are determined by market demand instead of the state. The implementation of FPRS and abolishing of the grain rationing system have given rural families and individuals more freedom to meet their needs, while earning profits, resulting in farmers becoming more energetic and productive. However, these policies have not kept farmers in the agricultural sector. One reason is the fact that arable land in China is limited, consisting of only about 15 percent of China’s total territory, so not all potential rural laborers can be absorbed into the farm sector. (Ministry of Land and Resources of PRC 中华人民共和国国土资源部 2015) This situation has been further aggravated due to China’s continuing industrialization, as more and more agricultural land has been converted into industrial land. As a result, surplus rural laborers have been forced to leave their hometowns and look for other alternatives for income. Along with this push-out force in rural areas, a draw-in force has existed in urban areas. Profiting from economic reform and the opening-up policy since 1978, China’s urban areas, especially cities along the south-eastern coast, have witnessed a prospering of transnational companies, both private and joint-investment, which have provided working opportunities for laborers from rural areas. Moreover, economic reform and opening-up policies have led to the rapid improvement of urban livelihoods. Although the general quality of life in rural areas has also been improved in the last decades, the disparities between urban and rural livelihoods have become more salient. More and more farmers, especially younger ones, are attracted into cities by the higher income, more diverse urban cultures, and higher quality of urban life.

When it comes to China’s rural-to-urban mobility of individuals, a special focus should be given to the *hukou* (户口) system. The *hukou* System, which was established in the year of 1958, is one of the strict administrative systems aimed at controlling the free flow of labor. (Taylor 2011:8) The *hukou* system was set up on the basis of households, either in rural or urban areas, whose members must

register at the local public security office as a legal resident. After registration, each person is issued a *hukou* certificate, classified as "rural" or "urban," and is thereby closely controlled by either the local street offices in urban areas, or village committees in rural areas. (Zhan 2005:18) Converting a rural *hukou* to an urban *hukou* is extremely difficult, and the person has to satisfy the conditions set out in the policy control criteria (i.e. recruitment by a state-owned enterprise, enrollment in a university, or promotion to a senior administrative job in the government) whilst at the same time obtaining a space under a strict quota control. (Chan 2012:823-828) As a result, for about two decades, the *hukou* system tied the farmers to the land and prevented them, in effect, from departing the countryside and streaming into the cities.

Only since the mid-1980s, after the beginning of economic reform with the ascent of labor-intensive and export-oriented industries in urban areas, has the *hukou* system been modified. Control over rural residents has been generally loosened, allowing rural laborers to migrate into the cities to fill industry's labor demand. Since the mid-1990s, laborers coming from rural areas have become the pillar of the export manufacturing industry, also staffing almost all of the low-end services in urban areas. (Chan 2012:188) This trend of rural-to-urban labor migration has become unstoppable. According to the annual survey of the National Bureau of Statistics (2013), the total migrant laborers in 2012 amounted to 262.61 million. Among them, 33.75 million migrated with the whole family. It must be noted that despite a series of adjustments, the *hukou* system has not yet been eliminated. Even though the rural laborers and their family members have left their rural origins and live de facto in cities, their status as rural residents is maintained.

In this sense, I define the term "rural-to-urban migrant" (*nongmingong* 农民工, literally peasant worker)[7] used in this thesis as follows: individuals who have a rural *hukou*, have migrated from rural to urban areas, and reside most of the time in cities. This population includes labor workers and their family members (e.g. their spouse, parents and children), who also have migrated into cities regardless of

[7] Besides *nongmingong* the other term that was frequently used to refer this rural-to-urban population in China's official documents and scientific researches for a long time is *liudong renkou* (流动人口, literally "floating population"), which semantically emphasizes the high and unpredicted mobility of these population. The term "migrant" is used more frequently in recent years to meet the recent situation that the unpredicted mobility of rural-to-urban population has become less frequent. There are increasing amount of rural-to-urban individuals and families who prefer to stay in one city instead of moving frequently between cities. Moreover, *nongmingong* can better point to migrants' place of origin (rural areas) and their occupation. Another Chinese term that is relatively less applied is *wailai wugong renyuan* (外来务工人员). Hereafter, I employ the English translation of "rural-to-urban migrants" only.

their status of employment. *Migrant labor workers* refers to those who work in both formal and legal (e.g. factories, hotels, restaurants, and construction sites) and informal and illegal (e.g. in the sex industry as prostitutes) sectors, regardless of whether they are employed formally (with working contract) or informally (without working contract), or are self-employed. In Subchapter 4.1, I further explain why I regard female prostitutes working in sex industry as *laborers,* and the common characteristics of female prostitutes and other migrants.

It must also be noted that *hukou* status is classified not only by a citizen's residential location, but also the socio-economic eligibility. Thus, without holding an urban *hukou,* the rural-to-urban migrants are not eligible for regular urban welfare benefits and social services, such as employment, housing and education. As Chan points out (2012:189), rural-to-urban migrants are nowadays in an awkward social "half-arrival" situation, never fully belonging to rural or urban populations.

1.3 The influence of individuals on policy: different roles of dominant and non-dominant individuals in present China

As mentioned in the "Introduction", the new institutional approaches that I apply for the analysis in present thesis were generally developed by researchers in political context for Western countries with a well-developed democracy and civil society. Compared to Western countries, despite observable progress, neither the political democracy nor civil society in present-day China is developed to the same extent. With continuous economic and political reforms, China's society is situated in a transitional period. The new institutional approach developed in the Western political context can be used to explain China's issues. However, the context of a transitional society should not be neglected when a study addresses political issues in present-day China. Thus, in this subchapter I look at the different roles of dominant and non-dominant individuals in the political decision-making process as associated with the allocation of action resources in present-day China.

Addressing political decision-making, such as the decision of making or changing a policy, an individual's capability of action/behavior is determined by the action resources that one possesses. Action resources, which include organizational resources (e.g. organized group), economic resources (e.g. wealth),

and cultural resources (e.g. authority based on reputation and social network) are tools that individuals/actors use to achieve their goals (Li 2007:29) Action resources are crucial to individuals' behaviors as Scharpf (1997:51) notes, stating that "in the absence of action resources, even the most enlightened perceptions and preferences will fail to make a practical difference." To understand the various influences of individuals on policy in China, I differentiate individuals into dominant individuals and non-dominant individuals regarding the degree of their capability to influence a political decision-making. The cluster of dominant individuals consists of political elites (high-ranking cadres of the CCP), cultural elites (middle- and high-ranking intellectuals) and economic elites (capitalists and bourgeoisies of the middle class), the number of which has increased significantly since economic reform. The counterparts to elites are the non-dominant individuals or the so-called masses, which in this thesis are the rural-to-urban migrants, for example.

In present-day China, action resources are allocated unequally between dominant and non-dominant individuals. Along with the establishment of PRC in 1949, the political elites of CCP seized the majority of action resources. Regarding cultural and economic elites, especially the later, they ought to be a foundation of democracy, and act as the competitors to political elites. (Moore 1966) In China's political arena, however, there is insufficient competition between political elites and the cultural and the economic elites. As Li (2009:41) points out, the insufficient competition is derived firstly from the political elites' calculated strategies, with which cultural and economic elites have been integrated into the "community of shared interests" led by political elites. Such strategies are manifested by policies such as providing institutional guarantees for private property rights, confirming the legitimacy of private ownership, welcoming intellectuals and entrepreneurs into CCP, and participating in political affairs (e.g. as deputies to the people's Congress), et cetera. As long as the cultural and economic elites are "locked in" within the institutional structure set up by political elites, within which they are able to maximize their interests, the incentive of resistance dims. Secondly, cultural and economic elites' obedience and cooperation with political elites can be explained by their fear of the authoritarian Leviathan. A private entrepreneur expressed such fear, for example: "Today you may have 1 million, but tomorrow the CCP can make you a pauper." (Li 2009:45) Because of these two reasons, cultural and economic elites have voluntarily, or to some extent, been forced to give up the

competition against political elites. Instead, they have chosen to take part in the "community of shared interests" built by political elites. This community commands the majority of action resources and correspondingly has a massive capability for intentional action. Regarding policy making, this capability is manifested in the fact that elites, especially the political elites, are the leading and even wield monopolistic power in making and changing policies.

As counterparts to elites, non-dominant individuals lack the action resources with which they might be able to realize their preferences and conduct their intentional actions. With regard to rural-to-urban migrants, they are obviously lacking economic resources and cultural resources, due to their relatively low income and educational levels. One point that must be noted here is their lacking of organizational resources. When Scharpf introduced actor-centered institutionalism, he emphasized the role of corporative and composite actors. A *corporative actor* is formally organized by assigning individuals as members. A corporative actor reflects the interests of its individual members, because a corporative actor is also an institutional structure with whom the individual members interact to produce the intentional actions ascribed to the corporative actor. Simultaneously, a corporative actor has a capacity for intentional action at a level above the individuals. As a well-organized unit, a corporative actor can also employ certain resources in strategic action, vis-à-vis, other corporative actors. (Mayntz and Scharpf 1995:49-50, Scharpf 1997:52) In this sense, the elite community mentioned above can be regarded as a corporative (although not formally organized) actor, which uses synthesized resources from the individual elites, and through conducting intentional action (e.g. making policies), maximizes the interests of its members.

For rural-to-urban migrants, the absence of participation in a corporative structure is a crucial reason of their lack of capacity to negotiate with their employers (economic elites) and express opinions. Taking rural-to-urban migrant workers as an example, there is a lack of labor unions as corporative actors that are able to present workers' demands and negotiate with employers. Nevertheless, in some large-scale manufacturing environments where unions exist, the unions have become the vassal for state corporatism instead of workers' agents. (Walder 1986) As it is discussed in Subchapter 4.3.2.2.1, although there are Non-governmental organisation (NGO) that are dedicated to protecting migrants' rights, their functions as agents of migrants have been repressed and limited by the governmental authority.

Lacking protection by formally-organized corporative structures, non-dominant individuals are likely to resort to supports from informal structures, such as families, loose network or quasi-groups, which are entities without a recognizable structure, but whose members have certain interests or modes of behavior in common. (Mayer 2004:97) Quasi-groups lack the obvious capacity for action that corporative actors have. In certain circumstances, however, the single individuals in a quasi-group can be modeled as intentional actors if every single individual reacts to an external stimulus in the same way (Mayntz and Scharpf 1995:51) and individuals may also rely on the quasi-groups can to cope with certain problem that they can hardly cope with as single individual. *Tongxianghui* (同乡会), associations of migrants from the same province or county, is an identified quasi-group to which migrants resort for support. My empirical research doesn't reveal any direct clues related to *tongxianghui*'s activities on migrants' *health-seeking behaviors*. However, China' media reported organized mass activities among rural-to-urban migrants, such as the large-scared armed fight between migrant workers from Guizhou Province and Guangdong Province in the manufacturing company, Foxcon in Yantai City, in 2013. (Shi 2013) Based on such reports, and also due to the fact that networks among fellow townspeople play a critical role in migrants' migrating into cities and job-seeking, it is fair to assert that *tongxianghui,* as quasi-groups, more or less represent certain intentions of migrants. Due to the authorities' fear of civil coalitions, resulting in rigorous restrictions, *tongxianghui* have a negligible effect on improving migrants' rights when confronted with state authorities and their coalition partners, the economic elites. Few *tongxianghui* are able to influence policymaking in favor of migrants' interests. Social network is regarded as an informal organization in present thesis used by migrant women to cope with health issues they meet. However, there is not any clue showing direct influence of migrants' social network on policymaking.

In sum, the disparity in the significance of different individuals in policymaking is enormous within the social and political context of present-day China. Due to the extremely disparate allocation of action resources, the political elites, and especially the high-ranking CCP politicians, possess the majority of action resources and play a key role in policymaking and leading positions in policy change. The authority of political elites hasn't been challenged by cultural and economic elites due to their fear of state and CCP's coercion and subordination. Although cultural and economic elites are not the main political decision-makers,

as members of the "community of shared interests," policies will reflect their preferences and interests. Non-dominant individuals, such as the rural-to-urban migrants, lack action resources, and are thereby extremely disadvantaged in the political arena, having a negligible effect on political decision-making. Whereas non-dominant individuals are much less powerful in the changing of policies, namely the formal institution, I argue that they are able to affect (not necessarily intentionally) the change within informal institutions, such as taboos, traditions, moral values, beliefs, and so forth. The present thesis elaborates this argument addressing the research question of change of informal institutions.

1.4 Reviewing of previous research and concretizing of research objectives

This subchapter presents a review of the previous literature on migrant women's health-seeking behaviors and policy related to migrants' sexual health. This helps avoid repetition of relevant information that has been thoroughly discussed in previous studies, so that my own detailed research topics and research objectives can be the sole focus of this thesis.

Literature on migrant women's sexual health and health-seeking behavior

The existing literature on migrant women's sexual health and health-seeking behavior address three main areas: 1) sexual health status, 2) knowledge, attitude and practice, and 3) usage of medical service.

1) Sexual health status of migrant women

With regard to sexual health status of migrant women, scientific results such as the studies of Wu et al in Shanghai (2007) and Hu et al in Xinjiang (2011) indicate that reproductive tract infection (RTI) is a major sexual health problem among migrant women. The study by Wang et al (2009) in four urban villages in Guangzhou compares the health status of migrants and local urban residents, indicating that migrants are more likely than local urban women to catch RTI. Another study conducted in 18 provinces in 1999-2000 (Wang, Wei et al. 2010) found that migrant women are more likely to have a Chlamydia infection than rural women, with migrants suffering infection at a similar rate to urban women. The survey by

Zheng et al in Guangzhou (2013) collected self-reported information by migrant women on the current status of their reproductive health, identifying a high prevalence of RTI symptoms in both married and unmarried migrant women, while even more prevalent among the married respondents. Symptoms of RTI, such as abnormal vaginal discharge, prorates vulvae, pain or burning sensation on perineum, ulceration perineum, aberrant menses, genital neoplasm, abnormal vaginal bleeding, pain during intercourse, etc., are reported.

All above-mentioned research is generally based on information self-reported by migrant women and collected by quantitative surveys. For research on health status, self-reporting is considered to be a relatively limited approach to testing the overall prevalence of illness, because it represents only the perceived prevalence of health-related problems. (Zheng, Lu et al. 2013:9) Another barrier, determined by Jacka (2006:19) after her field work targeting migrant women in China, is the considerable number of rural migrant women who don't know how to express themselves, therefore providing answers to certain questions that reflect their limited education. Moreover, because sex is considered as an embarrassing topic, especially in China's society with its Confucian tradition, it is difficult to assembling interviewees capable of reporting their own sex-related problems frankly.

In this thesis, I address the issue of the sexual health status of migrant women before I address their *health-seeking behaviors*. To minimize the disadvantages of collecting above-mentioned data, I collected data for this thesis not only through semi-structured interviews with migrants, but also through expert interviews with doctors and physicians who worked at medical institutions and provided medical service for migrants. In other words, both self-reported information and information reported "concerning others" are used in my thesis research. This method of data collecting is used to address not only the sexual health status of migrant women, but also their *health-seeking behaviors*. The overall qualitative research design and the method of data collecting are further elaborated in Chapter 3.

2) Migrant women's knowledge, attitude and practice in relation to sexual health

Scouring the literature regarding sexual health knowledge, attitudes, and practices among Chinese migrant women, with a preliminary focus on utilization of

contraceptives, a common result is the low level of knowledge or awareness about sexual health and the importance of sexual health care. Surveys by Zheng et al (2001), conducted in five Chinese cities, and by Wang (1999), conducted in Shanghai, reveal a low level of knowledge and use of contraceptives among unmarried migrant women, leading into consequences of unwanted pregnancy or induced abortions. Similar results can be found in more recent research. For example, based on a survey conducted with 944 unmarried migrant women in Shanghai from 2009 to 2010, Wang et al (2013) concluded that unmarried migrant female workers lack sexual knowledge, with a substantial proportion of them engaged in premarital sexual behaviors. Interventions aimed at improving their sexual knowledge and related skills are needed. Emergency contraception is a way to lessen the consequences of unprotected intercourse or contraception failure. However, research (e.g. Liu, Ru et al. 2004, Huang, Yu et al. 2005) reveals that female migrant women have limited knowledge of this contraceptive method. Moreover, a negative attitude toward emergency contraception is prevalent among migrant women, with the assumption that this contraceptive method is linked with sterility. In such cases, a migrant woman may also not use emergency contraception, even knowing its advantages. (Zheng, Lu et al. 2013) The study by Chen et al (2010) reveals that migrant women living in large cities have more opportunities to receive modern contraceptive education than non-migrant women.

In this thesis I regard culling an adequate knowledge of contraception, and using contraception appropriately, as *health-seeking behaviors* (i.e. to prevent unwanted pregnancy, STDs, and HIV/AIDS). I try to answer the question seldom addressed in previous research, and raised but not yet answered in the study by Chen et al (2010): Why do migrant women still lack knowledge related to sexual health, even if living in cities where such knowledge is relatively easy to access. Based on interviews with migrant women living in urban villages, I look at the health education targeting migrant residents in urban villages and ask the following questions: What kind of health education is provided? Is the education sufficient and provided effectively? Is the lack of knowledge among migrant women related to the insufficiency and/or ineffectiveness of the provided education?

A series of studies that focus on the issue of condom usage and AIDS prevention, derived from quantitative surveys targeting FSWs, emerges in a literature search of the knowledge, attitudes, and practices associated with sexual health. A general common finding among this literature is that in spite of their high

risk of contracting AIDS, FSWs have limited AIDS knowledge and there is a low level of condom usage among them. For example, the survey by Cai et al (2010) interviewing 324 FSWs in Shanghai shows that only 60.8% of the interviewees could answer all AIDS-related questions correctly and 33.6% of the interviewees have provided unprotected commercial sex at least one time. The survey by Xu et al (2007) conducted in Panyu District of Guangzhou City, shows that only 12.39% among the 355 interviewed FSWs had used condoms in the last five sexual intercourse.

My thesis also concerns STD- and AIDS-related issues among FSWs, seeking reasons for the low level of condom usage among them. Two approaches are used in my analyses: First, I look at the governmental policies targeting prostitution control and find out how the policies influence FSWs' condom usage. Moreover, I try to shed a light on the role of the NGO on AIDS prevention in the sex industry. After reviewing governmental policies of NGO regulation, and based on interviews with employees of one NGO devoted to a community-based AIDS intervention program in Shenzhen, I address how such interventional programs influence FSWs' behaviors related to sexual health, including condom usage. Second, I look at the influence of gender on condom usage. In other words, my focus is the relationship between FSWs and their male sexual partners, including their male clients and other sexual partners, to see how they interact with regard to condom usage and AIDS-prevention. One of the gaps in previous research targeting FSWs is the negligible attention given to FSWs' background as rural-to-urban migrants. To fill this gap, I focus on FSWs' mobility, one of the general characteristics of rural-to-urban migrants, and find out the correlation between their mobility and prevention of STDs and HIV/AIDS. Given the importance of clients in commercial sex as the first-party attendant, the mobility of clients is also discussed in this thesis.

3) Migrant women's use of medical services with regard to sexual health

With regard to migrant women, the under-utilization of health care services, including maternal health services, is a common result of different studies. (e.g. Xiao 2001, Zhan, Sun et al. 2002, Chen, Xia et al. 2005) The study by Chen et al (2006) reveals that the number of migrant women having regular gynecological check-ups is 30-40% less than urban residents, and among those diagnosed with gynecological symptoms, an even lower proportion of migrant women have visited

a doctor than urban residents. With regard to the utilization of maternal health services, Xiao's community-based comparative study in Wuhan (2001) shows that migrant women of the interviewed the 452 households, 63.4% had prenatal check-ups, 53.6% had given birth in a medical institute, and 26.8% had postnatal check-ups, while 100% of interviewed urban residents had used all these aforementioned services. Another survey conducted in Guangzhou in 2003 (Zeng, Wei et al. 2005) also used these indicators to compare migrant women and local residents, with the finding of a much lower level of utilization of maternal services among migrant women than local residents in the city. Previous literature lacks an explanation of the low service usage. Moreover, discussions are scant regarding migrant women's behaviors when confronted with unwanted pregnancy, whether inducing abortions or giving birth.

To understand the utility of medical services among migrant women and with regard to migrant women living in urban villages, three issues are addressed in present study: The first emphasis is health facilities located in urban villages. Instead of asking the question addressed in previous studies, namely, how do the migrants use the services, I ask the following questions: Which services are provided for migrants, and how are they provided? Is the provision effective? Can these services be used effectively by migrants? Second, I examine the implementation of urban medical and maternity insurance, looking at the influence on migrant women's usage of medical services. Third, my discussion delves into migrant women's decisions regarding abortion and childbearing and birth, providing the possible reasoning behind these choices. These issues are seldom discussed in previous literature. Results of previous research (e.g. Wang 1999, Shi, Shi et al. 2000, Zheng, Zhou et al. 2001) indicate a high rate of induced abortions among migrant women. I ask why migrants are easily prone to abortion, where they receive the medical abortion services, and why these decisions are made. With regard to the issue of childbearing, I question where migrant women choose to give birth, and why they make such a decision. Based on the interviews with FSWs in Shenzhen, I look at FSW's approach to sexual health knowledge, as well as medical services provided by medical institutes and NGOs. To explain FSWs' particular *health-seeking behaviors*, a focus is given to the personal network within the sex industry.

Literature on public policies and policy change related to migrants' sexual health

Public policies play a significant role in individual behaviors. With regard to this point, Williamson (2000) notes that while health promotion places emphasis on individual behavior, the lens needs to be broadened on other determinants of health, including policy directives to enhance population health. However, there is generally a lack of thorough review of China's public policies related to migrant health. Research on the impact of public policies on migrant sexual health is also scant.

Among the limited previous literature addressing policy review, Schnack and I (2010) did a text analysis on documents released by China's central government from 1984, in which China's central government enacted the first regulation targeting rural-to-urban migrants, to the year 2010, grouping policies into two categories: 1) those aiming at migration regulation and 2) those addressing concrete pressures on migrants, such as low wages, delayed payment of wages, extended working hours, poor safety conditions at the working place, insufficient education opportunities for migrant children, poor housing conditions, a general lack of judicial safe-guarding of rights, etc. Governmental regulations regarding migrant sexual health, thus far, focus on sexual health education, service provision, and AIDS prevention. Regulations on family planning[8] not only assist the migrant residence management, but also prescribe knowledge and access for migrant women regarding basic contraception and reproduction, medical examinations regarding reproduction, and other technical services. In governmental documents addressing AIDS prevention, migrants are regarded as the focus group under the framework of Chinese AIDS prevention campaigns. [9]

Among the scant scientific research on the impact of policies affecting the sexual health of individuals, two studies must particularly be mentioned. The first is the study by Doherty et al (2001), addressing the effect of China's one-child policy (also often called the family planning policy) on prenatal and obstetric care

[8] These regulations include: "Some regulations on management and service of family planning among floating population" (National Population and Family Planning Commission 2003), "Notice on publishing and distribution of the 'Measures for convenience and right protection of floating population and migrant workers in respect to family planning" (National Population and Family Planning Commission 2007a) and "Suggestions on strengthening family planning among floating population" (National Population and Family Planning Commission 2007b)

[9] These regulations include: "Notice on cooperative implementation of national AIDS education campaign targeting migrant workers" (State Council of AIDS Prevention and Control Working Committee et al. 2005), "Regulations on AIDS prevention and treatment" (State Council of PRC 2006a) and "Notice on publishing and distribution of 'China's Action Plan to Prevent and Control AIDS (2006-2010)" (State Council of PRC 2006b)

utilization. Based on a statistical analysis of the data from the China Health and Nutrition Survey collected in 1991 and 1993, the authors conclude that the one-child policy's financial penalties negatively impact the usage of obstetric care strongly, as Chinese women with unapproved pregnancies will likely forgo seeking modern obstetric service due to the fear of being fined. Tucker et al (2010) conducted a study regarding the influence of detention policies on STD and HIV/AIDS risks for FSWs. After a data study of over 11,000 STD clinic patients (including both incarcerated and non-incarcerated individuals) in Guangxi Province, the authors come to the conclusion that incarcerated FSWs face substantive inequalities inscribed in physical and psychological suffering, and the practices of detention camps targeting sex workers may systematically increase HIV/syphilis risks among incarcerated FSWs. Both Doherty et al and Tucker et al provide interesting points, examining the interrelation between policy enforcement and individual health issues. In this thesis I also look at the impact of one-child policies on women's decisions to seek prenatal and obstetric care. Unlike the study by Doherty et al, my study concerns itself more on major changes in the one-child policy, which have taken place in the last decade after the study by Doherty et al was conducted. Moreover, my aim targets the one-child policy as it applies to migrant pregnant women, and the impact of policy on them, which was not specifically addressed by Doherty et al. With the belief that Tucker et al have identified the crux of the matter, I go deeper into China's governmental policies targeting individuals involved in sex transactions and scrutinize how the policies impact FSW behaviors related to sexual health. Moreover, given the fact that NGOs are playing a increasingly important role in providing public services to meet social welfare needs in China, and that cooperation between state and NGOs are appealing to an increasing number of scholars (e.g. Gu, Zheng et al. 2007, Zhu 2007, Hasmath and Hsu 2008, Kaufman 2009), another focus of my research is given to the state's policies towards the activities of NGOs in the areas of STDs/AIDS-prevention. Based on interviews with employees of an NGO devoted to AIDS prevention in the local community, I see how de facto state policy influences NGO activities in STDs/AIDS-prevention.

The literature review presented above shows the research areas related to migrants' health-seeking behaviors that have not been addressed adequately or at all. Keeping in mind these research gaps and linking the main research questions and sub-questions elaborated above, my own detailed research objectives are as

follows:

1) To identify a variety of health-seeking behaviors of rural-to-urban migrant women when they contract gynecological diseases and STDs, face unexpected pregnancy, are in need of maternity care, and when they are in need of education and information related to sexual health.

2) To analyze the impacts of policies to provide urban community-based health services, policies of medical and maternity insurance in PRD and family planning policy on migrant women's health-seeking behaviors.

3) To identify and analyze the impacts of informal institutions on migrant women's health-seeking behaviors.

4) To identify and analyze the policies of prostitution control and policies regarding NGO activities for prevention of STDs and HIV/AIDS and their effects on FSWs' health-seeking behaviors.

5) To analyze the impacts of informal institutions on the effectiveness and change of policies for providing urban community-based health services, policies for medical and maternity insurance in PRD and family planning policy.

6) To develop a theoretical approach to improve the understanding the patterns of policy change based on the analysis of the family planning policy, polices for prostitution control and NGO regulation.

7) To discuss the change of informal institutions and its influence on policy change based on the analysis of the informal institutions identified.

CHAPTER 2

Theoretical framework: The new institutionalism as analytical tool

The aim of this thesis is to understand and explain the influence of formal and informal institutions on migrant women's *health-seeking behaviors*, the impact of informal institutions, through individuals' behaviors, on policy effectiveness, how formal and informal institutions change and how the change of informal institutions influences the change of formal institutions. To achieve these research purposes I draw on the theory of the new institutionalism as an analytical tool. In this chapter I first introduce new institutionalism's general approach regarding individual behavior, institutions and their relationships. I then provide an explanation of the definition of *institution* (2.1), following by the approaches to the influence of institutions on individuals' behaviors (2.2), and the approach developed by Helmke and Levitsky (2004) regarding the influence of informal institutions on the effectiveness of formal institutions (2.3). In the last subchapter (2.4) the approaches to understanding policy changes are elaborated.

The rising of the new institutionalism in political science can be traced back to the 1980s symbolized by the publication of March and Olsen's contribution "The New Institutionalism: Organizational Factor in Political Life" in "American Political Science Review" in 1984. Since then and after two more decades of development, new institutional studies were so widespread that some scientists claim: "We are all institutionalists now". (Rhodes, Binder et al. 2008:5) Genealogically, new institutionalism in political science is a reaction to behaviorism, which was itself a reaction to the old institutionalism of the 1950s. (Black 1997:56) Whilst old institutionalism and behaviorism put their emphasis on political structure/institution and individual actor respectively, the new institutionalism as the successor has the heritages of both of these two approaches. New institutionalism can be regarded, as Black (1997:56) explains, "at some levels at least, as an attempt to integrate (or steer a middle way between) the two lines of

analysis: to say that the actions [behaviors] of individuals are clearly important, but that actions of those individuals, and the goals that they have, are shaped by the institutional structure." There is a lack of a unified body of thought in new institutionalism, whereas according to Hall and Taylor (1996), at least three schools of thought can be identified: the rational choice institutionalism, sociological institutionalism, and historical institutionalism. Despite the various labels, the initiated focuses of new institutionalism are content, namely: individual behavior, institution and their relation. I selected a rational choice institutionalism and a sociological institutional approach to understand how the institution influences individual behaviors and decision-making. Also, a historical institutional approach on institution transformation helps me to understand the change of policies relevant to migrant sexual health. Before I begin to explain my approach to the relationship between institution and individual behavior, I must elaborate my approach to understanding the question: what is an institution?

2.1 Definition of institution: formal and informal institutions and their interaction regarding individual's behavior

In this thesis, I follow Douglass North and define institution in a broad sense as "the rules of the game in a society or, more formally are the humanly devised constraints that shape human interaction". (North 1990:3) Institutions have at least three functions: 1) defining the rules of conduct and (formal) procedural norms under certain situations; 2) defining the division of resources; and 3) defining the relationship, epically dominant and dependent relationship between actors (individual and combined individuals) (Mayntz and Scharpf 1995:47-48). Institutions can be either formal or informal and can be created or simply evolve over time. *Formal institutions* are those written rules established by governments such as constitutions, laws, and other governmental regulations. (North 1990:4) Formal institutions are enforced by governmental authorities by means of sanctions such as fines, imprisonment, and execution. (Pejovich 1999:167) I am incorporating this sense of policy with the definition that I elaborated in Subchapter 1.1. I understand *policy* as a government's decision and further action to create, change and implement certain formal institutions, as well as government's purposeful decision for inaction towards creating, changing and implementing

certain formal institutions. In this sense, policy change concerns the change of the formal institution.

Compared with the relative unambiguous definition of the formal institution, the term of informal institution has been applied in the previous literature much more discerningly, as noted in the criticisms of Helmke and Levitsky (2004:727) “informal institution is often treated as a residual category, in the sense that it can be applied to virtually any behavior that departs from, or is not accounted for by, the written-down rules”. The term informal institution was used to refer at least to personal networks, clientelism, corruption, clans and mafias, civil society, traditional culture, and a variety of legislative, judicial, and bureaucratic norms. (Helmke and Levitsky 2004:727) This wide range of understanding for *informal institution* must be delimited for the analysis of this present thesis. I purpose this thesis to follow the cultural traditions of sociological institutionalism and define informal institution as unwritten “codes of behavior”. As mentioned in Chapter 1, my focus is not given to informal institutions that are rather relevant to dominant individuals of China’s society, such as clientelism, corruption and the personal networks built up among the dominant individuals. Instead, I look at the informal institutions that are relevant to non-dominant population. Among these are for example tradition, taboos and customs that are produced by people’s habitual, adaptive actions, and their interaction and embodiment of the community’s prevailing perceptions about the world, the accumulated wisdom to the past, and a current set of values.[10] Informal institutions can be perceived by individuals (Hall and Taylor 1996:939), and the enforcement actions of informal institutions take place by means of “sanctions such as expulsion from the community, ostracism by friends and neighbors, or loss of reputation.” (Pejovich 1999:166)

After defining *institution*, North (1990:4-5) elaborates on the relevant term *organization*. He does not regard an organization as an institution. Instead, he argues that organizations are the consequence of the framework built by formal and informal institutions. Organizations provide incentives and constraints for individuals, and within organizations where interactions and exchanges take place, individuals are bound by some common purpose to achieve objectives. Based on the perspectives of North, Heilmann (2000:29) differentiates organizations into formal organizations represented by public authorities, political parties, enterprises

[10] This definition refers to North (1990:4), Young (1998:78) and Pejovich (1999:66)’s definition to informal institutions.

and associations, and informal organizations represented by social networks. Following Heilmann, I look at the role of migrant women's social network regarding their *health-seeking behaviors*. I don't regard the social network as an informal institution, but a self-organized and informal organization which has impacts on FSWs *health-seeking behaviors*.

2.2 The influence of institution on individual's behavior

Regarding the relationship between institution and individual, new institutionalists have arrived at the consensus that institutions have influence over individual behavior. To answer the question: *how do institutions affect an individual's behavior*, two approaches, namely the calculus approach and the cultural approach, were developed by rational choice institutionalism and sociological institutionalism respectively.

The calculus approach assumes that individuals have exogenously determined preferences and goals not affected by institutions. Rational individuals try to achieve their goals in strategic ways, comparing all possible options and selecting that which can maximize their interests. Institutions generally do not affect individuals' preferences, but they are able to influence individuals' behaviors. More precisely, institutions influence individuals' choice of strategic ways to achieve certain goals by providing them with "greater or lesser degree of certainty about the present and future behaviors of other actors, … enforcement mechanisms for agreement, penalties for defection, and the like." (Hall and Taylor 1996:939) In sum, institutions alter one individual's expectations from certain behaviors and the cost of the route taken to achieve certain goals.

Strategic acts/behaviors by individuals have the key role in analyses using a calculus approach. The cultural approach is often used by sociological institutionalists stressing the role of institutions. Although these institutionalists do not deny that an individual's behavior is rational or purposive, they assume that individuals and also their behaviors are deeply embedded in the institutions in which they exist. With regard to the way that institutions influence individuals, and within the "cognitive dimension," informal institutions (e.g. symbols, scripts and routine) provide a filter for an individual's interpretation of both the situation and oneself. (Hall and Taylor 1996:939) Institutions specify not only what an individual

should do, but also what the individual imagines about oneself in a given context. (Hall and Taylor 1996:948) The individual then further chooses conducts (e.g. making a certain decision) that he or she regards as suitable to his or her self-image.

I analyzed migrant women's *health-seeking behaviors* by merging the calculus and cultural approaches. I assumed that on the one hand, migrant women's behaviors are strongly influenced by institutions, as institutions determine not only the initial setting of certain preferences and goals for migrant women, but also their decision to take certain strategic actions to achieve them. On the other hand, the migrant women are not totally subjected to institutions, as they are able to make strategic decisions to achieve their goals after deliberate, if not necessarily comprehensive, consideration and then behave, if not necessarily effectively, rationally. Their decision-making is a process of internalizing the institutional context, in which they exist.

2.3 The influences of informal institutions on policy effectiveness

To understand the influences of informal institutions on policy effectiveness I draw on the approach developed by Helmke and Levitsky (2004:728). In order to describe the relationships of formal and informal institutions Helmke and Levitsky developed a typology that is based on two dimensions. As Table 1 shows, the first dimension is the degree to which the outcomes of formal and informal institutions converge, and the second dimension is the situation within which the formal and informal institutions lead to a substantively different outcome, i.e. in which they diverge.

Table 1: Possible impacts of informal institution on formal institution (Helmke and Levitsky 2004:728)

Outcomes	Effective formal institutions	Ineffective formal institutions
Convergent	Complementary	Substitutive
Divergent	Accommodating	Competing

On the left side of Table 1 are informal institutions that coexist with effective

formal institutions. Informal institutions may be *complementary* (upper left corner in Table 1) to formal institutions. They may serve as a foundation for formal institutions if they correspond to the spirit of formal institutions and support the desired functions of formal institutions. For example, formal institutions may not be able to deal with contingencies sufficiently or flexibly enough or fulfill the goals of individuals within the formal institutional framework. In such cases informal institutions may pragmatically "fill the gaps" of the formal institutions with a quicker solution and reduce the transaction costs (Helmke and Levitsky 2004:728). In this way, informal institutions increase the effectiveness of formal institutions and the stability of the overall institutional structure.

The lower left corner in Table 1 shows the combination of effective formal institutions and *accommodating* informal institutions. Informal institutions are accommodating to formal institutions when they adapt to the existing formal institutions, contradicting the spirit but not the letter of the laws set forth by the formal institutions. (Helmke and Levitsky 2004:728) Helmke and Levitsky (2004:729) argue that accommodating informal institutions are often created by individuals/actors "who dislike outcomes generated by the formal rules but are unable to change or openly violate those rules." In some instances, accommodating informal institutions may also be adaptive if existing formal institutions are (increasingly) incapable of providing sufficiently for the public good (Tsai 2002). Another case is the personal networks in the former Soviet Union commonly known as *blat*, which were studied by Ledeneva (1998). *Blat* enabled factory managers, workers and bureaucrats to find a way around formal procedures, helping enterprises fulfill state targets and helping individuals obtain essential goods and services. Although accommodating informal institutions do not necessarily increase the effectiveness of the entire institutional structure, they can increase the stability of formal institutions by alleviating demands for change (Helmke and Levitsky 2004:729).

On the right side of Table 1 are combinations of informal institutions and ineffective formal institutions. If informal institutions function in a different way than existing formal institutions and the latter cannot be enforced or complied with, they can be labeled as *competing* informal institutions (lower right corner in Table 1). In such instances, formal and informal institutions coexist within the framework of an institutional structure, but the latter are essentially the guiding rules for the behaviors of individuals/actors. Competing institutions that have been studied in

previous research include clientelism, patrimonialism, clan politics and corruption. Competing institutions are often found in an institutional setting where formal institutions have been introduced by Western democracies and imposed on indigenous traditional informal rules and authority structures. The individuals/actors involved are more likely to adhere to the informal rather than the formal rules, believing that they will thus incur less social cost (Helmke and Levitsky 2004:729). In such instances, the formal institutions are violated and function ineffectively.

Last but not least, informal institutions can have a *substitutive* relationship with formal institutions (upper right corner of Table 1), if both types of institutions seek the same outcomes (as in a *complementary* structure) but the formal institutions are not routinely enforced (as in a *competing* structure). In a substitutive institutional structure, formal institutions are ineffective and substitutive informal institutions are able to achieve what the formal institutions were designed, but failed, to achieve. Substitutive informal institutions are found mainly where state structures are weak or lack authority, such as in large parts of sub-Saharan Africa. Helmke and Levitsky also noted another case in rural China in which some local officials compensate for the state's inability to raise revenue and provide for the public good by mobilizing resources through temple and lineage associations (Helmke and Levitsky 2004:729-730). The survival of indigenous informal institutions, such as clientelism, corruption, clan networks and mafias, which may play a competing role in competing structures, are enabled by the absence of effective governmental enforcement of formal rules and laws (Helmke and Levitsky 2006:16). Substitutive institutions also exist where new formal institutions have been created – for example in the context of transitional processes – whereas they are deliberately undermined or de facto replaced by the ruling elites through informal institutions. Such a situation was described in Grzymala-Busse's study (2010) on state development in post-communist democracies in Europe (i.e. Hungary, Slovenia, Poland, the Czech Republic, Latvia, Slovakia, and Bulgaria). In autocracies, substitutive informal institutions may also function if the existing key formal institutions such as constitutions or parliaments have not been established as solid foundations for the entire institutional structure (Köllner 2012:20). Leaks within the key formal institutional structure enable the survival of informal institutions and their substitutive functions.

Helmke and Levitsky developed this approach based on their study of the

role of political elites (dominant individuals) and their actions/behaviors within institutional frameworks, and I argue that this approach can also be applied to analyze the cases of non-dominant individuals' actions/behaviors (e.g. those of rural-to-urban migrants). Below, I examine whether the informal institutions relevant to rural-to-urban migrant women's behaviors can also be categorized into these four types as concerns their impacts on the effectiveness of governmental policies. This discussion also links to the topic of policy change, addressing the question of whether informal institutions can contribute to the development of more stable formal structures (and if so, which of the four types), or whether they disturb such development, hinder the preservation of the formal rules and encourage policy changes.

2.4 Approaches to understanding policy change

To understand policy change with regard to migrant women's sexual health, I rely on new institutionalist approaches to explain institutional change. First of all, I explain the linkage of *institution* and *policy* to meet the possible critique that institution cannot be equated with policy. In response to this critique, I argue that *institution* and *governmental policy* can overlap. As elaborated in Subchapter 1.1, *governmental policies* consist of the conduct (actions or inactions) of political elites (dominant individuals in political decision-making). When one speaks of *policy,* the emphasis is on the "process" and "content" of the conduct of political elites. *Institutions* (here, the formal institutions) refer to elements such as constitutions, laws and other governmental regulations. They can be regarded as the written forms of the conduct of political elites. Although these *policy* and *formal institutions* emphasize different interfaces, they share the same content and spirit. Hence, I argue that the new institutionalist approaches to institutional change are also suitable to explain policy change. The following two analytical approaches are used to explain the policy change: 1) the concept of path dependence and 2) the mechanism of incremental institutional change developed by Kathleen Thelen et al.

2.4.1 Path dependence

The concept of *path dependence* was initially developed in economics, and afterwards adopted in political science to explain policy change. According to Sewell, *path dependence* refers to the situation that "what happened at an earlier point in time will affect the possible outcomes of a sequence of events occurring at a later point in time." (Pierson 2000:252) With this definition the question, why does path dependency emerge and persist, is not explained. To fill this gap, Levi (1997:27) provides a further definition, noting that path dependence means "once a country or region has started down a track, the costs of reversal are very high. There will be other choice points, but the entrenchments of certain institutional arrangements obstruct an easy reversal of the initial choice." Levi's definition shows that earlier steps in a certain direction lead to further movement in the same direction. Moreover, it points out the cause of path dependence, namely the phenomenon of increasing return, which could also be described as self-enforcing or positive feedback processes. (Pierson 2000:251) Within a process of increasing return, the possibility of further steps down the same path increases with each movement along that path. Increasing return happens because the relative benefits of the current activity, compared with other possible options (switching to some previously plausible alternative), increase over time. (Pierson 2000:252)

Applying the concept of *path dependence* to explain policy change, one can argue that policy is hardly to be changed, because institutions are sticky. More precisely, governmental policies are path dependent because the cost of changing a policy is usually much higher than preserving it. Seeking reasons for path dependence, researchers have looked into the role of political individuals/actors. Based on the research on the health care reform in the United Kingdom, Greener (2002) argues that individuals/actors involving in an existing institutional structure are inclined to protect the existing model, even it is suboptimal. Pierson (2000:261) further analyzed political individuals/actors' roles, addressing the concept of "time horizon". He argues that although many of the implications of political decisions, and especially complex policy interventions or major institutional reforms, play out in the long run, political individuals/actors, and especially politicians, are usually most interested in the short-term consequences of their actions, ignoring the long-

term effects. It is also difficult to monitor the acts of policy makers, as indicators used to evaluate policy makers' performance is limited and often oriented in transparent economic issues (e.g. budget deficits and monetary policy). In the case of China, such quantifiable indicators are, for example, the development of local GDP and the rate of newborns (regarding implementation of the one-child policy). Along with the difficulties of monitoring, the relatively rapid turnover of key positions of political individuals/actors makes it hard to expect their accountability. Ultimately, all these causes lead to the phenomenon of "credible commitment" (Pierson 2000:261), which refers to the situation in which policy makers tend to opt for less complex options and deliberately reject alternatives, so that they are able to stay with the old institution. (North and Weingast 1989, North 1993) In brief, path dependence as an analytical approach explains why certain policies survive for a long time, despite their poor performance, and why new political decisions are rarely made and implemented even though a good performance or outcome is predictable.

In order to understand the path dependence of formal institutions, one can also draw on the linkage between informal and formal institutions. North (1990:107-108) points out that formal institutions are obstructed by informal institutions because political and other economic individuals/actors tend to use and follow old informal institutions continuously. Supplementary to this point, I argue that change within informal institutions is also path dependent, and this characteristic of informal institutions further underpins the path dependence of formal institutions.

Path dependence of informal institutions and its obstruction to policy change

While formal institutions may change rapidly because of political and judicial decisions, informal institutions are more impervious to deliberate policies. (North 1990:6) Informal institutions are path dependent because they are "the part of a community's heritage that we call culture," (Pejovich 1999:166) and changes in informal institutions can happen only through cultural accumulation. (Zhang 2008:30) Cultural accumulation is a process in which people inherit and internalize the ethical values, habits of thought, emotional patterns, and behavioral norms of their ancestors. The special elements of the elders' version of culture accumulate, and are passed to the next generations. Change and recreation of culture happens, but they are strongly based on the accumulating and selecting of the elders, and

hence, cultural change is a continuous, but slow, and path dependent process. (Zhang 2008:30) As part of culture, informal institutions also have the characteristics of path dependence. Informal institutions are so tenacious that formal institutions can only suppress them, but cannot change them. (Pejovich 1999:170) Even under a context within which new formal rules supplant the persisting informal ones, a deep-seated cultural inheritance underlines many informal institutions. Thus, as North notes (1990:91), it is common that an ongoing tension develops between informal institutions and the new formal institutions, as many are inconsistent with each other. While the informal institutions may gradually evolve as an extension of a previous formal one, they, in fact, drag down the change of the latter. Extending North's argument, introduced above, that political and other economic individuals/actors usually prefer to use and follow old informal institutions, I argue that this preference is the consequence of the impervious informal institutions. The influence that informal institutions impart on individuals and individuals' ideological and emotional convictions to existing cultural practices is strong and hardly changeable. Within the tension of old informal institutions and new formal institutions, a new balanced and compromised version will eventually emerge, which is less revolutionary but more moderate. (Heilmann 2000:33) With regard to political decision, such versions may be a changed policy, which is however path dependent.

While the concept of path dependence can be applied to explain policy continuity, in other words, why it is difficult to change policies, explanations are lacking as to why and under what conditions a policy changes. To fill this explanatory gap, I draw on the concept of the five mechanisms of incremental institutional changes, developed initially by the historical institutionalist Kathleen Thelen and her co-authors (Thelen and Steinmo 1992, Thelen 2003, Streeck and Thelen 2005, Mahoney and Thelen 2009): *layering, conversion, drift, exhaustion*, and *displacement*.

2.4.2 Mechanisms of incremental institutional change

As previously mentioned, there are five mechanisms of incremental institutional introduced by Kathleen Thelen and her co-authors: *layering, conversion, drift, exhaustion* and *displacement*. In previous literature, these mechanisms were

usually discussed separately and independently of each other. In my following discussion, I put them into two clusters with respect to the result of institutional change: 1) the pattern with which an institution changes from a *layering* stage to a stage of *conversion* (the *layering*>*conversion* pattern). This pattern leads to a transformed but not a replaced institutional collocation, as the old institution remains; and 2) the pattern with which an institution changes from a stage of *drifting,* to *exhaustion* and to *displacement* (the *drift*>*exhaustion*>*displacement* pattern). This pattern leads to a breakdown of the old institution, which is replaced by a new institutional collocation.

2.4.2.1 The "*conversion* > *layering*" pattern

I combine *layering* and *conversion* as the first pattern of an incremental institutional change. This combination was also applied by some other researchers (e.g. Hacker 2004, Boas 2007, Thatcher and Coen 2008) who applied the typology introduced by Thelen to analyze concrete cases of institutional change. The essence is that despite transformation, the new institution does not replace the old ones. Based on this point, "layering is the means by which conversion ultimately occurs; the two processes are intimately interconnected." (Boas 2007:50) In other words, conversion may be considered as the reason for institutional change and through the process of layering, the change takes place ultimately. The reason for institutional change conversion relates to a "redeployment of old institutions to new purpose." (Streeck and Thelen 2005:31) The redeployment might happen as a result of new environmental challenges or through changes in power relationships, or it may occur through political contestation over what the functions and purposes an existing institution should serve. (Streeck and Thelen 2005:26) Individuals/actors involved in the institutional collocation and their roles are the focus of studies that apply the concept of conversion. One example is Streeck's (1997) study on labor productivity, focusing on how individuals/actors (including individual labors and organizations) learn to use the new external situation to protect and maximize their own advantage using the term "political conversion". In order to meet the changed external situation, *layering* is conducted by individuals/actors as an intentional strategy or merely a mechanism that unintentionally occurs. Layering is a gradual institutional transformation through a process in which new elements are attached to the existing institutions. (Mahoney

and Thelen 2009:16) After the process of layering, the old institutions are not replaced by the new ones. Instead, their status and structure change over time through the adding of the new elements. In previous literature, categorization of the new elements adding to the existing institutions are identified: they may be new agencies, such as individuals/actors, organizations and layers of government (Ackrill and Kay 2006); new structures, such as rules, laws and control mechanisms (Thatcher and Coen 2008); or both new agencies and structures (Bruszt 2008). I use this pattern combining layering and conversion as the tool to understand the change of policies in family planning, towards prostitution control, and towards NGOs' activities in the area of STD and AIDS prevention. The analytical foci is given to the external environment that leads to the conversion of policy and the concrete layering elements that are added to the existing policy, ultimately resulting in policy changes.

2.4.2.2 The "*drift>exhaustion>displacement*" pattern

To explain institutional change, I combine *drift, exhaustion* and *displacement* as the second pattern, which results in the breakdown of the old institution and the raising of a new one. Drift, exhaustion, and displacement can be regarded as the three different stages of a changing process with a causal sequence. The first stage *drift* refers to a situation under which the existing institutions face the pressure of change due to shifts in the institution's political and economic environment, and a lack of adequate adjustment by the exiting institution to meet the changing environment. (Streeck and Thelen 2005:24-26). The situation of drift is similar to that of *conversion*, as the existing institutions face impacts from changing external environments. The difference between these two mechanisms is that under conversion, the implementation and use of institutions change, whilst with drift, the changing environment alters the effects of the existing institutions and policies. (Hacker 2004) In drift, due to the absence of adequate adjustment, the existing institutions are subject to erosion, and might ultimately break down over time and "wither away". (Streeck and Thelen 2005:29-30) Then, the institutional change proceeds to the second stage, namely *exhaustion*. *Exhaustion* refers to a process in which behaviors invoked or allowed under existing institutions operate to undermine these, and in which an erosion of the resources that support the existing institutions takes place. (Streeck and Thelen 2005:29). Exhaustion may lead to a

breakdown of the old institution. A collapse may be the end of the process for this institutional change. However, the institutional change may also further advance into the next stage of *displacement*. In *displacement*, the traditional institutional arrangements are discredited or pushed to the side in favor of new institutions and associated behavioral logics, and the new institution eventually replaces the old one. (Streeck and Thelen 2005:20) Thelen regards *displacement* rather as the consequence of other mechanisms of incremental change than a standalone mechanism in itself. Hence, displacement often occurs through rediscovery or activation, and the cultivation of alternative institutional forms. (Streeck and Thelen 2005:20) Additional to this aspect, I argue that the "alternative institutional forms" may be a series of totally new institutional settings, perhaps with some settings inherited from the old institutions, which have either withered away or still exist. In relation to the concept of path dependence discussed above, I argue that through "rediscovery," "activation," and "cultivation" that Streeck and Thelen note, fragments of the old institutional settings can always be identified within a new institution. I use this pattern of incremental institutional change combining the mechanism of *drift*, *exhaustion,* and *displacement* to explain the policy changes of urban health care delivery, focusing on service provision in urban villages.

CHAPTER 3

Research method, sources of research materials and method of analysis

This chapter is dedicated to introducing the methodology used in my research. In the first Subchapter (3.1), I discuss reasons for why I used a qualitative method for my research purposes, as well as the advantages. The data collection, utilizing semi-structured interviews with migrant women living in urban villages, FSWs, experts, and other stakeholders, was conducted in Guangzhou and Shenzhen. Details of the interviews are examined in Subchapter 3.2. Lastly, I explain the technique used for data analysis. (3.3)

3.1 Qualitative research method

For the purpose of my thesis, I decided to use qualitative research methods for both data gathering and analysis. Qualitative research refers to "any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification." (Strauss and Corbin 1990:17) Qualitative methods have become a widely-used method in political science, with a deep historical and scientific root from the qualitative research of social science. (Blatter, Jannig et al. 2007) Addressing the topic of migration, both quantitative and qualitative methodology can be found in previous sociological studies. Researchers were most likely to use qualitative methods when their research interests addressed motivations for migration, examining in depth the individual's decision-making process to migrate. (e.g. Gruner-Domic 2005, Hein 2006, Berg 2009, Eggert 2013) Although my purpose is not to find reasons for migration, I am interested in how and why certain individual decisions, more precisely, decisions surrounding certain health-related behaviors, are made. Moreover, qualitative methods are more helpful than quantitative methods when approaching a complex, less visible theme,

unfamiliar to researcher. (Kleining 1995:16) Qualitative research is “a situated activity that locates the observer in the world. [It] consists of a set of interpretive, material practices that make the world visible. These practices transform the world. … This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret phenomena in terms of the meanings people bring to them.” (Denzin and Lincoln 2011:3) As stated in Chapter 1, there is a lack of information in previous research concerning the individual behaviors of migrant women, in particular that regarding their sexual health. Due to the illegal status of commercial sex in China, FSWs, as a group, are extremely difficult to approach. Using qualitative methods, such as distributing questionnaires among FSWs to gather sufficient numbers of samples for analysis, was unrealistic for both the thesis project and the PRD 3 project mentioned above. Moreover, since the thesis project targeted Chinese migrants, and Chinese is my mother tongue, I had the advantage of conducting interviews face-to-face, initiating dialogues to gather data, and afterwards, analyzing the interview transcripts. Considering all these determinants, I was of the opinion that qualitative methods would be the suitable method for my research purpose.[11]

3.2 Data gathering: semi-structured interviews and expert/stakeholder interviews

As stated in the introductory chapter, the data used for my thesis was gathered during the field work as part of the PRD3 project. This data was collected using semi-structured interviews targeting migrant women, as well as guided interviews (leitfadengestützte Interviews) (Blatter, Janning et al. 2007:62) targeting experts and stakeholders. The methods of semi-structured interview and guided interviews (leitfadengestützte Interviews) are similar as they are both conducted based on a list of guiding questions, although they served different research purposes in this thesis project.

[11] In framework of the PRD3 project, my colleague, Bork-Hüffer, PhD, MSc, applied a quantitative method targeting rural-to-urban migrants in urban villages. The results of her research on migrants' health-seeking actions with geographical aspect can be referred to in her publication. (Bork-Hüffer 2012)

Semi-structured interview

A semi-structured interview (also called a focused interview) is a qualitative method used to collect data by setting up a situation that allows a respondent or a group of respondents the time and scope to talk about their opinions on a particular subject. The face-to-face interview is often preceded by observation, as well as informal and unstructured interviewing, to allow researchers to develop a keen understanding of the topic of interest necessary for developing relevant and meaningful semi-structured questions. During the core interview process the interviewer follows a guide with predetermined questions, but is allowed to raise other questions from the dialogue occurring in the interview. While the predetermined questions are often asked in a systematic and consistent order, the interviewer has the flexibility to digress and forgo certain questions, also asking probing questions not initially planned for the purpose of clarification (Sociology Central UK 2010)

The method of using semi-structured interviews has the following advantages that encouraged me to use it for the research project: First, since a semi-structured interview is like a conversation, so the interviewer is able to practice protocols of respect for interviewee (Dunn 2010:102). As such, a positive rapport can more easily be established between the interviewer and interviewee. With positive rapport, data from that which can't easily be observed, such as feelings and emotions, may better be collected. Second, during a semi-structured interview, the interviewer is able to converse in detail and depth. Thus, the high level of conversational interaction between interviewer and respondents allows complex issues to be discussed and clarified. Hence, doing semi-structured interview is well suited to explorations of attitudes, values, beliefs and motives. (Richardson 1965) Third, as Blatter et al (2007) explain, semi-structured interviews are better than other methods to confirm or contradict the interviewers' hypothesis about respondent behaviors. Fourth, guided with predetermined questions, the method of semi-structured interview ensures that all questions are answered by each respondent so that one interview can be compared with another. (Barriball and While 1994:329)

With regard to the research subject of this thesis, namely, migrant women's sexual health behavior, the method of semi-structured interview has two further advantages. As Bernard (2006:54) points out, semi-structured interviews are best used when the researcher will not be able to interview a respondent more than once.

High mobility is a common characteristic of rural-to-urban migrants, as they move between their rural inland hometown and destination in the cities, between work sites within a city and sometimes between different cities. Although the PRD Project lasted several years, it was barely possible for the research team to interview a single respondent more than one time. So, the method of semi-structured interviews allowed us to collect as much information as possible in each interview conversation. Further, I follow the Chinese sexologist Yinhe Li, and regard semi-structured interviews an effective method when the interview topic addresses private and embarrassing topics. Li conducted her research on Chinese women's emotions and sex using the method of semi-structured interviews. (1998) To explain the decision to choose this method, Li (1998:2-3) pointed out that the research area regards totally the history of private life which is highly privacy. It is very hardly to receive true information with the method of conducting sociological questionnaire. Without denying the advantage of quantitative research methods, and considering a combination of quantitative and qualitative methods would be the best way for sexology, she explains that in studying a culture, the core of a culture is homogeneous. Therefore, the thoroughness of how research is conducted and the validity of the findings are the key issues, and not sampling methodologies. To avoid bias, inaccurate observations, and misinterpretations, with a study targeting a small group of people, the researcher should be particularly observant. (1998:5) The research project addressed personal health issues and sexual life, both of which are very private and embarrassing issues. With regard to FSWs' commercial sex, also a concern given it is illegal in China, a higher sensitivity towards the research topic would be expected. With all these considerations, I was convinced that semi-structured interviews are a reliable and suitable method for the PRD 3 project, and also my own thesis project, to collect firsthand data. Therefore, all interviews with rural-to-urban migrants were conducted with this method.

Expert/stakeholder interview

Along with semi-structured interviews, *leitfadengestützte* expert and stakeholder interviews (an interview with a general guide approach based on researcher's previous knowledge and theoretical approach to the research theme) (Blatter, Janning et al. 2007:62) were also conducted during the fieldwork of the PRD3 project. The expert/stakeholder interviews had two main functions for the project research: First, they provided background information helping a researcher to

understand the complexities of the research context and objectives, although the questions raised did not specifically address the core research questions (e.g. health issues of rural-to-urban migrants). These interviews were especially important at the beginning of my field research. For example, before the research team conducted semi-structured interviews with migrants in urban villages in Guangzhou, I interviewed employees of Guangzhou's municipal government, one employee of one urban village in Tianhe District in Guangzhou, and several local residents in one urban village in Liwan District, among which were landlords of rural-to-urban migrants. These interviews gave me a better perspective over rural-to-urban migration under the backdrop of urbanization (e.g. the reconstruction of urban villages and its social and economic consequences), and gave me my first insights into the targeted groups for my research, namely migrants living in urban villages (e.g. the size of the migrant population, their demographics and characteristics, living conditions, habits, etc.) Second, interviews with experts/stakeholders (e.g. interviews with medical practitioners, indigenous of the urban villages) were supposed to supplement, confirm, or contradict the validity of migrant interviewee responses, so that the bias derived from the "one-sided voice" can be avoided. It must also be noted that there were a few respondents who had a role as both migrants and expert-interviewees. These respondents, who were medical practitioners at the time of interview, had a rural-to-urban migration background. Interviews with these respondents were much longer and were conducted with the methodologies of both semi-structured interviews and guided *leitfadengestützte* interviews.

All semi-structured interviews and expert/stakeholder interviews, by which the data was developed for this thesis, were conducted in two phases by undergraduate and postgraduate students of the Sun Yat-sen University (Guangzhou, PRC), all majors in anthropology[12] and working under the guidance of Dr. Yue Que (phase 1), Prof. Dr. Yu Cheng (phase 2) and me in Mandarin. Before the research team conducted the interviews, I had developed a list of categories related to the overall project topics. Based on this list, I generated two different guidelines with semi-structured questions for each group of targeted respondents, namely migrants living in urban villages and FSWs. For the later

[12] Data gathering with the method of semi-structured interview depends on the skill of the interviewers, requiring some level of training or practice of the interviewer in order to prevent interviewer suggesting answers, for example. Majoring in anthropology, these interviewers had received adequate training conducting face-to-face interviews during the study. That was the crucial reason why the project team chose them as interviewers.

comparisons, there were overlapping questions regarding health-seeking behaviors, such as the questions: "In which medical facility did you seek medical service in case you were ill? And why did you choose this facility?" The guidelines for interviews with migrant women living in urban villages and FSWs are presented in Appendixes II and III, respectively. The guidelines for stakeholder interviews (e.g. interviews with employees of the administrative departments of urban villages) are provided in Appendix IV, and the guidelines for expert interviews (i.e. interviews with doctors at various medical facilities) are given in Appendix V.

Interviews of targeted rural-to-urban migrants living in urban villages in Guangzhou phase 1 took place between November 2007 and January 2008, with a few supplementary expert interviews in December 2008. Phase 1 embraced 55 semi-structured interviews with male and female rural-to-urban migrants living in 14 urban villages[13] and 14 experts/stakeholder interviews. Because this thesis concentrates on migrant women's health issues, I only use the data collected by 25 interviews with female interviewees. During these interviews 26 female migrants were interviewed[14]. They were at the time of interview between early twenties and early fifties, coming from 9 provinces. In phase 2 (September - October 2009), 30 semi-structured interviews were carried out with FSWs. These respondents were from 11 provinces/municipalities, between 17 and 35 years old, and at the time of the interviews working in brothels, hair salons or entertainment sites (KTV, leisure salons and night clubs) in the SZ community of FT District and the SW community of LG District, two of the reputed red-light areas in Shenzhen city. One additional expert-interview was conducted with two employees of the Institute of Population and Family Planning of Shenzhen City. They were engaged in a community-based AIDS-prevention program, organized and financed by the Hong Kong NGO "AIDS Care" from 2006 to 2009. This interview is coded with "NGO/Shenzhen".[15] All of these interviews are listed in Appendix I.

All interviews in phase 1, besides two with officials of government sectors, were voice-recorded with the respondent's permission, and the voice records transcribed into Microsoft Word. In Phase 2, 10 out of the 30 interviews with FSWs and the expert interviews were voice-recorded and transcribed into Microsoft Word. The other 20 interviews with FSWs were documented in protocols.

[13] Tangxi, Tanwei Villages in Baiyun District; Xiadu, Lijiao, Xin Fenghuang Villages in Haizhu District; Chajiao, Haizhong, Yongan, Baihedong Villages in Liwan District and Dongpu, Chebei, Changban, Tangxia, Shipai Villages in Tianhe District.
[14] In one of these 25 interviews two female migrants were interviewed at the same time.
[15] The guideline of this interview is presented in Appendix VI.

For these interviews, two attending interviewers focused separately on oral conversation and documenting. The interviewers were also required to document related information, such as the atmosphere of the interview location, the perceived emotional state of the interviewee, whether the interview was interrupted, and if so, by whom and under what circumstances.

3.3 Method of analysis

The text of transcribed interview dialogues and protocol were the basic materials for the analysis using Mayring's (2003) method of qualitative content analysis. Methodologically, this is an investigational process with the help of concept-based category schemas to decrypt the dimensions of the meaning of statements and texts. (Blatter, Janning et al. 2007:74) With regard to the detailed analysis theory, three types were developed by Mayring: summarizing (Zusammenfassung), explicating (Explikation), and structuring (Strukturierung). I decided to apply the structuring type to analyze the text materials with the help of the Atlas.ti software. The following procedures were applied: First of all, a coding tree with keywords (a guided "Kategoriensystem" (Mayring 2003:85ff) for text screening) according to research foci (elementary codes) was established (see Appendix VII and Appendix VIII). Then, in the first round of text screening, the transcripts and protocols were screened, and the single phrases related to research foci were found, copied, and sorted according to the elementary codes. In the second round of text screening, the function of Atlas.ti, namely "double code," targeted building the relationship between different elementary codes. Taking the analysis of interviews with FSWs as an example, the relationship between FSWs and their boyfriends (also see Subchapter 4.3.3.3.3) (categorized under the elementary code: "relationship with other persons") is related to FSWs' drug use (also see Subchapter 4.3.1.4) ("drug use" as another elementary code). The reason for building this interrelation is that some FSW respondents reported their boyfriends were addicted to drugs, and they were enticed into using drugs by their boyfriends. Such interrelations have been revealed to give a deeper understanding of the relationship between FSWs' social network and their risky health behaviors. Using the other function of Atlas.ti, namely "memos," the explanations of the interrelation and interpretations with regard to the research foci have been recorded.

The findings of the empirical research in the two case studies targeting migrant women living urban villages and FSWs in Shenzhen are presented in Chapter 4.

CHAPTER 4

Empirical context and analysis: findings of the case studies

This chapter presents the findings of the empirical research, providing further discussion regarding migrant women living in urban villages in Guangzhou and FSWs in Shenzhen. Before I present the findings of the two case studies, I introduce in subchapter 4.1 the two population groups that I interviewed during my field research: migrant women living in urban villages in Guangzhou and FSWs in Shenzhen. After explaining the reasons for the emergence of urban villages as a typical settlement for migrants, I give an approximate classification of rural-to-urban residents living in urban villages according to their employment status. With regard to FSWs in Shenzhen, the history of prostitution in China is briefly introduced. This concise historical overview is intended to provide background information regarding the status of sex work and FSWs in China for a better understanding of the discrimination against FSWs that is embedded in Chinese society. I then develop a classification of FSWs in modern-day China as a whole, of which the FSWs interviewed in Shenzhen are a part. At the end of this subchapter, a brief comparison of these two groups is provided with regard to their sexual health.

4.1 Introduction of the two target groups: migrant women living in urban villages in Guangzhou and female sex workers in Shenzhen

Migrant women living in urban villages in Guangzhou

The first target group of rural-to-urban migrants that was chosen for my research is migrant women living in urban villages in Guangzhou City. Among the migrant population in this city, presumably, half of them are living in urban villages, the

number of which varies from 139 (Cai 2003:47) to 277 (Zhang, Zhao et al. 2003:919).

Urban village (*chengzhongcun* 城中村, literally 'village encircled by the city'), also called village-in-the-city, has become common in Chinese large and middle-sized cities (Wang and Wang 2008:142) as a result of rapid urbanization, and transformed from suburban rural villages. Following the expansion of urban areas, many rural villages owned by rural collective communities have been engulfed by urban areas. According to the Chinese constitution, all members of a rural village community are entitled to partake in an equal share of the collectively-owned land as de facto land owners. Hence, every member of the community is allocated a plot of collectively held land, called *zhaijidi* (宅基地) in Chinese, on which he or she is allowed to build their own house. (Zhang, Zhao et al. 2003:917-918) To maximize their income, community members in urban villages rebuild their houses to multi-story, apartment buildings for renting, or in some but scant cases, for self-housing. (cf. Photo 1, Photo 2)

Photo 1: Multi-story buildings with rent apartments in Xian Village © Yuan-Ihle

Photo 2: A migrant woman in front of a bulletin board advertising rental information in Tangxia Village ©Yuan-Ihle

There are several reasons to explain why urban villages have become favorable residential locations for rural-to-urban migrants. First of all, although the quality of the building structure is low, in urban villages in PRD, most of these rental apartments are equipped with essential facilities like piped water, electricity, private kitchens, flush toilets, and sewage systems, which offer better living conditions than many un- and underdeveloped rural areas where the migrants have come from. Secondly, rents for these apartments are much lower than for housing outside these settlements. This makes them an attractive destination for rural-to-urban migrants with low-incomes and no access to low-cost state housing due to the lack of urban *hukou*. Thirdly, in many cases workplaces and shopping areas are located in the vicinity of urban villages, and are hence easily accessed by the migrants (Zhang, Zhao et al. 2003:921-923). Last but not least, urban villages offer income opportunities as they host a variety of small shops, street markets and restaurants run by migrants (Wang and Wang 2008:141).

Due to lack of regulation and high mobility among migrants, comprehensive official data of the socio-demographic characteristics of rural-to-urban migrants residing in urban villages can hardly be drawn, and thus is merely reflected in research based on random data collection (e.g. Zhang, Zhao et al. 2003, Wang, Gao et al. 2009). Within the framework of the DFG-Project mentioned above, a quantitative survey with migrants was also conducted in four urban villages in Guangzhou City (Bork, Kraas et al. 2010), that hereafter is being used to reflect the issue of socio-demographic characteristics of migrant dwellers in urban villages. With regard to migrants' geographical origin, this survey reveals that the majority of migrants crossed provincial borders: "Besides intra-provincial migrants from within Guangdong province (27.6 percent), the five major sources of inter-provincial migrants were Hunan (18.2 percent), Sichuan (11.1 percent) Henan (8.9 percent), Guangxi (7.6 percent), and Hubei (6 percent). The majority of migrants were under age 29 (46.9 percent), while 32.2 percent were between 30 and 49, and 20.9 percent were over age 50. The minimum age was 15 and the maximum age was 67. In comparison to the general migrant population, this urban village sample is slightly older, with a mean age of 31.1 years versus 27.2 years.[16] Almost 60 percent of this sample is married, with three quarters of the spouses residing also in

[16] This comparative data for the migrant population is taken from the 2000 census result from Fan 2008.

Guangzhou, which is slightly higher than the migrant population's average (54.1 percent of which was married in the 2000 census)." (Bork, Kraas et al. 2010:74-75) This situation could be explained by the higher average age and possibly the special housing conditions in urban village, which allows couples to share rented apartments, and gives spouses more private spaces than in other forms of migrant communities, such as single-sex dormitories or other living spaces provided by the employer. (cf. Pun 2007, Pun 2012) Interviewing migrants in urban villages is more advantageous to my research when it comes to the focus of this thesis - sexual health - as it can be assumed that migrants residing in urban villages have at least more possibility of sexual behaviors than other migrant groups, and correspondingly, may also face more problems with regard to sexual health. Interviewing migrants living with spouses also gives me a chance to look into gender relations, which is an important aspect when it comes about sexual health issues. Moreover, more than one generation of migrants could be interviewed when my field research targeted migrants in urban villages, because compared with other migrant communities, the urban village migrant communities have a higher percentage of children and elderly. This facilitated my approach to information about fertility and inter-personal relationships within migrant families, not only between migrant couples, but also between in-laws, which should also be taken into account as relevant factors of sexual health.

It is difficult to compare migrants according to their employment status, and especially occupation, because widely-differing groups are used for delimitation in existing classification. Moreover, in existing classifications often only superficial categories, such as economic sectors, are often be used, which do not reveal a great variety of jobs. (Bork, Kraas et al. 2010:75) However, the employment status determines rural-to-urban migrants' income levels to a great extent, playing a significant role in financial decision-making that is related daily livelihoods, as well as health issues. Hence, I developed an approximate classification of rural-to-urban residents living in urban villages according to employment status aiming at pointing out the occupational characteristics of this specific migrant group and link them with health issues. This classification is based on the field work of the DFG-project, including field observation, interviews with migrant residents and local dwellers in urban villages, and with employees of village administration departments.[17]

[17] The content of the following paragraph regarding the classification of migrant residents in urban

Employees are the first group of migrant residents. They hold work contracts and mainly employed in local service sectors (predominantly restaurants and hotels), middle- or small-sized manufacturing industries run either by the village economic cooperatives[18] or external enterprises which rent the factory sites owned by village communities, or in small migrant-owned craft workshops (mainly metalworking workshops). Some of these migrant employees reside in dormitories rented out and paid by their employers. In such a case, a single apartment will be shared by several migrant colleagues of the same gender. The number of people sharing an apartment depends on the apartment's size and the employees' financial situation. It was also observed that several migrant couples rent one apartment with separate bedrooms but a shared bathroom, toilet and kitchen. This is the case when each spouse works in a different working unit and neither of their employers offers them private accommodations.

The second group of migrant residents is **odd-job migrant workers**, who are called *sangong* (散工) in Chinese. According to Zhou et al. (2007:18), "*sangong*" refers to those informal "free-lance" migrant workers, who do not have a contract and who are also not licensed as individual business proprietors. Sangongs can be further differentiated into three groups: able-bodied laborers, handicraftsmen and street market vendors.[19] Sangongs belonging to the first group are usually engaged in low-skilled but labor-intensive positions such as porters, scrap collectors, and short-term workers on construction sites, as well as in urban physical infrastructure projects, where they are hired by foremen without a contract. The second group of sangongs are professional handicraftsmen, who work exclusively in one occupation, such as carpentry, bricklaying, shoe repair, and bicycle repair (Zhou 1997:277). Those who belong to the third sangong group are street market vendors selling vegetables, fruits or ready-made fast foods. Usually they do not have a business license, and are able to evade taxes due to their high mobility, but they also easily become targets of government control campaigns against informal businesses. This can result in instability of their businesses and

---

villages was published in the collective article by Bork, Kraas and the author within the framework of the DFG-Project (Bork, Kraas et al. 2010: 75-77).

[18] The forms and titles of village economic cooperatives vary in present Chinese urban areas. The most popular form is Shareholder Company Ltd., a reformed form of the previous rural village collective, in which the original villagers are shareholders. The cooperative's profit is made by running industries and renting out collectively owned housing or land. The profit is used to pay the cooperative's management fee or for income distribution to the villagers. (Wang and Wang 2008: 142)

[19] According to Zhou's definition, a part of the laid-off employees of the previous state-owned enterprises (*xiagang zhigong* 下岗职工) also belongs to the *sangong* category, but this is not the main component of *sangongs*. The majority of sangongs are rural-to-urban migrants.

incomes. Middle-aged migrants between 30 and 40 years of age constitute the majority of odd-job migrant workers. Some of them have migrated to the cities with their spouses (cf. Zhou and Zhou 2006:2). Given the short-term nature of their jobs, odd-job migrants' incomes are less stable than those of migrant residents in the first category, and their employers do not offer them accommodations. Hence, they normally choose low-rent apartments in urban villages.

The third group of migrant residents living in urban villages is **private businessmen or entrepreneurs**. According to the 6th national sample survey on private enterprises in 2004, about one out of five private businessmen in Chinese cities has a rural-to-urban migration background (Gu, Zheng et al. 2007:4). Among these migrants are those who live in urban villages are commonly owners of grocery stores, restaurants, shops related to the entertainment sector (e.g. video rentals and music shops), or small handicraft workshops located in urban villages. Compared to the other migrant residents in the two categories mentioned above, migrants in this group are generally older, have lived in the cities for a longer time period and have a higher and more stable income. To a certain extent, these migrants are an "upgraded" group of the odd-job migrant workers in the last category in terms of career (cf. Zhou, Zhou et al. 2007:18). Through working as employees or odd-job workers at the beginning of the migration period, these "upgraded" migrants were able to accumulate some capital, making it possible for them to cover the costs of running their own business (e.g. pay shop rents, taxes and hire additional personnel). Despite their comparatively higher income, expensive housing in other areas in the cities is still unaffordable for this migrant group. They still rely on the low-rent housing in urban villages, which offers them the opportunity to live together with their family members, to live in proximity to their workplaces and, to meet their financial responsibilities. (Du 2007) The female migrant residents living in urban villages in Guangzhou that I interviewed cover all of these three groups of migrants. Besides these three groups there were also a few unemployed interviewees, such as housewives and elder migrant women that had migrated with their children into the city.

Prostitution in China, FSWs and sex industry in Shenzhen

The second target group of rural-to-urban migrants targeted in present thesis is females involved in prostitution in Shenzhen City. Females involved in sex trade are called *chang* (娼) *or ji* (妓) in the Chinese of the pre-republic era. In present-

day China, in both scientific literature and official documents, three terms are used mostly to describe this population, namely *anchang* (暗娼, literally hidden prostitute), *xiaojie* (小姐, literally young lady) and *xing gongzuozhe* (性工作者, literally sex worker). (Wang 2004:204-205) The term *sex worker* is widely used in counties where commercial sex is legal. (Fu 2006:74) I use the term sex worker, since sex for sale is considered like any other profession, prefixing the word "female" to describe the target group in this thesis. So hereafter, the working term is female sex worker (FSW). Selling sexual services is the only way an FSW earn moneys and makes her living. With the same attitude to FSWs, Li, a Chinese sexologist points out: "FSWs earn money because of what they do, but not because of what they are or what they have. … They are entertainers, same as striptease, porn models and actresses. … Like other females, their job should be regarded as a profession which relies on skills and effort, but not an inborn ability that every woman posses." (2009:183) Since I consider FSWs' job is 'selling' sexual services, accordingly, I use the term *client* in this thesis to refer to males who buy the service provided by FSWs.

Before giving further information on the situation of FSWs and the prostitution industry in Shenzhen, it is necessary for me to give a brief overview of the history of prostitution in China. China has had a history of prostitution for more than 2,000 years, which can be traced back to the Shang dynasty (17th-11th century B.C.). China was one of the first countries in the world to institutionalize prostitution, when Emperor Wu recruited female camp followers for his armies in the Han dynasty (256-200 B.C.). (Liu 2011:8) Until the establishment of PRC, prostitution was legal and was regarded by the government as a cultural occupation. The commercial sex industry was regulated and managed by state agencies. In the Ming Dynasty (A.D. 1368-1644), a ministry was established by the state for this purpose. In the pre-PRC periods, FSWs and pimps were leniently treated as members of a status group. (Zhou 2006:238-240) Commercial sex industry reached its highest point of proliferation after the opium war in the second half of the nineteenth century, when China was forced to open its doors to the rest of the world. (Liu 2011:9) The number of females involving in commercial sex business, both registered and unregistered, increased. By the year 1935, in Shanghai City for example, FSWs constituted 2.3 percent of the total population of the city. (Liu 2011:9)

The CCP outlawed prostitution and launched large-scale crackdown

campaigns against prostitution as soon as it seized the power in China in the year 1949, viewing it as incompatible with the Marxist orthodoxy and as a "cancer" of the old feudal-capitalist society. In 1958, the central government announced that prostitution had been eradicated from mainland China. (Zhou 2006:241-242) This announcement might exaggerate the achievement of the crackdown campaigns, yet prostitution rates did remain extremely low during the Maoist era. Even though commercial sex continued to exist, it became essentially invisible. (Liu 2011:9) To a certain extent, the absence of visible prostitution during this era was derived from the *danwei*- (单位 work unit) and *hukou* systems, which highly restricted the physical and moral spaces in which such activities could occur. (Jeffreys 2012:2-3)

The resurgence of prostitution in PRC has taken place since the end of the Maoist period. The market-based economic reforms and the opening-up policy weakened the *danwei*- and *hukou* systems and resulted in the massive rural-to-urban population mobility (cf. Subchapter 1.2), as well as a more lax social venue for anonymous and private behaviors. Simultaneously, economic reform contributed to the heterogenization of China's cities, demonstrated by an emerging gap between rich and poor, establishing a more diversified consumer society. (Jeffreys 2012:3) Against this backdrop, prostitution began to flourish in the 1980s in eastern coastal cities where opening-up reform was first conducted, becoming prevalent throughout present-day China. (Liu 2011:10-11) Because commercial sex is officially prohibited in PRC, there is a lack of official statistics for FSWs. As the World Health Organization (WHO) estimate, there are six million Mainland Chinese women engaging in prostitution. According to other sources, the number of women who engage in commercial sex can be considerably higher. For example, Zhong estimates that China's capital City Beijing, alone, has between 200,000 and 300,000 prostitutes. According to the US State Department Human Rights Report released in 2001, there are about 10 million sex workers in China. (Zhou 2006:243-244) Shenzhen City, where the empirical study targeting FSWs was conducted, has also experienced the booming of the prostitution industry along with its process of urbanization. Estimably, there are 200,000 FSWs working in sex business. (Liu 2011:14) Similar to the situation in labor-intensive industries and service sectors, rural-to-urban female migrants built the majority of sexual service providers in different sex establishments in Shenzhen, such as massage salons, nightclubs, karaoke lounges, beauty salons and brothels.[20] It must also be noted that as China's

[20] With regard to the legal status of these establishments, only brothels, which engage in merely

first special economic zone and being located on the frontier to the international metropolis Hong Kong, Shenzhen witnesses a high level of cross-border personal mobility. Among the great amount of cross-border travelers, there are male clients of FSWs from Hong Kong. (Lau and Siah 2001, Lau and Thomas 2001, Wong, MB ChB et al. 2007, Xiao 2015) Hence, by targeting FSWs in Shenzhen I am able to link China's internal population and population outside China, so that I can gain a better understanding of the transregional/transnational spread of STDs and HIV/AIDS.

In present day China, FSWs are a highly heterogeneous population. To better understand this population, a brief categorization is needed. Huang et al. (2004:695) classifies FSWs in present-day China into seven categories. Based on my empirical study in Shenzhen, I extend this classification by adding brothel-based FSWs as a further category (see Table 2, page 64).

As Table 2 illustrates, FSWs in present-day China can be grouped into eight categories according to their work organization, employment status, income, and demographic characteristics. These categories are arranged with second wives and courtesans on top, escorts in recreational enterprises and massage girls as the middle-layers, brothel-based girls and barbershop girls as the middle-low layers, and girls working in the streets and in sheds at the bottom. Interviews that were conducted with FSWs in framework of this thesis, represent the fourth, fifth and sixth categories. It must be noted that these interviewees were conducting prostitution transactions related to categories 4, 5 and 6 at the time of interview. Due to vertical mobility, these categories may change at any time. Linked with spread of STDs, such vertical mobility is important and is elaborated in Subchapter 4.3.1.6.1.3. FSWs in the first and second categories (second wives and courtesans) and those in the seventh and eighth categories (standing girls and shed girls), while considered, are not the main targeted groups in this thesis. As high-level FSWs, second wives and courtesans usually solicit in high-end hotels or clubs and service clients in private residences. (cf. Xiao 2015) Hence, their status as FSWs can hardly be identified. Although the status of the street-standing girl and shed-street girl is relatively easily identified, they are usually self-employed and due to the lack of shielding by employers, they are the highly-vulnerable FSW groups facing police-led crackdowns. (cf. Xu 2008, Cheng, Han et al. 2010) As a result, these FSWs are highly cautiously towards external inquiry and difficult to be reached by

commercial sex, are illegal. The other establishments are usually legally registered as business units, which provide however under-table sexual services.

researchers.

Table 2: Categories of FSWs in present-day China

Category	Name (Chinese Term)	Organization of Work and Employment Status	Income	Demographic Characteristics
1	Second wife (*er'nai* 二奶)[21]	Being hired for a period of time by one client, self-employed	High & stable	Different educational levels and ages
2	Courtesan (*xiaojie* 小姐)	High-end hotel and club, self-employed	High	Well-educated, relative young
3	Massage girl (*anmo nü* 按摩女)	Leisure centre and foot massage salon	Middle	Moderately well-educated, relatively young
4	Girl working in recreational enterprises (*zuotai xiaojie* 坐台小姐)	Big KTV night club, employed by the work site, employed by recreational enterprise, managed by procuress	Middle	Moderately well-educated, relatively young
5	Brothel-based girl (xiaojie 小姐)	Underground brothels rent and run by procuress, employed and managed by procuress, cooperated with pimp	Middle-low	Moderately well-educated, relatively young
6	Barbershop girl (falang xiaojie/falang mei 发廊小姐/发廊妹)	Barbershop, employed and managed by procuress and/or pimp	Middle-low	Moderately well-educated, relatively young
7	Street standing girl (zhanjie nü 站街女)	Solicits in street or park, employed by pimp or self-employed	Low	Low education, relatively old
8	Girl working in sheds (gongpeng nü 工棚女)	Solicits in construction field or small factory, employed by pimp	Lowest	Low education, relatively old

[21] There are also arguments that a relation between a second wife (er'nai) and her client should not be regarded as a prostitution transaction because such a relation is usually a one-on-one relation within a period of time and doesn't fit the definition of prostitution by the Ministry of Public Security (2001). According to China's governmental definition, a prostitution transaction refers only to a homosexual or heterosexual behavior between uncertain partners. In this sense, a second wife doesn't legally belong to FSWs.

Photo 3: FSWs in front of a KTV in SW[22] District, Shenzhen ©Yuan-Ihle

In sum, the present thesis analyzes migrant women's behaviors under three situations: 1) facing/or perceiving risks of diseases related to sexual health (e.g. in cases of contracting gynecological diseases and STDs), 2) being in need of childbirth-related care, and 3) facing unexpected pregnancy. Situation 1) and 3) are addressed in the discussions based on interviews with both migrant women living in urban villages and FSWs. Situation 2) is only addressed in the discussion regarding migrant women living in urban villages, because a big component of interviewees living in urban villages are married. Childbirth-related care is less relevant to FSWs because all FSWs that I interviewed were single. They are more worried about contracting sex-related diseases and unexpected pregnancy due to their commercial sex work than childbirth-related care.

4.2 Case study 1: Sexual health and *health-seeking behaviors* of migrant women living in urban villages

Subchapters 4.2 and 4.3 present the findings of the two case studies regarding migrant women in urban villages in Guangzhou and FSWs in Shenzhen, respectively. These two chapters have a similar structure, as each of them are separated into three subchapters: 1) a demonstration of the identified sexual health

[22] For the purpose of anonymity the precise names of districts and towns are not presented. This procedure is followed throughout the thesis with regard to prostitution and FSWs in Shenzhen.

problem, needs or demands and *health-seeking behaviors* of the target groups (4.2.1 and 4.3.1), 2) demonstration and discussion of formal institutions that affect the target groups' *health-seeking behaviors* (4.2.2 and 4.3.2), and 3) demonstration and discussion of informal institutions that affect target groups' *health-seeking behaviors* (4.2.3 and 4.3.3).

4.2.1 Identified health problems, health care needs and demands, and *health-seeking behaviors*

In this Subchapter I delve into a demonstration of the detailed sexual health problems that migrant women confront of, their demands and needs regarding sexual health and the concrete health-seeking behaviors that they conduct to deal with the problems or to meet the demands and needs. Because of the nature of embarrassment and privacy of sexual health it happened during the face-to-face qualitative interviews from time to time that an interviewee refuse to respond frankly to the question regarding sexual diseases she had caught. Hence, I also resort to research findings from previous quantitative researches on migrants' sexual health to give a more comprehensive overview of sexual health problems that migrant women face.

4.2.1.1 Sexual health problems: gynecological diseases, STDs, unexpected pregnancy and induced abortion

In present-day China, particularly in urban areas, more liberal attitudes toward sexual behaviors have become apparent with rising prevalence in pre-marital sex and prostitution in the general population, including rural-to-urban migrants. Regarding the demographic characteristics, rural-to-urban migrants are generally young and in a sexually active period of their life. (Long 2004:61) Moreover, rural-to-urban migration offers young migrants the opportunity to separate from their old rural social networks providing relatively strict moral constraints on individual behaviors. Urban life with an anonymous setting allows them to have a more liberal attitude towards sexual behavior. (Hoy 2008:118-119) It was also indicated by Zheng et al (2001) that far from home, in unfamiliar and difficult circumstances in the cities, migrants are more likely than before to engage in casual sexual

behaviors to cope with the feelings of anxiety, loneliness and isolation. As a result, premarital sex is no longer taboo among unmarried migrants. For the project purpose I also interviewed young unmarried migrant couples who lived in rented apartment in urban villages in Guangzhou. As to married migrants, particularly among male migrants whose spouses stay in hometown or don't resident in the same city, extramarital sex is considered to be acceptable and common. (Long 2004:60) It was also reported in the interviews in urban villages that there are young migrant women engaging in casual commercial sex for additional income.

Associated with the active and casual sexual behaviors, rural-to-urban migrants are facing risk of genitourinary system diseases. With regard to migrant women, inflammation of the reproductive organs, such as cervicitis, pelvic inflammation, ovarian cysts, and STDs, are reported in interviews.[23] Moreover, unexpected pregnancy due to unprotected sex and induced abortion among young migrant women are of a special concern, as reported by interviewed gynecologists. The high rate of induced abortion can be linked with the strict attitude toward premarital pregnancy in China. Despite the tolerance to premarital sex, premarital pregnancy remains taboo in China. The survey of unmarried migrant women by Zheng et al (2001:123) shows that if a hasty marriage cannot be arranged, a premarital pregnancy usually ends in induced abortion, because they consider premarital pregnancy a shame, causing the couple and their parents to lose *face*[24] if discovered. A quantitative survey (Shi, Shi et al. 2000) of 693 migrant women who had experienced induced abortions also showed that induced abortion is also correlated with previous delivery history of the married migrant women, and is influenced by China's birth control policy. This research indicates that three groups of migrant women are most likely to have abortions: those whose firstborn child is a boy, those whose first- and second-born children are both girls, and those who have given birth to a girl and are on the four-year waiting period before allowed to have a second baby, according to China's birth control policy. Subchapter 4.2.2.3 further discusses China's birth control policy and explains how it influences migrant women's decisions to give birth or resort to induced abortion. Subchapter

[23] Due to the high sensibility of the issue of sexual health and to avoid the possible embarrassment of migrant interviewees the interviewers did not raise questions addressing directly the name of sexual diseases, such as "was kind of gynecological disease or STDs have you ever had?" or "what kind of facilities did you visit when you faced gynecological disease or STDs?" Thus, the names of diseases listed here were reported by interviewed doctors and by only two migrant interviewees (07/Shipai/51) (08/Lijiao/29), who on her own initiative, talked about her experience of coping with a gynecological disease.

[24] "Losing face" is discussed in chapter 4.2.3.1 and chapter 4.3.3.2.

4.2.3.1 reviews Chinese tradition of preference for boys and seeks a linkage with the sex-selective abortion.

Using condoms is the commonly accepted or recognized method of STD prevention, and contraception and condoms are available everywhere in China's urban areas (Hoy 2008:125). Apart from numerous condom vending machines distributed in main streets and different residential areas, including urban villages, free condoms are also provided by the administration of urban villages and local public health facilities from time to time. However, the frequency of condom use among migrants is still rather low. Quantitative research by Li et al (2007) shows, for example, 49.5% of a total of 425 interviewed migrants never have used a condom during sexual intercourse and only 7.5% of all interviewees have used a condom the last three times they had sexual intercourse. A survey with unmarried migrant women in five Chinese cities (Zheng, Zhou et al. 2001:123) indicates the four obstacles that limit condom use among migrants: 1) unplanned and spontaneous sexual activities; 2) migrant women's inability to negotiate condom usage with their partners who do not want to use contraception; 3) embarrassment about obtaining condoms (this is also related with the issue of *losing face*); and 4) an incorrect consideration that free condom distribution is only for married women.

4.2.1.2 *Healthcare-seeking behaviors* in cases of contracting gynecological diseases, STDs and facing unexpected pregnancy

Migrant women's *healthcare-seeking behaviors* to cope with gynecological diseases or STDs are similar to their behaviors when they contract other illnesses. When they are aware of contracting an illness, a three-step strategy would be employed: The first and most common step when symptoms emerge is adopting a "wait and see" attitude instead of taking any therapeutic measures. (Gransow 2010:24-25) When the symptoms become more serious, they are likely to go to pharmacies and buy medications based on their own knowledge, which they receive from advertisements, friends, or family members. Only when the situation becomes much more severe will they seek counsel from a doctor. In previous researchers distinct difference regarding the "wait and see" attitude and the behavior of delaying seeking healthcare between male and female migrants has not been revealed. The statement of a gynecologist working in a community-based

public health clinic summarized this three-step strategy of coping with gynecological diseases as follows:

> "Migrants would wait and see rather than go to a clinic and be checked when they faced minor illnesses which have little negative influence on the daily life, unaware that these minor illnesses, such as cervicitis and pelvic inflammation may turn to chronic diseases. If the symptoms are not severe, they may also buy and take medicines. Only if an illness is so severe that it influences the daily life badly will they would go to clinics or hospitals." (08/Chajiao/H)[25]

Interviews reveal that the high cost of health care services and financial constraints are the crucial reasons why migrants are likely to adopt self-treatments instead of seeking care in medical facilities. Regarding this issue, a drugstore owner in Tanwei village on the fringe of the city reported as follows:

> "Seeing a doctor in a hospital costs at least 100 to 200 Yuan, sometimes it costs even more than 300 Yuan. This is just the price for those small outpatient departments around there［the urban villages where the drugstore is located］. You tell me, how can I afford the costs in the hospitals in the urban district? I don't have medical insurance and must pay all the costs by myself. And medical checks in a hospital cost a lot of money too." (08/Tanwei/34)

To avoid the high costs in the city, it was also reported by some interviewees that they would return to their inland hometowns to seek health care. Before making a decision between going back to their hometown or staying in the city, migrants tended to do quite precise calculations of the total costs and compared the treatment they are going to receive at the different locations. An interviewee described such a calculation, for example:

> "Whether I would go home to medical treatment? It depends. For

---

[25] Hereafter the interview quotations are indicated by code. Interviews with migrant women in urban villages and expert/stakeholder are coded by three digits. The first two number indicate the year of the interview (for example, 08 refers the year of 2008). The middle letters refers to the location where the interview took place (i.e. the name of urban village in case of migrant interviews and stakeholder interviews or district in case of expert interviews). The last digit refers to the number in the interview list (see Appendix I). In case of expert/stakeholder interview the number is replaced by a letter. In case of an interview with an expert who has migrant background, the last digits are a number and a letter. For example, "08/Chajiao/H" refers to an expert/stakeholder interview conducted in 2008 in Chajiao Village. Interviews with FSWs were coded by two digits- "FSW" and the corresponding number in the interview list (see Appendix I).

example, if the treatment is going to cost more than 1000 Yuan ［in the city］, I will definitely go home, because the treatment in the hometown will cost less than here anyway. Some easy operations cost more than 10,000 Yuan here, but in my hometown, only a couple of thousands Yuan. In such a case, I would also definitely go home. " (08/Tanwei/34)

After calculating the performance-price ratio, some migrants would rather stay in the city for health care. The owner of a food shop (08/Chajiao/19) responded as follows, for example:

> Q[26]: "Would you go back to your hometown for medical treatment?"
>
> A: "No. I know that it will cost less in the hometown, but if you count in the travel costs, the total costs will be almost the same as in the city."
>
> Q: "In your eyes, how is the health care service in your hometown compared with that in the city?"
>
> A: "The difference isn't significant."

In terms of the types of health facilities migrants use for seeking health care in case of facing severe illnesses, the interviewees showed a clear preference for public and large hospitals. Migrants commonly believe that public ownership and the large-size facilities represent a high quality of health care provision, as they have skilled practitioners and modern medical equipment. Some migrants report that they are reluctant to use health care services provided by private small clinics due to mistrust in the service quality and the accountability of the practitioners. For example, an interviewee considers that aiming at reducing cost, private clinics may violate the medical safety regulations. Regarding this consideration she reported:

> "Sometimes you need to get intravenous injections ［to treat e.g. fever］. If you go to a small clinic … you may be worried that the injector ［which should be disposable according to Chinese medical safety regulations］ they used is unclean. You may also be worried that they keep the used injector und use them for the next patient." (07/Xinfenghuang/52A)

In some previous studies (e.g. Zou, Wu et al. 2005, Zheng and Lu 2007, Anonymous 2008, Yang and Yang 2009) there were comments noting that rural-to-

---

[26] In interview quotations hereafter presented as dialog, the letter "Q" refers to the question raised by interviewer and the letter "A" refers to the answer by interviewee.

urban migrants use health care in private clinics because the service cost in private clinics is lower than that in public hospitals. However, interviews in Guangzhou reveal that migrants have realized that the service cost in private clinics may be also high because practitioners may use tricks to convince the patients to pay for additional treatments. Due to this consideration, migrant patients are less likely than before to be attracted by private clinics. One interviewee reported such considerations, for example:

> "Private clinics gave me a feeling that their costs are lower［than big hospitals］, but generally they are not better than big hospitals. Medicines prescribed by the doctors in private clinics cannot heal you. Then you must go there again. So, at last you are going to pay as much money as you pay in big hospitals." (07/Xinfenghuang/52B)

Tricks used by private clinics were confirmed by interviewed practitioners with working experience in private clinics. These tricks are further elaborated in Subchapter 4.2.2.1.4.

Interestingly, it was reported by a few migrant interviewees that they had sought health care in private clinics. Two reasons were identified to explain this decision. The first reason is that this migrant may have migrated into the city just recently, and is unfamiliar with the neighborhood. If this migrant had suddenly fallen ill with serious symptoms, he/she might easily be inclined to visit facilities located close to the place of residence, where many private clinics are located. A medical practitioner reports that the business of some private clinics depends exclusively on the high mobility of rural-to-urban migrants. She described this situation as follows:

> "Why are these private clinics able to survive? Because there are a lot of migrants! They don't live in a place permanently. … They will realize they are cheated［by private clinics］later. But they will leave and new people come. The new people become ill and will see a doctor ［in a private clinic］nearby. As long as the patient visits the clinic he/she will get ripped off, like the predecessor. This is the way the private clinics run their business." (07/Tangxi/E54)

Recommendation of friends and family members seems to be the other reason why some migrants visit private clinics. To some extent, the general distrust in private

clinics will be dimmed by a good reputation among the patients' social network. An interviewee about 20 years old, living with her parents and siblings in Chajiao village, reported the reason why she visited a private clinic providing Chinese traditional medicine as follows:

> "I did visit a private clinic prescribing Chinese medicine named Fangxin. We［interviewee and her family members］often passed by the clinic and saw that it had quite a few patients and we were told by friends that the clinic is very good. And they［friends and family members］say that Chinese medicine is good for girls. So, I visited the clinic sometimes." (08/Chajiao/16)

It was also reported by some migrant interviewees that they consult doctors in private clinics in their hometown run by acquaintances or relatives. For example, an interviewee (07/Shipai/51) from Jiaoling County, Guangdong Province responded to the question about her experience with private clinics as follows:

> Q: "Have you ever seen a doctor in a private clinic?"
>
> A: "No, not here［in Guangzhou］. But I did visit private clinics in my hometown, because I trust these clinics. They are facilities run by my own relatives or relatives of my relatives. … In Guangzhou I've never dared to visit a private clinic."

Another interviewee from Donghai County, Guangdong Province who claimed that she would never visit a private clinic in the city reported that she seeks health care exclusively in one private clinic in her hometown:

> "I did visit a private clinic. … That's a clinic run by my aunt. Since I was a kid I visit her clinic when I got sick. Only this one… My aunt is very good at pediatrics. Everybody in the five towns of the Donghai County knows about her reputation. … Outside my hometown I've never visited a private clinic." (07/Xinfenghuang/52B)

Compared to their high distrust of private clinics in the city, it was reported by some migrant interviewees that they sought health care in community health care service centers (CHCSCs) or community health care service stations (CHCSSs), which were initiated by the Chinese central government and affiliated to public district hospitals. Given migrants' favor for public hospitals, it can be assumed that the public status of CHCSCs and CHCSSs is the main reason to gain migrants' trust. However, CHCSCs and CHCSSs are facing a series of problems that weaken

their advantage as public facilities and result in disfavor of patients. These problems are elaborated in Subchapter 4.2.2.1.2.

Generally, a voluntary induced abortion is legally allowed in China.[27] A drug abortion in the first trimester is easily available in both hospitals and public community-based health facilities, for example, Family Planning Service Stations (FPSSs)[28], CHCSCs, and CHCSSs. However, migrant women are likely to delay seeking abortions because they either have not recognized the pregnancy or have not dealt with the situation in time. As a result, some of them have to experience multiple abortions, including complicated surgical abortions, in a late stage of pregnancy. Migrant women are likely to conduct induced abortion in private and sometimes unqualified clinics. Such decisions may be derived from their believing that their confidentiality can be better protected, so that they can avoid a situation of *losing face*. Similar to the situation of facing gynecological diseases, STDs and other illnesses, financial consideration seems to be another crucial determinant to migrant women's decision of choosing a facility for an abortion. Some of them decide to conduct an abortion in private clinics, because they believe that the price is lower than in public hospital. However, interviews reveal that there isn't a significant difference regarding price of abortion at the private and public health facilities. This is reported by a doctor who was used to be employed by a private clinic as follows:

> "［Compared with public hospitals］an abortion in a private clinic will be a little bit cheaper, which may cost around 1,000 to 2,000 Yuan. Nobody［health practitioner］would give a surgical abortion for only a couple of hundred Yuan, there is a considerable risk involved." (07/Tangxia/F55)

The risk of conducting an abortion reported by 07/Tangxia/F55 was confirmed by a gynecologist (07/Tangxi/E54). She reported a case of a migrant woman who sought surgical abortion in a private clinic and faced a severe health risk:

> A: "The woman already had a drug abortion several days ago, but failed. So she came to the clinic for a uterine curettage. She had inflammation and her uterine wall was very thin. Under such circumstances, the doctor should not conduct a uterine curettage.

[27] Attempting to avoid sex-selective abortion, there are special municipal regulations regarding abortion. For example, it is stipulated in Ha'erbin City that an induced abortion after a 14 weeks pregnancy can only be conducted with an administrative approval. In Guiyang City, an induced abortion after a 14 weeks pregnancy is completely forbidden. (Li 2009)

[28] Health services provided by FPSS are discussed in Subchapter 4.2.2.1.3.

> But the doctor, a doctor older than 50, did that and caused a uterus perforation."
>
> Q: "The doctor did that because he had little experience?"
>
> A: "Absolutely right! The doctor caused the medical accident."
>
> Q: "Was the woman a migrant and young?"
>
> A: "Yes, she had given birth for two or three babies. She was bold and thought that she would be ok after the drug abortion. So she delayed the time for seeing a doctor."

In sum, delayed seeking of abortions or seeking surgical abortions from an unqualified private clinic or physician enhances migrant women's health risks in the event of unexpected pregnancy.

4.2.1.3 Needs of sexual health education

Inconsistent to their sexually-active status and the related health risks, rural-to-urban migrants are generally lacking the knowledge of diseases related to sexual health, and have limited access to education on disease prevention and contraception. This situation can be linked to the general lack of sex health education for young Chinese at the age of sexual initiation, both at home and in schools. Since sexuality is considered as an embarrassing topic, information about contraception and other sex-related information are seldom imparted by parents to their children. Due to the consideration of some educators and members of the governmental authorities that sexual education may encourage premarital sex, sexual health education is only given as a small component of the courses on basic human physiology in middle school for teenagers from 12 to 17, according to national education curriculum. (Zheng, Zhou et al. 2001:125, Hoy 2008:122-123) Given the poor educational conditions in rural areas in China, particularly in the remote hinterlands, young migrants from rural areas have less access to sexual education than young people in the cities. (Long 2004:60) As a result, migrants are likely to use informal sources of information (e.g. medicine advertising given on the internet exaggerating the function of the medicine), which are often inaccurate and misleading (Hoy 2008:124), resulting in risky and unprotected sexual behaviors and enhancing the risk of infection with STDs and unexpected pregnancy. An interviewee devoted to migrant rights protection reported a case of unexpected

pregnancy of a young migrant woman due to her lack of contraception knowledge as follows:

> "A lot of young girls are new migrants in the city and have little gynecological knowledge. There was a young migrant girl who fell in love with a migrant boy and had sex with him. They saw the advertisement of cool tea[29] noting that the tea is not suitable for pregnant women. Then, they assumed that cool tea had a contraceptive function. So the girl drank a lot of cool tea but still got pregnant." (07/Tianhe/D)

Lacking of contraception knowledge is also common among married migrant women. For example, misleading information common among migrant women was reported during the interviews: a nursing woman cannot become pregnant and contraceptives during the nursing period are not needed.

4.2.1.4 Demands of maternity care and *care-seeking behaviors* in case of giving birth

Questions on migrant women's usage of maternity care and *care-seeking behaviors* regarding childbearing were raised during the interviews. With regard to maternity care, the interviews reveal that compared with permanent residents, pregnant migrant women were less likely to seek to maternity care services in the city. Without relinquishing all prenatal examinations, they take examinations irregularly and based on their own knowledge. According to the recommendations of professional Western gynecology, a pregnant woman should attend prenatal examinations at least five times during the pregnancy. (Zhan, Sun et al. 2002:53) This standard is barely held among pregnant migrant women. A gynecologist reported the common strategies of migrant women regarding prenatal examinations as follows:

> "Most migrants do go to take prenatal examinations, but not systematically and regularly. Sometimes, they take an ultrasonic check or an amniotic check. Some take a check to exclude ectopic pregnancy as well. They may also see a doctor in case of vaginal bleeding. With a pregnancy of seven or eight months they

[29] Cool tea (*liangcha* 凉茶) is one kind of widely available local drink in Guangdong Province to deal with the high temperature and humid climate.

may come to check the position of the fetus. Close to delivery time, … they may also take a placenta check and amniotic check." (07/Tangxi/E54)

Similar to the situation of contracting illnesses, financial constraints seem to be the main obstacle for migrant women's to access to maternity care. Without maternity insurance, which is included in the urban medical insurance system and covers the cost of routine prenatal examinations,[30] migrant women must pay for all these services out-of-pocket. The cost consideration forces them to relinquish necessary services or resort to private and even illegal clinics, where service prices may be cheaper, but treatment often insufficient and unreliable, as a gynecologist reported:

> "Prenatal examination at a private clinic means checking the position of the fetus and the fetal heart beat, sometimes also an ultrasonic check. That's all, nothing else. The cost is very low, about 10 to 20 Yuan, in some clinics even only 2 to 5 Yuan." (07/Tangxi/E54)

Interviews in Guangzhou reveal that migrant women also lack access to postnatal care due to financial constraints. This situation is reported by a gynecologist as follows:

> "［To give birth］some migrant women choose to go to hospitals, some go to private clinics, but that can cause problems. All of the costs are at the expense of the migrants. For example, the poor ones try to save money and leave the hospital earlier ［than the doctor recommends］. Some even leave after the birth immediately and ［in case of caesarean delivery］come back to have stitches removed." (08/Chajiao/H)

During the interviews, migrant women were asked about the location where they gave or they are going to give birth. It was often reported that they preferred to return to their hometowns and give birth in a county hospital. A department director of a private plastics factory located in Haizhong village (08/Haizhong/13) reported that it is a common phenomenon among pregnant migrant workers that they will ask for a maternity leave for a few months and go back to their hometown to give birth. At the time of interview, it was stipulated in the Chinese Labor Law that all female employees were entitled to a maternity leave of 90 days. (Department of

---

[30] Urban medical insurance and maternity insurance are further discussed in Subchapter 4.2.2.2.

Women's Right of Women's Federation Shenzhen 2004:211)[31] In the words of the interviewed director, maternity leave of the migrant workers is tolerated by the factory, and migrant employees are welcomed to come back after the delivery. However, the interviewee didn't make it plain how long a maternity leave is tolerated. Since she reported that some pregnant migrant workers "simply quit the job" and didn't come back to work again, a situation cannot be excluded that pregnant migrants were not able to keep their job because of too "long" a leave. Surveys of the Department of Women's Rights at the Shenzhen Women's Federation (2004:211) also revealed that some private firms will not fire pregnant migrant workers directly. Instead, they will relocate pregnant workers to lower-paid positions on the pretext that former jobs cannot be fulfilled anymore due to the pregnancy and force the pregnant workers to resign at the end. Chinese Labor Law (Standing Committee of the National People's Congress 1994) and regulations later on (e.g. the special regulation on labor protection of female employees, State Council of PRC 2012) stipulate that during the maternity leave, wages should be paid as usual. However, without exception, migrant women interviewed reported that their employers stopped paying wages as long as they were on leave for giving birth. Thus, pregnancy means a period of termination of financial sources for migrant women, as a matter of fact, and exacerbates their financial constraints.

Financial constraints and the high cost of delivery in the city seem to be the key reasons why the pregnant women return to the countryside. As reported by interviewed migrants, an easy delivery in the countryside costs only about 400 to 500 Yuan, whereas at a hospital in the city, it costs about 3000 to 4000 Yuan. The cost of a delivery in complicated situations, such as in case of a difficult birth or premature birth, can be much higher and reach up to more than 10,000 Yuan. Another explanation for migrant women's decision for giving birth in the countryside is that some of them wish to have traditional birth attendants, and they trust in some indigenous methods which are not necessarily accepted by Western medical practices, but deemed to facilitate delivery. Moreover, migrant women lack access to postnatal care, and rest in the cities after the delivery, whereas they can be better taken care of by family members at home in the countryside. This is also a consideration that drives them to give birth at home. A customary expectation of the postnatal care in China is known as *zuoyueyi (坐月子),* which means that

[31] According to the stipulation of maternity leave which was released in 2012, female employees are entitled a maternity leave of 98 days. Those who had a difficult delivery are entitled to 15 more days. (State Council of PRC 2012)

women who have given birth are entitled to have a resting period of about one-month. In Subchapter 4.2.3.2, I give a further explanation of this custom and try to elaborate its influence on migrant women's preference of giving birth in the countryside.

Interviews in Guangzhou also reveal that the family planning policy plays a crucial role to some migrant women's decision as to where they are going to give birth. Interestingly, as reported in the interviews, the attempt to evade the family planning regulations can be the reason for both a decision of returning to the countryside or staying in the city to give birth. As to the former, a gynecologist reported:

> "Most migrant women prefer to give birth in their hometown, except for those who want to evade the family planning policy. They are afraid to go home." (07/Tangxi/E54)

Meanwhile, a migrant interviewee working in a glass factory reported in the interview as follows:

> Q: "Do the female migrant workers in the factory give birth here in the city?"
>
> A: "Some do so. But those without open minds who want to have a boy don't." (08/Haizhong/45)

These responses reveal that the family planning policy seems to have a significant impact on migrant women's strategy of choosing the location for giving birth. Thus, I give a further discussion on family planning policy in Subchapter 4.2.2.3, with a focus on the detailed regulations targeting rural-to-urban migrants. A further question can be raised here: why a migrant woman would rather to violate the governmental policy to have a boy, as interviewee 08/Haizhong/45 reported above, even if she is already aware of the potential punishment? To answer this question, I elaborate in Subchapter 4.2.3.1 the patriarchal tradition of preference for boys deeply embedded in Chinese society and the obsession of having male offspring.

4.2.2 Formal institutional factors influencing migrant women's *health-seeking behaviors*

This subchapter discusses the formal institutional factors that have impacts on migrant women's health-seeking behaviors. Firstly, the discussion focuses on

community-based health facilities in urban China and the health care they provide and used by migrant women. (4.2.2.1) I looking at the health facilities and the health service they provide and explore how are governmental policies of health care provision implemented on the local level in urban China. Linking the situation of service usage the effectiveness of policy implementation can also be revealed. Subchapter 4.2.2.2 then delineates the findings of the linkage of the medical insurance and maternity insurance and the health-care seeking behaviors. Subchapter 4.2.2.3 focuses on the policy of family planning and birth control and their influences on migrant women's health-care seeking behaviors.

4.2.2.1 Community-based healthcare facilities and services

This subchapter focuses on health facilities located in or on the fringe of urban villages, and medical services they provided, as reported in the migrant interviews in Guangzhou. I classify these health facilities into three categories according to ownership: (1) public facilities, represented by large public hospitals (4.2.2.1.1), CHCSCs and CHCSSs (4.2.2.1.2) and FPSSs (4.2.2.1.3); (2) private health facilities (private clinics) (4.2.2.1.4) and (3) health facilities financed and run by public-private partnerships (4.2.2.1.5). Health care facilities that are not included in the discussion here are the private hospitals in medium- and large-size cities. These facilities are usually visited by affluent Chinese inhabitants or foreign employees of international corporations with high incomes. The service prices in these facilities are too high to be affordable for rural-to-urban migrants. The analysis takes into particular consideration the policies that shape the current status of health facilities. I also evaluate policy implementation with regard to the services these facilities provide and service utilization by rural-to-urban migrants.

4.2.2.1.1 Large public hospitals

As pointed out in Subchapter 4.2.1.2, rural-to-urban migrants generally have a quite obvious preference of seeking health care in large public hospitals, but face the obstacle of high service costs. To understand this situation, it is necessary to review the thus-far reform of the urban health care sector and its consequences on

public hospitals.

As part of the nation-wide market-oriented economic reform since 1978, the urban health sector has experienced an impressive structural change. With regard to public hospitals, one of the significant changes is the revising of financial resources. Vast cutting of public subsidies resulted from financial decentralization and the withdrawal of central government as the main contributor in public sectors (e.g. education and public health) have led to increasing pressure on public hospitals, and forced them to resort to financing themselves. Inconsistent with their financing responsibilities, public hospitals are not totally autonomous economic entities, and lack the right of pricing. The price of almost every single medical service provided by public health facilities (i.e. public hospitals and CHCSCs, CHCSSs, FPSSs discussed later on) are stipulated by provincial health ministries. According to the governmental price regulation, the price of diagnostic services and treatments are much lower than machinery medical examinations. For example, in Guangdong Province in 2008, a complicated emergency rescue involving multiple medical practitioners cost only 20 to 80 Yuan, while the price of a single examination with magnetic resonance imaging was up to 1100 Yuan. (cf. Price Control Administration of Guangdong Province and Department of Health of Guangdong Province 2009) Under such price regulation, public hospitals and their practitioners may entice patients to seek high-cost medical examinations instead of concentrating on diagnostic services and treatments. (Yang, Zhang et al. 2003:212) Parallel to the price regulation, the government has loosened the restrictions on another source of income, pharmaceutical sales, allowing public hospitals to retail medications in their own pharmacies and keep 15-25% from the wholesale price as profit. (Xu 1998:34) Statistics show that about 85% of all medications were sold in this way in 2005. (Jiang, Yan et al. 2005:149) This situation can be explained by the fact that, unfamiliar with medical and pharmacological knowledge, patients are likely to purchase medications in the hospital pharmacies directly after consulting, although the same medications may also be available and cheaper in other pharmacies. Moreover, pharmaceutical industries send representatives to hospitals, drumming up business for prescribing their products, luring medical practitioners with high profit-sharing. An investigation (Wang 2005) reveals that an internist may obtain 10% to 20% from the sale medications recommended by a pharmaceutical representative. In some cases, profit from medication sales could account for 80% of the total income of an internist. Against this backdrop,

medication sales have become the most important source of income at public hospitals, making up 42.75% of the total income of all "General Hospitals" managed by the Ministry of Health in 2005, for example.[32] Counteracting this phenomenon, which is called *yiyao yangyi* (以药养医, literally "using medications to feed medicine") in Chinese, and significantly increasing drug prices, China's central government stipulated the price of the medications most commonly used. Moreover, when medication sales covered over 30% of its annual income, the public hospital is subjected to an investigation by health administrative departments. (Ministry of Health and Ministry of Finance of PRC 2000) However, researchers (e.g. Yang and Shi 2006) criticized this policy, pointing out that the price regulation of medication applies only to a small number of medications, and medical practitioners can find other strategies to keep more costly medication consumption at a high level, over-prescribing expensive medications, for example. Overuse of machinery medical examinations and medication over-prescription have led to the high cost of seeking health care services in large public hospitals, which was reported by interviewed migrants.

A further question may be raised now: why the interviewed migrants still prefer to seek health care services in large public hospitals? The question can be explained by the good reputations of large public hospitals, built through the possession of medical resources consisting of large-scale and high-tech inspective and diagnostic medical devices and qualified and experienced medical staff. Reputation is crucial for competition and for consumers' decision-making, as Stiglitz and Walsh note (2002:291): "The necessity of establishing a reputation acts as an important barrier to entry and limits the degree of competition … Given a choice between purchasing the product of an established firm with a good reputation and the product of a newcomer with no reputation at the same price, consumers will normally choose the established firm's good."

As discussed above, machinery examinations have became a crucial resource of income for large public hospitals to deal with the shortage of state subsidies. As a result, large public hospitals have the incentive of purchasing medical devices, and as a matter of fact, they possess many more medical devices than other health facilities of smaller size. High-tech medical devices, and the potential profit they bring, give large public hospitals the advantage of attracting

[32] Own calculation according to the statistic on income and expenditure of general hospital published by Health Ministry of PRC 2005

qualified and experienced medical staffs. Due to the asymmetric information in the doctor-patient relationship, and the characteristics of heterogeneity of health care, it is difficult for patients to assess the quality of health care. (Stiglitz and Walsh 2002:291-299). Patients easily regard modern medical devices and qualified medical staffs as the symbols of the good reputation of a health facility, linking them with good service quality. It was observed during my field work that advertising medical devices, in particular those newly purchased from time to time, and listing the specialists with photos on the registration office, are the strategies commonly used by health care facilities to attract patients.

4.2.2.1.2 Community health care service centers and community health care service stations

In 1997, a community-based health care system was initiated by the Chinese central government with the goal of improving basic medical services in urban areas. (Zhou and Ma 2009:87) Within the framework of this system, community health care service centers (CHCSCs) and their affiliated stations, community health care service stations (CHCSSs),[33] have been established in cities at the Street Office level and below. In Guangzhou, CHCSCs and CHCSSs are under the authority of district hospitals. District hospitals have the authority to make official appointments and dismissals of CHCSC and CHCSS personnel. According to the guidelines, CHCSCs and CHCSSs provide basic clinical and public health services. Basic medical services include diagnosis and treatment of common diseases, Traditional Chinese Medicine, emergency care, home visits by doctors, and referral services. Public health services include management of non-communicable chronic diseases, maternal and child care, geriatric care, resident health record management, health care contracting, physical rehabilitation, planned immunizations, and health education (Yang, Guo et al. 2008:426). Guidelines for the establishment of a CHCSC or CHCSS are oriented to the size of the population. According to the statement of a representative from the health administration of Guangzhou, on average, for every 10,000 residents, at least one CHCSC or CHCSS should be available, which can be reached within 15 minutes on foot. In the developed areas of the city of Guangzhou, 92 CHCSCs and 109 CHCSSs had been established by

[33] Generally one CHCSC is in charge of three to six CHCSSs. (Yang, Guo et al. 2008:422)

the end of 2007. According to the same data source, the permanent population in Guangzhou has exceeded 6.34 million. The total population would presumably be much higher if migrants were included. In other words, on average, every CHCSC or CHCSS de facto serves more than 30,000 residents instead of 10,000, as required by the guidelines. (Guangzhou Municipal Statistic Bureau and Guangzhou survey office of National Bureau of Statistics 2008:60,593). This situation indicates that at least in terms of quantity, the scope of CHCSCs and CHCSSs cannot meet the health care needs of the rapidly-increasing urban population in Guangzhou yet. Aiming at providing medical services for inhabitants on the grass-roots level and reducing inhabitants' time and costs for seeking these services, CHCSCs and CHCSSs were established in or near local residential communities, for example, urban villages with a high inhabitant density.

According to the interviewed physicians working in CHCSCs or CHCSSs (08/Liwan/O), the development of CHCSCs and CHCSSs are facing two main obstacles, financial constraints and personnel shortages. As to the former, the government expenditures can hardly meet the CHCSC and CHCSS financial needs, although the community-based health care system is supported by financing from both central and local governments. Government appropriation for CHCSCs and CHCSSs is paid according to the number of residents for which the CHCSCs and CHCSSs are responsible. However, this calculation of residents counts only the residents with urban *hukou,* ignoring the migrant population. Moreover, financial support for CHCSCs and CHCSSs strongly depends on the financial capacity of local governments and varies from city to city. (Shi 2009:299, Xu, Sun et al. 2009:74) In 2002, for example, governmental compensations could cover only 10% of the overall costs of CHCSCs and CHCSSs in Guangzhou while CHCSCs and CHCSSs in two other cities in PRD, Dongguan, and Shunde, did not receive any governmental compensation at all. (Zou, Wu et al. 2005:1111) Along with financial constraints, personnel shortages represent another problem which the CHCSCs and CHCSSs have to face. As already discussed in Subchapter 4.2.2.1.1, large public hospitals maintain a monopolistic position. Although CHCSCs and CHCSSs are also public facilities, there is a significant disparity in salaries and opportunities for promotion between CHCSCs/CHCSSs and large public hospitals. As a result, medical personnel with better educational backgrounds and higher professional titles are inclined to work at hospitals rather than in CHCSCs and CHCSSs. A physician in his fifties working in a CHCSC in Yuexiu District, dissatisfied with his

job, stated in the interview:

> "When I was 20 years younger than now, I would never choose to work here." (08/Yuexiu/K)

Financial constraints and lacking of human resources are leading to an emphasis on CHCSCs and CHCSSs for out-of-pocket diagnosis and treatment, as well as a neglect of low-profit and non-profit public health services. In other words, in terms of the quality of health care services, the desired function of a community health care system, providing both basic curative and preventive health services, has not been implemented so far. The contradiction between the ambitious aim and the harsh situation faced by CHCSCs and CHCSSs was reported by an interviewed physician as follows:

> "The annual 25 Yuan per capita contributed by the governments isn't much money. Because we [CHCSCs and CHCSSs] are bearing a lot of tasks after obtaining the money, not only outpatient service, but also building up medical files for patients in the precinct, giving education for disease prevention, and so on. To do all these jobs we need more personnel, which costs quite a lot. … As clinicians, we really hope that the governments can contribute more money so that we can concentrate on serving the people instead of earning money. Health care is a special area and is about public welfare." (08/Yuexiu/K)

Lacking of experienced practitioners, CHCSCs and CHCSSs can hardly build up a good reputation to attract patients. This situation further enhances their financial constraints. Financial constraints, lacking of medical resources and shortage of patients have shaped a vicious circle, encumbering the development of CHCSCs and CHCSSs. It must also be noted that migrants are more likely than permanent residents to seek care in CHCSCs and CHCSSs. For some CHCSCs and CHCSSs, out-of-pocket services used by migrants have become their major income source, as a physician working in a CHCSC in Liwan District reported:

> "We must make a profit for surviving. … Serving migrant patients is the single way for us to survive now. They pay out-of-pocket. We make profits mainly through giving some examinations and dealing with traumas." (08/Liwan/O)

Migrants' preference for CHCSCs and CHCSSs can be explained, firstly, by the fact that CHCSCs and CHCSSs are affiliated institutions of large public hospitals,

which to some extent create a linkage with a good reputation. Secondly, due to financial constraints, CHCSCs and CHCSSs are generally not able to purchase high-tech medical devices that would enable the facility to provide more unnecessary and expensive machinery medical examinations. As a result, the cost of health care services in CHCSCs and CHCSSs are generally lower than in big hospitals. This is the reason why CHCSCs and CHCSSs are able to attract some migrant patients.

Concerning health care services for migrants, health education provided by CHCSCs and CHCSSs should be highlighted. In urban villages in Guangzhou, community-based health care education is offered by village administrations with the support of CHCSCs and CHCSSs, e.g. through posting posters about STDs/AIDS and communicable disease prevention, as well as giving lectures that target all village residents. However, interviews revealed that migrant interviewees were not very interested in community information, neither in posters nor in information campaigns conducted by CHCSCs and CHCSSs. This may be explained by the fact that migrant residents are generally marginalized and discriminated against in the communities. Migrants usually don't have any identity to the communities where they live in and pay little attention to events happening in the neighborhoods, including health education. Hard work and lack of leisure time are also reasons why migrants pay little attention to health education given in urban villages. An interviewee responded to the question on the health education targeting women as follows:

> "I'm quite unfamiliar with these events. I go to work early and come back home late. How can I know what happens in the village during the day? Even on the weekend, I usually stay at home and seldom go out. I don't care about these things." (08/Xiadu/48)

The director of a CHCSC in Liwan district reported the following embarrassing situation faced by his facility:

> "In order to attract an audience (to the health care lectures) we must offer them soap, shampoo or laundry-powder, purchased with our own budget. … Pictures of the lectures should be taken to prove that the lectures were actually held and must be handed in to the government for annual service assessment. Sometimes the size of the audience was too small to take pictures so that we had to hand in pictures of the same lecture (with a relatively bigger

audience) for different occasions. … We asked the people to shift their places. But they were actually the same people." (08/Liwan/O)

What this interviewee reported reveals that the target population's low interest in health issues decreases the effectiveness of community-based health education.

4.2.2.1.3 Family Planning Service Stations

Besides CHCSCs and CHCSSs, Family Planning Service Stations (FPSSs) were another type of public health facility located in urban villages and identified during field investigations. Compared to CHCSCs and CHCSSs, FPSSs have relatively smaller scale. They are managed and financially supported by district health bureaus and bureaus for family planning. Their focus is on periodical obligatory check-ups for all female residents of childbearing age, which are annually conducted in April, August and December and outlined in the family planning policy. To enhance the birth control policy, the gynecologists of FPSSs also visit factories with high proportions of migrant women and provide check-ups there. In terms of routine work, FPSSs offer free obstetric examinations, counseling and basic out-patient diagnosis and treatments to both local female residents and migrant women. In complicated cases, patients will be transferred to higher-level hospitals, such as district Maternal and Child Care Hospitals or district Peoples' Hospitals, also subordinate bodies of district health bureaus and bureaus for family planning. Moreover, as a component of the family planning policies, free condoms are provided by FPSSs when their visitors come for contraceptive counseling. Local residents are required to show "certificate for family planning services" (*jihuashengyu fuwuzheng* 计划生育服务证) before receiving services, while migrant women need to show resident identity card and "marriage and birth certificate" (*hunyu zhengming* 婚育证明). A "marriage and birth certificate" carries information on the holder's marital status, record of giving birth and status of the implementation of contraception in line with family planning policies. As reported by the employee of FPSSs, since 1998, every married migrant is required to apply for a "marriage and birth certificate" before leaving the place of their residence registration and to carry it during the migration. It can be concluded that migrant women who tend to avoid the birth regulation and didn't apply for a marriage and

birth certificate will be excluded from accessing services provided by FPSSs.

4.2.2.1.4 Private health facilities

The booming development of private facilities is a significant phenomenon which has been observed in the sector of health care services in urban villages in recent years. Among the private health care providers, there are legally-registered facilities and also illegal facilities or practitioners. Since 1998, a legal health facility must at least hold three licenses: a business license, a license for the medical unit, and a doctor's license for the practicing physician. If a health facility lacks one of these licenses, it is officially regarded as being illegal. (Lim, Yang et al. 2002:15, Meng 2005:20) Due to the flourishing of health care providers, the Guangzhou administration started to set limits for new registration of providers. As a result, in some cases, practitioners have opened a clinic without acquiring a doctor's license or registration for their facility. In other cases, practitioners do not register their facility in order to avoid having to pay taxes. Such a case was reported by villagers in Baihedong Village in Liwan District:

> "One private doctor is a local villager. … He used to be a barefoot doctor[34] in this village for more than twenty years. … Since the medical station of village was dissolved, he runs his business at home. He is good at pediatrics. All the people living in the village know that. But now the local people are not likely to visit him anymore, only migrants often do." (07/Baihedong/B)

As reported by local media (Anonymous 2008), to avoid inspections by local governments, practitioners without a doctor's license are likely to give diagnoses and treatments in officially registered pharmacies. Moreover, widespread trade with fake licenses makes the government's initiatives to contain illegal medical practitioners more difficult. A former doctor employed by a private clinic described the situation in Guangdong Province as follows:

> "There are lots of people who sell fake licenses. I received flyers for fake licenses in Tangxia village where I live. … A friend of

[34] In the former rural health care system based on the collective planned economy, barefoot doctors were members of the village collectives and responsible for the primary health care of other collective members. They were given a short training in the district hospital or the county health department and provided medical counseling and treatment for villagers from time to time. The health care services provided by barefoot doctors were paid out of collective funds for health care. After the collective economy and the former rural health care system collapsed, barefoot doctors vanished. (Huang 2004)

> mine has worked in different health facilities in urban villages in Dongguan city for several years. He is even a chief physician. Only when the government sent people for license inspections recently, he told his boss that he was not holding a license." (07/Tangxia/F55)

My field observation and interviews with health care providers suggested that illegal providers tend to concentrate in urban villages due to the weak exertion of state control in these settlements. This hypothesis is supported by the fact that illegal providers were usually ensconced in smaller side streets deep in the villages. The number of illegal providers is higher in villages located near the core areas of the city. This situation is probably linked to the much higher concentration of migrants in these areas, who are the major customers. However, as discussed in Subchapter 4.2.2.1.1, Chinese patients hold a common attitude of distrust towards small private health facilities. Thus, the number of patients at private clinics is generally low, and private clinics are likely to use tricks extorting every single patient. Such tricks were reported by a gynecologist:

> "For example, a patient can be cured by paying three Yuan. But they (the private clinics) are able to squeeze 3000 Yuan from the patient at the end. They may persuade the patient to use some instruments for check-ups, some simple and cheap physiotherapeutic instruments for example, claiming that they are instruments imported from Germany, Japan or Australia and exaggerating the treatment effects." (07/Tangxi/E54)

The same interviewee also reported how a gynecologist of a private clinic lures a patient suffering gynecological illness to pay more money step by step:

> "Firstly, the patient visits the clinic and the doctor gives her a regular diagnosis. Then the doctor sends her to an examination, using colposcope, for example …, which can show the diseased organ clearly. The doctor shows the picture to the patient and says: 'You see, you're ill and must be treated. A simple cervicitis may develop to a cervical cancer.' Everybody is afraid of cancer. So the patient will take the doctor's advice for further treatments. … The doctor uses firstly a regular treatment, which hurts badly. Then he talks to the patient: 'You're so sensitive to pain. We should use a microwave therapy. It hurts less. One therapy costs only 200

Yuan.' … Just like that, step by step, more than 2000 Yuan will be squeezed at last."

During the field observation, clues that support the report of the gynecologist were found. Photo 4 was taken in front of a private clinic in Shipai Village. The red board hanged on the wall in the clinic advertises the extremely low price of service: two Yuan for a pregnancy test, five Yuan for a gonorrhea test and twenty Yuan for a B-Ultrasound check.

Photo 4: A private clinic in Shipai Villages ©Yuan-Ihle

As discussed in Subchapter 4.2.2.1.1, patients usually lack the ability to estimate the quality of health service due to asymmetric information and simply link service quality with the size of the facility, medical devices and the perceived qualifications of practitioners. The interviews reveal that asymmetric information is also used by private clinics as tricks to attract patients. Since private clinics are usually small in size, they concentrate on faking medical devices and the qualification of their practitioners. An interviewee (07/Tangxia/F55) who had worked in a private clinic responded to the question on medical devices used by the clinic as follows:

> Q: "How about the medical devices? Are they new or second-hand?"
>
> A: "I can hardly tell whether they are new or old. In case they are old devices, the boss［of the clinic］ could do some 'make up' on them, (so that they looks new)."
>
> The response of the same interviewee to the question on the price of registration reveals the fact that private clinics may exaggerate

> the qualification of practitioners to attract patients:
>
> Q: "How much must a patient pay for the registration before seeing a doctor in the clinic?"
>
> A: "There are different prices, from one Yuan to four Yuan."
>
> Q: "Why are there such differences?"
>
> A: "The price to consult an expert doctor is higher. Consulting a normal doctor is cheaper. … If the clinic doesn't claim that it has expert physicians, it wouldn't have any patients."
>
> Q: "You mean we don't know whether a practitioner is really an expert?"
>
> A: "Exactly. In order to gain the trust of patients, some practitioners who aren't experts are claimed to be experts. This is a psychological strategy［to attract patients］."

Despite of all these illegal and sly tricks, private clinics still have some advantages in attracting migrant patients. Compared with those in large public hospitals, practitioners in private clinics are more patient and polite towards patients. Thus, migrants who often feel being discriminated against in the cities may feel more comfortable when they consult doctor in a private clinic. Moreover, private clinics have usually longer business hours than public health facilities. This is convenient for migrants who often work late and overtime. Such advantages of private clinics were explained by a gynecologist as follows:

> "It's difficult to see a doctor in big hospitals. There are too many patients there and you must wait for a long time. In private clinics you don't need to wait. The doctors in private clinics are much more friendly and they are good at communicating with patients, while doctors in big hospitals are so busy that they have little time to talk with the patients. Furthermore, private clinics have a longer opening time, usually from 8 to 12 am. After a lunch break for about two hours they are open until 10 pm or 11 pm, at least until 9 pm. So, it's convenient for migrants to see a doctor after work." (07/Tangxi/E54)

More convenient services provided by private clinics were observed during the field observation. For example, Photo 5 (page 91) shows a vehicle advertising the name, address, phone number and hotline number of a private clinic in Tangxia Village. The vehicle is arranged by the clinic. Patients who have a reservation will

be picked up from and sent back to the underground station nearby.

Photo 5: A vehicle that provides pick-up service for patients in Tangxia Village ©Yuan-Ihle

4.2.2.1.5 Health facilities financed and run by public-private-partnership

During the field work, facilities that are operated by both public and private owners were identified in urban villages. For example, one type of these facilities is the reformed health care station of the former collective villages which cooperated with private health facilities. According to the statement of the chairman of the economic cooperative of Changban village in Tianhe district, the former village health care station still exists nowadays and provides basic and routine diagnoses and treatments, but has been integrated into a middle-sized private hospital, called Changxing Hospital. Within the cooperation framework, Changxing Hospital hires former barefoot village doctors and provides practical training programs for them. As the hospital's cooperation partner, Changban village's economic cooperative and its local members benefit from the program in the form of a share of the annual earnings and a remission of registration fees from the health care state, while other patients (e.g. migrant residents) must pay all of the costs for services out-of pocket.

4.2.2.2 Medical insurance and maternity insurance

Social medical insurance and maternity insurance belong to the five essential social insurances in present-day China.[35] To provide universal, nationwide coverage for China's rural and urban population, and along with the initiative of private medical insurance, three social health insurance schemes, namely: the urban employees' medical insurance (UEMI), the urban resident's medical insurance (URMI), and the

[35] The other three social insurances refer to: pension-, work-related-injury, and unemployment insurances.

new rural cooperative medical insurance (NCMI), have been developed. (Gu 2007:90) The UEMI is planned to cover all employees and the self-employed population, including rural-to-urban migrants, with the insurance contribution expected to be shouldered by both employers and employees. However, the coverage rate of UEMI among rural-to-urban migrants remains quite low. As China's National Bureau of Statistics (2013) reported, in 2012 only 16.9% of rural-to-urban migrants carried an employees' medical insurance. This low coverage rate can be derived from the fact that the UEMI is non-compulsory. As to the employers of migrants, in particular the private and small-sized enterprises, they are unwilling to join the medical insurance because of potential higher cost considerations. Migrant employees, whose income is generally low, are also unwilling to join to insurance, regarding it as a financial burden. Migrants' attitude towards participating in UEMI was reported by Mr. Ma, the manager of a village-owned business centre of Chajiao village, who is also a migrant from Hunan Province:

> "Although the enterprise pays a part of the contribution for the medical insurance, the migrant employee must pay the other part. That means a cut of 100 to 200 Yuan from their monthly income. His/her total monthly income is only about 1000 Yuan. After paying the insurance, there is less left. So, they aren't willing to take the insurance." (08/Chajiao/P32)

Self-employed migrants (e.g. shop owners in urban villages) and unemployed migrants (e.g. housewives or parents of migrant workers who also live in cities) should be covered by UEMI and URMI, respectively. However, it was reported by both of these two interviewee groups that they were unfamiliar with urban insurance policies, and did not know either which insurance they could join or where they could apply for it.

It was reported by some interviewees that they had participated in the NCMI in their rural hometown, and for that reason, did not join any urban medical insurance. The NCMI was initiated by China's central government in 2003. After a dismal period in the first three years, NCMI has begun to proliferate due to a series of policy modifications, which include increasing governmental subsidy to the insured population and providing higher levels of benefits covering both out-patient and in-patient medical services, for example. (Gu 2007:95-96) According to the official statistics, NCMI has covered 98.5% of all the rural population (including rural-to-urban migrants that hold a rural *hukou*) by the end of 2006. (Gu

2007:94) As reported in interviews, the annual payment for NCMI amounts to 10 Yuan per person, much lower than a monthly contribution to UEMI and URMI. As a result, NCMI is more preferred by rural-to-urban migrants than UEMI and URMI. However, only medical services provided by health institutes on the village, town, and county levels in the rural areas, where the insurance contract is signed, can be paid by NCMI. Hence, although some rural-to-urban migrants have taken part in NCMI, they cannot actually profit from NCMI in the cities. In need of health care, they are prone to conduct self-treatment instead of consulting medical professionals, or they choose to return to their hometown for medical treatment when facing serious illnesses. (cf. 4.2.1.2)

Maternity insurance that is implemented in present-day China refers to maternity leave, prenatal and postpartum medical services, and birth allowance. (Song and Shi 2009:57-58) Unlike medical insurance, contribution to the fund of maternity insurance is paid by employers to cover insured employees' cost of birth-related medical services and birth allowance. According to "the Interim Measures of Maternity Insurance for enterprise employees" released in 1994 (Ministry of Labor of PRC), maternity insurance "merely applies to enterprises and their employees in the cities" and should be conducted based on the "principle of territorial jurisdiction". Since this regulation has not provided further explanation to the principle of territorial jurisdiction, local governments link maternity insurance with the *hukou* registration and exclude rural-to-urban migrant employees from entitlement. (Wang 2012:22) The practice of amalgamating rural-to-urban migrants into maternity insurance was firstly conducted by Xiamen, Chengdu, and Guangzhou Cities in 2007. (Xiang 2010:16, Feng 2011:54) In 2008, Guangdong Province released "Regulation on maternity insurance for employees in Guangdong Province," stipulating that all employers must pay the maternity insurance contribution for their employees, including rural-to-urban migrants. (Shang 2009:52) Migrant employees' right to maternity insurance is reaffirmed in the nationwide law, "the Social Insurance Law," promulgated in 2010 (Standing Committee of the National People's Congress). The Social Insurance Law also stipulates that unemployed spouses of insured employees are also entitled to medical services in line with maternity insurance. (Luo and Lu 2012:93) This adjustment of policy shows a tendency that more and more rural-to-urban migrants will be covered by maternity insurance. However, rural-to-urban migrants having a status of formal employment is still a precondition to join maternity insurance, so

far. Self-employed migrants (e.g. shop keepers), as well as migrant workers without contracts and their spouses, are not entitled to maternity insurance. Moreover, an insured employee can benefit from the maternity insurance only after the employer has contributed into the insurance fund for at least one year. (Shang 2009:52) In order to avoid their responsibility for maternity insurance, it is of frequent occurrence that employers sign a working contract that is valid for less than one year. (Huang 2013:53) Migrants usually consider birth-related issues as private matters and are unfamiliar with the legislation of maternity insurance. Thus, they usually not to ask for maternity insurance while seeking a job, and often merely take job payment into consideration (Hu, Jiang et al. 2012, Huang 2013) Interviews with female factory workers in Guangzhou also reveal that they are not familiar with either birth allowance or birth-related medical services included in maternity insurance. An employee of a plastic factory (08/Haizhong/13) reported that migrant women would be deeply grateful if the employer allowed them to take an unpaid maternity leave instead of dismissing them. Intensive working conditions and lack of necessary protection are two crucial reasons for pregnant migrant women to quit the job. Such involuntary leave is often used by migrant women's employers as an excuse to avoid paying maternity insurance, claiming that involuntary leave implies a voluntary abandonment of the entitlement to maternity insurance. (Hu, Jiang et al. 2012:28-29) In addition, interviews reveal that migrant employees greatly lack information about which insurance they are entitled to, and often lump different insurances together. For example, a migrant woman working a glass factory (08/Haizhong/14) responded to the question about her medical insurance as follows:

> Q: Has the factory paid for medical insurance for you?
>
> A: Yes.
>
> Q: Have you ever used the insurance? Have you ever gotten money back when you were ill?"
>
> A: No, and it will never happen, because the insurance can be used only when you are hospitalized."

In this case, the interviewee confused medical insurance with work-related injury insurance, which is enforced by China's government more strictly than medical insurance, due to a high work-related injury rate among factory workers, and available to cover in-patient medical treatments. In another case, an interviewee (08/Tanwei/36) wrongly regarded private accident insurance as maternity insurance:

> Q: “Have you joined maternity insurance?”
>
> A: “Maternity insurance? Yes, I bought one when I gave birth. ... I gave birth in my hometown, and then came to Guangzhou. … We didn’t pay too much for the delivery. 400-500 Yuan was enough. … That maternity insurance could be used only when accidents (during delivery) happened. It doesn’t mean that it pays the delivery.”

The lack of awareness of their right to insurance and inadequate knowledge provides opportunities for migrants’ employers to evade their duty of paying a contribution for employees’ insurance. To deal with the insurance policy and governmental supervision, it is of frequent occurrence that employers buy insurance for only a small part of their employees, leaving a great part of employees uninsured. As criticized by Zheng et al. (2007:383) and Gu (2007:92), such deceit is often tolerated by local governments, considering enterprises’ contribution to local fiscal revenue.

4.2.2.3 Family planning policy and birth control targeting rural-to-urban migrants

In an attempt to slow down the rapid population growth, the Chinese central government decided to introduce family planning in the early 1970s, and announced in 1980 the one-child-per-couple policy across the country. Since then, this draconian policy has been modified several times due to the strong resistance, especially from peasant families in rural areas (Gu, Wang et al. 2007:130) Although birth control remains a basic state policy, its implementation varies from one locale to another. Under the general principle of slowing down population growth, modifications to the state policy have been left to each province/autonomous regions. With regard to the allowable number of child, there are different regulations in different province/autonomous regions, which are summarized as follows (Xie and Tang 2011:5):

- One-child policy, which is applicable for Chinese citizens with an urban *hukou* and all Chinese citizens in Jiangsu and Sichuan Provinces, regardless of the *hukou* status
- One-and-a-half-child policy, which is applicable for Chinese citizens with rural *hukou* in most rural areas, except Jiangsu and Sichuan

Provinces, stipulating that couples in these areas are allowed to have a second child after a specified birth internal if the first child is a girl

- Two-child policy, which is applicable for Chinese citizens with rural *hukou* in Yunnan, Qinghai, Hainan, Xinjiang and Ningxia Provinces
- Two-and-above-children policy, which is applicable to minority ethnic groups, overseas Chinese, and people with disabilities

Exemptions of the one-child-per-couple rule can also be found in the provincial-level birth control regulations. For example, 29 provinces/autonomous regions allow rural couples, both of whom are the only child in their family, to have a second child; six provinces/autonomous regions allow rural couples to have a second child as long as one of them is the only child in the family. Moreover, nine provinces have abolished the requirement of four-year interval between the first and second birth, which used to be applied in almost all provinces/autonomous regions. (Xie and Tang 2011:35)

Since the early 1990s, leading politicians in all government levels at or below provincial level are held responsible for policy enforcement. Population control became a key indicator for the evaluation of performance of local politicians. A "vote-veto system" (一票否决权) was initiated, whereby all policies of a particular politician would be voted down if his/her designated locale failed to meet the birth control target. In rural areas where most migration originates, township governments and villager committees are the enforcement bodies of the birth control policy. The leading politicians of each governmental apparatus would sign a so-called "responsibility contract" with their superiors to ensure strict enforcement. Under such pressure, the implementation of the birth control policy is strict, rough, and inhumane, in particular in rural areas. (e.g., Anonymous 2015, Liang and Huang 2015) In some areas, for example, regardless of the actual conditions, all women are subjected to inserting intrauterine devices after giving the first birth and all couples are subjected to perform sterilization after the second birth. Some pregnant women were forced to conduct induced abortions for alleged transgressions of birth control policies. (Xie and Tang 2011:6) Over the years, with growing international criticisms and the rising awareness of human rights violations in Chinese society, China's government gradually shifted away from utilizing forceful restrictive administrative methods as a penalty for not adhering to the family planning policy, to charging "Social Maintenance Fees" (社会抚养费, SMF), instead. Local difference is reflected in the policies of charging SMF. The

"Measures for Administration of Collection of Social Maintenance Fees," released by China's central government in 2002 (State Council of PRC), set up the general principles for charging SMF, stipulating that local governments should take into consideration the local income level and the income levels of the persons involved. Provinces/autonomous regions and municipalities were allowed to determine their own specific standards for charging SMF. Taking Guangdong and Sichuan Provinces as an example, for the first birth violating the family planning policies, a rural couple in Guangdong would be charged a fee 3 to 6 times local per capita net income. Whereas, in Sichuan Province, the fee would be 6 to 8 times the local per capita net income. (cf. Standing Committee of the People's Congress of Sichuan Province 2007, Standing Committee of the People's Congress of Guangdong Province 2008)

Until 1991, the implementation of family planning policies targeting rural-to-urban migrants was based on the *hukou*-system. In the rural areas, township governments and villager committees were responsible for birth control policy. Rural-to-urban migrants hold rural *hukou*, but live de facto far away from the countryside. Thus, the implementation of birth control policies based on the *hukou*-system has become more and more ineffective. A survey conducted in 2005 (Cao 2010:83-84) shows that 95%, 87%, and 61.1% of all births in Shenzhen, Guangzhou and Dongguan cities, respectively, avoiding family planning policies were given by rural-to-migrants living in the cities. To meet this challenge, local governments of migrants' current residences were authorized to manage the issue of birth control regarding migrants through the "Measures for family planning management among floating population," released in 1991 and revised in 1998, stipulated that "family planning among floating population should be managed jointly by governments of their residence registration and by those of their current residence, but mainly by the latter." (Li 2003:15) In an attempt to enhance family planning management among migrants in cities, and recognizing that a great number of migrants rent and settle in private apartments (e.g. in urban villages), further central and local regulations (e.g. "Suggestions on strengthening family planning among floating population," released in 2007 (National Health and Family Planning Commission of PRC) stipulated that property owners or managers were responsible for their migrant lodgers if the lodgers avoided the family planning policy. Photo 6 that was taken in Kengkou Village shows the local regulation on reporting cases of violating the family planning policy targeting

migrant residents in the village. According to this regulation, who reports a birth against family planning policy, an evading of performing sterilization, an evading of inserting intrauterine devices and evading of regular intrauterine devices check-up will be rewarded with 100 Yuan, 20 Yuan, 10 Yuan and 5 Yuan, respectively.

Photo 6: Regulation on reporting cases of violating the family planning policy in Kengkou Village ©Yuan-Ihle

Another change of the family planning policy targeting rural-to-urban migrants was the stress of providing reproductive health care and contraceptive education. As the "Regulations on management and service of family planning among floating population" (National Population and Family Planning Commission 2003) stipulates, rural-to-urban migrants should be treated as equally as local residents by local governments and are entitled to receive the same education and services as local residents. The implementation of this changed policy on a local level is demonstrated by the fact that services provided by FPSSs are available for both local female residents and migrant women (cf. 4.2.2.1.3). The vice-chief of Haizhong village reported in the interview how his village provides reproductive services to migrant women associated with a CHCSC, emphasizing the equal treatment to migrants:

> "Every year we provide at least one gynecological check for all women of child-bearing age, and simultaneously, check whether

> they have had intrauterine devices inserted or gotten pregnant. Now, with regard to family planning, we treat local women and migrant women the same. … Gynecological check-ups are free. We also give gifts to the women ［to attract them to come in for check-up］ Because we give gifts and other villages don't, some women living in other villagers also come to our village to have a check-up. If they cooperate well, we can then do our job well." (08/Haizhong/L)

However, equal treatment of local and migrant women with regard to reproductive services has not been implemented in the entire Guangzhou urban area. For example, migrant women living in Chajiao Village do not receive any subsidy for gynecological check-ups like local female villagers, as the head of the village reported:

> "Every quarter, the community hospital offers a free check-up for women. Our business association supports this, contributing 10 Yuan per check-up. … We don't provide subsidies for migrant women, because they are not entitled to welfare paid by us. They have to go back to their hometown where their family planning documents are issued for care." (08/Chajiao/I)

The draconian family planning policies play a significant role in migrant women's decisions about where they give birth and their utilization of health services. If pregnant migrant women are aware that the birth of their child is going to violate the family planning policies, and they attempt to avoid the charged fees and rigorous processes of policy execution, they usually choose to give birth at the locations without strict official control. If the implementation of birth control is draconian in the city and her hometown on the countryside, pregnant migrants would likely resort to illegal facilities or even delivery at home without any professional medical attendants. This is the most risky decision for both the parturient and the newborn in words of an interviewed gynecologist:

> A: "Some migrants would rather give birth at home, thinking that giving birth is a risk anyway."
>
> Q: "Giving birth at home? What would they do without any professional medical knowledge?"
>
> A: "I don't know what their considerations are, but they give birth at home anyway. A migrant couple wanted to hide from family planning control and decided to give birth at home. The husband

> had no idea how to cut the cord accurately and cut it at the root."
> Q: "He shouldn't cut it at the root but leave a section, right?"
> A: "Right. He should leave 1.5 to 2 centimeters. What he did was really dangerous. … Besides, giving birth at home may cause profuse bleeding. And a difficult birth may easily lead to death."
> (07/Tangxi/E54)

Moreover, as discussed in Subchapter 4.2.2.1.3, FPSSs are the subordinated bodies of district health bureaus and bureaus for family planning. Although they provide free contraceptive counseling and prenatal services available for all residents, these service would not be used by migrants who tend to/or have already violated the family control policy.

The most recent change in the family planning policy is the rule, released in October 2015, stipulating that every legally married couple may have two children. Abandoning the one-child-per-couple principle, which had been observed for over 30 years, this brand-new regulation implies a significant change in the family policy. Further studies on the implementation of this new regulation and consequences of this policy change are needed.

4.2.3 Informal institutional factors influencing migrant women's *health-seeking behaviors*

This subchapter is dedicated to trace out the two informal institutions- son preference and the practices of "doing the month" that have impacts on migrant women's health-seeking behaviors. The former is in relation with migrants' fertility behaviors and the latter can be used to explain migrant women's behaviors regarding giving birth and their usage of maternity care. The tradition of son preference and the belief of "doing the month" are deeply embedded in Chinese society, especially in rural areas where migrants come from, and perdurable. On the other hand, they are facing the percussive challenges from the changes of society. Among these are the changes of gender relation, the family roles of women and the belief on what are adequate and healthy postnatal cares. This subchapter attempts to reveal why and how far such changes taken place so that migrant women's health-seeking behaviors can be explained.

4.2.3.1 Persistence and change of son preference

In order to understand migrant women's fertility behaviors and their concrete decisions made regarding childbirth, the tradition of son preference cannot be neglected. The tradition of son preference is deeply embedded in Chinese culture and can be explained by the ancestral worship, kinship system and the derived patrilineal and patrilocal marriage custom. Afterlife is of important for many Chinese people due to the tradition of ancestor worship. They believe that the departed souls can be ensured and protected by the ancestors, so they perform a series of rituals to worship their ancestors. Because these rituals should be carried out by male offspring, one's afterlife is insecure without sons, grandsons and great-grandsons. (Gupta, Jiang et al. 2003:166) In China's society of strong kinship, traditional genealogical records are regarded as vital, and the family line can only be continued by male offspring. The main family assets such as land, which is a significant asset in rural society, are passed on through male line. Thus, males of every generation have the compelling obligation to produce the male offspring. Not bearing male heirs is an unfulfilled duty for the family, and is regarded as the most unfilial conduct. (Cao 2008:39) In a patrilocal culture, a daughter leaves her parents' home and resides at husband's home at marriage. Uxorilocal marriages are extremely rare in China's society. (Li 1996:24) With regard to land assets in China's rural villages, as long as a daughter marries out, her share of land in her parents' village will be seized and reallocated among village residents. (Gupta, Jiang et al. 2003) Regarding the association between son preference and old-age support, analysts (e.g. Attané 2009, Ebenstein and Leung 2010, Leutner 1989) point out that in the patrilocal cultures, a son provides his parents with two caregivers, as his wife moves to his home at marriage, while the wife's parents can't count on the daughter for old-age support. Given the fact that married women can contribute little to her parental family's welfare, raising daughters is therefore regarded as a "losing business" (Cao 2008:39), and therefore, female offspring are unwelcome. Bearing a son is the way for a woman to ensure her standing and gain respect in her husband's household. As the saying goes that "mother becomes valued because of her son" (*mupingzigui* 母凭子贵) (Chen 2009:56), it was often noted by analysts (e.g. Li 1996:56, Li 2004:174, Chen 2009:56, Leutner 1989), that a women without a son is vulnerable to both taunts by others in the community she lives in, and blame and mistreatment from her husband and parents-in-law (e.g.

suffering isolation, physical harm, and even forced to divorce). As to the husband and parents-in-law of the woman, without male offspring, they also suffer public humiliation and private grief that the family lineage has come to an end, and they have let down the ancestors. For the whole family, such taunts and humiliation by the community is considered a loss of *face*, which is associated with severe shame and linked with high mental stress and dissatisfaction. (Gupta, Jiang et al. 2003, Chen 2009) In Subchapter 4.3.3.2, I give further explanation on the system of maintaining *face* in China's society, linking Chinese attitudes to sexual behaviors and sex work. In sum, Chinese, and especially those living in and/or originating from rural areas (e.g. rural-to-urban migrants) that observe great conformity to traditional values and a strong kinship system, are likely to seek better emotional satisfaction and more economic advantages from having male rather than female offspring. Therefore, they are likely to persistently adhere to son preferences when it comes to making a decision regarding fertility. The preference for sons is manifested in sex ratio at birth, which shows the number of male infants compared with female infants. A quantitative survey (World Bank 2006) using data taken from China's population censuses from 1953 to 2000 reveals that the disparity in sex ratio at birth has been widespread in most regions of China, with the highest ratios in Guangdong Province and Jiangxi Province. To some extent, it can be inferred from this result that the preference for sons has a stronger influence in these two provinces than in other provinces.

With regard to rural-to-urban migrants' fertility behaviors, two driving forces that potentially facilitate changes in migrants' attitudes towards son preference should be pointed out. The first one is migrants' urban life, which is significantly different from that of rural areas. As noted above in Subchapter 1.3, social networks (e.g. *tongxianghui*) are significant for the movement and job-seeking of migrants in cities. Simultaneously, migration into cities allows migrants to remain distant from their rural social networks, reducing the influence of others on their individual conduct. Whereas a family living in a rural village without male offspring will face taunts and discrimination from other village residents, a couple who have migrated into a city may have less such pressure and are less likely to feel they are *losing face* when the wife bears a daughter instead of a son. The second driving force is associated with economic considerations, which may result in a decision of having fewer children. During the interviews, migrants often reported concern of the high cost of raising children as a main stress in their daily

life. For example, a worker at a plastics factory (08/Haizhong/44) reported the high school tuitions of her children in Guangzhou as follows:

> Q: “Where does your stress come from?”
>
> A: “The main problem is that we are short of money. We have three children. Two of them ［a son and a daughter］ go to school. Another son has gone to work saying that he wants to earn money by himself for education. … Our living expenditure is very high. The education for my son costs a lot of money.”
>
> Q: “The two children go to school at your hometown or in the city?”
>
> A: “They now go to school in Huadu District［in Guangzhou］. We pay more than 10,000 Yuan for tuition for each year.”

Another interviewee (08/Lijiao/29), a housewife that raises a little baby and lives with her husband in Lijiao Village, also reported the high stress from raising child in the city:

> “It is my husband who earns all money, about 1000 Yuan per month. Baby articles and foods are very expensive. …The majority of our money is spent raising the child, such as costs for seeing a doctor, buying clothes and milk powder. ”

Moreover, as Attané (2009:99) argues, it becomes a common attitude of parents (including migrant couples) in present-day China that they demand a better quality of life for their offspring. Facing the high cost of raising children, they prefer to have fewer children and invest more in them, especially by providing them better diets and education. Research by Wu et al also reveals that rural-to-urban migrants of the younger generation are more inclined to reduce their family size than the elder generation, because they are much more reluctant to face a worse quality of life due to the burden of raising too many children.

In sum, in present-day China, rural-to-urban migrants’ decision regarding fertility is still influenced by the tradition of son preference, which demands male offspring in quantity. Simultaneously, migrants face sweeping economic and social changes associated with the experiences of rural-to-urban migration, as well as the governmental regulation of birth control. Taking all these factors into account, two main fertility strategies might be practiced by migrants: 1) Due to the tradition of son preference and the consideration of the high value of a son to the family, a migrant woman may continue childbearing until reaching their desired number of sons (usually at least one son) and then stop bearing. The strategy was mentioned

by a gynecologist for example:

> "Generally, migrant parents want to keep bearing babies covertly. As long as the women get pregnant, the babies would be born. They would rather send the babies to other families or relatives than incur abortions. … Migrants from rural areas will keep bearing children, until they have a son." (07/Tangxi/E54)

2) An alternative strategy practiced by some migrant couples who have fewer children either voluntarily or involuntarily is sex-selecting a child and aborting the female fetus. Attané's research (2009:97) reveals that sex selective abortion more likely occurs in the second or later pregnancy, in particular for female fetuses that have an older sister already. China's government has criminalized prenatal sex determination, facing increasing male preference at birth that drives sex-selective abortions. However, the techniques of prenatal sex determination is still of widespread availability. (Attané 2009:99) None of the interviewees reported using techniques of prenatal sex determination or aborting female fetus, perhaps due to the illegality of prenatal sex determination or embarrassment. However, during field observation in urban villages in Guangzhou, private clinics advertising B-Ultrasound checks, one of the techniques of prenatal sex determination, were observed. Given rural-to-urban migrants are the main clients of these private clinics, it can be inferred that prenatal sex determination is, in fact, frequently conducted among migrants in Guangzhou.

4.2.3.2 Practices of "doing the month"

It was often reported by interviewed migrant women that they prefer to go back to their hometown to give birth. (cf. 4.2.1.4) To understand this decision, the Chinese custom of "doing the month" (*zuoyuezi* 坐月子) should be taken into consideration. The custom of "doing the month" can be traced back to the Song dynasty (960-1279 CE), and its conceptual origins based on Chinese traditional medicine may extend back to Han dynasty around 2000 years ago. (Heh 2004:11, Tung 2010:369, Zhu 2010:97) The term "month" refers to the postpartum period of about four to six weeks, during which a postpartum woman recovers after childbearing. "Doing the month" refers to a series of taboos, rituals, and proscriptions in relation to how a woman should behave during her postpartum period. (Zhu 2010:97) It is believed that conducting proper practices of "doing the month" can help a postpartum

woman to recover quickly and to avoid illnesses that may be incurred by childbearing. Conversely, improper practices during *the month* may lead to contracting illnesses that cannot be cured unless the patient gives birth again and does *the month* properly. (Heh 2004:12-13)

In the context of Chinese traditional Medicine, the foundation of health is the balance of *Yin* (阴) and *Yang* (阳) in the human body, which is related to cold and warm, respectively. Giving birth is viewed as a process of breaking the balance, and a postpartum woman is under the condition of extreme *Yin.* The practices during the "month" are designed to help the woman receive more *Yang* energy and avoid *Yin* energy, so that the body can ultimately equilibrate the balance towards recovery. (Liu, Maloni et al. 2012:55-56) Thus, practices that postpartum women should engage in during the *month* includes avoiding cold water (e.g. bathing and brushing teeth); eating certain types of Yang-foods (e.g. chicken, pig's trotters, ginger, internal organs, eggs and rice wine) and refraining from eating Yin-foods (e.g. fruits, vegetables, cold water and ice cream). They are also required to stay indoors with closed windows, and prohibited from going outside to avoid getting the wind and maintain warmth in the body. Postpartum women's indoor activities are also limited. They are required to avoid squatting, standing for long time (harmful for uterine recovery), watching television and reading books (disturbance in vision). (Tung 2010:369, Zheng 2011:21) Even their maternal role is strictly restricted. For example, they are prohibited from holding or carrying the newborn baby for a long time, because these activities are believed to lead to chronic pain in arms and back. (Liu, Maloni et al. 2012:56) The strict rules of *doing the month* are not easy to follow, and some traditional rules are now to be questioned and modified, particularly with the introduction of Western medicine, Nevertheless, most Chinese women still believe *doing the month* necessary for the sake of their future health and conform to these rules. (Heh 2004, Holroyd, Lopez et al. 2011, Liu, Maloni et al. 2012) During the period of *doing the month*, social support from family members is essential for postpartum women. Research (e.g. Heh 2004, Liu, Maloni et al. 2012) demonstrates that a postpartum woman can benefit physically and psychologically from the social support of family. Female family members of the postpartum woman, usually her mother or mother-in-law, care for the new mother and her postpartum body, and perform housework and other more physical duties that the postpartum woman should avoid. (Zhang, Liu et al. 2009:52) Furthermore, since the elder women have the maternal experience, and have done

the month before, they are able to give the new mother practical advice on nursing the baby and how to practice *the month*. All this support allows a postpartum woman to have more time to rest and recover, as well as giving them a "buffer period" to adapt to motherhood. (Holroyd, Lopez et al. 2011:51) In association with the patrilineal and patrilocal cultures, a Chinese woman resides with her husband's family after marriage, and her status in the family remains low until she gives birth to the offspring for her husband's family. Childbirth is a significant event for a woman to confirm her status as wife, daughter-in-law and an important family member. (Heh 2004:12) Some postpartum women regard *doing the month* and the attentive care they receive as a right to which they are entitled, and a kind of reward honoring them after the extremely demanding tasks of pregnancy and giving birth (Zhang, Liu et al. 2009:57) There are studies (e.g. Heh 2004, Zhang, Liu et al. 2009) that observed the correlation between *doing the month* and the psychological health of postnatal women, revealing that the greater the level of family support during the period of *doing the month*, the lower the risk of postnatal depression. International comparative studies also found a much lower incidence of postnatal depression in Chinese women than women in the Western world, owing to the tradition of *doing the month* in China. (Zhu 2010:98)

Migrant women's adherence to practicing *doing the month* provides an explanation of why they are likely to go back home in the countryside to give birth. Poor living conditions (e.g. living in a rental apartment in urban villages or dormitories lacking of space, light and poor access to warm water) are not suitable for practicing *doing the month*. Living space in a migrant's residential dwelling is usually confined, not allowing the migrant woman's mother or mother-in-law to stay in the city and care for the postpartum woman and her new-born baby. During interviews with migrant women, seeking care during the period of *doing the month* was repeatedly mentioned as a serious concern when it came to the decision of choosing a place to give birth. This consideration was reported by a gynecologist coming from countryside, as follows:

> "Most pregnant migrants go home to give birth. ... There they have family and people who take care of them. It's more convenient ［than in the city］. They feel at home there, whereas they feel being isolated here［in the city］." (07/Tangxi/E54)

Moreover, food prices in the cities are much higher than that in countryside. This situation also drives migrant women to give birth in the countryside, so that the

specific diet prescribed to a postpartum woman *doing the month* can be better assured.

4.2.4 Conclusion

This chapter has presented the findings addressing sexual health and health-seeking behaviors of rural-to-urban migrant women living in urban villages in Guangzhou. I have described the sexual health problems faced by migrant women. Among these are gynecological diseases, STDs, unexpected pregnancy and induced abortion. Contracting STDs, unexpected pregnancy and the burden of having induced abortion are linked with the lack of sexual health education. Behaviors engaged in by migrant women to cope with gynecological diseases or STDs are similar to their behaviors when they contract other illnesses. When facing minor illnesses or when patients are not aware of the severity of the illness, they are prone to ignore the illness and take a “wait and see” approach. Only when the symptom has become severe do the patients begin active coping strategies, such as self-treatment with medications purchased through private pharmacies and seeking advice from a doctor. Migrant women often consult a doctor or seek medical care in private (sometimes illegal) clinics, although they often favor the medical services in large public medical facilities and distrust the service quality in private clinics. Regarding the issue of childbirth, migrant women are in need of maternity care but they are less likely to seek such services in the city. It is a common decision of migrant women to go back to their hometown to give birth.

Policies of providing urban medical services, medical and maternity insurance and family planning policy affect migrant women’s health-seeking behaviors. Financial decentralization, the withdrawal of the central government as the main contributor and the strict governmental price regulation in the public sector have led to financial pressure on public hospitals and their physicians. It has become common for large public hospitals to provide profit-oriented medical services, which manifests itself in the form of excessive medical treatment and medicine overprescription, in turn leading to a high cost of service. Many migrant women favor the health services provided by large public hospitals due to their good reputation. However, this preference is limited due to the high cost. Superfluous medical treatment and medicine overprescription have also

undermined the reputation of large public hospitals and led to distrust among patients.

The policy of developing CHCSCs and CHCSSs has been designed by China's government to provide affordable basic public health services to inhabitants (including rural-to-urban migrants) on the grass-roots level. However, the service quality and reputation of these facilities have eroded due to the limited financial support from the government. Moreover, the majority of rural-to-urban migrant women are covered neither by urban medical insurance nor maternity insurance, as these policies are designed to do. This situation increases their financial burden. Due to their rising distrust of public medical facilities and financial burden, migrant women are driven to consult doctors in private (sometimes illegal) clinics, although some of them are aware of the poor service quality of these facilities and the tricks they use to attract patients. Health facilities financed and run by public-private partnerships are a new form of medical facility on the community level. However, due to information asymmetry, it is unlikely for migrant patients to make a distinction between facilities based on public-private partnerships and private facilities. Family planning policy and the policy of birth control play a significant role in migrant women's health seeking behaviors. Because of the worry of being fined and other penalties, pregnant migrant women who plan to give birth avoiding the family planning policy are likely to reduce or abandon their use of maternity service in public medical facilities in the cities. Free maternity services provided by FPSS are also used less often. Instead, these migrant women are prone to seek services in private clinics.

This chapter has also discussed the influence of informal institutions on migrant women's health-seeking behaviors. Giving birth to male offspring is related to the dignity of women and their families. The birth control policy stipulates the number of children that a couple is allowed to have. Due to the pressure from this policy, preference for sons leads to the usage of techniques for prenatal sex determination and sex-selective abortions. The influence of son preference on rural-to-urban migrants' fertility behaviors has gradually become debilitating due to their migration experience. However, the tradition of son preference remains highly persistent in Chinese society, especially in rural society. Practicing *doing the month* after giving birth is also a tradition with strong persistence in Chinese society. Chinese women, including migrant women, believe that *doing the month* provides physical and mental advantages. Migrant women's

adherence to this practice provides an explanation for why they are likely to go back home to the countryside to give birth.

4.3 Case study 2: Sexual health and *health-seeking behaviors* of FSWs in Shenzhen

This chapter demonstrates the findings regarding the second target group, FSWs in Shenzhen, with a structure similar to that of Chapter 4.2. Firstly, I present the identified problems and risks that FSWs face with regard to their sexual health and the behaviors they engage in to cope with these problems and risks. This is followed by a discussion of the policies of prostitution control and policies towards NGO activities for prevention of STDs and HIV/AIDS (formal institutions) that have impact on FSWs. Finally, I discuss the informal institutions that affect the health-seeking behaviors of FSWs.

4.3.1 Identified problems and risks with regard to sexual health and *health-seeking behaviors*

In the Subchapters 4.3.1.1, 4.3.1.2, 4.3.1.3 and 4.3.1.4, I firstly present health risks (i.e. physical harm, gynecological diseases, STDs and HIV/AIDS, unexpected pregnancy and low condom usage, mental health problems, and drug use) that were identified during the interviews and have linkage with FSWs' sexual health. Then, Subchapter 4.3.1.5 discusses issues on the FSWs' approach to sexual health knowledge, *care-seeking behaviors* when they contract illnesses, and condom usage. Subchapter 4.3.1.6 focuses on the mobility of FSWs and their clients, linking the spread of STDs, HIV, and AIDS as a risk not only for a single person within sex industry, but for the nationwide and worldwide population.

4.3.1.1 Physical harm

During the interviews, some FSWs reported that they or their peers were physically harmed by clients. The reported physical harm consisted of slapping, pinching, and

beating, which in one reported case caused a broken leg. In such cases the clients were more typically drunk, at times trying to force the FSWs to provide unprotected sexual service, but getting rejected. It has also been reported by some FSWs that they have been beaten by employers or managers in some underground brothels in B Town, LG District, which is a relatively remote district of Shenzhen City. It can be conjectured that in these brothels, a "semi-slavery" working arrangement (Pan 2002:66) is practiced. It was reported by some interviewees that brothels in B Town were their first working sites in the sex industry. Young women working there were usually intimidated into prostitution or recruited from other cities (stated by our respondents as "being lured" by boyfriends or acquaintances). Unlike their counterpart FSWs in SZ and SW District, who have much more personal liberty, the new entrants in the prostitution industry in BJ usually have a stronger dependence on their employers. They usually have paid the employers an appreciable deposit before they begin work, and their certificates of identification, which are obligatory for police registration in the city, are also kept by the employers. Lacking power to negotiate with employers, FSWs in B Town have to face much worst treatment by their employers and clients, and are forced to provide services for many more clients than in prostitution sites in SZ and SW. Unprotected sex is also required more often in these brothels. An interview who used to work in a brothel in B Town reported as follows (FSW/08):

> "We were beaten and slapped when we didn't work hard. … In BJ I was forced to serve the clients without condoms every day. I had to do that, otherwise I would be beaten. I saw that some sisters ［other FSWs］ were slapped and kicked for refusing service to the clients. It was very terrifying. … I didn't know how I got along. Every day appeared like a year in length ［in the brothel in BJ］. Clients there were much more uncultivated than those here."

The experience of this interviewee provides an example of how, in brothels with a "semi-slavery" working arrangement, physical abuse may easily be suffered when a FSW refuses to engage in unprotected sex.

4.3.1.2 Gynecological diseases, STDs and HIV/AIDS, unexpected pregnancy, and low condom usage

Gynecological diseases (e.g. cervical erosion, vaginitis, pelvic inflammatory disease, ovarian cysts and uterine bleeding) and STDs (e.g. genital warts, gonorrhea and syphilis) were reported by the interviewed FSWs. It must be noted that during the interviews, regarding the question on contracting STDs, all of the interviewees reported frankly that they now had gynecological diseases. However, they tried to avoid answering the question directly by stating that they had heard that other FSWs had caught these diseases (e.g. FSW7, FSW8, FSW15, FSW17), instead. This reaction of FSWs may result from their consideration of *losing face*, fearing being discriminated against by peers and even by interviewers. FSWs regarded gynecological diseases as inevitable, and a relatively minor health problem, whereas they had great fear of contracting to STDs and AIDS, regarding them as incurable diseases. Nevertheless, FSWs are unaware of the risk that untreated gynecological diseases may lead to an increasing risk of STD and HIV infection. (Fu 2006) Unexpected pregnancy and abortions were also reported by the interviewed FSWs. FSWs regard abortion as a considerable health risk linked with sterility. A 24-year-old girl working in a night club in SW District, who had experienced an induced abortion, reported her dreadful memory of the abortion and fear as follows (FSW/29):

> "I am afraid of being pregnant much more than being ill. … I had a boyfriend when I was 18, then I got pregnant. I can still recall the procedure of the induced abortion and remember it for all my life. It hurt very, very badly. So I am afraid of being pregnant very much."

The interviews reveal that FSWs are aware that condom usage plays a significant and effective role to contraception, and prevention of STDs and HIV/AIDS. Some interviewees reported that they have tried to persuade their clients to use condoms, reminding them that they should "think about ［the health of］ their family" (FSW/19). However, there are still FSWs who provide unprotected sexual service from time to time. It was reported by the FSWs that it was always the clients who ask for non-condom sex services. In such an instance, some FSWs may refuse to provide service. However, it happens often enough that the FSWs take the risks if the clients pay more money for non-condom services. Moreover, high competition

between peers and the intention to keep frequent clients also motivate FSWs to provide unprotected sexual services. A 27-year-old respondent who has worked in the sex industry for a relatively long time reported her different treatment towards general and frequent clients (FSW/07):

> Q: "What do you do in case when a client is not willing to use condom?"
>
> A: "Well then, I will not do it ［providing the sex service］ anyway, except for one frequent client that I have known for half or maybe one year. We have some feeling towards each other. Maybe he can be seen as my boyfriend in some way. Every time he comes ［to the recreational enterprise, where I work］, he asks for me, as always. I know, he will not ask for other women, only me. He has only one day free per week and comes to me on the same day every week."

It was also reported that condoms were surreptitiously taken off by the clients during sexual intercourse. In such instances, FSWs were usually unable to stop intercourse, but instead, would ask for extra tips and take emergency contraception afterwards. According to the statement of the interviewees, condom awareness among clients from mainland China is much weaker than those from Hong Kong. This situation may result from the relatively inadequate sexual health and AIDS prevention education in mainland China. The interviews also reveal that clients' awareness of condom use plays a significant role in commercial sex, along with the FSWs' de facto lack of negotiation rights. This situation can be explained by the tradition of male chauvinism in Chinese society and the social discrimination against FSWs, which is elaborated in Subchapter 4.3.3.1.

It was generally reported by the interviewed FSWs that they have boyfriends at the time of interview, but have seldom or never used condoms during sexual intercourse with them. 'Love' and 'trust' are the reasons of the unprotected sex, as an interviewee (FSW/3) reported, for example:

> Q: "Do you have boyfriends?"
>
> A: "Yes I do. I have two boyfriends. They treat me very well. We have been together for about five or six months and know each other very well. I know they don't have any problems［STDs or HIV/AIDS］and I feel quite comfortable with them."
>
> Q: "Do you have sex with them? How about use condom?"

A: “Yes I do. Usually I don’t use condoms when I am with them.”

As with the situation with clients, FSWs lacked the capability of negotiation on condom use with their boyfriends, and seldom refused non-condom sex if boyfriends insisted, although both were aware of the risk of unprotected sex. A 22-year-old respondent (FSW/12), who broke up with a boyfriend recently, reported:

> “With boyfriends I didn’t use condoms most of the time. Because those guys [the boyfriends] are real sweet talkers. They always are able to lull me [into non-condom sex]. I didn’t always use condoms because I trusted them.”

Unprotected sexual behaviors in short-term relationships and one-night-stands were also reported during the interviews. For example, a 22-year-old interviewee (FSW/23) said that she often looked for a “temporary” boyfriend when she felt lonely, and would be with each one for a few days. Despite the very short relationship period, she had never used a condom with her boyfriends. Along with the risk of contracting STDs and HIV/AIDS, unprotected sexual behaviors with boyfriends enhance an FSW’s risk of unexpected pregnancy. According to the interviewees, they hadn’t practiced any effective contraception measures after the non-condom sex with their boyfriends.

4.3.1.3 Mental health problems

The interviews revealed that FSWs generally face mental stress, manifested in frequent crying and sleeping disorders. Some respondents regarded their stress as a problem much more serious than any other physical risks they face. The reasons for FSWs mental stress can be summarized as follows:

1) *Disillusionment of* the *migration dreams.* As noted above, FSWs that were interviewed were rural-to-urban migrants, and harbored similar reasons as other young migrants for deciding to migrate: Their family in rural areas had financial constraints or/and they came to the city seeking a better life and self-fulfillment. (cf. Pan, Huang et al. 2005) Such expectations were expressed in the statement of a 22-year-old interviewee (FSW/12), for example:

> Q: “What’s the biggest pressure you are faced with?”
>
> A: “My biggest pressure is that I want to change myself. I desire another kind of life. I have aspirations, not like them [other

FSWs］.”

However, in reality, labeled as a migrant and sex worker, these young girls have an extremely marginalized and lowly status in the cities, and feel themselves to be a great disappointment. An interviewee (FSW/18) stated as follows, for example:

“I feel that I am so far away from my goal. I wanted earn more money, but now … I don’t know.”

An interviewee (FSW/2) working in a leisure centre expressed her dissatisfaction with her job as follows:

“Absolutely I will change my job. I have no future here. Everyone should struggle upwards. But now my future is so blurry.”

2) *Social discrimination* against commercial sex, which enhances the mental stress of FSWs. The respondents stated generally that their dignity was seriously injured when they were insulted by clients or other persons. They reported discrimination they perceived from other people as follows:

“I hate this job, but it’s not up to me. I can recall an experience when a security guard arrested me and said ‘You guys who do this job are not human beings.’ I was very sad［for hearing that］. ” (FSW/19)

“Our job is the most despised job in the world. Some people may even think highly of murderers, but people always look down upon a xiaojie［FSWs］.” (FSW/11)

Another respondent (FSW/12) expressed her expectation of being treated equally when she answered the question regarding her mental health:

Q: “Do you have mental stress because of your job?”

A: “Yes. I feel that I live in a totally different world and on a different［social］level compared with other people. If other people would regard me in an equal way, I could feel less pressure.”

Discrimination from other people leads to feelings of great inferiority and self-denial, even possibly causing behaviors of self-abandoning, which are manifested in a statement by an interviewee when she responded to the question regarding seeking health care:

“I seldom went to see a doctor. In fact, those people like us, … I don’t know how to say, … we do this kind of job ［being FSWs］, … so we don’t have the right to be taken seriously, right?

My life is degraded anyway. It's not precious." (FSW/24)

Some respondents also reported that they are constantly devastated with anxiety, worrying that their family and friends are going to learn about their job. An interviewee (FSW/05) reported that she asked her mother living in hometown to change her phone number so that the people knowing about her job could not contact her mother anymore. Another interviewee (FSW/03) reported that she had never gone to shopping since she started the job, because she is afraid of running into a client on the street.

3) The third pressure faced by FSWs is their *fear of contracting STDs or HIV/AIDS and the concern of sterility.* FSWs consider STDs and HIV/AIDS incurable diseases, and they are constantly fearful of contracting STDs and HIV/AIDS. An interviewee (FSW/09) expressed her fear about STDs as follows:

"Sometimes I think about that［contracting STDs］ and feel very depressed and even want to die."

Moreover, FSWs are disturbed constantly by the fear that they may become unable to carry a baby in the future. They believe that sterility is closely related to their frequent sexual intercourse, injuries of sexual organs, and abortions. When the interviewer raised the question: "Among STDs, unexpected pregnancy, and sterility, for which one do you have the most fear?" an interviewee (FSW/11) responded as follows, for example:

A: "Sterility, of course."

Q: "Why?"

A: "Because I am a woman. If I could not give birth, I would not be a woman anymore. Diseases can be cured. Unexpected pregnancy can be aborted. But there is no way to deal with sterility. "

Another interviewee (FSW/24) reported the same reason for fear of sterility:

"I think, if a woman could not give birth anymore, she would have nothing. Diseases can be cured, but sterility makes you desperate."

It was reported by FSWs that they would surf the internet, chat on the internet or with handheld device/phone, read magazines, drink alcohol, dance, sing in karaoke bars, play Mah Jongg, talk with peers, and use drugs to deal with the mental stress. One-night-stands had also been practiced when they were facing severe depression. Moreover, the interviews revealed that FSWs intended to seek emotional support through their boyfriends, strongly relying on them. This phenomenon enhances

FSWs' passive position in relationships with their boyfriends, and further explains the unprotected sexual behaviors with boyfriends. The relationship between FSWs and their boyfriends is further elaborated in Subchapter 4.3.3.3.3.

4.3.1.4 Drug use

It was reported by some FSWs that they had used drugs in the past, such as methylamphetamine hydrochloride (ice), ecstasy, and ketamin, when they felt upset or because of curiosity. It was also reported that some FSWs were enticed into using drug by their boyfriends, among who were also addicts and intravenous drug users. Intravenous drug users belong to the bridge population contributing to the spread of AIDS, and FSWs often practiced unprotected sex with their boyfriends. Hence, FSW are in fact facing a high risk of contracting HIV/AIDS. Although some interviewees claimed that they used drugs only occasionally and they are not addicted addicts, they were unaware of the risks of addiction. An interviewee (FSW/01) responded to the question on drug use, for example:

> "I play［She means here that she uses drugs］ just on holidays or when I feel unhappy. I will not get addicted. I can control myself. It's just for kicks."

Another interviewee (FSW/12) responded to the same question as follows:

> "Taking drugs is a kind of entertainment. It will be all right."

During interviews there are also FSWs who claimed that they had never used drugs. A drug-addicted FSW will usually not be accepted by the clients. Therefore, neither entertainment sites nor brothels would be willing to hire or cooperate with drug-addicted FSWs. It was reported in the interviews that FSWs addicted to drugs were fired by the employers. In addition, some FSWs had realized that drug consumption was a big expense, and they were not willing to waste their "hard-earned" money for drugs. It seems that the linkage of drug use and health risks is not the main concern of interviewed FSWs. Only one interviewee (FSW/30) pointed out that she had never used drugs because she read drug control slogans on the KTV where she worked, and was aware that drugs were harmful for health.

4.3.1.5 Approaches to sexual health knowledge and *healthcare-seeking* behaviors

Interviews revealed that compared with interviewed migrant women in urban villages, the FSWs had more STD- and HIV/AIDS-related knowledge. Moreover, they were more familiar with regular physical and gynecological check-ups. However, FSWs' knowledge of STDs and HIV/AIDS was limited to knowing the names and visual symptoms of the diseases. There were misconceptions regarding contraception, as well as STD- and HIV/AIDS-prevention, among FSWs. These misconceptions can be summarized as follows:

- FSWs believe that they are able to identify whether a client carries a STD or HIV/AIDS by assessing the appearance of the client, unaware that most STD and HIV carriers don't have any visible symptoms at all. For example, an interviewee reported how she judged her clients' health condition as follows:

> "People carrying AIDS are black and thin. So I will not accept a client who is black and thin." (FSW/3)

- FSWs generally consider that hygiene is vital for STD and AIDS prevention, and use intimate wash products regularly (several times per week as reported), while they are unaware that frequent vagina wash may lead to vaginal dysbacteriosis and vaginitis, making them even more susceptible to STD- and HIV-infection. (Ding, Yi et al. 2006)
- Frequent use of antibiotics was revealed through the interviews. FSWs take intravenous antibiotics injections not only for curing inflammations (e.g. vaginitis and pelvic inflammation), but some of them regard using antibiotics as a preventative measure against STDs and AIDS, as an interviewee (FSW/12) reported:

> "I go to my health check-up regularly. So I keep myself healthy. I go to the private clinics nearby. Those people [medical practitioners] have done the job [health check-ups] for years. I go to the clinics every half of month and take an injection of a little bit of antibiotics and interferon. It costs just a few Yuan."

- Although FSWs often practice unprotected sex, they seldom take oral contraceptives because of the fearing that oral contraceptives are harmful to health and may lead to sterility. FSWs generally take vaginal douching after no-condom sex to prevent getting pregnant. An interviewee (FSW/11) working in a barbershop

was even convinced that the opportunity to be pregnant depended on the emotional feeling of the sex partners and claimed:

> "Working here I will definitely not get pregnant. … I've used to have sex with clients without condoms, but getting pregnant needs the feeling of both partners. There is not any such feeling between me and the clients …. Anyway, I will not get pregnant."

It was generally reported by the interviewees that they were very interested in health-related, and especially gynecology- and STD-related, information. Some interviewees reported that they had taken part in community-based free health counseling and health check-ups provided by hospitals and private clinics. They also paid attention to the information on health-related posters and leaflets. Similar to the response of migrant women in urban villages, there were also some FSWs holding a attitude of distrust towards community-based health counseling and health education, believing that the purpose of these health services was "to cheat the people" (FSW/01) or "to attract the people to see a doctor [in the facilities] " (FSW/06). Some other interviewees preferred to learn health information through watching television programs, surfing the internet, and reading magazines and books. Moreover, FSWs often approached health-related information through small talks with their peers and female employers (e.g. panderers). For example, an interviewee (FSW/15) reported how she learned preventative methods of contraception as follows:

> "There are so many girls [FSWs] here. Sometimes we talk about it [health-related information] when we get together. Then you know how."

Beauty salons near their working sites, where FSWs do make-up before they go to work, were important meeting points where they could exchange information, including health-related information.

With regard to FSW's *care-seeking behaviors*, there were significant similarities between FSWs and other migrant women in urban villages: Facing minor illness (e.g. cold, headache, slight fever), FSWs preferred to purchase medicines in pharmacies for self-treatment. Under the circumstance of severe illness (e.g. high fever, gynecological diseases), they were likely to consult a doctor in small private clinics nearby their working sites and take antibiotics injections. Like other migrant women, FSWs disfavored both hospital and community-based health facilities, when they needed to consult doctors. This situation was associated

with distrust and dissatisfaction of the high service prices. Two interviewees reported their unpleasant experiences in a hospital and a CHCSC, respectively:

> "Those big hospitals cheat people. The costs were high and the hospital cheated me. My situation was not so severe, but they [doctors in the hospitals] dealt with it very complicatedly. …And hospitals always prescribe medicines recklessly." (FSW/10)
>
> "I used to see a doctor in a CHCSC. It cost me a lot of money. I just had a stomach-ache. Even after taking the medicines [that I brought in the community health centre] the stomach-ache lasted for a long time. It was only a minor problem at first. They made it to turn into a big problem. And then I wouldn't dare go there again. They cheat people." (FSW/06)

Interviews also reveal that FSWs' decisions regarding care-seeking was closely related to their income and household expenditure. Depending on their working sites, appearance and the amount of clients they had, a net monthly income ranged from 4000 Yuan (in brothels and barbershops) to around 10,000 Yuan (in recreational enterprises). The majority of their income was spent for rent, foods, clothing and cosmetics. Similar to migrant women in urban villages, some interviewed FSWs reported that they send a proportion of their income back to their hometown to support their family. Regarding this, an interviewee (FSW/07) working in a brothel reported as follows:

> "I earn 200 Yuan per day, sometimes 400 Yuan if I have good luck, so about 5000 to 6000 Yuan per month. … I send money back home, because my family is poor. I have to send money back to build a house."

Another interviewee (FSW/01) working a brothel also reported that she had financial pressure coming from her family that needed support:

> "I am the only child in the family. … I do the job on my own will. … The elder people [her parents] also work hard. … I even have any private room at home. I can't rely on my parents but myself. I've paid off the debt that my family owed and built a new room at home. … I send 1200 Yuan back home every month. I would send the money even though I have little money. I must send money back even when I have to borrow money."

A girl (FSW/09) working in a barbershop told the interviewer about her monthly income and expenditures more precisely:

> "The money I earn is quite ok, about 5000, 6000 Yuan. Foods and accommodations [provided by the owner of the barbershop] are free here. Usually I send money to my family. And I save some money too. I am interested in buying clothes and other things like that. That costs about 2000 Yuan per month. I send 1000 Yuan per month back home and save about 2000 Yuan."

Similar to the response of FSW/09, it was quite often stated by the interviewees that they were trying to save money so that they could run their own business, such as a drugstore, beauty salon or fashion stores, in the future. In some cases (e.g. FSW/08, FSW/09, FSW/12, FSW/16), the money they saved accounted for a significant portion of their income.

Moreover, it was reported that some FSWs spend a big portion of their income on their boyfriends. An interviewee (FSW/14) with the title "department manager" (one kind of panderer) in a KTV talked to the interviewer about the financial relationship between FSWs and their boyfriend:

> "Some girls were brought by their boyfriends to be FSWs. They are willing to earn money to support their boyfriends. They give almost all of the money they earn to the boyfriends."

Based on the findings of FSWs' income and expenditures, it could be inferred that FSWs were generally not in an easy financial circumstance. As a result, they cared about prudent spending, including the costs of health service. The financial constraint explains in some extent FSWs' preference to seeking care in private small clinics and their dislike of big hospitals. With regard to preferences, an interviewee (FSW/15) reported:

> "Usually I go to private clinics, because [health services] in private clinics are relatively cheaper. In big hospitals even a minor treatment may cost a lot. So I seldom go to big hospitals."

Recommendation from panderers and peers played a significant role for FSWs' choice of health facilities. Prices, service quality and physicians' attitude were discussed among FSWs and they were inclined to visit facilities that had a good reputation. It was also reported by some interviewees that their panderers were very familiar with some clinics near the working sites, and recommended them to FSWs. It must be noted that such private small clinics were often unlicensed and

illegal, as elaborated in Subchapter 4.2.2.1.4 and the service quality was not reliable. FSW patients might receive inadequate treatments (e.g. vagina douching and antibiotic abuse as reported) in such clinics. Misleading health information might also be transferred from unqualified physicians to their patients and further spread among FSWs.

4.3.1.6 Mobility of FSWs and their clients, and the risk of spreading STDs and HIV/AIDS

China is facing a critical challenge of rapid and widespread HIV/AIDS increase. Replacing infections through blood and plasma transfusions, sexual intercourse has become the main HIV/AIDS transmission mode in China. (Hu 2007) Along with men who have sex with men, FSWs and their clients as first-party participants (seller and buyers respectively) in prostitution transaction have become the most at-risk population, as well as the bridge population of STDs and HIV/AIDS transmission.[36] (Jeffreys et al. 2009: 155) High-level mobility of virus carriers might enhance their role as bridge population for emerging epidemics of STDs and HIV/AIDS. So, to gain a deeper insight into the risk of STDs and HIV/AIDS spreading it is necessary to look at the characteristics of high-mobility FSWs and their male clients. Geographical mobility of FSWs' clients, namely clients from Hong Kong and male rural-to-urban migrants, is discussed in Subchapter 4.3.1.6.2.1 and Subchapter 4.3.1.6.2.2, respectively. And then, Subchapter 4.3.1.6.3 discusses how the high-level mobility of the FSWs and their clients enhances their role as a bridge population in the spread of STDs and HIV/AIDS.

4.3.1.6.1 Mobility of FSWs

This subchapter discusses the mobility of FSWs. I differentiate "geographical mobility" from "social mobility." *Geographical mobility* refers to movement of individuals or groups between two or more geographic areas (e.g. migration,

[36] "Men who have sex with men" refer to men who engage in sexual behaviors with other men, but who do not necessarily self/indentify as 'gay' or 'bisexual'. Other identified bridge populations of STDs and HIV in current China are: long-distance truck drivers; intravenous drug users; former blood donors; and people who engage in casual, premarital, extramarital or non-monogamous sex. (Jeffreys et al. 2009: 155)

immigration), whereas *social mobility* refers to movement of individuals, families, or groups through a system of social hierarchy or stratification. If *social mobility* involves a change in position, especially in occupation, but no change in social class, it is called "horizontal mobility." If, however, the move involves a change in social class, it is called "vertical mobility," and involves either "upward mobility" or "downward mobility". (cf. Shepard 2011:226) Using the terms "geographical mobility" and "social mobility," I elaborate in this chapter on the high-level mobility of FSWs and their clients. With regard to FSWs' *geographical mobility,* I firstly present FSWs' mobility between working sites and hometowns, focusing on the question of how FSWs enter and retreat from the prostitution industry. And then, I look at FSWs' changes of working places within prostitution industry. At last, I elaborate on FSWs' social mobility within prostitution industry, focusing on their vocational shifts.[37]

4.3.1.6.1.1 Geographical mobility between working places and hometowns

Just like migrants engaged in other occupations, FSWs are a part of the rural-to-urban migrant population in the labor market, and move between the cities of their working places and hometowns in rural areas. This kind of mobility can be regarded as *geographical mobility*, and is closely associated with the pathways through which young women are recruited from their hometowns, or other working sites in the cities, into the prostitution industry. Before they enter the prostitution industry, some interviewed FSWs have already migrated into the city, and worked in factories or the service sector. Then, they were recruited by pimps, who usually also have a migration background. Some pimps come from the same province or county of the targeted girls, so they are called by the girls as *laoxiang* (老乡 fellow-townspeople). As *laoxiang* the pimps are more easily trusted by the girls and persuade them to quit the current job and engage into sex transactions for better income. An interviewee from Guizhou Province, who worked in a night club, reported how she entered prostitution as follows:

> "I used to work in a factory. A *laoxiang* told me that I would earn money in a relatively faster way in doing this job [being FSW]. So

[37] The framework within which I discuss how FSWs' social mobility within the sex industry is set up is inspired by Pan, Huang et al's (2005) research on FSWs' position shifting between different working sites

I came here. My *laoxiang* also did this job. … I have worked in the factory for two or three years and earned little money. But now [as FSW] I can save a little money." (FSW/03)

It seems that the consideration of income is not the single reason why a girl enters into the prostitution industry. An interviewee working in a night club, who used to work as a team manager in a factory reported that she chose to engage in commercial sex because she is able to have more freedom as an FSW than working in factory. She stated as follows:

"Those (previous) jobs were very tiring. And I like freedom. At that time I went out with a friend to play. She told me that I could do the job [as FSW] together with her and the job is great fun. So I came here." (FSW/12)

It was also reported by some interviewees that they entered the prostitution industry as soon as they went to Shenzhen. In these cases, the girls usually were recruited by their *laoxiang*. Attempting to attract clients, brothels and entertainment sites involved in prostitution were always in need of new FSWs. Thus, employers of FSWs ask them to take advantage of returning home during the holidays of Spring Festival (Chinese New Year) to recruit new young women. (Fu 2006, Zhuang and Zhao 2009)

It was often reported by FSWs that they would likely go back to their hometowns as soon as they saved enough money to run their own small businesses, such as drugstores. This consideration may be derived from the Chinese traditional idea of devotion to one's hometown, often described with the parlance of *luoyeguigen* (落叶归根) – literally falling leaves settle on the roots (Fu 2006). Moreover, FSWs are discriminated as outsiders in the city, and carry the notoriety as a sex worker, as well, so they are dissatisfied with their social status in the city. FSWs regard running own business in the hometown as the way to regain their confidence and social identity from their social network. Such a wish was revealed in the statement of an interviewee working in a brothel as follows:

"I am planning to run a store in my hometown village. If you have a store in your hometown, no matter how big it is, the people in the village will call you *laobanniang* (老板娘, proprietress). If you work somewhere outside［in the city］, they will always call you *dagongde* (打工的, the one who works for others)." (FSW/01)

Getting married and having a baby were also often mentioned by the interviewed

FSWs as a wish when they were asked about their future plans. A 27-years-old interviewee stated such a wish as follows:

> "I want to find a stable job and the most important thing is finding a good husband, who is able to support me. And [I am going to] bear children. I'm not young any more, not like them [some other FSWs] who are still young." (FSW/07)

Whereas the FSWs considered men from cities are tricky, disloyal and dangerous, they regarded men who come from the hometown, and ideally, have a rural-to-urban migration background, as the best partners to marry.

Although the interviewed FSWs repeatedly claimed that they would leave the prostitution industry and go back to their hometowns soon, there were also clues identified in the interviews revealing that the FSWs often went back and stayed at the hometown as a break, and then returned to the prostitution industry after a short time. For some of the interviewees, the pendulum swing between Shenzhen and the hometowns happened fairly frequently, as an interviewee (FSW/18) reported:

> Q: "How long have you done this job?"
>
> W: "Not very long. … Altogether almost one year. Sometimes I stop working for one or two months and go back home. And then I come back to work again."
>
> Q: "How often you go back home?"
>
> W: "As long as I miss home, I go back."

In sum, like migrants engaged in other occupations, FSWs are a part of the rural-to-urban migrant population in the labor market, and move between the cities where they work and their hometowns in rural areas. The difference between FSWs and other migrants' geographical mobility is that the latter commute between cities and hometowns primarily around the Chinese New Year (Spring Festival), whereas the commuting pattern of the former is relatively spontaneous and sometimes related to police-led suppression of commercial sex. This suppression of prostitution and its impacts on FSWs is further described in Subchapter 4.3.2.3.

4.3.1.6.1.2 Geographical mobility between different working sites within sex industry

Another kind of *geographical mobility* of FSWs, identified in the interviews, is their high mobility between different working sites within sex industry. An important precondition of such high mobility is the "free employment relationship" (Pan, Huang et al. 2005) between the FSWs and their employers. The "free employment relationship" gives FSWs more personal liberty compared to girls working in brothels with semi-slavery conditions in BJ, for example, and allows them to choose their working sites. The organizational forms of the prostitution industry in Shenzhen are various. FSWs are not working in one fixed working site, but in a network with a great number of prostitution sites involved. Such a network has an ultimate aim of building up business relations connecting FSWs with their clients. Taking brothel-based FSWs as an example, although one FSW is usually employed by a certain panderess, she also gives her cell-phone number to other panderesses, so that the panderesses can call her to their brothels if clients ask for her. (Pan, Huang et al. 2005, Fu 2006) This form of exchange of FSWs between brothels was reported explicitly by an interviewee who has moved from a KTV in SW District to a brothel in SZ District less than one month before the time of interview as follows:

> "Clients can choose the girls here (in the brothel where she is working). They can also call girls from other brothels to come here. … After each business trade, the *mami* [妈咪 panderess] retains half of the earnings. … If a girl wants to quit, she just needs to explain the reason with her *mami*. It's also ok, if she wants to change to another *mami*." (FSW/27)

Compared with brothel-based FSWs, FSWs hired by recreational enterprises usually have tighter employment relation with their employers (often having working contracts) and correspondingly more constraints regarding working time. However, it is not forbidden if they wish to leave.

The high mobility of FSWs between working sites is firstly derived from clients' desires of fresh faces of FSWs, which stimulates the employers to renew their FSWs. (Fu 2006:77-78) Because prostitution is legally prohibited in China, soliciting is often conducted by panderesses instead of by FSWs. An experienced panderess is not only familiar with the way of soliciting, also, they has regular

client groups, both of which are crucial for FSWs. (Pan, Huang et al. 2005) As a result, such "two-way selection" between FSWs and panderesses happens frequently. FSWs are willing to work for panderesses who can potentially bring them transaction opportunities and panderesses are glad to cooperate with FSWs who may attract clients for her prostitution sites.

Along with the "free employment relationship," FSWs' mobility is impelled by their seeking higher income. FSWs' income is closely related to the levels of their working sites. Interviews reveal that the income levels of FSWs working in small-scale brothels located in rental houses or barbershops (e.g. in SZ) and large-scale recreational enterprises (e.g. in SW) are of significant difference. For the brothel-based FSWs, providing sex services is the only way to earn money. A client pays for each sex visit 130 to 250 Yuan, of which 100 to 150 Yuan will be kept by the FSW, and the rest of the money will be handed over to *mami*. If a girl works in a recreational enterprise, she would have more channels of income. As the interviewees in SW reported, the service prices are identical among different recreational enterprises, with similar levels in SW, namely, 200 Yuan for non-intimate companionship (e.g. singing, dancing, and drinking), described with the parlance of *bufangbian* (不方便), literally not available; 300 Yuan for sex visit at the recreational site called *fangbian* (方便), literally available; and 600 Yuan for overnight sexual services (usually in hotels outside the recreational sites paid by the clients) called *baoye* (包夜), literally buying out the night. FSWs in recreational enterprises must hand over 50 Yuan to *mami* for each transaction, regardless of what kind of service, listed above, that they provide. They can keep the rest of the money, which is much more than brothel-based FSWs can earn. Moreover, the recreational enterprises pay the FSWs a fixed basis wage and allow them to deduct commissions from additional consumption by their clients (e.g. purchasing drinks and booking compartments). Because clients that visit recreational enterprises are essentially richer than those visiting brothels, they usually pay more tips. Among brothels, the price of a sex visit is related to the popularity of the location, and indirectly influences the FSWs' income. An interviewee (FSW/10) responded to the question of the price of a prostitution transaction as follows:

> Q: "Is the price with every *mami* different?"
>
> A: "It depends on the location. If there are more clients, the price will be fixed. If there are less people, the price will be lower, for example in Shawei［a less popular location in Shenzhen City］. "

Furthermore, as mentioned by those relatively young FSWs (e.g. FSW/27, who is 18 years old), working in recreational enterprises were more fun than in brothels. Some interviewees (e.g. FSW/12) also mentioned that clients visiting big recreational enterprises were more well-bred than those visiting brothels, and treated the girls more politely.

Thus, FSWs made an effort to change to more popular working sites with better conditions and an opportunity for a higher income. With this aim, shifting between different working sites happened frequently. Mobility between working places at the same level (e.g. from one brothel to another) can be regarded as a "lateral mobility," while mobility between working places at a different level (e.g. from brothel to recreational sites), or in an opposite direction, defined as "vertical mobility". (Pan, Huang et al. 2005) Vertical mobility of FSWs is elaborated upon in Subchapter 4.3.1.6.1.3.

The high mobility of FSWs is also associated with the governmental crackdown against prostitution transactions. The fear of being arrested and punished motivates FSWs to move between different working sites within a city and even between different cities. Crackdowns also alarm clients of FSWs visiting prostitution sites, forcing FSWs to change their working sites. For example, interviewee FSW/27 reported that although KTV is a better working site than a brothel with regard to income and working conditions, she had to move to a brothel in SZ District from a KTV in SW District because of the harsh crackdown against prostitution in SW. Governmental policies for prostitution control, and their influence on FSWs, are further elaborated in Subchapter 4.3.2.

4.3.1.6.1.3 Social mobility: vertical vocational shifts within sex industry

To understand the vertical mobility of FSWs within the sex industry, one can refer to Table 2 (see Subchapter 4.1), which illustrates the different categories/layers of FSWs. A vertical mobility of a FSW can be upward or downward. An upward shifting may take place through an FSW's efforts, defined by Pan et al (2005) as a process of professionalization. However, upward shifting can rarely be achieved in reality. A downward vertical mobility happens more often among the FSWs. Prostitution is generally considered as a typical job with high competition, with which the FSWs make a living on the strength of the youth, as the Chinese parlance says *chi qingchun fan* (吃青春饭, literally "feed by the youth"). The relatively

young and good-looking women are usually situated on the higher layers of the prostitution structure and fall gradually to lower layers due to aging, accompanied with a decline of competitiveness (Fu 2006:77-78, Zhuang and Zhao 2009:29-30) A FSW who used to be at the top of the prostitution structure may slide into the lowest layer if she has not ultimately left the prostitution industry or turned from a FSW to third-party participant in prostitution industry - a procuress. (Zhuang and Zhao 2009) Even for those FSWs who have achieved an upward occupational shifting, downward occupational mobility is rarely avoidable. As Table 2 shows, for example, an *er'nai* is on the top of the FSW-category. She is hired by one client with relatively higher and more stable income. However, this employment relationship is strongly influenced by the general economic condition. As reported in interviews, the economic slump (e.g. the latest economic crisis starting in 2007) led to decreased income for a number of *er'nais*' clients, who then suspended the employment relationship with the girls. This situation forced the *er'nais* to shift downwards to lower layers of the prostitution structure. The reported experience of one interviewee (FSW/07), who had engaged in sex work for about 10 years, represents one's precarious vertical mobility: In an age of 17, this interviewee was recruited by a pimp from a factory, and worked in a recreational enterprise (middle-layer) at first. After a couple of months, she was hired by a client as his *er'nai* (highest-layer) for a period of time. At that point, the interviewee had achieved an upward mobility. Thereafter, the interviewee experienced gradual and continuous downward shifting: After suspension of the relationship as *er'nai,* she went back to her hometown in a rural area in Hunan Province and returned to the prostitution industry later, working as a courtesan soliciting in hotels (the second highest-layer). On the day of the interview at age 27, the interviewee had just begun her first day of business soliciting in a barbershop (middle-low layer). Although she repeatedly stressed her advantages over other barbershop-based FSWs (such as better looking, having more experience amusing clients), it was revealed by her reported experiences that she had, as a matter of fact, fallen into a lower layer of the prostitution structure. Apart from aging, drug addiction was the other crucial reason for downward vertical mobility of some FSWs. Research by Cheng et al (2004) regarding recreational enterprises in Guangzhou City showed that a drug addict girl would be detested by clients and fired by her employer. She would fall directly into the lowest level of the prostitution industry (e.g. street standing girls or shed girls). Due to the financial pressure associated with drug

consumption, a drug addict girl is more likely to accept unprotected commercial sexual intercourse and she is more vulnerable to STD and HIV/AIDS. (Jing 2006:136-137, Zhang, Rou et al. 2006:1060)

4.3.1.6.2 Mobility of FSWs' clients

This subchapter discusses the Geographical mobility of FSWs' clients, namely clients from Hong Kong and male rural-to-urban migrants. Along with FSWs, these clients have become a curial part of the bridge population in the spread of STDs and HIV/AIDS due to their high-level of mobility. The next subchapter (4.3.1.6.3) discusses the risk of STDs/AIDS transmission related to mobility of FSWs and their clients.

4.3.1.6.2.1 Mobility of clients from Hong Kong

As reported by the interviewed FSWs, their clients consist of males from foreign countries (e.g. Malaysia, South Korea and Japan), mainland China, and Macao, with Hong Kong contributing a high proportion of married male travelers between presumably 30 and 50 years old, with a background of low- and middle-income employment. The large quantity of Hong Kong males involved in commercial sex as reported by interviewees is in line with the findings of a quantitative study (Lau and Thomas 2001), undertaken at the Lo Wu immigration checkpoint with Hong Kong male permanent residents (ages 18 to 60 years old), which reveals that about 1/3 of the male Hong Kong travelers had sexual intercourse with FSWs in mainland China in the last 6 months before the survey. High mobility of FSWs' clients from Hong Kong was also revealed from the interviews, as two interviewees reported, for example:

> "Usually they［clients］came and then went away. And then other clients came ... I never saw them anymore." (FSW/15)
>
> "We don't have regular clients. The most faithful ones come about three or four times a month." (FSW/27)

Apart from high mobility, having commercial sex in multiple locations is the other vital characteristic of FSWs' clients from Hong Kong. As revealed by a telephone interview, Hong Kong male residents practice commercial sex not only in mainland

China, but also frequently in Hong Kong and Macau. More than half of them engage in commercial sex at more than one location and more than 1/4 of them at three or more locations. (Lau and Siah 2001:225-229)

4.3.1.6.2.2 Rural-to-urban male migrants as FSWs' clients

Regarding the risk of STD- and HIV-transmission in China, rural-to-urban male migrants that practice commercial sex with FSWs and have high mobility should not be ignored. As discussed in Subchapter 4.2.1.1, and analogous to the female migrant situation, male migrants are generally young and in a sexually-active period, and rural-to-urban migration puts them into an anonymous setting lacking of social moral control. Meanwhile, they are facing anxiety and loneliness associated with social and financial marginalization in cities. As for many married migrants, migration has also caused long-term separation from spouses and the deterioration of a stable sexual relationship. (Xiang, Cao et al. 2010, Cheng, Xu et al. 2012) All these demographic and social factors make rural-to-urban migrants presumably conducive to casual sexual activities with other migrants (e.g. colleagues and *laoxiang*), and for male migrants, buying sex from FSWs. (Su 2014) Mobility of rural-to-urban male migrants refers to their pendulum swings between cities of working places and rural hometowns (e.g. the annual pendulum of spring Festival) as well as their shifting between working places in urban areas. Male migrants working in construction sites, for example, belong to the typical migrant group with high mobility, as they are usually hired by certain foremen or construction firms and move frequently from one construction site to another. (Yang, Yang et al. 2015:116-117) Construction work is a typically masculine work, performed at locations with a very high density of male workers. Moreover, due to the high mobility and the poor living condition (e.g. in improvised sheds with little private spaces on the working sites), a large number of male construction migrants are unable to live together with their spouses and suffer a long-term sexual frustration. This situation has resulted in occurrences of rape, homosexual behaviors, and buying sex from FSWs. (Su 2014) Due to economic strains, rural-to-urban male migrants usually practice commercial sex with lower-status and lower-paid FSWs, for example, the street-standing girls and sheds girls situated at the two lowest layers of the prostitution structure (cf. Table 2). Among these FSWs are those who have fallen from higher levels due to vertical occupational mobility

(cf. 4.3.1.6.1.3). They are more vulnerable to STDs and HIV/AIDS compared to FSWs of higher levels, because they are more likely to accept unprotected commercial sex due to financial constraints.

4.3.1.6.3 The risk of STDs/AIDS transmission related to mobility of FSWs and their clients

As first-party participants in sexual transactions, FSWs and their male clients are a high-risk population for STDs and HIV/AIDS. With regard to STDs and HIV/AIDS transmission, their high mobility has strengthened their bridge role in "sex social networking" (Pan 2000:325-326) between different geographical entities, genders, and populations, summarized as follows:

- The geographical lateral mobility of FSWs between different working sites enhances the spread of STDs and HIV/AIDS among the population at some level, but at different working locations within sex industry. The population affected includes FSWs, their clients, and FSWs' sexual partners other than clients, such as pimps and their male employers.
- The geographical mobility of rural-to-urban male migrant clients between different working sites and cities enhances the spread of STDs and HIV/AIDS among populations in different urban areas, which includes low-layer FSWs and female migrants who practice casual sex with male migrants.
- The vertical occupational mobility of FSWs exacerbates the spreading of STDs and HIV/AIDS in the population on different levels within the sex industry.
- The geographical mobility of rural-to-urban FSWs and their migrant clients between cities of their working places and hometowns enhances spreading of STD and HIV/AIDS between the urban and rural population, including spouses of male migrants left behind in hometowns, and current and/or future spouses of FSWs in rural areas, who may be less likely to know about STDs and HIV/AIDS, or question the fidelity or safety of sex with their partners. (Hoy 2008:119)
- The geographical mobility of FSWs' Hong Kong clients between Hong Kong, mainland China, and Macao enhances the transregional spreading of STDs and HIV/AIDS among the population within (e.g. FSWs in the three different areas of prostitution transaction) and outside (e.g. spouses of the clients) the sex industry.

4.3.2 Formal institutional factors influencing FSWs' *health-seeking behaviors*

4.3.2.1 Policies of prostitution control

As discussed in Subchapter 4.1, prostitution has resurged and upsurged after the implementation of economic reform and the opening-up policy of 1979, whereas its status remains illegal. Governmental policies and policy implementation aiming at prostitution control, which I regard as formal institutions, have vital impact on the prostitution industry and the people involved within. As first-party participants in commercial sex transactions, FSWs are inevitable targets of the policy enforcement, and their behaviors, including their *health-seeking behaviors*, are indirectly influenced by governmental policies, which are discussed in this chapter.

4.3.2.1.1 Transformation of policies of prostitution control since 1979

This chapter firstly outlines the transformation of prostitution-related policies since 1979, focusing on the detailed penalty provisions targeting FSWs and other populations involved in sex transactions (4.3.2.1.1.1). The details regarding the changes of prostitution-related policies are elaborated. Then, the discussion focuses on police-led "strike hard" (*yanda*) campaigns against prostitution. (4.3.2.1.1.2) By showing some cases of "strike hard" campaigns in Shenzhen this subchapter reveals how the policy against prostitution implemented at the local level.[38]

4.3.2.1.1.1 Provisions of prostitution control

The first governmental provision that can be identified after China began to implement economic reform and opening-up policy is the 'Regulations of the People's Republic of China on Administrative Penalties for Public Security' (1986 中华人民共和国治安管理处罚条例, hereafter the 1986 Regulations) (State

[38] Chapter 4.3.2.1.1 is based on the research by Jeffreys (2012) on China's penalty policy with regard to prostitution, with supplementary details that were overlooked in Jeffreys' research and that I summarize after my own review of the prostitution-related regulations issued since 1979.

Council of PRC 1986) promulgated in 1986, and effective on 1 January 1987. The 1986 Regulations detailed punishment references to both first- and third-party participants in the prostitution transaction. Its article 30 stated that it is forbidden to sell and buy sex, to introduce others into prostitution, and to provide accommodation for the purposes of prostitution. The offenders could be detained for a period of up to 15 days, be warned, be ordered to make a statement of repentance, be sent to rehabilitative education, and be fined up to 5,000 Yuan. The 1986 Regulations also confirmed the Chinese police's status as the main body to investigate, determine guilt and penalize the activities of prostitution-related offenders. Only serious cases, such as those relating to organized and forced prostitution and whoring with girls under the age of 14, were dealt with by the courts and criminal justice systems. Although the 1986 Regulations were revised in 1994, the provisions related to sanctions for prostitution-related offenders remained intact until its abolishment on 1 March 2006.

To supplement the limited reference to prostitution in the 1979 Criminal Law, and to provide a legal basis for police-led crackdowns against the flourishing of prostitution throughout China, the Chinese central government promulgated in 1991 the 'Decision on Strictly Forbidding the Selling and Buying of Sex' (严禁卖淫嫖娼的决定 hereafter the 1991 Decision). Regarding the first-party engagement in prostitution, the 1991 Decision kept the prostitution transaction under the purview of the system of administrative sanctions by stipulating that prostitutes and clients should be handled according to Article 30 of the 1986 Regulations. (Article 4) Furthermore, the 1991 Decision stipulated strict provisions aimed at STD control. As Article 4 stated, whoever sells or buys sex should be sent to a compulsory STD examination, and whoever carries an STD should be sent to compulsory treatment. According to Article 5, sex workers and clients who are aware that they are carrying serious STDs such as syphilis and gonorrhea should be sentenced to a maximums 5 years' imprisonment or detention and should be fined up to 5,000 Yuan. Whoever whores with girls under the age of 14 should be sentenced as a rapist. Article 5 of the 1991 Decision was codified in Article 360 of the revised Criminal Law of 1997.

The provisions regarding sanctions to third-party participants in the prostitution transaction, contained in the 1991 Decision, were also codified in Article 358 of the 1997 Criminal Law, stating that whoever organizes or forces others into prostitution should be fined and sentenced to between 5 and 10 years of

imprisonment. Whoever committed at least one of the following crimes should be sentenced to not less than 10 years imprisonment or life imprisonment, be fined, and property confiscated, with the following serious cases possibly even incurring the death penalty: forcing girls under the age of 14 years into prostitution, forcing a number of persons or repeatedly forcing others into prostitution, raping and then forcing others into prostitution, and causing severe injuries, death or other serious consequences to persons forced into prostitution. Article 358 further stated that whoever helps others organize people for prostitution should be fined and sentenced to a maximum 5 years, and with serious cases, between 5 and 10 years imprisonment. Article 359 stipulated that whoever lures, introduces and shelters others into prostitution should be fined and sentenced to a maximum 5 years, and with serious cases, such as luring girls under the age of 14, not less than 5 years imprisonment.

As with the 1991 Decision, the 1997 Criminal Law also stipulated provisions aimed at prostitution control in the hospitality and service industry. According Article 361, personnel working in the hospitality and service industry who takes advantage of their work unit to organize, force, lure, introduce or shelter others to engage in prostitution, should be convicted and punished in accordance with Articles 358 and 359. According to Article 362, personnel who leak information about police investigations into prostitution activities should be convicted of harboring and covering up a criminal and be sentenced to 3 years maximum, and with serious cases between 3 and 10 years, imprisonment. The 1997 Criminal Law was revised in the year of 2011. However, in the 2011 Criminal Law, the provisions regarding punishments for prostitution-related offenders remained unchanged.

The 'Regulations Concerning the Management of Public Places of Entertainment' promulgated in 1999 (娱乐场所管理条例 hereafter the 1999 Entertainment Regulations) stimulated further provisions aimed at controlling potential locations for prostitution by forbidding all forms of commercial sexual activities in recreational enterprises, including providing of 'accompaniment/hostess' services, which had become a notable front for prostitution activities by the mid-1990s. Recreational enterprises ignoring this prohibition should be sentenced with a fine up to 100,000 Yuan, with the business license revoked in serious cases. (Article 40) Owners and managers of these recreational enterprises should be fined with up to 1,000 Yuan (Article 40), and in

cases of organizing, forcing, luring, introducing, or sheltering others to engage in prostitution and obstruction of police-led investigations, may be convicted as criminals or punished in accordance with the 1991 Decision. (Article 39 and 40) All personnel in recreational enterprises must possess a residency permit. Among them, those who have a migration background must possess, in addition, a temporary residency (*zanzhuzheng* 暂住证) and work permit. (Article 24) To control government corruption, the 1999 Entertainment Regulations banned officials of police authorities and culture departments from running recreational enterprises, but gave officers above county level the authority of surveillance to investigate the recreational enterprises.

No further provision related to prostitution control was promulgated until 2005. In August 2005 China's central authorities enacted the 'Public Security Administrative Punishments Law' (中华人民共和国治安管理处罚法 hereafter the 2005 Punishments Law), effective on 1st of March 2006, which instantaneously abolished the 1986 Regulations. Administrative sanctions stipulated by the 2005 Punishments Law for both first-party engagement and third-party facilitation of the prostitution transaction were more lenient and precise than in previous provisions. Firstly, compulsory rehabilitative education was completely abolished. Secondly, the period of detention and amount of fine were reduced, as Article 66 stated that selling and buying sex is punishable by between 10 and 15 days' administrative detention with the possible addition of a maximum fine of 5,000 Yuan; in less serious cases, by a maximum of 5 days' administrative detention or a maximum fine of 500 Yuan. Article 67 stipulated the same administrative sanctions to third-party participants in prostitution transactions. According to Article 74, personnel in the hospitality and service industry who leak information about police investigation into prostitution should be punished with 10 to 15 days of detention. That is a much more lenient penalty than the counter provision in the 1997 Criminal Law (with imprisonment of a maximum of 3 years, and with the more serious cases, of 3 to 10 years).[39] Furthermore, according to Article 66, third-party activities occurring not only in recreational enterprises, but also in all public places, should be punished. The offenders should be sentenced to a maximum 5 days of administrative detention or a maximum 500 Yuan fine.

In the revised 'Regulations Concerning the Management of Public Places

[39] Despite the lenient provisions in the 2005 Punishments Law, the strict provisions regarding punishments to prostitution-related offenders are not abolished. Two regulations proceed in parallel and it can be presumed that this situation embarrasses the policy enforcement.

of Entertainment' promulgated in 2006 (娱乐场所管理条例 hereafter the 2006 Entertainment Regulations) commercial sex are still forbidden. A recreational enterprise, in which commercial sex is practiced, should be penalized with confiscation of income and property related to prostitution and suspended for 3 to 6 months. In serious cases, owners and managers of the recreational enterprise should be fined 10,000 to 20,000 Yuan, and the business license revoked. (Article 42) Moreover, the 2006 Entertainment Regulations show a more lenient approach to personnel control. Personnel working in recreational enterprises are not required to possess a temporary residency permit or a work permit (except for foreigners) anymore. Instead, recreational enterprises are required to set up lists containing the real names of all employees and maintain copies of domestic employees' resident identity cards and foreign employees' work permits on file. (Article 25) Aiming at controlling government corruption, more restrictive provisions were stipulated, stating that officials of police authorities and culture departments themselves, as well as their family members and relatives, are not allowed to run any recreational enterprises. (Article 4) However, police authorities and culture departments above the county level are still empowered to keep surveillance and investigate recreational enterprises.

In sum, the 1991 Decision, the 2005 Punishments Law, the 2006 Entertainment Regulations, and the 2011 Criminal Law are the four main current legislations containing detailed provisions and regulations on prostitution control, and sanctions to individuals and recreational enterprises involving in prostitution. Whereas the penalties, including fines and administrative detention for first-party participants, have become more lenient, the illegal status of prostitution-related activities as a whole has not changed. Both first-party (sex workers and clients) and third-party participants (pimps, panderesses) in prostitution transactions should be sent to a mandatory examination for STDs, and if confirmed as STD-carriers, to compulsory treatments. They also should be penalized with administrative fines and detention and in cases of sex with minors and the premeditated spread of STDs, to a longer incarceration. Recreational enterprises involved in commercial sex face confiscation of income and property, as well as temporary or permanent liquidation. Their owners and managers should be fined. Personnel in the hospitality and service industry (including recreational enterprises) who interfere with police-led investigations should also be punished with administrative detention. These detailed penalties are illustrated in Table 3 below:

Table 3: Current provisions regarding penalties and measures to individuals and organizations involving in prostitution

Party affected		Penalties/measures	Relevant legislation	Execution organ
First-party participants	Sex worker	Mandatory STD-examination and treatment in cases with confirmed diagnosis	The 1991 Decision	Police
		< 5000 Yuan fine and in cases of premeditated spread of STDs < 5 years detention/ incarceration	The 1991 Decision, The 2011 Criminal Law	Ministry of Justice
		10-15 days administrative detention and/or < 5000 Yuan fine; in less serious cases < 5 days administrative detention or < 5000 Yuan fine	The 2005 Punishments Law	Police
	Client of sex worker	Mandatory STD-examination and treatment in cases with confirmed diagnosis	The 1991 Decision	Police
		< 5000 Yuan fine and < 5 years detention/ incarceration in cases of premeditated spread of STDs	The 1991 Decision, The 2011 Criminal Law	Ministry of Justice
		Fine and > 5 years' incarceration in cases of whoring with girls under the age of 14	The 1991 Decision, The 2011 Criminal Law	Ministry of Justice
		10-15 days administrative detention and/or < 5000 Yuan fine; in less serious cases < 5 days administrative detention or < 5000 Yuan fine	The 2005 Punishments Law	Police
Third-party participants	Pimp, Panderer	Fine and < 5 years detention/incarceration (in cases of luring,	The 1991 Decision, The 2011	Ministry of Justice

		introducing and sheltering); fine and > 5 years incarceration (in cases of luring girls under the age of 14); 5-10 years incarceration and fine (in case of organizing and forcing); fine, confiscation of property, and > 10 years incarceration or life imprisonment or death penalty (in serious cases)	Criminal Law	
		10-15 days administrative detention and/or < 5000 Yuan fine; in less serious cases < 5 days administrative detention or < 5000 Yuan fine	The 2005 Punishments Law	Police
Personnel in hospitality and service industry (including recreational enterprises) interfering with police investigation		< 3 years administrative detention or incarceration; in serious cases 3-10 years' incarceration	The 1991 Decision, The 2011 Criminal Law	Ministry of Justice
		10-15 days administrative detention	The 2005 Punishments Law	Police
Recreational enterprise	Owner and personnel in charge	In serious cases 10,000-20,000 Yuan fine	The 2006 Entertainment Regulations	Police
	Recreational enterprise itself	Confiscation of income and property and 3-6 months suspending; in serious cases revoking business license	The 2006 Entertainment Regulations	Culture department (for investigation); Police (for investigation, confiscation and fine); Department for industry and commerce (for revoking)

4.3.2.1.1.2 Police-led "strike hard" campaigns and policy implementation at local level

All of the laws and regulations mentioned above have provided a basis for the implementation of police-led campaigns against the resurgent prostitution industry, among which the 'strike hard' (*yanda* 严打) campaign is the most significant and notorious one. Aimed at reducing criminal activities rising rapidly in the reform era since 1978, the first 'strike hard' campaign was launched in 1983 and lasted for three years. Since then, another three 'strike hard' campaigns with a relentless series of police-led crackdown activities at the local level were conducted nationwide in 1996, 2000-2001 and 2010-2011. (Li 2012:84) Some of these campaigns were in the form of generic 'struggles,' others were directed against a range of specialized targets such as murder, robbery, rape, gang crime, prostitution, gambling, drug trafficking, and crime committed by domestic migrants, in the western province of Xinjiang against separatists, terrorists and fundamentalists, or to ensure public order prior to major sporting events or festivals. (Trevaskes 2010:11-13) Since the late 1980s, prostitution business and practices have been targeted by police-led crackdowns as part of the broader 'strike hard' campaigns, but also as a part of specialized anti-vice campaigns known as *saohuang* (扫黄) - literally seeping away the yellow, or the pornographic and obscene. (Jeffreys 2012:9)

So far, the conducting of crackdowns against prostitution within the framework of 'strike hard' and *saohuang* campaigns was often accompanied by the introduction of harsh enforcement, ignoring the dignity of offenders and violating human rights. One of the severe cases was the *saohuang* campaign conducted in Henan Province in October 2009, during which the police officers and journalists shot photos of naked FSWs and clients at the location of prostitution transactions and posted them thereafter on internet. (Wang and Yang 2012:40) Another incident of public humiliation that attracted broader critics was the "shame parade" of FSWs, clients, pimps, and panderers in FT District, Shenzhen City in December 2006. The offenders arrested by local police during the *saohuang* campaign were dressed in bright yellow prison garb, publically named, walked along one of the major thoroughfares of the city, and put to trial in public. (Tucker, Ren et al. 2010:124) (cf. Photo 7) Also, during the latest "strike hard" campaigns in 2010, police in the city of Dongguan which is another city in PRD, were facing severe

criticism for allegedly humiliating participants of prostitution. In this incident, the police sent two alleged FSWs back to the crime scenes in order to collect visual evidence, as the police thereafter proclaimed in front of public critics. During this procedure and as the photos released on internet showed, the suspected offenders were in bare feet, wearing handcuffs, and being tied up with a long piece of rope that aimed to constrain their movements, and/or stop them from escaping. (Jeffreys 2012, Wang and Yang 2012) (cf. Photo 8) Furthermore, it was noted by some Chinese scholars (e.g. Huang, Henderson et al. 2004:698, Hu 2007:26) that some crackdowns again prostitution were abusively carried out by local police authorities to create income, and resulted in arbitrary arrests and convictions, extortions, and issuing extra fines. Research by Pan and et al (2005:16) on the prostitution industry in an urban village in Shenzhen also revealed that one of the village government departments, the public security committee, was authorized by police in crackdown campaigns to arrest and fine participants involved in prostitution. Taking advantage of this power, the public security committee extorted so-called "protection fees" (*baohufei* 保护费) from participants in prostitution and stealthily withheld parts of fines from arrested offenders as a bonus for its own employees. Such extra gains could make up to 80% of the total income of the committee employees.

Photo 7: "Shame parade" of offenders involved in prostitution in FT District, Shenzhen in December 2006 (Hua and Zha 2010)

Photo 8: An alleged FSW was identifying the crime scene in Dongguan in July 2010 (Han 2006)

Facing sharp public criticisms of violating human rights, China's authorities released a series of provisions to regulate the conduct of police officers in policy enforcement. In late July 2010, just a few weeks after the Dongguan incident happened, the Ministry of Public Security issued a directive reminding police officers involved in the 'strike hard' campaigns against drugs and prostitution to follow the law and professional codes of conduct, and to guarantee the rights of reputation for both criminal and non-criminal offenders. (Jeffreys 2012:149) Moreover, in line with the appeal of the central government to improve condom usage aimed at HIV/AIDS control, some local police authorities have stopped citing condom possession as the evidence of prostitution transactions during enforcement campaigns. (Deng 2004, Zhang and Han 2009:71) Despite all these changes, policy implementation against prostitution remains repressive and harsh, in general. The fear of being arrested, fined, detained, and humiliated shadows the conduct of first- and third parties in prostitution, and further influences the FSWs' health. This is summarized in Subchapter 4.3.2.3.

4.3.2.2 Policies towards NGO activities promoting STDs and HIV/AIDS prevention

As discussed in Chapter 2, the roles of different individuals/actors involved in an institutional collocation are of importance in an actor-centered institutional analysis. When it comes to the discussion of institutional change, especially, new actors can be regarded as new elements that are added to the old institutional structures. (cf. 2.4.2) In this sense, the role of NGOs devoting to STDs and HIV/AIDS prevention targeting population involving in commercial sex is of importance. With the case study of "AIDS CARE" project in Shenzhen the following chapter discusses the change of governmental policies toward these NGOs' activities so that policy change addressing new individuals/actors involving is revealed. The question how these policy change influence FSWs' health seeking behaviors is also be addressed.

4.3.2.2.1 Transformation of NGO status in China

Before elaborating on NGO activities in the areas of prevention of STDs and

HIV/AIDS, and related public policies, it is necessary to present an overview of the NGO status in PRC. "Non-governmental organization" (NGO) and "non-profit organization" (NPO) are the two terms often used to represent China's mass civil organizations, defined as "*minjian zuzhi*" (民间组织) or "*gongmin shehui zuzhi*" (公民社会组织), which cover all non-governmental institutions, public organizations, and non-governmental organizations, to distinguish from governmental and for-profit enterprise. (Gu, Zheng et al. 2007:32) The abbreviation *NGO* is used in this thesis to refer to both registered and non-registered organizations. NGOs have experienced prodigious development in the last decade in China. In the 1960s, there were less than 100 registered NGOs throughout China. (Gu, Zheng et al. 2007:29) In the late 2000s, the number of NGOs registered with the Ministry of Civil Affairs (MOCA) had increased to about 320,000. Counting the non-registered ones, foreign NGOs, trade and science associations, charity groups, farmers' organizations, and doctors' organizations, there are probably about two million NGOs in China. (Kaufman 2009:161)

Since the establishment of PRC, the development of NGOs in China was beset with distrust, and is regarded by the central government as a potential threat to its authority. As early as the 1950s, laws concerning NGOs were passed, aimed at eliminating counterrevolutionary organizations. The releasing of the "Interim Regulations on Registration Administration of Private Non-enterprise Units" (State Council of PRC 1998) aimed at identifying who the groups were, so as to restrict and control them. In 1990, the MOCA set up a nationwide system to deal with NGOs. An arduous "dual management" system of NGO registration was instituted requiring that, in order to operate legally as a NGO, an organization usually had to register both with MOCA, with a minimum of 100,000 Yuan, as well as a sponsoring government department. (cf. Gu, Zheng et al. 2007:30, Hasmath and Hsu 2008:32, Kaufman 2009:161) To avoid this strict "dual management" policy, some NGOs had to apply a tactic of registering with the Commercial and Industrial Bureau as commercial entities. However, commercially-registered NGOs are required to pay a five percent tax on any revenue, including all fundraising, even if collected for charitable purposes. (Kaufman 2009:161) All of these policies have set up administrative and financial hindrances to NGO operations. I interviewed Mr. J, the manager of an NGO dedicated to protection of rural-to-urban migrants' rights. This NGO has also registered as a firm, and Mr. J talked in the interview about the NGO's difficulties regarding registration and

financial shortages:

> Q: "According to information we found on the Internet, you have registered as a firm, but you carry out non-profit activities in practice."
>
> A: "Right, due to the Chinese legal system, it's extremely difficult for an NGO to register. There are two regulations that we can't fulfill: First, we have to find a governmental department in charge ［the sponsoring organization］. But to be honest, what department will be willing to cooperate with us, since we can't make any financial revenue from it? Secondly, we must have a lot of money for registration. But we didn't have much money. So it was impossible for us to register［as an NGO］Without a registration, we would be destined to be banned as an illegal organization. So we had to register as a firm. And then we are facing the tax issue. … Looking at foreign NGOs, they are free from paying taxes and also receive subsidies from the government. Our poor budget and paying taxes trap us in a terrible situation."

The purpose of controlling NGOs is also manifested in the policies aimed at limiting NGO activities. For NGOs working at the county level and below, a registration is not required. However, for each particular issue at the local level, only one group is allowed. Moreover, NGOs are prohibited from working on the same issue in different places, a thinly-veiled attempt to prevent the emergence of these groups as a larger-scale regional, provincial, or national organization. (Kaufman 2009:161) Moreover, cooperation between NGOs and the personal activities of NGO members are supervised, and might be taken as an excuse for their prohibition. Regarding this, Mr. J reported in the interview:

> Q: "Do you cooperate with other NGOs?"
>
> A: "There are few opportunities for cooperation. If other NGOs organize such events as conferences and trainings, which need our aid, we will send representatives there to help them. Generally speaking, we seldom have collaboration within such a project framework, because we have to consider the situation in China. If the NGOs have too many activities and develop too much rapport with each other, 'the party is concerned' and［the government］may worry about them.［Mr. J mentioned possible punishments

faced by NGOs, using relatively mild language to mask harsh realities］. To avoid such disturbances to our work, we've decided not to have too much contact with other NGOs."

Despite the strict control and restrictions discussed above, increasing research (e.g. Gu, Zheng et al. 2007, Zhu 2007, Hasmath and Hsu 2008, Kaufman 2009, Shieh 2009) demonstrates that the Chinese government has cautiously opened the doors for NGOs as providers of social services in several areas such as education (e.g. education for children in underdeveloped regions), environmental protection (e.g. recycling), and health care. The governments' tolerance of NGOs' activities regarding STD and HIV/AIDS is an example of such change of policy, which is elaborated in the following subchapter 4.3.2.2.2.

4.3.2.2.2 NGOs' activities regarding prevention of STDs and HIV/AIDS and the case of the "AIDS CARE" project in Shenzhen

The change of their attitudes towards NGOs' activities is in relation with the policy dilemma that China's governments, especially local governments, face: On the one hand, the governments are trying to retain control over NGO activities, aiming at remaining as the main provider of social services, in consideration of its political authority. On the other hand, the governments are aware of their decreasing capacity to provide social services due to the fiscal decentralization and devolution of financial responsibility. (Kaufman 2009:161) In the prevention of STDs and HIV/AIDS, governments' incapacity necessitating the NGOs' involvement and aid has become apparent. First-party participants in prostitution transactions (e.g. FSWs and their clients), for example, are the high-risk groups of HIV/AIDS, and the bridging population of HIV/AIDS transmission, but they are not easily reached because of high mobility. Engaged in illegal behavior, FSWs and their clients also try to avoid government services for fear of being arrested and fined. Moreover, governments are reluctant to provide service and education regarding HIV/AIDS prevention among the sex industry population because of the worry that the public may regard these governmental activities as acquiescence to prostitution legalization. Therefore, in response to HIV/AIDS, China's governments have so far mainly devoted themselves to acting as a sponsor to provide interventions (e.g. funding for building up blood banks, drug substitution and syringe exchange for

drug users, testing of blood supply) (Kaufman 2009:158-159) and allow the NGOs' front-line interventions to provide services to populations involved in prostitution.

Another crucial phenomenon in response to the HIV/AIDS epidemic is the emergence of pragmatic partnerships between China's local institutions (e.g. institutions with the purpose of providing public services and governmental support, *shiye danwei* [事业单位]), institutions that already have capabilities and experience in disease control (e.g. Centers for Disease Control [疾病控制中心]), and transregional or international NGOs. As a relatively new participant cooperating in the global fight against HIV/AIDS, China's local institutions often play a role as recipients of information and knowledge imparted by transregional or international NGOs. These NGOs are aware that cooperation can reduce expected impediments from China's government, so they provide guidance that can be tailored to the current local situation to enhance its usefulness and relevance. Community-based HIV/AIDS intervention projects, which focused attention on the kind of first-party participants of prostitution in Shenzhen that I interviewed in 2008, were examples of this kind of partnership. At the time of the interview, the project had continued for three years and was about end. Initiated by the Hong Kong NGO, "AIDS CARE," the project has been devoted to HIV/AIDS intervention since 1990, funded by the Kadoorie Charitable Foundation, and conducted within a framework in cooperation with the Shenzhen Institute of Population and Family Planning (SZIPFP). The six-man project team was assembled by an "AIDS CARE" manager from Hong Kong, and included five associated members recruited in Shenzhen with a medical science education, three who had worked in SZIPFP. The project provided HIV/AIDS education through seminars, telephone counseling, and publicity materials, concentrating in communities with a high density of brothels and recreational entertainment sites, distributing free condoms and providing free HIV tests. While the Hong Kong NGO played the role of sponsor and planner of the project, the local team in Shenzhen was in charge of the practical implementation, and was allowed to undertake modifications in accordance with local conditions. For example, to meet the FSWs' interests, the project invited gynecologists to provide counseling and added an additional gynecological section to the HIV/AIDS seminars. Personal networks of Shenzhen project members with local residents proved to be advantageous for reaching the target group. One project member reported the following case (NGO/Shenzhen):

"In XS Community, you may see quite a lot of cha chaan tengs ［茶餐厅 a certain kind of Hong Kong-style restaurant］, which have a lot of clients from Hong Kong. We are very familiar with one of these cha chaan tengs and have good relation with its owner. He allows us to give HIV/AIDS education in his restaurant, as long as the clients don't reject. We also know some people from Hong Kong who live in XS, such as retired workers and police officers. They have introduced us to their friends, including those who live in Hong Kong and travel between Hong Kong and mainland China frequently. In this way, we have won a lot of participants for peer education."

By and large, the project earned remarkable achievements in HIV/AIDS interventions targeting FSWs, giving HIV/AIDS education to an estimated 1,800 FSWs. A project member reported the participation achievement in a seminar as follows (NGO/Shenzhen):

"At the late stage of the project, the AIDS education centre flourished. A lot of girls have known about our project. … and realized that we weren't threatening them. So they were glad to come to the seminar. Some of them would even rather pay their working sites so that they could stay here longer and hear the lectures."

Clients' health awareness and conscientiousness play a significant role in STD and HIV/AIDS prevention, and thus, clients should be an important target population of HIV/AIDS education. However, some researchers (e.g. Tucker, Henderson et al. 2005, Jeffreys and Huang 2009) argue that in China, as in many countries in the world, it is more difficult for HIV/AIDS intervention to target sex workers' clients than sex workers, due to clients' mobility and inconclusive involvement. This aspect is confirmed by the experience of the HIV/AIDS project in Shenzhen reported in the interview. With an original plan to provide HIV/AIDS education for both FSWs and their clients, the project provided education to only 600 male clients of FSWs, or merely a third of the FSWs approached, and much fewer than planned. The difficulty reaching male clients of FSWs was reported by an interviewed project member as follows (NGO/Shenzhen):

"Actually the clients from Hong Kong also need AIDS education. But they are very difficult to approach … because they come to

> Shenzhen for fun, and whoring is such a sensitive issue. So they are very reluctant to be approached. Actually they are reluctant to be in contact with any mainland Chinese, and to be pulled over by us on the streets." (NGO/Shenzhen)

To deal with the difficulty reaching male clients of FSWs more efficient and engagement of NGOs is necessary.

4.3.2.3 Influences of governmental policies on FSWs' *health-seeking behaviors*

The first issue regarding the influence of governmental policies on FSWs' sexual health is the illegal status of prostitution in China. Due to the illegality of prostitution and resulting penalties, both the FSWs and their employers more readily repudiate help through police intervention when faced with confrontations, including physical and sexual abuses by their clients. FSWs are afraid that their identity as sex workers could be exposed during a police investigation, and they might be detained, fined, and even humiliated. Hence as reported in the interview, when FSWs find themselves in a dispute with clients, they rarely contact police authorities. Rather, they usually seek help from pimps, panderesses, and managers at the working site, even under the risk of facing severe physical harm. Panderesses, pimps and owners/managers of recreational enterprises involved in prostitution are among groups targeted for more rigorous punishment (longer imprisonment, more fines, confiscation of income and property, and even the death penalty, see Subchapter 4.3.2.1.1.1). Thus, they are also reluctant to seek police support when disputes between FSWs and clients take place. In some cases they even forbid FSWs to seek police intervention. (Chen 2008, Xu 2008) It must also be noted that FSWs working in lower-level prostitution sites have more limited rights to police protection, and hence, they are more likely to be subject to client abuses and harm. As reported by the interviewed FSWs, brothel-based FSWs are more vulnerable to client abuses as compared to those working in recreational enterprises. Recreational enterprises are registered as legal business units despite providing commercial sex services. Under the cover of their legal status, recreational enterprises are more likely to seek police intervention when dealing with client violence which can cause severe physical harm to employees (including FSWs) and result in mass destruction of enterprise property. Brothels run by panderesses

are completely underground and illegal, and hence, they are more reluctant to seek police support.

To some extent, low condom usage results from FSWs' fear of legal reprisal, because condom possession has been used by police as evidence of prostitution. (Xia and Yang 2005:183) In line with the effort of HIV/AIDS control, a law issued by the State Council was passed in April 2004, allowing condom distribution. As a result, some local police authorities (e.g. in Shanghai) have stopped citing condom possession as evidence of prostitution during enforcement campaigns. (Deng 2004) However, anthropological studies of accounts from sex workers reveal that they still fear that police will confiscate their condoms. News accounts of police raiding condom supplies from brothels suggest that time and training of local police would still be needed until old prejudices are thoroughly laid aside. (Tucker, Ren et al. 2010:125) Pan's research (2002:69) also reveals the interrelation between punitive fines assessed to FSWs and the resulting financial pressure, which could cause many FSWs to abandon necessary medical counseling and treatments. Due to their unprotected commercial sexual behaviors and *healthcare-seeking behaviors*, Pan pointed out that to pay the fines, FSWs would likely have to earn more to compensate for the losses, making it harder for them to reject unprotected sex requested by clients.

Furthermore, the illegal status of prostitution and the repressive crackdowns on the sex industry also have established de facto obstacles to NGO efforts in HIV/AIDS prevention. As reported by interviewed project members, a great number of FSWs were reluctant to take part in health seminars and face-to-face counseling, even though the seminar sites and counseling offices were located near their working site (in XS Community) and conveniently reached. A crucial reason for the low participation was the FSWs' fear of being arrested by police, because XS community was one of the main targeted locations of police-led crackdowns due to its high density of recreational enterprises. In June 2005, China's Ministry of Health published a document which encouraged sex workers to have STD check-ups regularly (Zhou 2006:250). However, as prostitution is deemed to encourage the premeditated spread of STDs and HIV/AIDS, and mandatory treatments remain enforced (cf. 4.3.2.1.1.1), regulations assessing penalties for first-party prostitution participants deter FSWs from taking STD or HIV/AIDS tests provided by prevention projects.

Peer education has been proven as one of the most effective ways to

distribute health knowledge among FSWs. (Jing 2006:139) However, the high mobility of FSWs, together with the police-led crackdowns, have made it extremely difficult for the NGO to stay in contact with the so-called "backbone" FSWs, who had been well-trained in health-related knowledge by the NGO, and are willing to help educate their peers. The interviewed HIV/AIDS project member reported such difficulty reaching the at-risk populations during the recent "strike hard" campaigns, which began about one month before the interview was conducted (NGO/Shenzhen):

> "Recently, the XS governments are conducting strike hard campaigns. Such campaigns were conducted during our project every a few months. These campaigns definitely interfered with our project and made the target group more difficult to approach. In order to avoid the crackdowns, the FSWs flee. Some of them go home, some of them leave Shenzhen and go to Guangzhou, Dongguan, even Beijing and Shanghai. … We've given peer education to the FSWs and selected some of them who had a good relationship with us, understood and accepted our work quite well, and were willing to help us with further education. Due to the crackdowns, we are not able to contact them anymore. … One of the characteristics of the group targeted for peer education is the very high mobility. … Data we collected shows that the girls change working sites about every two or three months. … Although we initially planned to conduct the project only in the XS and SZ communities in Shenzhen, we have to connect with other cities, such as Guangzhou and Dongguan, because the girls moved between the cities very frequently."

The experiences of the NGO interviewed in Shenzhen reveals that the governmental policies against prostitution and crack-down campaigns have still established obstacles to their engagements in STDs and HIV/AIDS prevention and have undermined FSWs' motivation of using medical services that NGOs provide.

4.3.3 Informal institutional factors influencing FSWs' *health-seeking behaviors*

This subchapter discusses the informal institutional factors that affect FSWs' health-seeking behaviors. The tradition of patriarchy and the system of *face* have been described in the previous discussion of migrant women living in urban villages. These two important informal institutions embedded in China's society also have significant impacts on FSWs. I link the patriarchal tradition with gender inequality and discrimination and prejudice against FSWs. I then elaborate on the impacts of the *face* system on FSWs' health-seeking behaviors, explaining how a situation of *losing face* impacts FSWs' social network and their decisions regarding use of health services. In the last subchapter I analyze FSWs' social networks within the sex industry and explain how these social networks influence their health-seeking behaviors.

4.3.3.1 Patriarchy, gender inequality, discrimination and prejudices

Patriarchy is a transnational and cross-cultural phenomenon presenting a male-dominated system with gender inequality. In a patriarchal society, males are considered dominant and significant, their bodies are regarded as valuable, and male behaviors are granted, guaranteed, and rationalized by the cultural values and different social institutions. Conversely, females are considered by patriarchy to be inferior and should be "ruled" by males, with the ultimate goals of female activities subject to the males' needs. (Li 2005:5-6)

Patriarchal tradition has also been embedded into China's society, and remains persistent in present-day China despite the development of feminism, which began to take foot at the end of ancient dynasties with the establishment of PRC. Patriarchal tradition highly values male offspring and son preference, as discussed in Subchapter 4.2.3.1. Furthermore, patriarchy is reflected in gender relationships of present-day Chinese, influencing their attitudes towards sexual behaviors. The sexual "virtue," based on patriarchal logic, puts a female into a subordinate position to her male sexual partner, and it is the female's duty in sexual intercourse to provide satisfying sexual relations for the partner. (Xia and Yang 2005:182-183) As the research of Pan et al (2008:148-149) on the clients of FSWs

reveals, sexual attitudes of Chinese males are also influenced by a system ranking their female sexual partners, which had been established and widely accepted in ancient Chinese society. In ancient China, a male was allowed to have multiple sexual partners, ranging from wife (*qi* 妻, which is only one, having a formal marriage relationship) on the top, to concubine (*qie* 妾, which could be more than one, having a formal marriage relationship), to handmaid (*bi* 婢, which can be more than one, but without a formal marriage relationship), and lastly, prostitutes (*ji* 妓, providing casual and commercial sex) at the bottom of the ranking system. Social ethics required a husband to respect his wife, as well as provide lifelong financial support to any of his concubines and handmaids who had ever had sex with him, raising their common offspring. However, prostitutes were discriminated against as amoral, indecent, 'toilets of male sexual desires," and deserved no respect from their male sexual partners. Although China's laws have protected monogamy since 1949, having multiple sexual partners and extramarital sex are not rare in present-day China. As for a great number of FSW clients, they are, in fact, practicing the polygamous sexual life inherent in ancient China's traditions. As Pan et al described (2008:149), "they have wives and lovers (or er'nai), go whoring with FSWs, practice cyber love, and also have one-night-stands. … The only difference from ancient times is that the handmaid as one kind of sexual partner doesn't exist anymore." This ranking system of males' female sexual partners in the old ethic still influences males' attitudes towards different sexual partners in present-day China. Whereas a male would be likely to use condoms to protect their wives or lovers from STDs or unexpected pregnancies because of respect or love, he would rarely take into consideration the protection of FSWs, often refusing to use condoms due to their discriminatory attitudes against FSWs. (Xia and Yang 2005:182-183) Moreover, gender inequality in commercial sex makes FSW clients fastidious about services provided by FSWs, considering FSWs as inferior females who earn money by selling their own bodies. As such, FSWs are supposed to meet all demands of their clients (superior males who are paying money). Discrimination towards FSWs may also make the clients unscrupulous, responding violently towards FSWs in cases where they are dissatisfied with the service, deeming that the service doesn't equate with the money they paid.

As reported in interviews, FSWs would try to persuade their clients to use condoms, but failed frequently. (cf. 4.3.1.2) Client prejudice against FSWs can explain this situation to some extent. Clients usually have a strong distrust of FSWs.

As the saying goes, “prostitutes are ruthless” (*biaozi wuqing* 婊子无情) (Pan, Huang et al. 2008:188). They believe that FSWs would never be considerate of the male clients’ desires. Thus, an FSW requesting condom use would typically cause resistance from her client, who would believe that she is only protecting herself from pregnancy, wishes to slack off, or purposely wants to deny clients their sexual pleasure. Due to this strong prejudice and distrust, FSW clients are more likely to accept persuasion of condom use from employers or managers of prostitution sites than from FSWs. This situation was also reported during the FSW interview.

4.3.3.2 The system of *face*

The role of *face* has been mentioned several times in the previous sections of this thesis, as in the discussion on migrant women’s attitudes towards premarital pregnancy (cf. 4.2.1.1), their choice of locations to seek induced abortions (cf. 4.2.1.2), their embarrassment with obtaining condoms (cf. 4.2.1.1), Chinese people’s attitudes towards the absence of male offspring (cf. 4.2.3.1), and FSWs’ embarrassment admitting that they are carrying STDs (cf. 4.3.1.2). In this subchapter, in order to understand these phenomena linking FSW attitudes toward sex work and their *health-seeking behaviors*, I further elaborate on the importance of the system of *face* for Chinese people, regarding it as an informal institution with roots that are deep in China’s society.

One characteristic of China’s fundamental social structures is that “the degrees to which Chinese ethics and laws expand and contract depend on a particular context and how one fits into that context.” (Tucker, Ren et al. 2010:124) Within that context, social networks between individuals and groups of individuals (e.g. families, neighborhoods, working units, and communities) are constructed together with implicit moral codes and responsibilities. Members of social networks owe it to each other to supervise behaviors, ensuring the adoption of community standards and reciprocity of norms, while applying substantial social and personal pressure on those exhibiting unsuitable/indecent behaviors. In ancient times, corporal or criminal punishments were practiced, including drowning women who committed adultery. (Tucker, Ren et al. 2010:124) As a part of social networks, individuals are required to seek and maintain suitable positions within the networks, and ought to conduct themselves suitably and decently. This is the way to earn and maintain one’s social dignity, the social *face*, or so-called *mianzi*

(面子). Conducting unsuitable or indecent behaviors portends moral failure, not only on the part of the individual, but also other members within his or her social networks, and is called *diu mianzi* (丢面子), literately *losing face*. *Losing face* is regarded as a vital and severe shame for individuals, and as Troyer and Rojek stated (1989:9), "is to be denied all social worth and to be cut off from the group or collectivity that is the essence of life". Thus, such highly-supervised social networks result in two consequences, regarding individual behaviors, to avoid the situation of *losing face*: conducting suitable behaviors, or else, conducting unsuitable behaviors but trying to keep other members of the social networks from knowing.

China doesn't have an ascetic tradition. However, sex in both ancient and present-day China is a topic associated with shame and indecency, which "can be done but not be talked about". (Li 2009:34) Moreover, for present-day Chinese, extramarital sex, including involvement in commercial sex, is regarded as a highly-sensitive topic. Participants in commercial sex greatly fear that these sexual behaviors will be known by other members of their social networks, beyond those also involved in similar activities (e.g. peers of FSWs or other clients of FSWs), and will associate exposure with *losing face*.

As to FSWs, there are generally two approaches to avoid *losing face*: 1. reducing public exposure that may be linked with their identity as sex workers as much as possible and 2. misleading, limiting, or even terminating contact with their old social networks. The first approach is manifested by the reluctance of some FSWs to take part in voluntary STD, HIV/AIDS-counseling, and testing programs provided by an NGO, as reported in interviews. FSWs are more apt to seek private counseling instead of going to public health care institutions when they suffer from illnesses associated with prostitution (cf. 4.3.1.5). With regard to the second approach, the decision for a young woman to sell sex portends moral failure not only on the part of the individual, but also her family, community, and hometown village (Tucker, Ren et al. 2010:125) FSWs, themselves, subjectively link their conduct in selling sex with shame and *losing face* in their social networks in hometown villages, fearing that it will cause discriminatory behaviors from other village members. This was revealed in the responses of two interviewees when they were asked whether they would let their family or friends know about their job:

> "No, because this [being sex worker] is a very shameful thing. They would look down upon me, both my family and friends."

(FSW/08)

"No, because my family would be very sad about that and it would bring me a bad reputation and influence badly my marriage in the future. My hometown is a quite conservative place." (FSW/07)

A strategy that interviewed FSWs used to hide their identity as sex worker is deceiving their family and friends into thinking that they are doing other jobs (e.g. baby-sitter, factory workers) in the city. The fear of *losing face*, and the strong psychological pressure this worry causes (cf. 4.3.1.3), forces some FSWs to reduce or even sever their ties with their old social networks. For example, an interviewee (FSW/29) reported that since she has been involved in the sex industry, she has seldom contacted her *laoxiang,* or townspeople, while working in Shenzhen, and has visited her family in her hometown less frequently than before.

It must also be noted that public humiliation in line with administrative enforcement against prostitution (cf. 4.3.2.1.1.2) results in the most severe and cruel form of harming the *face* of FSWs affected, as it formalizes and publicly exposes these women's identity as sex workers. Being publicly identified as morally corrupt because of sex work can be considered by the affected FSWs as irreparable damage to their social *face*, representing severe psychological harm, which may lead to drug use and even suicide. (Tucker, Ren et al. 2010:125) Interestingly, it was reported by one interviewed FSW (FSW/30) that she has no fear of exposure of her identity as a sex worker to her family members. FSW/01 stated in the interview that she keeps in touch with her family, although her parents know that she participates in prostitution. The attitude of these interviewees can be first explained by referencing Pan et al's (2005) view of professionalization by FSWs, arguing that compared with other FSWs, "professionalized" FSWs[40] have more independent consciousness and a better adaption to sex work: they consider sex work like any other job, instead of regarding it with shame. In this regard, FSW/30 and FSW/01 can be considered professionalized FSWs. Their fearless attitude to their identity as sex workers can also be explained by a social concept - *xiao pin bu xiao chang* (笑贫不笑娼), literally "people laugh at the poor but do not laugh at prostitutes" (Zhou 2006:248). This concept has become more and more popular in the last two decades, along with increasing social tolerance to the sex industry and its participants. (Huang and Pan 2003:59) To a certain extent, people's

[40] According to Pan, professionalized FSWs account for a very small proportion of the total FSWs in China's prostitution industry.

adoption of *xiao pin bu xiao chang* reduces FSWs' high psychological cost for conducting commercial sex, and is used by some FSWs as a psychological weapon to protect themselves from stigmas and discrimination from their social networks. For example, in the interview, FSW/01 described how she reacted to her parents, who were against her job:

> Q: "Are your parents against your job?"
>
> A: "They didn't approve it at first. But I told them: 'Look at you! You're not able to earn any money! If I were not doing this job, how would you have paid the debts? … I do the job for the family!' After hearing that, they said nothing anymore."

Except for particular cases like FSW/30 and FSW/01, FSWs generally endure psychological stress because of the fear of public exposure and losing of *face*. In order to avoid public exposure, they deliberately narrow their current social networks and retreat from their old social networks. As a result, the social network within the sex industry is of significance to FSWs. This situation was reported by an interviewee working in a barbershop (FSW/16) for example:

> Q: "With whom do you usually get along?"
>
> A: "Mainly with the people in our salon- other girls and the laobanniang［panderess］."
>
> Q: "What about with other people outside［the sex industry］?"
>
> A: "Seldom. I simply don't want to see that the people look down upon me."

The following Subchapter 4.3.3.3 then focuses on FSWs' social network within sex industry. FSWs' clients are first-party participants in prostitution activity, but FSWs' relationships with clients are discussed in a separate subchapter. I discuss the relationship between FSWs and procuresses/managers, FSWs and other FSWs, and FSWs and their boyfriends to elaborate how these relationships influence FSWs' sexual health. One influence involves the high mobility of certain FSWs, so that most clients are usually temporary visitors (Subchapter 4.3.1.6.2), and lasting relationships between FSWs and clients are rare. This argument can be supported by interviewed FSWs who stated that they are not familiar with their clients, and couldn't give details on a client's occupation, income, or social status. However, Subchapter 4.3.3.3.3 discusses the emotional support of clients who visit FSWs during a relatively long period of time, and who are regarded by the FSWs as boyfriends.

4.3.3.3 FSWs' social network within sex industry

This subchapter addresses FSWs' social network within sex industry. Social network within sex industry is extremely important to FSWs because FSWs' social connection with the world outside sex industry lacks, as discussed above. The discussion goes to the relationship between FSWs and other individuals involving in sex work, among which are managers of the prostitution sites where FSWs work, FSWs' female colleagues and FSWs' boyfriends. It must be reemphasized that I don't regard the social network as an informal institution according to my definition given to informal institutions. Instead, social network is an informal organization which FSWs self-organize and use to deal with the institutional setting where they live and work and has impacts on FSWs' *health-seeking behaviors*.

4.3.3.3.1 Trust for managers of prostitution sites

The empirical research in Shenzhen identified the following three groups of third-party participants in prostitution activity: 1. panderesses managing brothels called *mami* (妈咪), literally mother, 2. male owners of barbershops called *dage* (大哥), literally elder brother, and 3. female managers of recreational enterprises involved in prostitution activity called officially *buzhang* (部长), literally department manager. They are called *mami* by FSWs of who they are in charge. The discussion hereafter uses the term "manager" to refer to these three groups, as they are all more or less in charge of prostitution transactions of the FSWs.

As Zhuang et al. (2009:31-32) described, the sex industry in China is a quasi-patriarchal system, given the relationship between FSWs and their managers. A trust system has been developed between FSWs and their managers. Called mothers or elder brothers by FSWs, the managers act as householders of the prostitution sites and have a strong influence on FSWs. They provide FSWs accommodation (in brothels and barbershops), schedule their working times, solicit clients, and charge a certain portion of the payment from prostitution activities. (cf. 4.3.1.6.1.3) Whereas there is a high mobility among FSWs, managers usually stay in particular prostitution sites, and they are familiar with the local prostitution market and clients. Thus, income of a FSW in a new location usually relies on

solicitation by her manager. Moreover, networking between managers allows the high mobility of FSWs between different prostitution sites, and brings them financial advantage. (cf. 4.3.1.6.1.3) Although managers charge a percentage from prostitution transactions, it seems that FSWs don't regard the relationship with their managers as an exploitation, but reciprocity. This is revealed from the response of an interviewee (FSW/11) to the question on physical abuse:

> "*Mami* would never hurt us. We earn money from her and she also earns money from us. So she would not treat us badly."

Responding to the same question, another interviewee (FSW/12) working in a night club stated the precondition of being a *mami* in sex industry:

> "*Mami* would absolutely not hurt us, because a *mami* must first of all get along with people well. Otherwise no girl would work with her. She would have few clients."

The importance of managers is also manifested in their role as mediators, both when FSWs face physical abuse from clients and in the negotiation of condom use by FSW clients. Whereas FSWs have a relatively weak social network with people outside the sex industry, managers substitute to some extent as FSWs' family members and friends as they lend money to FSWs and take care of FSWs in case of illnesses, as reported in interviews. Moreover, usually most female managers had been FSWs, themselves. The shared experiences allowed them to understand FSWs well and treat them, as reported in the interviews, "from heart to heart." For example, it was reported by one 17-year-old interviewee (FSW/05) in a brothel, a newcomer in the sex industry, that the *mami* didn't force her to serve a client immediately. Instead, she allowed her enough time for adaptation. To newcomers like FSW/05, managers also give them training in dress, makeup, and conducting appropriate behaviors (e.g. how to act naive, elegant, and educated rather than as a loud and abrasive girl") (Huang, Henderson et al. 2004:697), skills crucial for FSWs to attract clients and to achieve upward professional mobility. Regarding FSWs' approaches to health-related information and their *healthcare-seeking*, their trust of managers explains why FSWs prefer to acquire health-related information from their managers and visit health facilities recommended by managers when they are in need of health care (Subchapter 4.3.1.5).

4.3.3.3.2 Relationships with other FSWs

Except for managers, peers working at the same prostitution site are the people with whom FSWs communicate in daily life. As with factories that exclusively employ female migrant laborers, prostitution sites function as convergent points for girls from different regions of origin. With similar age, family, and migration backgrounds, as well as co-working life, it is easy for the girls to establish identity and trust with each other. Moreover, peer relationships play a significant role in FSWs' occupational mobility. Due to the illegal status of sex work in China, formal labor agencies are lacking in the prostitution industry. Compared with other branches, FSWs' occupational mobility more strongly relies on personal networks. According to Huang and Pan (2003:62), a personal network consists of "relation with kin" (e.g. with family members or relatives) and "relation with friends" (e.g. with peers). As discussed in Subchapter 4.3.3.2, FSWs deliberately loose or even terminate their relations with family members due to fear of exposure of their identity as a sex worker; thus, the function of "relation with kin" dims and the "relation with friends" becomes more important for FSWs' occupational mobility. Peers may be FSWs' guides for entering into the prostitution industry (cf. 4.3.1.6.1.1). Valuable information concerning better working sites within the prostitution industry is also exchanged between peers. As reported in the interviews, a close relationship between FSWs is also manifested when they talk and play games with each other, loan money to each other in case of low client traffic (e.g. during strike hard campaigns), pay police fines, and with regard to health issues, share health-related knowledge and information with each other (cf. 4.3.1.5) as well as care for each other in case of serious illnesses.

However, it was also reported by some interviewed FSWs that they did not get along well with peers. This situation may be derived from the fierce business competition among FSWs, revealed in the report of an interviewee working in a night club, who was responding to the question about her peer relationships:

> "Nobody understands me here. They［her peers］ have no sympathy with you if you tell them that you are not able to earn money. But, if you tell them that you earn quite a lot of money, they will envy you. They will envy you even when you have more boyfriends." (FSW/03)

The more strained peer relationships between FSWs can also be explained because some FSWs feel contempt towards prostitution, as a whole. They despise all FSWs, including their peers and themselves, and mentally resist friendships with peers. A brothel-based FSW talked about her peer relationships as follows:

> "I seldom make friends here, because here… all of us are doing such a [shameful] job. I don't want to make any friends here." (FSW/18)

This statement is an example that reveals FSWs resistance to their peers.

4.3.3.3.3 Relationships with boyfriends

According to the reports of interviewed FSWs, their boyfriends are usually also involved in the prostitution industry, and can be classified in two groups: 1. pimps or male managers of prostitution sites and 2. clients who have relatively long relationships with certain FSWs. Boyfriends play three roles in a relationship with FSWs: 1. enabling FSWs' prostitution activities (the first boyfriend group mentioned above); 2. providing physical protection (the first boyfriend group mentioned above); and 3. providing emotional support (both of the two boyfriend groups mentioned above). Point 1 and 2 are associated with the FSWs' business, and lead to the FSWs' occupational reliance on their pimps and male managers, whereas, point 3 reveals FSW's emotional reliance on their boyfriends.

Regarding the first role of boyfriends, pimps recruit young girls from their hometowns or other working sites (e.g. factories) into the prostitution industry (cf. 4.3.1.6.1.1), and male managers provide for FSWs their working location and accommodations, also soliciting clients (cf. 4.3.3.3.1). Regarding the second role of boyfriends, pimps and male managers are usually also involved in the local gang society and provide physical protection for FSWs when they face client violence. As discussed in Subchapter 4.3.1.1, FSWs are usually reluctant to seek police protection due to the illegal status of prostitution, even when they face physical harm by clients and ask the managers for help dealing with clients. When mediation between the managers and clients fails, boyfriends may take vengeance upon clients, resorting to violence or acquiring economic compensation for FSWs. An interviewee (FSW/16) working in a barbershop reported, for example, her experience as follows:

Q: "Have you or your peers ever been hurt by clients?"

A: "Once upon a time, I was hurt by a drunk client. … He sought to pay compensation for me, because he beat me for no reason. It wasn't my fault. … It was my boyfriend who handled the fuss at last."

Q: "How much compensation did the client pay?"

A: "5000 Yuan. My head was lacerated and got three stitches."

Emotional support is of great importance for FSWs, and it was often reported by FSWs in interviews that they are eager for marriage or a close relationship with a "proper guy." Facing harsh psychological stress (Subchapter 4.3.1.3), they are in need of having partners who can understand their pressures and provide consolation. Boyfriends are the ones on whom FSWs strongly rely, seeking emotional support. For example, the responses of two interviewees to the questions regarding their psychological stress reveal their high reliance on the emotional support from their boyfriends. One of them (FSW/03) stated that:

"Sometimes I think too much at night and my heart hurts so badly that I worry that I have a heart disease. But if he [the boyfriend] comes and talks to me, I feel better and fall asleep soon. I fell less anxious."

Another interviewee (FSW/16), who had a boyfriend that was one of her clients and worked in Hong Kong, responded as follows:

Q: "Do you feel lonely if your boyfriend is not with you?"

A: "Absolutely!"

Q: "And what will you do then?"

A: "Sometimes I will call him and beg him to visit me, just to take a look at me, it would be enough for me. He would say 'How can I visit you now? It's so far away. I must make a plan first.' He always likes to flirt with me in this way. I feel better by hearing that. I can understand he lives far away and he has little time."

It was also reported in the interviews that the emotional reliance on boyfriends of some FSWs is so strong that they are willing to give financial support to their boyfriends. This is revealed in the response of a brothel-based girl (FSW/08) to the question on her financial expenditures, for example:

"[My daily expense] also includes the cost of my boyfriend. Girls doing this job [being sex workers] like me usually look for

> boyfriends, and they are supposed to be financially supported by us. I have a boyfriend because I was afraid and needed someone to talk with and someone I could rely on. I've never changed my boyfriends and have the same one since July last year."

Such relationships between FSWs and their boyfriends can be regarded as an attempt by the FSWs to spend the money they earn to buy (or pre-order) a simulated (or sometimes fictional) relationship of marriage or a love affair. (Pan 2000:155) FSWs have deep concerns that they will not have a bright future of marriage due to their job (cf. 4.3.6.1.1), and therefore easily commit to a love affair, even though they are sometimes well aware that the boyfriends may only pretend to love them, may simply regard them as a tool to earn money, and are very likely unfaithful to them.

With regard to sexual health, FSWs' strong reliance on boyfriends weakens their capability of negotiation on condom usage. As discussed in Subchapter 4.3.1.2, FSWs seldom refuse unprotected sex required by boyfriends. It was also reported by some interviewed FSWs that they seldom ask for condom use with boyfriends although they are aware of the risk. This phenomenon can be explained by Pan et al's (2008) argument that no-condom sex is often regarded in an intimate relation as the proof of trust and faithfulness to the partner. Through unprotected sex, FSWs try to show their trust and faithfulness to their boyfriends, and expect the same trust and faithfulness in return. Such expectations can be revealed in the response of an interviewee (FSW/03) to the question on condom use with her two boyfriends, for example:

> "Having sex with them (boyfriends), I usually don't use condoms. Because I think they would not cheat me. They always tell me that they don't use condoms only when they have sex with me. With other people, they always use condoms."

It must be noted that as a matter of fact, boyfriends' faithfulness toward FSWs is usually not as strong as FSWs claim or expect, and most frequently, boyfriends have multiple sex partners and don't stay in a long-term relationship with a certain FSW. Betrayal by boyfriends may signal deep depression in affected FSWs. (Cheng, Han et al. 2010) FSW boyfriends that have multiple sex partners, and the frequent practice of unsafe sex, enhances the risk of cross-infection of STDs and HIV/AIDS among FSWs, their boyfriends, and other sex partners of the boyfriends, as discussed in Subchapter 4.3.1.6.3.

Interestingly, it was also reported by some FSW interviewees (e.g. FSW/01, FSW/02) that they didn't have a boyfriend at the time of interview, and they were reluctant to have a boyfriend, expressing contempt and ridicule to the boyfriends supported by FSWs, calling them *xiao bailian* (小白脸 gigolos, literately little white face). They also pointed out that having a boyfriend is unwise and the FSWs who seek a boyfriend are "out of their mind". Reviewing the reported history of these interviewees, it was found that all of these interviewees had experienced at least one time of unexpected pregnancy due to unexpected sex with ex-boyfriends that led to abortion. This finding encourages me to conclude that these interviewees' hostility towards having a boyfriend is closely associated with unpleasant experiences, and they are thoroughly disappointed with a previous relationship. For these FSWs, although they are still lacking the capability of negotiation on condom use during commercial sex, they are less likely to conduct unprotected sexual behaviors with males other than clients. They reported that they did have sex with males other than clients (e.g. for one-night-stand), however, they called these males sex partners instead of boyfriends and claimed that they always use condoms during sexual intercourse.

4.3.4 Conclusion

This chapter has demonstrated the findings with regard to the sexual health and health-seeking behaviors of FSWs in Shenzhen. In addition to gynecological diseases FSWs are vulnerable to unexpected pregnancy which is associated with their low rate of condom usage. They also belong to the population at high risk of STDs and HIV/AIDS. The high level of mobility of FSWs and their male clients has increased their risk of contracting STDs and HIV/AIDS and their role as a bridge population for transmission of STDs and HIV/AIDS within and outside the sex industry. Prostitution remains illegal in China. Although the penalties for first-party participants in commercial sex have become more lenient, enforcement of governmental policies against prostitution and the police-led crackdown are still the main institutional barriers leading to FSWs' relatively low usage of health care services provided by public health facilities or NGOs. Patriarchy, gender inequality and discrimination and prejudices against FSWs, as well as their concern about *losing face*, enhance their marginal status and result in an extremely narrow social

network of FSWs within the sex industry. Within this social network information exchange related to sexual health takes place between females involved in sexual transactions. Relationships with boyfriends are important for many FSWs because they are strongly reliant on their physical protection to prevent harm from clients, as well as the psychological comfort provided by boyfriends. On the other hand, due to such strong reliance, FSWs are frequently willing to accept unprotected sex with boyfriends and face a high risk of unplanned pregnancy and STDs and HIV.

CHAPTER 5

Analyses and answering the research questions on migrant women's *health-seeking behaviors* and changes of formal and informal institutions

The purpose of this chapter is to answer the research questions that were raised at the beginning of this thesis based on the theories of new institutionalism. First, I answer the question of which formal and informal institutions influence migrant women's health-seeking behaviors and how. I then apply the framework developed by Helmke and Levitsky to discuss how the informal institutions that impact migrant women's health-seeking behaviors influence the effectiveness and change of policies related to migrants' sexual health. The next question answered is: how do policies related to migrants' sexual health change. The theory of path-dependent and incremental change is applied and developed. The last part of this chapter addresses the question of how an informal institution changes. The two topics – change of informal institutions and change of formal institutions – are linked to answer the question: how does the change of an informal institution influence the change of a formal institution?

5.1 Understanding migrant women's health-seeking behaviors: rational calculated decision-making under restriction by formal and informal institutions

The first original research question of this thesis is to understand why migrant women conduct certain *health-seeking behaviors* in relation to sexual health. One issue is their *care-seeking behaviors*, when migrant women have perceived that they have contracted certain illnesses or diseases, and are in need of certain care regarding sexual health. Another issue is their *health-seeking behaviors*, when

migrant women strive to prevent contracting sexual-health-related illness or diseases, or an unexpected health situation such as unexpected pregnancy.

Findings from empirical field research, presented above, confirm my hypothesis that migrant women's *health-seeking behaviors* are rational decisions made with calculated forethought. Namely, migrant women as individuals are active decision-makers. Before a decision is made, they are able to and will evaluate the seriousness and outcome of certain health problems that have already presented, or will shortly present. Also, they evaluate the social and economic resources that they can use to deal with the problem, as well as the potential benefits or losses associated with taking certain actions, framed within the social context in which they act. Unfortunately, individuals' evaluations are not always comprehensive, and the decisions they have made may be ineffective and not always helpful to overcoming health problems or improving their overall health status. In some cases, the decision may even exacerbate the health status. Meanwhile, individuals' decision-making is restricted by formal and informal factors, which they can perceive. In this chapter, applying this theoretical explanation of individuals' behaviors, I combine the findings of the empirical field study for two target groups (migrant women living in urban villages and FSWs), and summarily explain migrant women's *health-seeking behaviors*. In the subchapters, the discussion addresses migrant women's *care-seeking behaviors* when they face illnesses or diseases related to sexual health and abortion (5.1.1), *care-seeking behaviors* regarding fertility and maternity care (5.1.2), and condom usage regarding contraception and prevention of STDs and HIV/AIDS (5.1.3).

5.1.1 Care-seeking behaviors of those facing sex-related illnesses and abortion

Upon recognition of having contracted an illness or disease and before a coping decision is made, a migrant woman, whether one living in an urban village or a FSW, will first evaluate the severity of the illness, the financial resources she controls, and the quality and availability of health service, including price, distance to facilities and waiting time for a doctor visit. Based on this evaluation, one of the following options is likely to be chosen: counseling by a doctor in a health facility in the city (i.e. large public hospital, a public community-based clinic, or private

clinic), returning to one's hometown for counseling by a doctor, self-treatment with drugs purchased in private pharmacies, or abandoning medical treatment completely.

Migrant women's decision-making is influenced by both formal and informal factors. With regard to the former, China's medical insurance system and health care provision system play a crucial role. The medical insurance system has a direct influence on migrant women's financial capabilities for affording health services. A great number of migrant women (both migrant women living in UV and FSWs) are not covered by the two urban medical insurances UEMI and URMI, and they can hardly benefit from the rural medical insurance NCMI. As a result, it is common that migrant women are not able to afford the high prices of out-of-pocket medical services in the cities. In need of health care, they are prone to seeking a doctor appointment in private clinics, which they presume provide lower-priced services; or self-treating; or returning to their hometown to seek medical treatment when facing serious illnesses; or even abandoning all medical treatment if they believe that their health condition is not serious.

An urban health care provision system, with allocation of medical resources between different health facilities, poses another formal restriction to migrant women's care-seeking decision-making. The reforms of the urban area health sector, with financial decentralization and significant reductions in government expenditures for the health sector, have led to higher competition between different health facilities. In the competition with other health facilities, large public hospitals have built up a monopolized status as they are holding more and better health resources, including medical equipment and experienced personnel. Information asymmetry is an undeniable feature of the doctor-patient relationship, which hinders migrant patients' assessment of health services. Under these circumstances, patients' decision-making in choosing service providers is easily based on the size and reputation of the facilities, and high quality services are often presumably linked with some flawed perceptions, such as the quantity of medical equipment and personnel. Hence, large public hospitals that possess the majority of medical resources have become the most favored facilities for migrant women to seek medical care. However, the preference is restricted by the high cost of medical service in large public hospitals, associated with over-prescription of medications and overuse of expensive instrumentation for medical examinations. Moreover, holding a monopolistic position, large public hospitals and their

physicians are correspondingly under pressure to serve an extremely high number of patients, resulting in long waiting times and negligent medical treatment. High costs, long waiting times, and negligent treatments are the principal factors motivating migrant women not to seek medical care in a large public hospital. Alternatively, they may resort to care from other health providers, especially in the case of having minor illnesses. As affiliated facilities of public district hospitals, CHCSCs and CHCSSs also hold a public status. Located in communities with a high migrant population density, such as urban villages, CHCSCs and CHCSSs have some advantages in attracting migrant residents seeking health services. However, lacking financial support from governments, CHCSCs and CHCSSs are entangled in financial constraints and personnel shortages. As a result, struggling to survive, many of them also turn to over-prescription of medications to fill the budget voids. This practice has worsened CHCSCs' and CHCSSs' reputations among migrant patients, and making them a less favored choice. Private small clinics are the main rivals to CHCSCs and CHCSSs. Along with their convenient locations in urban villages, flexible business times, and the low advertised prices for services (which are often not actually low), these private clinics have advantages making them more favorable to migrant patients. Moreover, insufficient state controls enable private clinics to offer illegal health services, such as prenatal ultrasound examinations to identify the sex of the fetus. Such services attract migrants who have the preference for a son, allowing them to request induced abortions in cases of a female fetus.

Regarding informal factors that influence migrant women's *care-seeking behaviors*, a strong consciousness of *face* embedded deeply in China's Confucian culture plays a significant role, which affects both of the two target groups. Sex and sex-related issues are generally considered as extremely private and intimate. Contracting gynecological diseases or STDs are usually regarded as the consequence for conducting indecent sexual behaviors, and are linked with *losing face* within one's social networks. Premarital pregnancy, especially, is considered a taboo and associated with severe shame. Hence, migrant women who face gynecological diseases or STDs, or have decided to undertake an induced abortion, are likely to keep the issue as secret as possible. They are prone to seek medical service in a private facility instead of a public one, assuming that their confidentiality can be better protected in the former.

An individual's social network is an informal organization, built into a

framework through which formal and informal institutions co-function. Migrant women's social networks play a significant role in their decision-making regarding their seeking health care. Due to information asymmetry and lacking the channels for reliable health-related information, migrant women are prone to taking advice from other individuals within their social network, such as family members, friends and colleagues. Such advice includes, for example, how to evaluate the severity of an illness by oneself, which medicine should be taken when one faces certain symptoms, where the medicine can be purchased, and, when in need of professional medical treatment, which health facility one should visit, et cetera. Reputations of health facilities, as discussed above, are shared in a widespread manner within patients' social networks. The high confidence in information distributed through one's social network also explains the reasons why migrants indicated in interviews that they generally mistrusted private health facilities, on the one hand, but they also went to doctor appointments in private facilities in their hometown, run by their relatives or friends, on the other hand. Compared with migrant women living in urban villages, FSWs has a much narrower social network through which they can approach health-related information. FSWs' limited social network is derived from the illegality of prostitution and social discrimination against prostitution. To avoid facing social stigma, related to the fear of *losing face,* and to avoid penalties from government authorities, FSWs have deliberately severed or narrowed their social connections with people outside the sex industry. As a result, FSWs' social network is limited within the sex industry, and health-related information is exchanged inside a narrow circle of individuals involved in sexual transactions, such as peers and female procuresses.

5.1.2 Care-seeking behaviors regarding fertility and maternity care

Migrant women's *care-seeking behaviors* regarding fertility and maternity care are influenced by informal and formal institutions. The informal institutions mentioned here are the tradition of son preference and the desire for male offspring in quantity. In the rural areas with a strong kinship system, a family without male offspring will receive taunts, and be humiliated by the community, having to confront the tragedy of *losing face*. A woman without a son is exposed to taunts by others in the

community, and to blame and mistreatment from her husband and parents-in-law. Simultaneously, migrants face the formal institution - strict birth control in a framework of family planning policy, and potential economic and physical penalties when birth control regulations are neglected. Migrant women's fertility behaviors are decisions based on the constraints derived from both informal and formal institutions: Due to the tradition of son preference, a migrant woman is likely to continue childbearing until at least one son is born, and before reaching this goal and especially when she has already one or more daughters, she is likely to sex-select the next child and abort the female fetus. In such cases, private clinics that provide illegal prenatal ultrasound examinations to identify a fetus' sex are favored by migrant women. Moreover, migrant women expecting newborns outside the family control policy dare not use maternity care (including necessary prenatal and postpartum examinations) provided by public facilities, such as CHCSCs, CHCSSs, and FPSSs, although the cost is affordable or even free for them.

It is a common decision among migrant women that they go back to their hometown to give birth. The formal institution that impacts this decision is the urban maternity insurance, which does not cover migrant women, so migrant women are not able to afford the cost of delivery in the urban cities. An informal institution affecting migrant women's decision to give birth in their hometown is the Chinese custom of *doing the month,* which plays a crucial role. Despite increasing criticisms and adaptations, Chinese women continue to practice strong adherence to *doing the month*. Through *doing the month,* a new mother receives physical and psychological support from the family members, especially from her own mother or mother-in-law. The poor living conditions in the cities (e.g. in the rental apartments in urban villages or factory dormitories) cannot provide them a comfortable place for practicing "doing the month". Moreover, the limited living spaces don't allow for the woman's mother or mother-in-law to stay in the city to provide care. Hence, returning to the hometown to give birth, and staying with the family after the birth for at least one month, is considered by many migrant women as the affordable and most comfortable alternative. Exceptions involve births that violate the family planning policy. Implementation of the family planning policy is based on the *hukou* system, and birth control is usually stricter in the hometown where the migrant woman is officially a registered permanent resident. In order to avoid the strict controls, some migrant woman may choose to give birth in the city, usually in a private clinic, and practice *doing the month* in the rental apartment

without being accompanied by family members from the hometown.

5.1.3 Condom usage for contraception and prevention of STDs and HIV/AIDS

Condom usage is a crucial issue in sexual health, because it is the most effective method for contraception and prevention of STDs and HIV/AIDS. The frequency of condom use among migrant women, both those living in urban villages and FSWs, is rather low. For migrant women living in urban villages and FSWs, the reason for limited condom use is the patriarchal tradition (an informal institution), which considers females as inferiors who should be submissive to males. Based on patriarchal logic, with sexual intercourse, the female's feelings and objectives are often repressed or even completely ignored, and it is her duty to provide a good sexual experience for the male partner. Influenced by the patriarchal tradition, females generally lack the capability of negotiation on condom usage with their male partners and they easily accept unprotected sexual intercourse if the male partners insist. Compared with other women, FSWs face more challenging situations regarding negotiations on condom usage. In addition to gender inequality derived from the patriarchal tradition, FSWs also face discrimination against sex workers, evolving from prejudices (informal institutions) that consider commercial sex as unconscionable and indecent, and resolving that FSWs deserve neither respect from their male clients, nor protection through using condoms for contraception and prevention of STDs and HIV/AIDS. The low ratio of condom usage among migrant women living in urban villages can also be explained by their lack of knowledge of sexual health, which is related to the ineffective sexual health education in China. Compared with migrant women, FSWs may hold more knowledge of sexual health, and yet, they seldom refuse unprotected sex with their boyfriends. This situation is related to FSWs' strong reliance on the boyfriends, which leads to their extremely weak negotiation on condom usage. FSWs' strong reliance on the boyfriends can be explained by the fact that boyfriends provide them emotional support, and sometimes, also job opportunities. Moreover, due to the illegal status of the commercial sexual transaction (formal institution) FSWs are usually reluctant to seek police protection, even when they face physical harm by clients, and therefore must seek physical protection from their boyfriends. Due

to such a strong reliance, FSWs would rather choose the consequences of unprotected sex, even though they are aware of the potential risks.

5.2 Understanding the impacts of informal institutions on effectiveness and change of policy

The second research question of the present thesis addresses the relationship between informal and formal institutions, asking how the informal institutions that impact migrant women's health-seeking behaviors influence the effectiveness and change of policies related to migrants' sexual health. To answer this question I apply the framework developed by Helmke and Levitsky, who identify four types of informal institutions in terms of their relationship with formal institutions: complementary, accommodating, competing and substitutive informal institutions (cf. 2.3). The present study found competing and substitutive informal institutions. Migrant women's social networks are not an informal institution, according to my definition of informal institution, but rather an informal organization. (cf. 2.1). However, the social network plays a significant role for migrant women to obtain health information and can be regarded as a crucial factor that impacts policy effectiveness and change. Hence, I integrate social networks into the analytical framework. These informal institutions and informal organizations and their relationship to policy effectiveness and change are summarized in Table 4 below. (page 172)

Table 4: Impacts of informal institutions/organizations on policy effectiveness and change

Types of informal institution	Informal institutions/ organizations	Policies affected	Impacts on policy effectiveness and change
Complementary	-	-	-
Accommodating	Social network regarding obtaining health information (in favor of public health facilities)	Policy of developing community-based provision of public health services	Not enhancing policy effectiveness, assessing policy effectiveness, alleviating demands for policy change
Competing	Social network regarding obtaining health information (against public health facilities)	Policy of developing community-based provision of public health services	Undermining policy effectiveness, assessing policy effectiveness, promoting demands for policy change
	Patriarchy, gender inequality, son preference, system of *face*	Family planning and birth control policy, policy of providing maternity service for rural-to-urban migrant women	Undermining policy effectiveness, promoting demands for policy change
	Patriarchy, gender inequality, discrimination and prejudices against FSWs	Policies for prevention of STDs and HIV/AIDS, targeting the population in the sex industry	
Substitutive	Tradition of practicing *doing the month*	Policy of maternity insurance for rural-to-urban migrant women	Not enhancing policy effectiveness, alleviating demands for policy change

Social network: accommodating or competing informal organization

As shown in Table 4, the social networks of rural-to-urban migrant women can be accommodating or competing with regard to the policy of developing community-based provision of health services. The social network plays a significant role in migrant women's health-seeking behaviors. Migrant women living in urban villages seek health-related information from family members, colleagues, and friends. They also visit doctors in private clinics recommended by family members despite having a general distrust of private facilities (cf. 4.2.1.2). FSWs strongly rely on the network within the sex industry to seek health-related information (cf.

4.3.1.5, 4.3.3.3.1, and 4.3.3.3.2). According to Helmke and Levitsky (2004:729) the reasons for establishing and using accommodating informal institutions are that the individuals involved dislike the outcomes generated by the formal rules but they are not able to change or openly violate those rules. This argument is adequate to explain migrants' usage of urban medical services. The interviews with migrants reveal that migrant women are quite dissatisfied with the outcomes of policies for the provision of urban medical services. Such dissatisfaction manifests itself in the form of complaints about the high cost of medical services in association with overuse of equipment, medical examinations and overprescription of medication by practitioners in large public hospitals (cf. 4.2.1.1), as well as complaints about the tricks used by practitioners in private clinics to attract patients (cf. 4.2.1.4).

Despite of their dissatisfaction, migrants are non-dominant individuals in China's political structure and lack the action resources to bring about their preferences and take their desired actions (cf. 1.3). As a result, they are unable to either establish or change the governmental policies which have not met their medical needs. Under these circumstances, social networks are used by the migrant women to obtain information in order to optimize their decisions regarding health-seeking behaviors. The social network of migrant women living in urban villages consists of their family members, friends, *laoxiang* and colleagues. Due to the illegal status of sex work, discrimination and prejudices against such work, and FSWs' self-denial, FSWs have a much narrower social network limited to sex industry (cf. 4.3.3.3). Through their social networks, migrant women (both those living in urban villages and FSWs) may obtain information on the reputation of certain health facilities, the location of the facilities, the cost and quality of the services, and the attitudes of the practitioners treating patients (cf. 4.2.1 and 4.3.1.5).

With regard to the effects of migrant women's social networks on policy, which in this thesis means the policy of developing provision of community-based public health services, the function of the social network can be *accommodating* or *competing*. As shown in Table 4, this depends on the "content" that is disseminated within the social network. When information in favor of public medical facilities is disseminated, the social network is accommodating to the policy and assists its stability and development. On the contrary, when, for example, a bad reputation of public facilities is spread within the migrants' social network, it becomes unlikely for the migrant patients to use the services in a public health facility. In such cases,

the social network plays a competing role with the policy of developing community-based public health services.

According to Helmke and Levitsky (2004:729), accommodating informal institutions do not necessarily promote the effectiveness of formal institutions, and they may enhance the stability of the latter by quieting demands for change. Addressing the relationship between competing informal institutions and formal institutions Helmke and Levitsky regard ineffective formal institutions as a precondition for the operation of competing informal institutions that are incompatible with the formal rules (cf. 2.3). Corresponding to Helmke and Levitsky, my findings also reveal that accommodating social networks may alleviate demands for policy change (in cases when information in favor of public health facilities is disseminated within migrant women's social networks), while competing social networks may promote demands for policy change (when information against public health facilities is disseminated through the migrant women's social network). My own findings enable further development of Helmke and Levitsky's argument. I am of the opinion that, regardless of whether they are accommodating or competing, social networks may function as a tool to *assess* policy effectiveness. More precisely, by looking at the health-related information exchanged within the social network, we may see whether the policy of providing medical services is effectively implemented. With effective policy implementation more pro-public health information is found within the social network. If the policy has not been effectively implemented and the migrants' medical care needs are not being met (the de facto situation in urban China), more information critical of public health facilities emerges within migrants' social networks.

Patriarchy, gender inequality, son preference, system of *face*, and prejudices against FSWs: competing informal institutions

Patriarchal traditions, gender inequality and son preference, and the system of *face* are informal institutions that compete with the family planning and birth control policy and the policy of providing maternity service for rural-to-urban migrant women. As elaborated in Chapter 4.2.3.1, China's society, especially in rural areas where migrants come from, has a persistent patriarchal tradition within which male children are more valued than female offspring. The patriarchal tradition generates a preference for sons. Son preference is further underpinned by the system of *face*. Without male offspring a rural family may face taunting and humiliation by the

community, leading to a feeling of losing *face,* which is associated with severe shame and linked with high mental stress and unhappiness. Influenced by the tradition of son preference, a migrant woman may continue childbearing until reaching their desired number of sons (usually at least one). This fertility decision may violate the family planning and birth control policy. As Helmke and Levitsky describe, competing informal institutions "structure incentives in ways that are incompatible with the formal rules: to follow one rule, actors must violate another" (2004:729). If migrant women decide to follow the tradition of son preference and bear children in violation of the family planning policy, the tradition of son preference, and the patriarchy, gender inequality and system of *face* from which it derives, play a competing role with the family planning and birth control policy. Moreover, if pregnant migrant women are aware that the birth of their children will violate the family planning policy, they are likely not to use the maternity services provided by FPSS, even though these services are free of charge (cf. 4.2.1.3). In this way, son preference, patriarchy, gender inequality and the system of *face* compete with the policy of providing maternity service for rural-to-urban migrant women. Competing informal institutions are often found in a context "in which formal institutions were imposed on indigenous rules and authority structures" (Helmke and Levitsky:2004:729). The competing relationship between the tradition of son preference and the family planning policy corresponds to this explanation, as the state power intervenes in the population's fertility decisions while ignoring the patriarchal tradition deeply embedded in Chinese society.

As discussed in Subchapter 4.3.3.1, the patriarchal tradition and gender inequality also result in discrimination and prejudices against FSWs. With an attitude of discrimination against FSWs, clients are likely to be fastidious about services provided by FSWs and refuse to use condoms. This situation may further deteriorate if the clients have prejudices against FSWs to the effect that prostitutes are ruthless and are never considerate of their male clients' desires. In such cases, condom use requested by FSWs may also cause resistance from her client. In this way, patriarchy, gender inequality, discrimination and prejudice against FSWs play a competing role with the policy for prevention of STDs and HIV/AIDS, which regards increasing condom usage in the sex industry as a crucial aim. As with the competing social networks discussed above, these competing informal institutions may undermine policy effectiveness. Due to the strong persistence of patriarchal traditions, son preference and the high value of *face*, and despite draconian policy

implementation and high fines, migrant women have long given birth to children in violation of the family planning policy. Patriarchy, gender inequality, discrimination and prejudices against FSWs can be regarded as hindrances to the implementation of policy for the prevention of STDs and HIV/AIDS. Simultaneously, competing informal institutions may also promote demands for policy change. This impact has been seen in the change of family control policy, as China's government gradually shifted away from the use of forceful restrictive administrative methods as a penalty and easing the preconditions for having more children. Policy changes regarding prostitution control that can be identified are the more moderate penalties to FSWs and their clients and increased permission for the activities of NGOs' for prevention of STDs and HIV/AIDS.

Tradition of "doing the month": a substitutive informal institution

The tradition of *doing the month* can be regarded as a substitutive informal institution to the policy of maternity insurance in the context of rural-to-urban migrant women's usage of maternity services. Substitutive informal institutions coexist with formal institutions in a situation where the formal and informal institutions seek the same outcome but the formal ones are not able to fulfill their specified goals. These goals are then achieved by the substitutive informal institutions (Helmke and Levitsky 2004:729). Both the policy of maternity insurance and the practice of *doing the month* are aiming at providing adequate maternity care for pregnant women and mothers with newborn babies. However, as discussed in Subchapter 4.2.2.2, the goal of maternity insurance that all pregnant women in the cities (including migrant women) should be entitled to maternity leave, free prenatal and postpartum medical services, and a birth allowance, has not yet materialized. Self-employed migrants and migrant workers without contracts, and their spouses, are not entitled to maternity insurance. Even insured migrants can only benefit from the maternity insurance after the employer has contributed to the insurance fund for at least one year. Lack of maternity insurance when giving birth in the cities is regarded by many migrant women as a severe economic pressure. Hence, many migrant women decide to go back to their hometown to give birth and *do the month*, with care provided by their family members. In this situation, the tradition of *doing the month* plays a substitutive role relative to the ineffective policy of providing maternity services, enabling migrant women to receive postpartum care which may not be necessary to their physical health as

defined by Western medicine, but is advantageous to their mental health (cf. 4.2.3.2). Helmke and Levitsky do not address the influence of substitutive informal institutions on the change of formal institutions. I argue that substitutive informal institutions may not necessarily enhance policy effectiveness, but they alleviate demands for policy change. The tradition of *doing the month* and the related postpartum care provided by private households mitigate the pressure on the government to cover all rural-to-urban migrant women with maternity insurance and provide them with maternity care. This being the case, the policy of maternity insurance faces relatively few incentives to change.

In sum, the above discussion suggests that informal institutions/organizations should not simply be classified as functional or dysfunctional with regard to their impact on the effectiveness of formal institutions. Although *substitutive* informal institutions such as the tradition of *doing the month* subvert formal rules and procedures (e.g. maternity service should be provided by licensed medical facilities), they may help achieve results (providing postpartum care to new mothers) that the formal institutions fail to achieve. The analysis of the social networks of migrant women reveals a new argument supplementary to Helmke and Levitsky's dichotomy of informal institutions, noting that the impact of one informal organization on formal institutions may be diverse. The type of the informal organization (accommodating or competing) depends on the "content" that is disseminated within the organization. Moreover, a social network can be used as a spectrum to assess the effectiveness of policies when a researcher looks at the content exchanged within the social network. Whereas accommodating and substitutive institutions may not influence policy effectiveness, the negative impact of competing informal institutions on policy effectiveness is trenchant and promotes demands for policy change. The next main research question of this thesis is addressed below: when a policy is faced with a demand for change, how does it change? Subchapter 5.3 attempts to answer this question by drawing on the approaches of incremental change developed by Thelen et al.

5.3 Understanding policy change: path dependent incremental change

How does a policy change? In other words, why and under what circumstances

does a particular policy change take place? To answer this question I follow an actor-centered analytical pathway and regard a policy as a goal-oriented action or inaction of the dominant individuals in a political institutional setting, namely the political elites, who has the majority of political resources and the leading position in policy change (cf. 1.3). In this sense, a policy change is the decision-making of political elites and the political elites can be called as political decision-makers. The findings of the empirical study demonstrate that policy changes are path dependent and incremental. The crucial factor of a policy change is how the political elites address (actions/inactions) the externally-changing environment. Policy change is dependent, because the political elites' conduct is restricted by existing formal and informal institutions. Regarding the characteristics of incrementality, two major patterns of policy change, the *conversion* and layering pattern and the drift-exhaustion-displacement pattern, are indentified. I integrate the three cases of policy change outlined by this thesis into these two patterns, so that the path-dependent, incremental characteristics of policy change can be further elaborated. Subchapter 5.3.1 examines the family planning and birth control policy applications in the conversion-layering pattern. Applying the same pattern, I discuss in Subchapter 5.3.2 the prostitution control policies and the policies of regulating NGOs in the prevention of STDs and HIV/AIDS. In Subchapter 5.3.3, the drift-exhaustion-displacement pattern is adopted to examine the policies of urban-community-based health service provision.

5.3.1 The family planning and birth control policy: a case of "*conversion> layering*" or "*conversion> layering> replacing*"?

Within the pattern of "conversion>layering", political elites face externally-changing situations that they perceive and consider as potential challenges to their political interests and the existing power structure. To meet these external changes (conversion), they conduct strategies intentionally or unintentionally, attaching new elements to the existing institutions. Such elements may be new agencies, such as individuals/actors, organizations, and layers of government; new structures, such as rules, laws, and control mechanisms; or both new agencies and structures. Adding new elements to old institutions is a process of layering. After this process, the old institutions are not replaced by the new ones, and yet, their status and structure

have changed over time.

Reviewing the change of the family planning policies, a series of *conversion* > *layering* processes can be identified. The family planning policy was introduced in the early 1970s, and announced in 1980, strictly stipulating that across the country, every couple would be allowed to have only one child. Since then, this draconian policy has been modified several times. The policy first experienced obstructions due to strong resistance within China's population, especially by peasant families in rural areas, because in the 1980s, there was still as strong adherence to the belief that descendants, and especially male offspring, were crucial for the family's economic activity and old-age support.[41] This resistance revealed the characteristics of path dependence on a policy change, showing that the development of a new policy was hindered by beliefs embedded in tradition, which is an informal institution. The layering strategies were then undertaken by the China's central government: While it maintained the principle of birth control as a basic state policy, it left the policy modification to provinces and autonomous regions (adding agencies to the policy), and allowed concrete localized rules for exemptions of the one-child-per-couple rule (adding decentralized structure to the policy). Another "conversion>layering" change was demonstrated by the family planning policy targeting rural-to-urban migrant. Until 1991, the implementation of family planning policies was based on the *hukou* system, and in rural areas, the township governments and villager committees were responsible for policy implementation. This policy arrangement was challenged by ever-increasing numbers of the already-massive rural-to-urban-migration population. To meet this situation, new regulations were released in 1991 that authorized the local governments of migrants' urban residences (as added agencies to the policy) to manage migrants for the purpose of birth control. Both the governments of the migrants' registered hometowns, and those of their urban residences would be responsible for policy implementation. Furthermore, since a great number of migrants live in private rental apartments (e.g. in urban villages), beginning in 2007, the government stipulated that landlords of rental apartments are also responsible for managing migrants for birth control purposes (adding agencies to the policy). The renters were required to inform the local governmental agencies if the lodgers ignored the family planning policy.

The present-day family planning regulations that allow every couple to

[41] Son preference also see chapter 4.2.3.1.

have two children can also be understood in terms of the government's decision for conversion, confronting the demographic changes. Due to the strict birth control policy implemented for about four decades, the fertility rate in China was seeing a continuous decrease. Demographers noted that to avoid a negative population growth alongside acute population aging, the fertility rate should remain at roughly 2.2, yet since 1995, China's fertility rate had remained under 1.5. (Zhao 2015)[42] Moreover, the previous draconian regulation of birth control was in conflict with the persistence of son preference (also see: son preference as a competing informal institution to the birth control policy in 5.2) and led to sex-selected abortions of female fetuses. As a result, China is also facing a deteriorating situation of unbalanced gender ratio. (Zhao 2015)

The concession allowing two children per couple is a significant change in the family planning policy. Previous to this policy change, the practice maintained a one-way "conversion-layering" pathway, which resorted to self-enforcing (e.g. more elements were added into the system to underpin the one-child-per-couple principle). However, as the previous one-child policy has now been substituted by the two-child policy, it seems that the one-way pathway has been broken. However, it must be pointed out here that despite this significant change, the family planning policy as a whole remains, and China's government continues the principle of controlling the population's fertility behaviors through governmental regulations. Because the two-child policy is less antagonistic to China's fertility tradition, it may be better accepted and implemented voluntarily by the population. In this sense, the family planning policy, as a whole, has taken the further step of self-enforcing. I argue that despite the significant change, the emerging of the two-child policy should not be regarded as a case of *displacement,* introduced previously by Thelen and her co-authors, because displacement implies the complete collapsing of the old institutional arrangement and the establishment of a new one. The changing of China's family planning policy does not conform to a displacement situation. The policy change from the one-child to two-child principle is a stage which has not yet been defined in previous studies of incremental policy change, and which I would term "*replacing*". Similar to *layering*, *replacing* is the stage of policy change within which political actors use strategies to respond to changed external circumstances. Unlike layering, strategies for *replacing* are not attaching new elements to the old institutions. Instead, components of the old institution are

[42] According to the Work Bank's data resource (2015), since 2001 China has a fertility rate of 1.7.

replaced by new ones (in the case of family planning policy, the old one-child-per-couple regulation has been replaced by the two-child-per-couple regulation), while the old institution as a whole (e.g. family planning policies) persists. In this sense, a "conversion>layering>replacing" pattern is more suitable than a "conversion>layering" pattern that one would use to explain the current changes to family planning policies.

5.3.2 Prostitution control policies and the policy of NGO-regulation: combined "*conversion>layering*" cases

The changes in prostitution control policies and NGO regulation follows a "conversion>layering" pathway. I discuss these two policies in a single chapter instead of two separate chapters, because these two policies have overlapping contents on STD control. More precisely, prevention of STDs and HIV/AIDS is an important issue in present-day prostitution control (cf. 4.3.2.1.1.1) and the change of NGO regulation here concerns the change of the governments' attitudes toward NGO activities in the area of prevention of STDs and HIV/AIDS.

5.3.2.1 The change of the policies of prostitution control

Reviewing changes in the policies of prostitution control up until now, evidence will demonstrate that policy changes were the government's strategies to address the externally-changing circumstances, namely, the "conversion>layering" process. As early as the year 1949, China's central government had outlawed prostitution, and launched nationwide crackdown campaigns against prostitution. However, until the 1980s, prostitution carried only a misconduct connotation, and the females involved in sexual transaction were regarded as victims of the old feudal-capitalist society who should be re-educated but not be strictly punished. Correspondingly, until 1986, penalties were assessed only to third-party participants in prostitution (e.g. pimps or procuresses), and not to the first-party participants – FSWs and their clients. (cf. Anderson and Gil 1994) Regulations with detailed punishments, referencing both first- and third-party participants in the prostitution transaction, were released in the 1986 regulations. This policy change was the Chinese

government's strategy to meet the resurgence of prostitution after the economic reforms and implementation of the opening-up policy (*conversion*). In the *layering* process, the judicial structure was changed by adding new components (first-party participants) into the pool of the target population for regulation. A similar "conversion>layering" process was also manifested in the policy change of 1999, as the government released the 1999 Entertainment Regulations to cope with the flourishing of recreational enterprises since the beginning of the 1990s, accompanied with an increase in sexual escort services (*sanpei* 三陪) provided by young females in the recreational enterprises. Facing the phenomena of increasing numbers of rural-to-urban young females, who flowed into recreational enterprises and engaging in providing sexual escort service, the 1999 Entertainment Regulations stipulated that all personnel in recreational enterprises must possess a residency permit. Among them, those with a migration background must, in addition, possess a temporary residency and work permit. The 1999 Entertainment Regulations gave the police the authority to conduct surveillance and investigate recreational enterprises, while the revised 2006 Entertainment Regulations empowered culture departments for surveillance and investigation. This policy change can be understood as a layering strategy by the government, to control the previous corrupt conduct by police authorities, such as accepting bribes from recreational enterprises in return for reducing or repealing their penalties. Culture departments should act as an oversight on the conduct of police authorities. Regarding concrete penalties towards offenders of prostitution regulations, administrative sanctions have become more lenient. For example, in the 2005 Punishments Law, compulsory rehabilitative education was completely abolished, and the period of detention and fine were reduced. In 2011, the Ministry of Public Security issued a directive reminding police officers to respect offenders' dignity during 'strike hard' campaigns against prostitution. These policy change decisions were made because the issue of human rights had become a societal concern, and the government had to face the pressure from the public, who criticized governmental enforcement actions for neglecting human rights of offenders as individuals.

Despite all these changes of policies, the illegal status of sexual transaction as a whole has not changed. This policy adherence can be explained by the concept of path dependence. As discussed in Subchapter 2.4.1, informal institutions may have an obstructive impact on formal institutions. China's government is still

governed by the CCP, and decriminalizing prostitution is not coincident to the Communist ideology, which the CCP claims. In recent years, there have been increasing public discussions on decriminalization of prostitution. However, a consensus has not yet to develop within China's society, neither among scholars nor among the general population. Whereas some scholars (e.g. Li 2000, Zhang and Han 2009) have appealed for decriminalization of prostitution to prevent the spread of STDs and HIV/AIDS, as well as protection of FSWs from physical harm, there are also opposing arguments (e.g. Zhang 2012, Li 2013) pointing out that decriminalization of prostitution may lead to further deterioration of the situation, as more females will engage in commercial sex while facing the double financial burdens from exploitation by gangs and taxing. The majority of the Chinese population holds a discriminatory attitude towards prostitution. FSWs, especially the *er'nais*, are regarded as destroyers of conjugal relationships and the traditional family system.

On the issue of decriminalizing prostitution, the characteristics of path dependence can also be revealed by looking at the entangled interests of the local government. Regarding the role of a political actor on institutional change, Pierson argued that political decision-makers are usually inclined to protect the existing institution instead of changing it, because they are usually interested in the short-term consequences of their action and ignore the long-term ones. (cf. 2.4.1) In other words, political decision-makers and their decision-making are usually shortsighted. Regarding the discussion of prostitution decriminalization, I am of the opinion that a supplementary point needs to be added to Pierson's aspect: Political individuals/actors' decision-making is usually shortsighted, because it is difficult to predict long-term outcomes of a policy. Moreover, in China's bureaucratic structure, a longsighted policy is usually unnecessary for local politicians. Focusing on the local government in SW District where I conducted field research as an example, recreational enterprises providing illegal sexual services were the most important source of local fiscal revenue, because recreational enterprises rent local estates, pay taxes, and their employees (e.g. FSWs) and clients spend their money in SW. As long as prostitution remains illegal and needs governmental tolerance to survive, individual employees of the local government can also extort a "fee for protection" (*baohufei* 保护费) and issue extra fines. For the purpose of prostitution control, even minor jobs (such as street inspectors) can be created for local inhabitants. If prostitution becomes legal, the recreational enterprises will continue to pay taxes,

but the opportunities of receiving hidden income will fade. For this reason, local politicians at the district level are generally not in favor of decriminalizing prostitution. As for politicians from higher levels, such as those from municipal or provincial governments, decriminalizing prostitution is also undesirable. In China's bureaucratic structure, key political positions at municipal or provincial levels, such as mayor or province governor, are not selected by election, but appointed by the CCP. The conflict between local and central governments is deeply embedded in China's political environment. Aiming at restricting the authority of local governments, the central CCP usually implements a strategy to undermine the appointment of any person originally coming from the same region to a key political position at the provincial-, municipal- and county level. Moreover, one person will be allowed to remain in one position for a maximum of ten years (two terms). Due to this political arrangement, and because politicians are rational and calculating individuals seeking to maximize their own interests, one can hardly expect that a politician would seriously make longsighted considerations for the development of one region that is neither his/her hometown, nor the place where he will permanently live. In this sense, it can be assumed that the mayor of city A, who comes from city B, and will be assigned to city C after a maximum of ten years, would have little interests in the development of the human rights status or improvement of public security in city A, if it is not required by the CCP. Moreover, as Pierson noted, indicators used to evaluate politicians' performance are limited and often oriented to transparent economic issues. In the case of China, one such indicator is the development of the local GDP. Because the sex industry contributes a significant part to the local GDP and the attitude of the CCP towards decriminalizing prostitution is still ambiguous, lenient penalties and police-led crackdown campaigns coexist, but there is a lack of incentive for local politicians to promote a policy change of decriminalizing prostitution.

In sum, the heretofore changes of prostitution control policies have consisted of a series of "conversion-layering" processes, with some interventional decision-making strategically changing due to external circumstances. Simultaneously, due to the characteristic of path dependence in these policies, it is still too soon to predict whether and when prostitution will be decriminalized in China. However, I am of the opinion that if the government does carry out a policy of decriminalizing prostitution in the future, this policy change will arise from political decision-making as a result of greater external pressure through human

rights appeals, as well as the need of more effective STD/AIDS prevention.

5.3.2.2 Change in policies for prevention of STDs and HIV/AIDS, targeting the population in the sex industry, and the change of policy concerning NGO regulation in the face of preventing STDs and HIV/AIDS

Since the 1990s, control of STDs and HIV/AIDS has remained a vital component of prostitution control policies. The first concrete provision was released in the 1991 Decision, stipulating that first-party participants should be sent to a compulsory STD-examination, and in case of identified STD infections, to compulsory treatment. Moreover, according to the 1991 Decision, people aware they are carrying STD, but still participating in sexual transactions, should be sentenced to a maximum of 5 years' imprisonment or detention, and fined up to 5,000 Yuan. Interestingly, although the later-revised regulations on penalties for first-party participants have become more lenient, the provisions for mandatory STD-examinations and treatment in cases with confirmed diagnosis, and the penalties, including a fine and a period of detention or incarceration, remain unchanged since 1991. Another policy change, which focuses on prevention of STDs and HIV/AIDS related to prostitution control, is improving condom usage among first-party participants of sexual transactions. Some local police authorities have stopped citing possession of condoms as evidence of sexual transactions during enforcement campaigns. The Chinese government's attitude of adherence to rigorous penalties to prevent the premeditated spread of STDs, and the policy changes regarding condom usage, can be regarded as the Chinese political elites' decision-making to meet the prevalence of STDs and HIV/AIDS, along with the resurgence of prostitution.

The impudent handling of the growing crisis of STDs and HIV/AIDS prevalence is also reflected in the policies towards NGO activities in prevention of these diseases. As my study with project "AIDS CARE" in Shenzhen (cf. 4.3.2.2.2) shows, the current policy allows NGOs to provide community-based education on prevention of STDs and HIV/AIDS, distributing condoms, and providing free HIV tests. Furthermore, cooperation between China's local health institutions and transregional/transnational NGOs aimed at prevention of STDs and HIV/AIDS is

also allowed and advancing. Reviewing the policies so far on prostitution control, as well as NGO regulation, it can be concluded that China's government is entangled in a policy dilemma, and is facing an awkward situation regarding their attitude to NGOs. On the one hand, since the founding of the PRC, China's government has maintained an attitude of distrust towards NGOs, worrying that the development of NGOs may bring potential threats to its authority. This watchful attitude towards NGOs is manifested in policies that obstruct registration, high taxes and high restrictions on NGOs' activities. On the other hand, China's political elites are already aware of the supplementary and effective role of NGOs' as providers of public services. In the area of STD/HIV/AIDS prevention within the sex industry, for example, due to high mobility, FSWs and their clients are extremely difficult to reach by service providers.

Moreover, policy considering prostitution illegal has set an obstacle to direct government involvement in STDs and HIV/AIDS prevention campaigns in the sex industry, because the government fears that direct intervention would be regarded by the public as acquiescence for legalization of prostitution. Hence, given such a dilemma, decision-makers have changed their policy allowing NGOs' participation in community-based STDs and HIV/AIDS prevention activities. This policy change can be regarded as a path dependent consequence of the existing judicial institutional context that considers prostitution illegal and restricts NGOs. Also, this policy can be explained as a layering strategy by the Chinese political decision-makers for its overall prostitution control policy, as NGOs, with a role as new actors, have been added into the existing institution for the purpose of more effective STDs and HIV/AIDS control.

5.3.3 The policy change of urban community-based health service provision: a "*drift>exhaustion>displacement*" case

Unlike the "conversion>layering" process of policy change, which upholds the old institution while effecting fragmented changes that modify the institution's status and structure over time, a "drift>exhaustion>displacement" process results in the breakdown of the old institution and the establishment of a new one. The policy change of community-based health service provision, up until now, can be understood as a "drift>exhaustion>displacement" process, as the current urban

form was established after the collapse of the previous rural cooperative medical system (RCMS), and some elements in the old system were adopted into the new one.

The RCMS was introduced in the mid-1950s in the provinces of Shanxi, Hubei and Henan, and implemented nationwide since 1968. Within the RCMS a "three-tier network of medical and preventive care" (*sanji yiliao baojian wang* 三级医疗保健网) was established. "Three-tier" refers to the health institutions at three rural levels: health clinics in the villages/brigades, township hospitals, and county hospitals. A patient was first treated by barefoot doctors[43] in his or her village or brigade. Only in an emergency situation would the patient be sent to a township or county hospital. Before economic reform launched in 1978, the RCMS played a significant role in health care provision for China's rural areas, as it fulfilled the rural population's basic needs of medical services. The breakdown of the RCMS can be understood as a sequential *drift to exhaustion* process. A *drift-exhaustion* process refers to a situation under which an existing institution lacks adequate adjustments to meet the external changes in the political and economic environment (drift) and begins to deteriorate over time, eventually reaching the end of the breakdown (exhaustion). In the case of RCMS, the breakdown has taken place incrementally, associated with the collapse of the rural collective economy. The financial support for RCMS was highly dependent on the rural collective economy. Whereas county hospitals received governmental financial support, the cost of health care provision on township- and villages/brigade-levels was primarily financed by rural collectives. Collective medical funding was set up at the township- and villages/brigade-level for collective members' payment for medicines, a portion of inpatient costs, medical equipment, as well as the remuneration of barefoot doctors. FPRS was implemented in the late 1970s and early 1980s. (cf. 1.2) Regardless of its positive impact on the overall rural economy, the implementation of FPRS subverted the collective system, and correspondingly, crippling the RCMS because the previous financial system and performance based on the collective declined. Facing financial constraints, health care facilities in rural areas had to resort to privatization and providing out-of-pocket services. There is no document showing when the RCMS actually ended exactly. However, there are statistics showing RCMS continuously declining: By 1989, RCMS existed in only about 5% of China's villages. (Zhang 2003:990) Since the early

[43] The explanation of *barefoot doctor* was given in footnote 34.

1990s, China's central government has made major efforts to revive the RCMS, developing a new system to provide health care in rural areas, which is the NCMI, discussed in Subchapter 4.2.2.2 regarding migrants' medical insurance.

Relevant to health care provision in urban areas, the establishment of community-based health care would be a displacement stage of policy change. In this stage, the old institutional arrangements of RCMS were pushed to the side by new institutions. Simultaneously, through rediscovery, activation, and cultivation, the elements of the previous RCMS were adopted by new institutions. Within the community-based health care system, two new institutions are identified: First, CHCSCs and CHCSSs are dispatched institutes of district hospitals having the authority to make official appointments and dismissals of CHCSC and CHCSS personnel, as well as allocating governmental appropriation. The second new institution is the public-private-partnership applied by some urban villages (e.g. Changban Village) to provide health care. Beside these new institutions, I argue that some elements of the setting of the old institution, the RCMS, were also adopted in the current community-based health care system.

The first fact identified to support my argument is that the sphere of care provision, ostensibly the "community-based" health care system, is to a great extent a renamed "village-based" health care system. In Guangzhou City, and almost without exception, all health care facilities that belong to the "community-based" health care system, the CHCSCs and CHCSSs, are located in, or at the border of, urban villages. As Subchapter 4.1 noted, urban villages were rural villages before urbanization. Nowadays, although local village residents are entitled to urban *hukou*, the land of the villages remains the property of the village collectives, which were renamed as if they were companies. As reported in the interviews, the administrative area of a so-called "community" is actually the area of one, or the collection of a few, previous rural villages. In this sense, as with RCMS, the current community-based health care system is providing care for residents within the unit of villages. The difference between the current and past system is that the target population of service provision is not only the indigent villagers, but also migrant residents. Second, the referral system of RCMS has been inherited by community-based health care. Just as with the previous village/brigade clinics, the task of CHCSCs and CHCSSs is to treat patients in cases of contracting minor illnesses, as well as providing health care education. In a severe situation, the patient would be sent to higher level facilities, such as district-level or

municipal-level hospitals. Some elements of previous RCMS can also be found in the case of health care provision in Changban Village. The CHCSS in Changban Village is financed and run by a cooperative partnership of the village collective company and a private hospital. Based on this partnership, the employment positions of the former barefoot doctors in RCMS remain and the barefoot doctors are trained by the partner hospital. Moreover, one of the concepts of RCMS, in which the collective funds cover collective members' health care expenditures, has also succeeded to some extent. The local villagers are entitled to a reimbursement of registration fees at the CHCSS, and the village collective company subsidizes every villager for an amount of 30 Yuan per month for health care, and reimburses 50% of their in-patient medical expenses, regardless of the facility in which the villagers seek care.

5.3.4 Developing the theory of incremental policy change: the unidirectional and bidirectional pathways of incremental policy change

I applied the *conversion>layering* pattern and the *drift>exhaustion>displacement* pattern to analyze the incremental changes in the family planning policy, the prostitution control policies, the policy of NGO regulation pertaining to STDs and HIV/AIDS prevention, and the policy of urban community-based health service provision. Regarding the change of family planning policy, I also established a "*conversion>layering>replacing*" pattern adding a new mechanism of *replacing* to the *conversion>layering* pattern. It must be pointed out that these three patterns presented above show unidirectional pathways of institutional change: the *conversion>layering* pattern and the *conversion>layering>replacing* pattern represent an institutional growth, while the *drift*> *exhaustion>displacement* pattern represents an institutional decline. Previous studies of Thelen and her colleagues also addressed such unidirectional policy changes. I argue, however, that the pathway of incremental institutional change is not always unidirectional, but may also be bidirectional, experiencing both self-enhancing and self-weakening interactions. I agree with Thelen that a changed external environment is the precondition of institutional change. Furthermore, I argue that the crucial point is

how individuals (especially those having the capability to influence institutional settings) react and cope with the external changing environment and the consequences. Policies and policy changes result from decision-making by political elites. Hence, the different reactions and coping strategies of political elites may alter the pathway of policies. Addressing the *drift>exhaustion>displacement* pattern as an example, in the stage of *drift*, when adequate adjustments are administered, *drift* may turn into *conversion* instead of *exhaustion*. In other words, the theme will be changed, and is addressed under another pattern of *drift>conversion>layering*. Even when the stage of *exhaustion* has begun, adjustments may still function, ultimately avoiding institutional breakdown. As a result, another pathway will show up, namely *drift>exhaustion>conversion > layering*, which is a bidirectional pathway of policy change.

5.4 Understanding of incremental change of informal institutions and its impact on policy change

After discussing how does a policy (formal institution) change, a question may naturally present itself in one's mind: how does an informal institution change? Further, how does the change of informal institutions influence policy changes? These issues are addressed by the last main research question of present thesis.

Regarding the change of informal institutions North (1990:45) notes that informal institutions possess a "tenacious survival ability" and are highly resistant to change. Formal institutions can suppress, but often are unable to change informal institutions in essence. Such impuissance is manifested, for example, in the implementation of family planning policy, as there were still numerous newborns outside the birth control regulations, despite the rigorous punishments. (cf. 4.2.2.3, 4.2.3.1) Pejovich (1999:170) argues that new formal rules are the compromise to the persistence of informal rules, as the former can only institutionalize the ongoing process cases in which they have failed to change the informal rules. This argument provides an explanation to the situation discussed in Subchapter 5.2: why competing informal institutions may urge demands for change of formal institutions (policies). This thesis is also approved by Heilmann's (2000) study on the transformation of the economic structure in Russian and China. Heilmann's study reveals that the strategic transformation undertaken by the

governments was merely the reaction to, or formalization of, the changes by informal institutions, which had happened long ago. Since an informal institution is so impervious to change, how does change occur?

I argue that change of informal institutions is slow and incremental. Informal institutions are behavioral codes, produced by individuals and members of a community. Hence, as with change within a formal institution, change in an informal institution is the reaction of individuals in a community, who are facing shifts in the external environment. In other words, changes in an informal institution happen as the status quo conditions that sustain it change. With regard to the linkage of individuals and change of informal institutions, Helmke and Levitsky (2004:732) argued that developments within the external environment may change the distribution of power and resources within a community, weakening those community members who benefit from the existing informal institution, and simultaneously, strengthening those who seek to change it. From an economic perspective, Pejovich (1999:172) explains how a changed informal institution becomes prevalent within a community. He assumes a situation in which a new idea hits a community, and the idea would be to expand opportunity choices for interactions with community members. If behaviors of those exploiting the new exchange opportunities would bring positive returns, and the returns were substantial enough to generate and sustain a large number of repeated interactions relative to enforcement costs, the very success of new activities would compel the old informal institutions to adjust and change in order to embrace the novelty. With this regard, I would like to use as an example the change of patriarchy traditions and gender inequality in China's rural areas, from where rural-urban-migrant women come. Migration has resulted, de facto, in an attenuation of patriarchal tradition and has contributed to the improvement of women's social status in rural China. This change can be explained by the fact that working in cities, rural-to-urban migrant women earn wages much higher than that they could obtain through traditional farming work. The income of a migrant woman can be as much, as or even higher, than a male also coming from a rural area. For a great number of rural families, females, just like males, have become the important income resource. Along with the improvement of their economic status, migrant women's social status has risen, with discrimination against females somewhat dimming. This change will become more prevalent as more and more women from rural areas choose to migrant into cities seeking jobs. It can be further asserted, with

conviction, that migration and the related improvement of females' social status will also cause son preference to languish in rural China, as females become important as economic contributors to the family household. Again, it must also be emphasized here that informal institutional change tends to be incremental because individuals reorient their expectations to reflect gradual, underlying changes in the bargaining power that they and others hold. (Helmke and Levitsky 2004:732) Like formal institutions, change in informal institutions is also path dependent. Grappling between new and old ideas is common. Taking the change in patriarchal tradition as an example again, although migrant women have become more confident due to the improvement of their economic status, a great number of them still consider marriage and having children obligatory (cf. interviews with FSWs). In other words, for the most part, migrant women are still holding perceptions shaped by patriarchal tradition, in which females are subject to traditional families, as opposed to being completely independent. In summary, change in an informal institution is subtle and incremental.

Linking "dominant individual" (e.g. political elites), "non-dominant individual" (e.g. rural-to-urban migrants), "formal institution" and "informal institution," it is possible to answer the last question: in the social context of China, how do the informal institutions (e.g. ideas) influence the change in formal institutions (policy)? Regarding the linkage of ideas and policy, Huntington (1981) points out that there is "friction" between political performance and ideas, and a mismatch between these provides opportunities for political elites to carry out policy change. I argue that this interpretation is applicable in the political arena of countries with a democratic electoral system, but not in present-day China. More precisely, in a democratic country, the political operation and the political life of politicians strongly relies on the preference of voters, namely the aggregates of non-dominant individuals, or the masses. When an opportunity for policy change arises, the voracity for votes incentivizes political elites to make a decision that matches the masses' preference (if not always). In this way, the change of informal institutions stem from the masses effecting change within formal institutions, e.g. the policies. There is a lack of a veridical electoral system in China. Without the pressure for pursuing votes, decisions made by political elites are less likely to be affected by preferences of the masses. It can be inferred that in China, only when a changed informal institution (e.g. new idea) has been embraced by the political elites, or they are at least aware of the advantage of embracing the new idea, elites

will formalize institutional policy changes to match the new ideas of informal institutions. This is also the only way that informal institutions can influence the change of formal institutions in present-day China.

CHAPTER 6

Summary and research limitations

Based on data gathered from the qualitative interviews in the cities of Guangzhou and Shenzhen in PRD in China, this thesis has addressed rural-to-urban migrant women's *health-seeking behaviors* with regard to their sexual health, as well as the governmental policies related to migrants' sexual health. The analysis of this study drew on new institutionalist approaches. Unlike previous political institutional analysis that focuses on political and economic elites, this study has concentrated on rural-to-urban migrant women, i.e. the non-dominant individuals in China's political institutional setting. The study shows that *health-seeking behaviors* evolve from individuals' rational calculated decision-making, and the combined results of self-evaluation and reaction to the institutional context in which they live. In addition to formal institutions (governmental policies), informal institutions may influence rural-to-urban migrant women's *health-seeking behaviors*. The informal institutions concerned in this study are not those in association with the official power structure, such as clientelism and factionalism, which lead to clientelistic, patronage-related, factional relationships and other behavioral structures of political and economic elites. Instead, tradition and ideas that are embedded in the society among non-dominant individuals were identified and analyzed. Among these were patriarchal tradition, gender inequality, the system of *face,* discrimination and prejudices against sex work and the tradition of *doing the month*.

The social networks used by migrant women to cope with health problems and exchange health-related information, regarded here as an informal organization, have been analyzed. This study has also addressed the issue of institutional effectiveness. I classify the identified informal institutions/organizations into accommodating, competing and substitutive institutions and discuss their influence on policy effectiveness and policy change. This study also shows that policy change is always path-dependent and incremental, and the crucial factor in a policy change is how political decision-makers face externally changing environments

and act. Based on this point, I extend the theory of incremental policy change developed initially by Kathleen Thelen and Wolfgang Streeck. In this regard, the analysis of policies related to migrants' sexual health demonstrates that the single stages of policy change introduced by Thelen and Streeck can be combined and used as patterns to explain policy change, and the process of policy change may be unidirectional or bidirectional. This thesis shows that informal institutions (e.g. traditions, ideas) are "codes of behaviors" among the masses, embedded in the culture. Change of an informal institution may take place due to shifts in the external environment, when the majority of community members embraces a new "code of behavior" that can bring them advantages. Finally, due to the lack of a genuine electoral system in China, political elites have few incentives to effect policy change that meets the needs of the masses. In sum, present-day China has a political institutional structure with a powerful alliance composed of political, economic and cultural elites, and a marginalized and weak counterpart comprised of the general public. Within this structure, although governmental policies can and do change, the issues addressed are generally more day-to-day problems rather than those at the political core. I do not deny that a political decision made by China's government may represent the public will, but there is a lack of substantial institutions to ensure that the governmental policies always represent the public will. The answer to the question of the extent to which policy can represent the public will is also intangible, and depends on the government's arbitrary decision-making.

This research is based on 54 semi-structured interviews with migrant women and 14 expert/stakeholder interviews. Compared to the relatively large sample of migrants, there was little data gathered in the interviews with political elites, such as high-ranking officers, who are the main actors in policy-making. This limits the research findings of this thesis. Hence, while I am quite confident in my analysis of migrants' *health-seeking behaviors*, I believe that more interviews with political elites may provide deeper insight into policy changes in present-day China. However, due to the Chinese government's caution towards potential opposition to its authority, it is difficult to obtain permission to interview government officials. Moreover, the repressive political atmosphere linked with the restrictions on the expression of opinions, and government officials' loyalty to the political structure in which they exist and from which they benefit, make candid dialogues with such officials extremely difficult. This situation is a crucial obstacle,

and also a perennial challenge, to all researchers interested in China's politics.

A further limitation is that this study did not address the impact of the internet on migrant women's health-seeking behavior and on policy change. Given the increasing number of internet users in China, new research questions may be raised: can cyberspace be regarded as a new form of informal institution? Do the non-dominant individuals affect the governmental decision-making through cyberspace and to what extent? Further, has the emergence of cyberspace generated a new social and political institutional structure? More research is needed in order to address these questions.

References

Ackrill, Robert & Kay, Adrian (2006): Historical-institutionalist perspectives on the development of the EU budget system. *Journal of European Public Policy* 13(1): 113-133.

Ahmed, Shameem; Sobhan, Farzana; Islam, Ariful & Barkat-e-Khuda (2001): Neonatal morbidity and care-seeking behaviour in rural Bangladesh. *Journal of Tropical Paediatrics* 47(2): 98-105.

Anderson, Allen F. & Gil, Vincent E. (1994): Prostitution and public policy in the People's Republic of China: an analysis of the rehabilitative ideal. *International Criminal Justice Review* 4(23): 23-35.

Anonymous (2008): 黑诊所平均每月医死一人 On average black clinics treat one person death monthly. *广州日报 Guangzhou Daily* (2008, 12.12.), p. A39.

Anonymous (2015): 终止计划生育一票否决 Ending of the vote-veto system. Retrieved from: http://www.thepaper.cn/newsDetail_forward_1333651. (30.06.2015)

Attané, Isabelle (2009): The determinants of discrimination against daughters in China: evidence from a provincial-level analysis. *Population Studies* 63(1): 87-102.

Barriball, K. Louise & While, Alison (1994): Collecting data using a semi-structured interview: a discussion paper. *Journal of Advanced Nursing* 19(2): 328-335.

Baumgartner, Frank R. & Jones, Bryan D. (1991): Agenda dynamics and policy subsystems. *The Journal of Politics* 53(4): 1044-1074.

Baumgartner, Frank R. & Jones, Bryan D. (1993): *Agendas and Instability in American Politics*. Chicago: University of Chicago Press.

Baumgartner, Frank R. & Jones, Bryan D. (2009). *Agendas and Instability in American Politics.* Chicago: University of Chicago Press.

Bedri, Nafisa (2001): Health-seeking behaviour for vaginal discharge: pathways, factors and processes influencing early modern care use for abnormal vaginal discharge in the Sudan (PhD), University of Manchester, Manchester.

Berg, Mette Louise (2009): Homeland and Belonging among Cubans in Spain. *The Journal of Latin American and Caribbean Anthropology* 14(2): 265-290.

Bernard, H. Russell (2006): *Reasearch Methodes in Anthropology: Qualitative and Quantitative Approaches*. Lanham: Altamira Press.

Black, Julia (1997): New institutionalism and naturalism in socio-legal analysis: institutionalist approaches to regulatory decision making. *Law & Policy* 19(1): 51-93.

Blatter, Joachim K.; Janning, Frank & Wagemann, Claudius (2007): *Qualitative Politikanalyse*. Wiesbaden: VS Verlag für Sozialwissenschaften

Boas, Taylor C. (2007): Conceptualizing Continuity and Change: The Composite-Standard Model of Path Dependence. *Journal of Theoretical Politics* 19(1): 33-54.

Bork-Hüffer, Tabea (2012): *Migrants' Health Seeking Actions in Guangzhou, China - Individual Action, Structure and Agency: Linkages and Change*. Stuttgart: Franz Steiner Verlag.

Bork, Tabea; Kraas, Frauke & Yuan, Yuan (2010): Migrants' health, health facilities and services in villages-in-the-city in Guangzhou. *Migrants and Health in Urban China, Berliner China-Hefte* 38: 72-93.

Bruszt, Laszlo (2008): Multi-level governance - the eastern versions: emerging patterns of regional developmental governance in the new member states. *Regional & Federal Studies 18*(5): 607-627.

Buse, Kent; Mays, Nicholas & Walt, Gill (2005): *Making Health Policy*. Milton Keynes, UK: McGraw-Hill Education (India) Pvt Limited.

Cai, Xiaobo 蔡小波 (2003): 广州市"城中村"改造策略探讨 On the strategies of the reconstruction of the urban villages in Guangzhou (master), Sun Yat-sen University, Guangzhou.

Cai, Yong; Shi, Rong; Shen, Tian; Pei, Bei; Jiang, Xueqin; Ye, Xiuxia; Xu, Gang; Li, Shenghui; Huang, Hong & Shang, Meili (2010): A study of HIV/AIDS related knowledge, attitude and behaviors among female sex workers in Shanghai China. *BMC Public Health* 10: 377.

Cao, Guizhi 曹桂芝 (2008): 从传统到现代的嬗变—改革开放30年农民生育观的变迁 From the traditional to mordern: Transformation of peasents' birth concept since the opening-up reform in the last 30 years. *湖南行政学院学报 Journal of Huanan Adminstration Institute* (6): 39-42.

Cao, Longhu 曹龙虎 (2010): 中国流动人口计划生育政策变迁的政治学研究 Political study on the transformation of the policies regarding floating population's birth control. *唯实 Weishi* (4): 82-86.

Capoccia, Giovanni & Kelemen, R. Daniel (2007): The study of critical junctures: theory, narrative, and counterfactuals in historical institutionalism. *World Politics* 59(3): 341-369.

Chan, Kam Wing (2012): Migration and development in China: trend, geography and current issues. *Migration and Development 1*(2): 187-205.

Chen, Gang; Lü, Jun; Zhang, Deying; Liu, Yingtao & Zhang, Li 陈刚;吕军;张德英;刘英涛&张立 (2006): 流动人口妇女儿童卫生保健服务现状及对策研究概述 Study on the maternal and child health care of migrant population. *中国全科医学 Chinese General Practice 9*(7): 541-543.

Chen, Jiajian; Liu, Hongyan & Xie, Zhenming (2010): Effects of rural-urban return

migration on women's family planning and reproductive health attitudes and behavior in rural China. *Studies in Family Planning 41*(1): 31-44.

Chen, Jinxi; Xia Tingsong; Hu, Xiaoxia; He, Zhenbin; Zhou, Zhiming; Peng, Ji; Wu, Yunhui; Lu, Zuxun & Zhao, Zhiguang 陈金喜;夏挺松;胡晓霞;何振彬;周指明;彭绩;巫云辉;卢祖洵&赵志广 (2005): 深圳市流动人口社区卫生服务利用及其影响因素分析 Analysis on the utilization and influence factors of the community health services of the floating population in Shenzhen City. 中国全科医学 *China General Practice 8*(9): 1638-1640.

Chen, Xiaoshu 陈晓舒(2008): 中国女性性工作者安全调查 Investigation on the security of female sex workers in China. Retrieved from: http://society.people.com.cn/GB/1062/7109531.html (12.07.2010).

Chen, Youyi 陈友义 (2009): 潮汕地区重男轻女社会现象探析 Research on the social phenomena of male-preference in Chao-Shan Area. *广州番禺职业技术学院学报 Journal of Guangzhou Panyu Polytechnic 8*(3): 56-60.

Cheng, Hua; Xu, Lei; Ren, Jinma; Fang, Hui: Yang, Meixia; Wang, Hongwei; Kang, Laiyi & Calyavara, L. 程华;许磊;任金马;方蕙;杨美霞;汪红卫;康来仪 & Calzavara, L. (2012): 上海市城区男性建筑工人的性行为特征及安全套使用情况调查 Study on features of sexual behaviors and condom use among male construction workers in the urban areas of Shanghai. *中国艾滋病性病 Chinese Journal of AIDS & STD 18*(11): 735-748.

Cheng, Yu; Han, Li & Huang, Yunshi (2010): Health needs and health risks among Chinese female migrant workers: a qualitative assessment. *Migrants and Health in Urban China, Berliner China-Hefte* 38: 40-51.

Cheng, Yu; Li, Jianghong; Duke, Michael & Singer, Merrill (2004): 社区外展:广州吸毒者的个案研究 Community-base outreach: a case study on injection drug users in Guangzhou City *广西民族学院学报（哲学社会科学版）Journal of Guangxi University for Nationalitie (Philosophy and Social Science Edition) 26*(4):

83-87.

Deng, Meifang 邓梅芳 (2004): 关于艾滋病与卖淫人员的调查报告 Report of the investigation on AIDS and prostitutes. Retrieved from: http://www.aids120.com/00/0xingxue/lunli/20040115162407.htm (12.07.2010).

Denzin, Norman K. & Lincoln, Yvonna S. (2011): Introduction: The discipline and practice of qualitative research. In: Denzin, Norman K. & Lincoln, Yvonna S. (eds.): *Handbook of Qualitative Research*. Thousand Oaks/London/New Delhi/Singapore: SAGE Publications. pp. 1-19.

Department of Women's Right of Women's Federation Shenzhen 深圳市妇联权益部 (2004): 深圳市女职工权益保障的现状与思考 Discussion on female emplyees' right protection in Shenzhen City. In: Long, Qiuxia; Zeng, Xiaoying; Wu, Meiying; Huang, Donghong & Liu, Yongxia 龙秋霞;曾小瑛;吴梅影;黄东宏&刘永霞(eds.): *广东省妇联系统优秀调研成果汇编 Anthology of the survey results of the Women's Federation of Guangdong Province*. Guangzhou: 广东科技出版社 Guangdong Technology Publishing House. pp. 209-213.

Ding, Xianbin; Yi, Huirong; Jiang, Xuefei; Han, Lisu; Wu, Guohui; Ling, Hua & Xiao, Bangzhong 丁贤彬;易辉容;蒋雪飞;韩力苏;吴国辉;凌华&肖邦忠 (2006): 重庆市 519 名暗娼艾滋病防治知识态度和高危行为特征分析 Analysis of status of AIDS related knowlege, attitude and risk behaviour among 519 female sex workers in Chongqing *中国艾滋病性病 Chinese Journal of AIDS and STD 12*(4):347-349.

Dittmer, Lowell & Wu, Yu-Shan (1995): The modernization of factionalism in Chinese politics. *World Politics* (47): 467-494.

Doherty, Jim P.; Norton, Edward C. & Veney, James E. (2001): China's one child policy: the economic choices and consequences faced by pregnant women. *Social Science & Medicine 52*(5): 745-761.

Du, Lexun 杜乐勋 (2007): 中国医疗机构产权公司合作模式和发展前景展望

Public-private partnership for medical institutions in China and its future. In: Du, Lexun & Zhang, Wenming 杜乐勋&张文鸣 (eds.): *医疗卫生绿皮书—中国医疗卫生发展报告 No. 3 Green Book of Health-The Development Report on China's Health No.3*. Beijing: Social Sciences Academic Press. pp. 194-211.

Dunn, Kevin (2010): Interviewing. In: Hay, Iain (ed.): *Qualitative Research Methods in Human Geography.* Oxford: Oxford University Press. pp. 79-105.

Ebenstein, Avraham & Leung, Steven (2010): Son preference and access to social insurance: evidence from China's rural pension program. *Population and Development Review 36*(1): 47-70.

Eggert, Jennifer (2013): *Brücken nach Kuba - Transnationale Austauschbeziehungen kubanischer MigrantInnen in Deutschland*. Norderstedt: Grin Verlag.

Fan, Cindy C. (2008): *China on the move: migration, the state, and the household*. London/New York: Routledge.

Feng, Xiangwu 冯祥武 (2011): 流动妇女生育保险问题新论 New research on the problem of migrant women's maternity insurance. *中华女子学院学报 Journal of China Women's University* (4): 52-57.

Feng, Yujun (2011): Power, rights, and interests: A legal and economic analysis of urban housing demolition and relocation in China. In: Huang, Xiaoming (ed.): *The institutional dynamics of China's great transformation*. London&New York: Routledge. pp. 78-97.

Fu, Xiaoxing 富晓星 (2006): 女性商业性性服务者的组织特征、流动规律及艾滋病防治对策研究——以四川 Y 县为例 The charateristics of the organisational forms of femal sex workers, the patterns of their movement and countermeasures against AIDS. *Population Research 人口研究 30*(6): 74-81.

Glasier, Anna; Gülmezoglu, A Metin; Schmid, George P; Moreno, Claudia Garcia

& Van Look, Paul FA (2006): Sexual and reproductive health: a matter of life and death. *The Lancet, 368*(9547): 1595-1607.

Gorges, Michael J. (2001): Blind alley: new instituionalist explanations for institutional change: a note of caution. *Politics, 21*(2): 137-145.

Gransow, Bettina (2010): Body as armor: Health risks and health consciousness among rural migrants in urban China. *Migrants and Health in Urban China, Berliner China-Hefte* (38): 9-27.

Gransow, Bettina & Zhou, Daming (2010): Introduction. *Migrants and Health in Urban China, Berliner China-Hefte* (38): 3-8.

Greener, Ian (2002): Understanding NHS Reform: the policy-transfer, social learning, and path-dependency perspectives. *Governance 15*(2): 161-183.

Gruner-Domic, Sandra (2005): *Latinas in Deutschland: Eine ethnologische Studie zu Migration, Fremdheit und Identität*. Münster: Waxmann.

Grzymala-Busse, Anna. (2010): The best laid Plans: The impact of informal rules on formal institutions in transitional regimes. *Studies in Comparative International Development* 45(3): 311-333.

Gu, Baochang; Wang, Feng; Guo, Zhigang & Zhang, Erli (2007): China's local and national fertility policies at the end of the twentieth century. *Population and development review 33*(1): 129-147.

Gu, Baochang; Zheng, Zhenzhen; Liu, Hongyan & Liu, Shuang 顾宝昌;郑真真;刘鸿雁&刘爽 (2007): *公民社会组织与生育健康 Civil Society and Reproductive Health in China*. Beijing: Social Sciences Adademic Press.

Gu, Shengzu; Zheng, Lingyun & Yi, Shance (2007): Problems of rural migrant workers and policies in the new period of urbanization. *China Population, Resources and Environment 17*(1): 1-5.

Gu, Xin 顾昕 (2007): 全民医疗保险走上正轨 Medical insurance system that covers the whole population along the right lines. In: Ru, Xin; Lu, Xueyi & Li, Peilin 汝信;陆学艺&李培林(eds.): *社会蓝皮书-2008 年中国社会形势分析与预测 Blue Book of China's Society: Society of China Analysis and Forecast*. Beijing: 社会科学文献出版社 Social Sciences Academic Press. pp. 88-101.

Guangzhou Daily: 广州流动人口首超常住人口多 5 万 For the first time floating population in Guangzhou is 50,000 more than permenant population *广州日报 Guangzhou Daily*. Retrieved from http://news.dayoo.com/guangzhou/201404/23/73437_36113286.htm (23.04.2014).

Guangzhou municipal statistic bureau & Guangzhou survey office of National Bureau of Statistics (2008): *Guangzhou Statistical Yearbook 2008*. Beijing: China Statistics Press.

Gupta, Monica Das; Jiang, Zhenghua; Li, Bohua; Xie, Zhenming; Chung, Woojin & Bae, Hua-Ok (2003): Why is son preference so persistent in East and South Asia? A cross-contry study of China, India and the Republic of Korea. *The Journal of Development Studies 40*(2): 153-187.

Hacker, Jacob S. (2004): Privatizing risk without privatizing the welfare state: the hidden politics of social policy retrenchment in the United States. *The American Political Science Review 98*(2): 243-260.

Hall, Peter A. & Taylor, Rosemary C. R. (1996): Political science and the three new institutionalisms. *Political Studies 44*(5): 936-957.

Han, Jinwang 韩金旺(2003): 我国经济转型时期政府与股市的制度分析 System analysis on goverments and stock market in China in the economic transitional period (master), Renmin University of China, Beijing.

Han, Yiming 韩一鸣 (2006): 走下警车的犯罪嫌疑人 Suspects out of the police car. Retrieved from: http://news.sina.com.cn/c/l/2006-11-30/144611664470.shtml (30.11.2006).

Hasmath, Reza & Hsu, Jennifer (2008): NGOs in China: issues of good governance and accountability. *The Asia Pacific Journal of Public Administration 30*(1): 29-39.

Health Ministry of PRC (2005): Income and expenditure of general hospitals of health sector in 2005. Beijing: Health Ministry of People's Republic of China.

Heemskerk, Eelke M. (2007): *Decline of the Corporate Community: Network Dynamics of the Dutch Business Elite*. Amsterdam: Amsterdam University Press.

Heh, Shu-Shya (2004): "Doing the month" and social support. *Fu-Jen Journal of Medicine, 2*(2):11-17.

Heilmann, Sebastian (2000): *Die Politik der Wirtschaftsreformen in China und Rußland*. Hamburg: Institut für Asienkunde.

Hein, Kerstin (2006): *Hybride Identitäten: Bastelbiografien im Spannungsverhältnis zwischen Lateinamerika und Europa.* Bielefeld: transcript Verlag.

Helmke, Grethchen & Levitsky, Steven (2004): Informal institutions and comparative politics: A research agenda. *Perspectives on Politics 2*(4): 725-740.

Helmke, Grethchen & Levitsky, Steven (2006): Introduction. In: Helmke, Grethchen & Levitsky, Steven (eds.): *Informal Institutions and Democracy: Lessons from Latin America*. Baltimore: Johns Hopkins University Press, pp: 274-284.

Hong Kong Enviromental Protection Department (2015): Pear River Delta. Retrieved from:http://www.epd.gov.hk/epd/sites/default/files/epd/english/environmentinhk/water/regional_collab/files/Fig1.jpg (13.04.2015)

Hong Kong Trade Development Council (2015): Map of Pearl River Delta. Retrieved from:http://www.hktdc.com/resources/Minisite/Article/uk/2009/03/200033/1238397910188_10_2_screen_15_200033.gif (13.04.2015)

Holroyd, Eleanor; Lopez, Violeta & Chan, SallyWai-Chi (2011): Negotiating "doing the month": An ethnographic study examining the postnatal practices of two generations of Chinese women. *Nursing and Health Sciences* (13): 47-52.

Hoy, Caroline (2008): Migration in China - reproductive and sexual health issues. In: Murphy, Rachel (ed.): *Labour migration and social development in contemporary China*. London & New York: Routledge. pp. 115-136

Hu, Shiyong; Jiang, Xiufen & Zou, Lijuan 胡仕勇;姜秀芬&邹丽娟 (2012): 女性农民工参与生育保险的现状、问题与对策—基于武汉市女性农民工个案的分析 The situation, problems and strategies regarding female peasent workers' maternity insurance: Analysis based on the case study among female peasent workers in Wuhan City. *社会福利 Social Welfare*(12): 20,26-29.

Hu, Xiaoyun & Wang, Fang 胡晓云&王芳 (2011): 1618 例流动人口妇女病普查结果分析 Analysis based on a survey with 1618 female migrants. *新疆医学 Xinjiang Medical Journal 41*: 130-132.

Hu, Yukun 胡玉坤 (2007): 社会性别与艾滋病问题研究——全球化视域下的中国个案 Research on social gender and AIDS - China's case with a perpective of globalisation. *社会科学论坛 Shehui kexue luntan* (5): 16-38.

Hua, Chunyu & Zha, Wenye 华春雨&查文晔 (2010): 卖淫女示众事件促使中国再纠执法陋习 The incident of of public of female prostituts prompts China to correct abuse of power in policing. Retrieved from: http://news.xinhuanet.com/legal/2010-07/28/c_12384776.htm (04.08.2011).

Huang, Jiangtao, Yu, Senquan & Yu, Xiaoying 黄江涛;余森泉&俞小英 (2005): 年轻女性流动人口生殖健康知识及需求调查 Survey on young female floating population's knowledge and needs of reproductive health *中国公共卫生 China J Public Health 21*(2): 216-217.

Huang, Manni 黄曼妮 (2013): 关于女性农民工生育保险的研究 Study on the maternity insurance of female migrant workers *蚌埠学院学报 Journal of Bengbu College 2*(3): 52-55.

Huang, Xiaoming (2011): Introduction-Instituional analysis and China's tranformation: Issues and concepts. In: Huang, Xiaoming (ed.): *The institutional dynamics of China's great transformation.* London & New York, Routledge, pp.1-24.

Huang, Yangzhong (2004): Bringing the local state back in: the political economy of public health in rural China. *Journal of Contemporary China 13*(39): 367-390.

Huang, Yingying; Henderson, Gail E.; Pan, Suiming & Cohen, Myron S. (2004): HIV/AIDS risk among brothel-Based female sex workers in China: Assessing the terms, content, and knowledge of sex work. *Sexually Transmitted Diseases 31*(11): 695-700.

Huang, Yingying & Pan, Suiming 黄盈盈&潘绥铭 (2003): 中国东北地区劳动力市场中的女性性工作者 Female sex workers in the labor market in northeastern China. *社会学研究 Sociological Studies* (3): 51-60.

Huntington, Samuel P. (1981). *American Politics: The Promise of Disharmony*. Cambridge, Massachussetts, and London: Belknap Press.

Isaacs, Rico (2011): *Party System Formation in Kazakhstan: Between Formal and Informal Politics*. London & New York, Routledge.

Jacka, Tamara (2006): *Rural women in urban China - Gender, migration, and social change*. London: M.E. Sharpe.

Jeffreys, Elaine (2012): *Prostitution scandals in China: Policing, media and society.* Abingdon/New York: Routledge.

Jeffreys, Elaine & Huang, Yingying (2009): Governing sexual health in the People's Republic of China. In Elaine Jeffreys (ed.): *China's governmentalities -*

Governing changing, changing government. New York/London: Routledge. pp. 151-173.

Jiang, Bin; Yan, Youqi & Shi, Luwen 江滨;鄢尤奇&史录文 (2005): 近年来我国药品监管政策分析 Analysis of the policies of drug administration in China. *中国药事 Chinese Pharmaceutical Affairs 19*(3): 148-151.

Jing, Jun 景军 (2006): 泰坦尼克定律：中国艾滋病风险分析 The Titanic Rule: A risk analysis of the HIV/AIDS epidenmic in China. *社会学研究 Sociological Studies* (5): 123-150.

Kaufman, Joan (2009): The role of NGOs in China's AIDS crisis - Challenges and possibilities. In: Schwartz, Joanthan & Shieh, Schwartz (eds.): *State and sociey responses to social welfare needs in China - Serving the people*. New York: Routledge. pp. 156-173.

Kleining, Gerhard (1995): Methodologie und Geschichte qualitativer Sozialforschung. In: Flick, Uwe; von Kardorff, Ernst; Keupp, Heiner; von Rosenstiel, Lutz & Wolff, Stephan (eds.): *Handbuch Qualitative Sozialforschung: Grundlagen, Konzepte, Methoden und Anwendungen*. Weinheim: Beltz-Psychologie Verlags Union. pp. 11-22.

Köllner, Patrick (2012): "Informelle Politik" und "informelle Institutionen": Konzeptionelle Grundlagen, analytische Zugänge und Herausforderungen für das Studium autoritärer und anderer politischer Herrschaftssysteme. Hamburg, German Institute of Global and Area Studies/Leibniz-Insititut für Globale und Regionale Studien.

Lau, J. T. F. & Siah, P. C. (2001): Behavioural surveillance of sexually-related risk behaviours of the Chinese male general population in Hong Kong: a benchmark study. *AIDS Care 13*(2): 221-232.

Lau, J.T.F. & Thomas, J. (2001): Risk behaviours of Hong Kong male residents travelling to mainland China: a potential bridge population for HIV infection. *AIDS Care 13*(1): 71-81.

Ledeneva, Alena V. (1998): *Russia's economy of favours: Blat, networking and informal exchange.* Cambridge, Cambridge University Press.

Leichter, Howard M. (1979): *A comparative approach to policy analysis - Health care policy in four nations*. New York: Cambridge University Press.

Leutner, Mechthild (1989): *Geburt, Heirat und Tod in Peking - Volkskultur und Elitekultur vom 19. Jahrhundert bis zur Gegenwart.* Berlin: Dietrich Reimer Verlag.

Levi, Margaret (1997): A model a method and a map: rational choice in comparative and historical analysis. In: Lichbach, Mark Irving; Zuckerman, Alan S. (eds.): *Comparative politics: Rationality, culture, and structure* (pp. 19-41). Cambridge: Cambridge University Press.

Li, Jing 李婧 (2013): 德国卖淫合法化外衣下的悲情面孔 The tragedy of legality of prostitution in Germany. *法律与生活 Law & Life* (16): 46-48.

Li, Ruojian 李若建 (2003): 关于地方性流动人口计划生育管理法规的几点探讨 Thoughts on local laws and rules of the floating populations family planning. *南方人口 South China Population 18*(1): 11-17.

Li, Xiaoming; Zhang, Liying; Stanton, Bonita; Fang, Xiaoyi; Xiong, Qing & Lin, Danhua (2007): HIV/AIDS-related sexual risk behaviors among rural residents in China: Potential role of rural-to-urban migration. *AIDS Education and Prevention 19*(5): 396-407.

Li, Yan 李燕 (2009): 人工流产: 权利抑或义务-女性主义视角下中美堕胎法比较研究 Artificial abortion: Right or obligation-comparative research on abortion law between America and China from the angle of feminism.*法学论坛 Legal Forum 24*(1): 116-121.

Li, Yinhe 李银河 (1998): *中国女性的感情与性 Chinese women's emotion and sex*. Beijing: 今日中国出版社.

Li, Yinhe 李银河 (2000): 卖淫非罪化 Decriminalization of prostitution. *人民公安 People's Police* (18): 9.

Li, Yinhe 李银河 (2004): 妇女、家庭与生育 Women, family and fertility. *江苏社会科学 Jiangsu Social Sciences* (4): 169-174.

Li, Yinhe 李银河 (2005): *女性主义 Feminism*. Jinan: 山东人民出版社 Shandong People's Publishing House.

Li, Yinhe 李银河 (2009): *性的问题 Issues on sex*. Huhehaote: 内蒙古大学出版社 Inner Monolia University Publishing House.

Li, Yongping 李涌平 (1996): 论传统的生育文化 On the traditional birth culture. *中国文化研究 Chinese Culture Research* (12): 21-26.

Li, Yuejun 李月军 (2007): 以行动者为中心的制度主义-基于转型政治体系的思考 Actor-centered institutionalism: Thinking based on experience about political system transformation. *公共管理学报 Journal of Public Management 4*(3): 28-35.

Li, Yuejun 李月军 (2009): 中国政治制度变迁中的制度依赖 Path dependance in the transformation of political system in China. *学海 Sea of Knowledg* (4): 38-46.

Li, Yuxiu 李玉秀 (2012): "严打"角度的中美刑事政策分析 Analysis of the "strike-hard" policies in China and the USA.*学理论 Theory research*(7): 84-86.

Liang, Jianzhang & Huang, Wenzheng 梁建章&黄文政 (2015): 莫让"计生一票否决制"再酿悲剧 Don't let tragedies happen again because of the "vote-veto system" of family planning policy. Retrieved from: http://opinion.caixin.com/2015-09-08/100847399.html (25.11.2015).

Lim, Meng Kin; Yang, Hui; Zhang, Tuohong; Zhou, Zijun; Feng, Wen & Chen, Yude (2002): The role and scope of private medical practice in China. Retrieved

from: http://www.worldbank.org.cn/english/content/Private_Medical_in_China.pdf (14.04.2007).

Lin, Xianghua 林湘华 (2013): 广东省女性非户籍人口状况-农业户口与非农业户口的对比分析 The demographics of the females without official resident status in Guangdong Province: A comparative analysis of those with rural and non-rural Hukou. *南方人口 South China Population 28*(5): 30-38.

Liu, Hongyan; Ru, Xiaomei & Ding, Feng 刘鸿雁;汝小美&丁峰 (2004): 流动人口的生殖健康服务 Reproductive health service for floating population. *人口研究 Population Research 28*(5): 92-96.

Liu, Ming (2011): *Migration, Prostitution, and Human Trafficking: The Voice of Chineses Women. New Brunswick*, London: Transation Publishers.

Liu, Yanqun; Maloni, Judith A. & Petrini, Marcia A. (2012): Effect of postpartum practices of doing the month on Chinese women's physical and psychological health. *Biological Research for Nursing 16*(1): 55-63.

Long, Qiuxia 龙秋霞 (2004): 妇女健康与艾滋病控制——基于广东的调查 Women's health and AIDS control - an investigation in Guangdong. In: Long, Qiuxia; Zeng, Xiaoying; Wu, Meiying; Huang, Donghong & Liu, Yongxia 龙秋霞;曾小瑛;吴梅影;黄东宏&刘永霞 (eds.): *广东省妇联系统优秀调研成果汇编 Anthology of the survey results of the Women's Federation of Guangdong Province.* Guangzhou: 广东科技出版社 Guangdong Technology Publishing House. pp. 59-63.

Luan, Jingdong 栾敬东 (2004): "民工潮"的成因及社会经济影响深层探析 The deep analysis of reason and social and economic effect of farmer labor migration. *安徽农业大学学报 Journal of Anhui Agricultural University 13*(1): 33-35.

Luo, Li & Lu, Min 罗莉&卢敏 (2012): 浅析我国生育保险制度中的男性生育角色及男性权益 On males' role regarding the maternity insurance and males' rights

in China. *中国市场 China Market* (5): 93-94.

MacKian, Sara (2003): *A review of health seeking behaviour: problems and prospects*. Health System Development Program, University of manchester. Retrieved from: http://www.infosihat.gov.my/infosihat/artikelHP/bahanrujukan/HE_DAN_ICT/PDF/Health_seeking_behaviour.pdf (12.04.2009).

MacKian, Sara; Bedri, Nafisa & Lovel, Hermione (2004): Up the garden path and over the edge: where might health-seeking behaviour take us? *Health Policy and Planning 19*(3): 137-146.

Mahoney, James & Thelen, Kathleen (2009): A theory of gradual institutional change. In: Mahoney, James & Thelen, Kathleen (eds.): *Explaining institutional change: Ambiguity, agency, and power*. New York: Cambridge University Press. pp. 1-37.

March, James G. & Olsen, Johan P. (1984): The new institutionalism: Organizational factors in political life. *The American Political Science Review, 78*(3): 734-749.

Mayer, Adrian C. (2004): The significance of quasi-groups in the study of complex societies. In: Michael Banton (ed.): *Social anthropology of complex societies*. London, New York: Routledge. pp. 97-122.

Mayntz, Renate & Scharpf, Fritz W. (1995): Der Ansatz des akteurzentrierten Institutionalismus. In: Mayntz, Renate & Scharpf, Fritz W. (eds.): *Gesellschaftliche Selbstregelung und politische Steuerung*. Frankfurt am Main: Campus. pp. 39-72.

Mayring, Phillip (2003): *Qualitative Inhaltsanalyse: Grundlagen und Techniken.* Weinheim, Basel: Beltz.

Meng, Qingyue (2005): Review of health care provider payment reforms in China. Retrieved from: http://siteresources.worldbank.org/INTEAPREGTOPHEANUT/Resources/502734-

1129734318233/Reviewofproviderorganization-0730-Acceptanceofchanges.pdf (25.09.2009).

Ministry of Health and Ministry of Finance of PRC (2000): 医院药品收支两条线管理暂行办法 Provisional measures for managing the income by selling drugs and pharmaceutical expenditure through two ways. Beijing.

Ministry of Labor of PRC (1994): 企业职工生育保险试行办法 Interim Measures of Maternity Insurance for enterprise employees. Beijing.

Ministry of Land and Resources of PRC (2015): 2014 中国国土资源公报 Communique on land and recources of China 2014. Beijing.

Ministry of Public Security of PRC (2001): 对同性之间以钱财为媒介的性行为定性处理问题的批复 Reply on the definition of money-mediated homosexual behaviours. Beijing.

Moore, Barington (1966): *Social origins of dictatorship and democracy: Lord and Peasant in the Making of the Modern World*. Boston: Beacon Press.

National Bureau of Statistics of China (2013): *2012 年全国农民工监测调查报告 Report on the nationwide survey of rural-to-urban migrants of 2012*. Retrieved from: http://www.stats.gov.cn/tjsj/zxfb/201305/t20130527_12978.html (09.09.2013).

National Health and Family Planning Commission of PRC (2007): 关于切实加强流动人口计划生育工作的意见 Suggestions on strengthening family planning among floating population. Beijing.

National Population and Family Planning Commission (2003): 流动人口计划生育管理和服务工作若干规定 Some regulations on management and service of family planning among floating population. Beijing

National Population and Family Planning Commission (2007a): 关于印发《流动

人口、农民工计划生育便民维权措施》的通知 Notice on publishing and distribution of the "Measures for convenience and right protection of floating population and migrant workers in resprect to family planning". Beijing.

National Population and Family Planning Commission (2007b): 关于切实加强流动人口计划生育工作的意见 Suggestions on strengthening family planning among floating population. Beijing

North, Douglass C. (1990): *Institutions, institutional change and economic performance*. New York: Cambridge University Press.

North, Douglass C. (1993): Institutions and credible commitment. *Journal of Institutional and Theoretical Economics 149*(1): 11-23.

North, Douglass. C. & Thomas, Robert Paul (1973): *The Rise of the Western World: A New Economic History*. New York, Cambridge University Press.

North, Douglass C. & Weingast, Barry R. (1989): Constitutions and commitment: The evolution of institutions governing public choice in seventeenth century England.". *Journal of Economic History 49*(4): 803-832.

Pan, Suiming; Huang, Yingying; Wang, Jie & Liu, Zhongyi 潘绥铭;黄盈盈;王洁&刘中一 (2008): *"男客"的艾滋病风险及干预 Male clients' AIDS risks and intervention*. Gaoxiong: 万有出版社 Universal Press.

Pan, Suiming; Huang, Yingying; Wang, Jie; Zhang, Huixia; Yang, Rui; He, Wei; Liu, Zhenying & Zhang, Chunmeng 潘绥铭;黄盈盈;王洁;张慧霞;杨蕊;何为;刘振英&张春萌 (2005): *小姐：劳动的权利——中国东南沿海与东北城市的对照考察 Xiaojie: Their right to work - A comparative suvery in coastal area and northeastern cities in China*. Hong Kong:大道出版社 Dadao Press.

Pan, Suiming 潘绥铭 (2000): *生存与体验 Subsistence and experience.* Beijing: 中国社会科学出版社 China Social Science Press.

Pan, Suiming 潘绥铭 (2002): 无法回避的存在——透视“性产业”的存在形式 A unavoidable existence - on the existing forms of sex industry. *社会学家茶座 Teahouse for Sociologists* (1): 66-70.

Pejovich, Svetozar (1999): The effects of the interaction of formal and informal institutions on social stability and economic development. *Journal of Markets & Morality 2*(2): 164-181.

Pierson, Paul (2000): Increasing returns, path dependence, and the study of politics. *American Political Science Review 94*(2): 251-267.

Pierson, Paul (2004): *Politics in time: History, institutions, and social analysis*. Princeton: Princeton University Press.

Price Control Administration of Guangdong Province & Department of Health of Guangdong Province 广东省物价局&广东省卫生厅 (2009):《广东省医疗服务价格项目规范》修订项目 Standard of the prices of medical services (revised). Guangzhou.

Pun, Ngai. (2005): *Made in China: Women factory workers in a global workplace*. Durham and London: Duke Universtiy Press.

Pun, Ngai (2007): Gendering the dormitory labor system: Production, reproduction, and migrant labor in South China. *Feminist Economics 13*(3-4): 239-258.

Pun, Ngai (2012): Gender and Class: Women's working lives in a dormitory labor regime in China. *International Labor and Working-Class History 81*: 178-181.

Qu, Hongwei 屈宏伟 (2013): 调查称深圳流动人口超 1500 万 为户籍人口 5 倍. Retrieved from: http://www.chinanews.com/gn/2013/10-29/5434760.shtml (28.01.2015).

Rhodes, Rod A.W.; Binder, Sarah A. & Rockman, Bert A (2008): *The Oxford handbook of political Institutions* Oxford: Oxford University Press.

Richardson, Stephen A.; Dohrenwend, Barbara Snell; Klein, David, (1965): *Interviewing, its forms and functions*. New York: Basic Books.

Scharpf, Fritz W. (1997): Games real actors play: Actor-centered instituionalism in policy research. Boulder, Oxford: Westview Press.

Schnack, Hans-Christian & Yuan, Yuan. (2010). Regulating Migration in China. A Selection of Recent Policy Documents. *Migrants and Health in Urban China, Berliner China-Hefte 38*: 124-150.

Shang, Fang 尚芳 (2009): 流动妇女生育保险路在何方 Where is the way for maternity insurance of migrant women. *中国社会保障 China Social Security* (1): 50-52.

Shepard, Jon M. (2011): *Cengage advantage books: Sociology*. Belmont: Wadsworth.

Shi, Junxin; Shi, Shuhua; Zhang, Jing; Wang, Shaohai; Hu, Meirong; Su, Changmei;Ye, Ming & Peng, Dayuan 时俊新;石淑华;张静;王绍海;胡美荣;苏长梅;叶鸣&彭大元 (2000): 武汉市已婚女性流动人口人工流产状况调查分析 Analysis of the survey of the situation of abortion of married migrant women in Wuhan City. *中国妇幼保健 Maternal & Child Health Care of China 15*(11): 707-709.

Shi, Meng 史萌 (2009): 中国社区卫生服务的制度选择 Discussing the choices of institution for Chinese community health service. *中国卫生事业管理 Health Service Management* (4): 229-231,245.

Shi, Yanjun 史燕君 2013: 富士康烟台工厂：贵州帮与山东帮械斗 Foxxcon factory in Yantai: armed fight between Guizhou gang and Shandong gang. *国际金融时报 International Finance News (*24.09.2013). pp. 5.

Shieh, Shawn & Schartz, Jonathan (2009): State and society responses to China's social welfare needs - An introduction to the debate. In: Shieh, Shawn & Schartz,

Jonathan (eds.): *State and society responses to social welfare needs in China - Serving the people*. New York: Routledge. pp. 3-21.

Sociology Central UK (2010): Sociological research skills: Focused (semi-structured) Interviews. Retrieved from: http://www.sociology.org.uk/methfi.pdf (03.07.2010).

Solinger, Dorothy J. (1999): *Contesting Citizenship in Urban China: Peasant Migrants, the State, and the Logic of the Market*. Berkeley, University of California Press.

Song, Juan & Shi, Jianyong 宋娟&史健勇 (2009): 论我国生育保险制度的完善 On improvement of maternity insurance system in China from the perspective of child-bearing and child-rearing. *科学决策 Scientific Desicion Making* (7): 55-61.

Standing Committee of the National People's Congress (1994): 中华人民共和国劳动法 Labor Law of the People's Republic of China. Beijing.

Standing Committee of the National People's Congress (2010): 中华人民共和国社会保险法 Social Insurance Law of the Pepole's Republic of China. Beijing.

Standing Committee of the People's Congress of Guangdong Province (2008): 广东省人口与计划生育条例 Regulation of Guangdong Province on Population and Family Planning. Guangzhou.

Standing Committee of the People's Congress of Sichuan Province (2007): 四川省人口与计划生育条例 Regulation of Sichuan Province on Population and Family Planning. Chengdu.

State Council of AIDS Prevention and Control Working Committee; Publicity Department of the Communist Party of China Central Committee; Ministry of Labor and Social Security (2005): 关于联合实施全国农民工预防艾滋病宣传教育工程的通知 “Notice on cooperative implementation of national AIDS education campaign targeting migrant workers”. Beijing.

State Council of PRC (1986): 中华人民共和国治安管理处罚条例 Regulations of the People's Republic of China on Administrative Penalties for Public Security. Beijing

State Council of PRC (1998): 民办非企业单位登记管理暂行条例 Interim Regulations on Registration Administration of Private Non-enterprise Units. Beijing.

State Council of PRC (2002): 社会抚养费征收管理办法 Measures for Administration of Collection of Social Maintenance Fees. Beijing.

State Council of PRC (2006a):艾滋病防治条例 Regulations on AIDS prevention and treatment". Beijing

State Council of PRC (2006b): 关于印发《中国遏制与防治艾滋病行动计划（2006-2010）》的通知 "Notice on publishing and distribution of 'China's Action Plan to Prevent and Control AIDS (2006-2010)". Beijing

State Council of PRC (2012): 女职工劳动保护特别规定 The special regulation on labor protection of female employees. Beijing.

Statistics Bureau of Guangdong Province & Survey Office of the National Bureau of Statistics in Guangdong, 广东统计局/国家统计局广东调查总队 (2013): *广东统计年鉴 2013 Guangdong statistical yearbook 2013*. Beijing: 中国统计出版社 China Statistics Press.

Stiglitz, Joseph E. & Walsh, Carl E. (2002): *Economic*. New York: W. W. Norton & Company.

Stiller, Sabina (2010): *Ideational Leadership in German Welfare State Reform: How Politicans and Policy Ideas Transform Resilient Institutions*. Amsterdam, Amsterdam Universtiy Press.

Strauss, Anselm L. & Corbin, Juliet M. (1990): *Basics of qualitative research: Grounded theory procedures and techniques*. California: Sage Publications.

Streeck, Wolfgang (1997): Beneficial constraints: On the economic limits of rational voluntarism. In: Hollingsworth, J. Rogers & Boyer, Robert (eds.): *Contemporary capitalism: The embeddedness of institutions*. New York: Cambridge University Press. pp. 197-219.

Streeck, Wolfgang & Thelen, Kathleen (2005): Introduction: Instituional change in advanced political economies. In: Wolfgang Streeck & Kathleen Thelen (eds.): *Instituional change in advanced political economies.* Oxford: Oxford University Press. pp. 1-39.

Su, Qi 苏奇 (2014): 35%外来工性压抑:建筑工中同性性行为比例高 35% migrants have sexual depression: high homosexual behaviors among construction migrant workers. *厦门晚报 Xiamen Evening Paper (*18.11.2014), p. A4.

Taylor, Guy (2011): *China's floating migrants: Updates from the 2005 1% population sample survey*. London: Migration Studies Unit, London School of Economics and Political Science.

Thatcher, Mark (2007): *Internationalisation and Economic Institutions: Camparing European Experiences*. Oxford & New York, Oxford University Press.

Thatcher, Mark, & Coen, David (2008): Reshaping european regulatory space: An evolutionary analysis. *West European Politics 31*(4): 806-836.

Thelen, Kathleen (2003): How institutions evolve: Insights from comparative historical analysis. In: Mahoney, James & Rueschemeyer, Dietrich (eds.): *Comparative historical analysis in the social sciences*. Cambridge: Cambridge University Press. pp. 208-240.

Thelen, Kathleen & Steinmo, Sven (1992): Historical institutionalism in comparative politics. In: Steinmo, Sven; Kathleen Thelen & Frank Longstreth (eds.): *Structuring politics: Historical institutionalism in comparative analysis*. Cambridge: Cambridege Universtiy Press. pp. 1-32.

Tipping, Gill & Segall, Malcolm (1995): *Health care seeking behaviour in developing countries: An annotated bibliography and literature review*. Brighton: Institute of Development Studies at the University of Sussex.

Trevaskes, Susan (2010): Policing serious crime in China: From 'strike hard' to 'kill fewer'. Abingdon/New York: Routlege.

Troyer, Ronald J. & Rojek, Dean G. (1989): Introduction. In: Troyer, Ronald J.; Clark, John P.; Rojek, Dean G. (eds.): *Social Control in the People's Republic of China*. New York, Westport, London: Praeger. pp. 4-10.

Tsai, Lily L. (2002): Cadres, temple and lineage instituions, and governance in rual China. *The China Journal* (48): 1-27.

Tucker, Joseph D.; Henderson, Gail E.; Wang, Tian F.; Huang, Ying Y.; Parish, William; Pan, Sui M.; Chen, Xiang S. & Cohen, Myron S. (2005): Surplus men, sex work, and the spread of HIV in China. *AIDS* (19): 539-547.

Tucker, Joseph; Ren, Xin & Sapio, Flora (2010): Incarcerated sex workers and HIV prevention in China: Social suffering and social justice countermeasures. *Social Science & Medicine* (70): 121-129.

Tung, Wei-Chen (2010): Doing the month and Asian cultures: Implications for health care. *Home Health Care Management & Practice 22*(5): 369-371.

Walder, Andrew G. (1986): *Communist Neo-Traditionalism: Work and authority in Chinese industry*. Berkeley: University of California Press.

Wang, Dingding 汪丁丁 (2005): 医生、医院、医疗体制改革. Doctors, hospitals, and reform of the medical system. Retrieved from: http://www.usc.cuhk.edu.hk/wk_wzdetails.asp?id=4635 (21.11.2005).

Wang, Dong; Gao, Yang & Chen, Liming 王冬;高杨&陈立明(2009): 广州市某区“城中村”内原住村民与外来人口卫生服务需求与利用调查 Demand and

utilization for health service in the native inhabitiants and the non-native inhabitants in village-in-city of the district in Guangzhou. *Modern Preventive Medicine 现代预防医学, 36*(4), 662-666.

Wang, Jinling 王金玲 (2004): 商业性性服务/消费者：一种新的命名 Commercial sex provider/consumer: the new names. *浙江学刊 Zhejiang Academic Journal* (4): 202-211.

Wang, Jufen 王菊芬 (1999): 上海市流动人口未婚先孕妇女的性行为、避孕方法使用以及怀孕结果选择 Sexual behavior, contraceptive use, and pregnancy outcome of unmrried migrant women in Shanghai. *人口研究 Population Research 23*(1): 50-55.

Wang, Junqiu 王俊秋 (2012): 论新生代女性流动人口生育保险权利的保护 On the protection of maternity insurance rights of newborn of floating female population. *山东女子学院学报 Journal of Shandong Women's University* (1), 20-24.

Wang, Shitao & Yang, Haitao 王世涛&杨海涛 (2012): 违法者人格尊严的法律保护——以"扫黄"行动中曝光性交易者为例 Legal protection of the dignity of law offenders - the incidence of public exposure of sex dealers. *法治研究 Research on Rule of Law* (5): 40-45.

Wang, Weibing; Wei, Chongyi; Buchholz, Michelle E.; Martin, Maria C.; Smith, Brian D.; Huang, Z. Jennifer; & Wong, Frank Y. (2010): Prevalence and risks for sexually transmitted infections among a national sample of migrants versus non-migrants in China. *International Journal of STD & AIDS 21*(6): 410-415.

Wang, Yaping, & Wang, Yanglin (2008): Housing and migrants in cities. In: Murphy, Rachel (ed.): *Labour migration and social development in contemporary China*. London&New York: Routledge. pp. 137-153.

Wang, Ying; Yao, Wen; Shang, Meili; Cai, Yong; Shi, Rong; Ma, Jin, Wang, Jin & Song, Huijiang (2013): Sexual and reproductive health among unmarried rural-

urban female migrants in Shanghai, China: A Comparative Analysis. *International Journal of Environmental Research and Public Health 10*(8): 3578-3589.

Wei, Wenxuan 魏文轩 (2015): "民工潮"的社会影响及对策研究 Research on the social influence and counterstrategies of the "migrant labor wave". *产业与科技论坛 Industrial & Science Tribune 14*(14): 5-6.

Weishaupt, Joerg Timo (2008): *The Emergence of A New Labor Market Policy Paradigm? Analyzing Continutity and Change in An Intergrating Europe*. Parkway, University of Wisconsin-Madison.

Williamson, Deanna L. (2000): Health behaviours and health: evidence that the relationship is not conditional on income adequacy. *Social Science & Medicine 51*(12): 1741-1754.

Wilsford, David (1994): Path dependency, or why history makes it difficult but not impossible to reform health care systems in a big way. *Journal of Public Policy 14*(3): 251-283.

Wong, William C.W., MB ChB, FRCGP, Tam, Siumi Maria, Leung, Phil W.S., & BSocSc. (2007). Cross-Border Truck Drivers in Hong Kong: Their Psychological Health, Sexual Dysfunctions and Sexual Risk Behaviors. *Journal of Travel Medicine, 14*(1), 20-30.

World Bank (2015): Fertility rate, total (births per woman). Retrieved from: http://data.worldbank.org/indicator/SP.DYN.TFRT.IN. (10.12.2015).

World Bank (2006): China: Research Report on Gender Gaps and Poverty Reduction. Retrieved from: http://documents.worldbank.org/curated/en/882321468019170235/China-Research-report-on-gender-gaps-and-poverty-reduction (10.10.2016).

World Health Organisation (a): WHO definition of health. Retrieved from: http://www.who.int/about/definition/en/print.html (12.08.2013).

World Health Organisation (b): Sexual and reproductive health. Retrieved from: http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/ (29.08.2014).

Wu, Qiong; He, Nai; Gu, Ping & Xu, Lei (2007): 上海市某区女性流动人口对性病艾滋病卫生服务利用的现状调查 Status quo of health service utilization of STD/HIV among migrant women in a district of Shanghai. *中国健康教育 Chinese Journal of Health Education 27*(7): 518-520.

Xia, Guomei & Yang, Xiushi 夏国美&杨秀石 (2005): 商业性性交易者爱滋病认知、态度与行为调查 Survey on commercial sex dealers' AIDS knowledge, attitute and behaviors. *社会 Society* (5): 167-187.

Xiang, Bing; Cao, Jinhong & He, Hancheng 向兵;曹金红&何翰成 (2010): 武汉市建筑工人性行为特征及安全套使用情况与干预效果分析 Analysis of the charateristics of construction migrant workers' sexual behaviors, their comdom usage and the effect of intervention. *公共卫生与预防医学 Journal of Public Health and Preventive Medicine 21*(3): 115-117.

Xiang, Chunhua 向春华 (2010): 广州生育保险现状调查 Survey on the maternity insurance in Guangzhou. *中国社会保障 China Social Security* (8): 15-16.

Xiao, Suowei (2015): Class, gender and globalized intimacy: The second-wife phenomenon in Greater China. In: Wang, Jenn-hwan (ed.): *Border crossing in greater China: Production, community and identity.* London and New York: Routledge. pp. 173-186.

Xiao, Xianwu 肖贤武 (2001): 外来流动人口社区卫生保健需求初探 On the rural to urban migrants' health needs in communities. *卫生软科学 Soft Science of Health 15*(2): 39-41.

Xie, Zhenming & Tang, Mengjun (2011): From population control to reproductive health: Evolution of China's family planning program. In: Kaining Zhang (ed.): *Sexual and reproductive health in China: Reoienting concepts and methodology*.

Leiden. pp. 1-36.

Xu, Jie 徐杰 (1998): 从药品回扣谈起 On medicine rebates. *International Medical & Health Guidance News 国际医药卫生导报* (1): 33-34.

Xu, Jinling; Sun, Lihua & Li, Xuan 徐金玲;孙利&李轩 (2009): 我国城市社区卫生服务存在的问题与对策探讨 The discussion of problems and countermeasures of health services in the national urban community. *中国医药技术经济与管理 Chinese Journal of Pharnaceutical Technology Economics and Management 3*(3): 73-77.

Xu, Nan 徐楠: 底层性工作者生存安全调查 Survey on the security of low-level sex workers. *南方周末 Southern Weekly* (05.05.2008). p. A08.

Xu, Xiaoyin; Yang, Yanjun & Xu, Huifang 许晓茵;杨燕君&徐慧芳 (2007): 高档娱乐场所服务小姐艾滋病相关因素研究 Correlation of AIDS and prostitutes in high-class rnterainment centers. *热带医学杂志 Jouranl of Tropical Medicine 7*(6): 610-611.

Yang, Caibu; Zhang, Fulin; Li, Shiping & Chen, Yan 杨才布;张福林;李世平&陈妍 (2003): 深圳市市属医院药品收支两条线管理的效果评价 Evaluation of the outcome of the divided management on medicine incomings and outgoings in municipal hospitals in Shenzhen. *中国医院统计 Chinese Journal of Hostital Statistics 10*(4): 209-212.

Yang, Gaosheng; Yang, Peng & Li, Xiuyun 杨高升;杨鹏&李秀云 (2015): 建筑工人流动性对施工安全水平的影响分析 Analysis on influence by liquidity of construction workers to construction safety level. *中国安全生产科学技术 Journal of Safety Science and Technology (11):* 116-120.

Yang, Jun; Guo, Aimin; Wang, Yadong; Zhao, Yali; Yang, Xinhua; Li, Hang; Duckitt, Roger & Liang, Wannian (2008): Human resource staffing and service functions of community health services organizations in China. *Annals of Family*

Medicine 6(5): 421-427.

Yang, Tuan & Shi, Yuxiao (2006): Governance and regulation: an alternative to the stalemate in health reform program in China. *Social sciences in China 27*(3): 117-133.

Yang, Yansui & Yang, Dan (2009): Community health service centers in China, not always trusted by the population they serve? *China Economic Review* (20): 620-624.

Young, H. Peyton (1998): *Individual strategy and social structure: An evolutionary theory of institutions.* Princeton: Princeton University Press.

Young, Jason (2011): China's changing hukou system: Institutional objectives, formal arrangements, and informal practices. In: Huang, Xiaoming (ed.): *The institutional dynamics of China's great transformation*. London & New York, Routledge: 130-151.

Zeng, Yuyun; Wei, Huangzhong & Xu, Meihao 曾玉云;魏煌忠&徐美好 (2005): 流动人口生殖健康状况分析 Analysis of floating population's reproductive health. *现代预防医学 Modern Preventive Medicine 32*(1): 53-54.

Zhan, Shaohua (2005): *Rural labour migration in China: Challenges for policies*. Paris: United Nations Educational, Scientific and Cultural Organisation.

Zhan, Shaokang; Sun, Zhenwei & Bals, Erik (2002): Economic transition and maternal health care for internal migrants in Shanghai, China. *Health Policy and Planning 17*(1): 47-55.

Zhang, Hanyu 张含宇 (2008): 非正式制度与经济体制变迁—一个新制度主义的研究框架 System and economy mechanism transition-a new mechanism's research frame. *特区经济 Special Zone Economy* (9): 29-31.

Zhang, Hongyan & Han, Yuehong 张红艳&韩跃红 (2009): 艾滋病防控中的一个

热点问题探讨-从生命伦理学视角驳卖淫合法 Disscussions on a hotspot in the prevention and control of AIDS-Refuting the legalization of prostitution from bio-ethical perspective. *昆明理工大学学报社会科学版 Journal of Kunming University of Science and Technology 9*(2): 70-78.

Zhang, Jing 张荆 (2012): 卖淫女性被害及社会保护研究 Murders of female prostitutes and social protection. *青少年犯罪问题 Issues on Juvenile Crimes and Delinquency* (6): 44-48.

Zhang, Junhua (2003): Der Aufbau eines sozialen Sicherungssystems in der VR China - eine kritische Betrachung (Teil 2). *China Aktuell* (8): 986-990.

Zhang, Kaining (2011): *Sexual and reproductive health in China: Reorienting concepts and methodology*. Leiden: Koninklijke Brill NV.

Zhang, L.; Zhao, Simon X.B. & Tian, J.P. (2003): Self-help in housing and chengzhongcun in China's urbanization. *International Journal of Urban and Regional Research 27*(4): 912-937.

Zhang, Meifang; Liu, Bing & Lu, Weihong 章梅芳;刘兵&卢卫红 (2009): "坐月子"的性别文化研究 A gender study on "childbed confinement". *广西民族大学学报 (哲学社会科学版) Journal of Guangxi University for Nationalities (Philosophy and Social Science Edition) 31*(6): 51-59.

Zhang, Xubin; Rou, Keming & Wu, Zunyou 张旭彬;柔克明&吴尊友 (2006): 从社会视角看城市街头暗娼艾滋病高危行为 On the high-risk behaviors of street-standing prostitutes from a social perspective. 实用预防科学 *Practical Preventive Medicine 13*(4): 1060-1061.

Zhao, Meng 赵孟 (2015): 中国实施"全面两孩"政策,每年或新增人口 300-800 万. The popoulation may increase of three to eight millions per year because of the nationwide implementation of the "two-children" policy. Retrieved from: http://www.thepaper.cn/newsDetail_forward_1390564 (03.11.2015).

Zheng, Gongcheng & Huang-Li, Ruolian 郑功成&黄黎若莲 (2007): *中国农民工问题与社会保护 Rural-Urban Migrant Workers in China: Issue and Social Protection*. Beijing: 人民出版社 People's Publishing House.

Zheng, Gongcheng & Lu, Quan 郑功成&鲁全 (2007): 农民工疾病与医疗保障 Problems of medical-care insurance for migrant workers from countryside. In: Chen, Jiagui & Wang, Yanzhong 陈佳贵/王延中 (eds.): *中国社会保障发展报告 No. 3: 转型中的卫生服务与医疗保障 China Social security system development report No. 3 - Health service and medical security system in the process of economic transformation in China*. Beijing: 社会科学文献出版社 Social Sciences Academic Press. pp. 138-157.

Zheng, Tao 郑涛 (2011): 产妇"坐月子"传统行为现状与健康教育对策 Parturient woman's "passing first month after childbirth": conventions and health education. *中国性科学 The Chinese Journal of Human Sexuality 20*(2): 21-23.

Zheng, Zhenzhen; Lu, Ciyong & Lu, Liming (2013): Reproductive health and access to services among rural-to-urban migrants in China. United Nations Research Institute for Social Development.

Zheng, Zhenzhen; Zhou, Yuan; Zheng, Lixin; Yang, Yuan, Zhao, Dongxia; Lou, Chaohua & Zhao, Shuangling (2001): Sexual behaviour and contraceptive use among unmarried, young women migrant workers in five cities in China. *Reproductive Health Matters 9*(17): 118-127.

Zhou, Daming; Zhou, Jianxin & Liu, Zhijun 周大鸣;周建新&刘志军 (2007): "自由"的都市边缘人——中国东南沿海散工研究 The "free" men on the brink in the cities- research of Sangong in southeastern coastal areas in China. Guangzhou: 中山大学出版社 Sun Yat-sen University Press.

Zhou, Daming, & Zhou, Jianxin 周大鸣/周建新(2006a): "自由的都市边缘人"——东南沿海散工研究（二）*The "free men on the brink in the cities" - research of Sangong in southeastern coastal areas (part 2)*. *西南民族大学学报（人文社科版）*

Journal of Southwest University for Nationalities (9): 1-12.

Zhou, Daming, & Zhou, Jianxin 周大鸣/周建新. (2006b). “自由的都是边缘人——东南沿海散工研究”（一）*The "free men on the brink in the cities" - research of Sangong in southeastern coastal areas (part 1)*. *西南民族大学学报（人文社科版）Journal of Southwest University for Nationalities* (8): 8-17.

Zhou, Daming 周大鸣 (1997): Investigative analysis of "migrant odd-job workers" in Guangzhou. In: Guldin, Gregory Eliyu (ed.): *Farewell to peasant China - Rural urbanization and social change in the late twentieth centrury*. New York: M.E. Shapre, Inc. pp. 277-240.

Zhou, Daming 周大鸣 (2005): 渴望生存——农民工流动的人类学考察 Desire to survive - A anthropoligic suvery of peasent workers' mobility. Guangzhou: 中山大学出版社 Sun Yat-sen University Press.

Zhou, Jinghao (2006): Chinese prostitution: Consequences and solutions in the post-mao era. *China: An International Journal 4*(2): 238-262.

Zhou, Pei 周沛 (1995): 建立三元社会结构是促成“民工潮”有序流动的战略抉择 Building of a ternary social structur is a strategic choice to improve the "wave of migrant labors". *南京社会科学 Social Sciences in Nanjing*(10), 45-50.

Zhou, Yuhua & Ma, Qishan 邹宇华&马起山 (2009): 社区公共卫生服务项目、成本及补偿现状 The state of the items, cost and compensation of community public health service. *中国社会医学杂志 Chinese Journal of Social Medicine 26*(2): 87-89.

Zhu, Demi 朱德米 (2007): 理念与制度: 新制度主义政治学的最新进展 Ideas and system: the newest progress of the new institutionalist political science. *国外社会科学 Social Sciences Abroad* (4): 29-33.

Zhu, Jiangang 朱健刚(2007): 国际 NGO 与中国地方治理创新—以珠三角为例

International NGO and the innovation of China's local governance. *开放时代 Open Times* (5): 34-49.

Zhu, Nong; Batisse, Cecile & Li, Qin (2009): The flow of "peasant workers" in China since the economic reform: a longitudinal and spatial analysis. Retrieved from: http://cerdi.org/uploads/sfCmsContent/html/317/Zhu_Batisse.pdf (09.10.2010).

Zhu, Yun 朱芸 (2010): 从"治未病"理论谈中国特色"坐月子" From"zhiweibing" theory with Chinese Characteristics to "puerperium care". *辽宁中医药大学学报 Journal of Liaoning University of TCM 12*(11): 97-98.

Zhuang, Kongshao & Zhao, Shiling 庄孔韶&赵世玲 (2009): 性服务者流动的跨国比较研究与防病干预实践 Comparative study on sex Workers' cross-border migration and prevention/intervention practices *中国农业大学学报（社会科学版） Journal of China Agricultural University (Social Sciences Edition) 26*(1): 22-33.

Zou, Yuhua; Wu, Xiaojia; Cheng, Xiaoming; Zou, Zongfeng & Chu, Huizhu 邹宇华;巫小佳;程晓明;邹宗峰&楚慧珠 (2005): 广东省社区卫生服务成本及补偿现状研究 A study on the state of cost and compensation of community health service in Guangdong Province. *中国全科医学 Chinese General Practice 8*(13): 1109-1111.

Appendix I. Interview list

Semi-structured interviews with migrant women between November 2007 and January 2008 in urban villages in Guangzhou

Decoding	Interviewee			
	Age	Occupation	Education	Home Province/Town
07/Chebei/2	34	Food vendor	Elementary school	Guangdong/Huizhou
08/Chajiao/11	27 or 28	Owner of a fruit store	Elementary school	Guangdong/Shantou
08/Chajiao/12	35	Owner of a clothing shop	illiterate	Hunan/Chenzhou
08/Haizhong/13	38	Department director of a small plastics	Senior middle school	Guangdong/Taishan
08/Haizhong/14	about 30	Employee of a small glass factory	UNK[44]	Guizhou/Zunyi
08/Chajiao/16	in her twenties	Member of a family owning a fruit store	Junior middle school	Guangdong/Shaoguan
08/Haizhong/17	34	Employee of a small plastics factory	Elementary school	Hubei
08/Chajiao/18	37	Grocer	Elementary school	Guangdong/Yingde
08/Chajiao/19	34	Grocer	Elementary school	Guangdong/Yingde
08/Lijiao/24	23	Waitress	Junior middle	Hunan
08/Lijiao/26	22	Warehouse guard	College	Sichuan
08/Lijiao/27	52	Unemployed	Elementary school	Anhui
08/Lijiao/28	34	Handicraftswoman	Elementary school	Guangdong/Shaoguan
08/Lijiao/29	in her twenties	Housewife	Junior middle school	Henan
08/Chajiao/33	30	Receptionist	UNK	Hunan
08/Tanwei/34	UNK	Grocer	UNK	Jiangxi
08/Tanwei/35	UNK	Waste collector	UNK	Sichuan
08/Tanwei/36	37	Secretary	UNK	Hunan

[44] UNK=unknown

08/Haizhong/44	about 40	Employee of a small plastics factory	UNK	Hunan/Chenzhou
08/Haizhong/45	in her forties	Employee of a small glass factory	University	Sichuan
08/Yong’an/46	38	Grocer	UNK	Guangdong,
08/Xiadu/48	25	Employee of a university	Senior middle school	Hubei/Zhijiang
07/Shipai/51	25	Employee of a international company	Bachelor	Guangdong/Meizhou
07/Xinfenghuang/52	27	beautician	UNK	Guangdong/Leizhou
	21	beautician	UNK	Guangdong/Donghai
07/Tangxi/E54	in her thirties	Gynaecologist (former) of public and private hospitals, also a migrant	Bachelor	Guizhou

Expert/stakeholder interviews between November 2007 and January 2008 and December 2008 in Guangzhou

Decoding	Interviewee	
	Gender	Profession
07/Tangxi/E54	Female	Gynecologist (former) of public and private hospitals, also a migrant from Guizhou Province
07/Tangxia/F55	Male	Physiotherapist of a red cross hospital in Yuexiu District, also a migrant from Guangdong Province
07/Changban/C	Male	Secretary and Chairman of Changban Economic Development Company, Tianhe District
07/Tianhe/M *	Female	Employee of Bureau of Agriculture, Water Resources and Forestry of Tianhe District
07/Ministry/N *	Male	Employee of Ministry of Labor and Security, Guangdong Province
07/Tianhe/A	Female	Employee of CDC of Tianhe District, Guangzhou
07/Tianhe/D	Male	Chair Director of a NGO
07/Baihedong/B	One male and one female (husband and wife)	Landlords of a flat in Baihedong Village, Liwan District
08/Tanwei/G	Female	Chairman of Women's Federation of Tanwei Village, Liwan District
	Male	Director of Bureau of civil affairs of Tanwei Village, Liwan District
	Female	Director of community cultural and physical activities of Tanwen Village, Liwan District
08/Chajiao/H	Female	Doctor of service center of family plan Bureau, Chajiaojie, Liwan District
08/Chajiao/P32	Male	Department director of a village-owned business center
08/Haizhong/J	Male	Director of health station of Haizhong Village, Zhongnanjie, Liwan District
08/Haizhong/L	Male	Vice-village head of Haizhong Village, Liwan District
08/Chajiao/K	Male	Director of health service community center of Qiaozhongjie, Liwan District

08/Chajiao/I	Male	Director of Chajiao Economic collective Community, Liwan District
08/Tianhe/J	One male and one female	Doctors of Sixth Affiliated Hospital of Sun Yat-sen University
08/Yuexiu/K	Male	Primary care physician of a community health care service center in Yuexiu District
08/Liwan/O	One male and one female	Doctors of the people’s hospital of Liwan District

* These interviews were not voice-recorded.

Semi-structured interviews with female sex workers in Shenzhen on September and October 2009

Decoding	Working site (District, location)	Age	Education	Home province
FSW/01	SZ, brothel	20	Elementary school (unfinished)	Sichuan
FSW/02	SW, leisure center	UNK	Senior middle school (finished)	Sichuan
FSW/03	SW, night club	about 35	UNK	Guizhou
FSW/04	SW, night club	24	UNK	Fujian
FSW/05	SZ, brothel	17	Senior middle school (unfinished)	Guangdong
FSW/06	SZ, Leisure center	20	Junior middle school (unfinished)	Hunan
FSW/07	SW, hair salon	27	Junior middle school (finished)	Hunan
FSW/08	SW, brothel	18	Junior middle school (unfinished)	Henan
FSW/09	SW, hair salon	18	Junior middle school (finished)	Hunan
FSW/10	SZ, brothel	18	Junior middle school (unfinished)	Guangdong
FSW/11	SW, hair salon	20	Junior middle school (finished)	Henan
FSW/12	SZ, hair salon	22	Junior middle school (finished)	Henan
FSW/13	SZ, brothel	22	Junior middle school (unfinished)	Jiangxi
FSW/14	SW, KTV	22	Junior middle school (finished)	Hubei
FSW/15	SW, hair salon	21	Junior middle school (finished)	Yunnan
FSW/16	SW, hair salon	22	Junior middle school (finished)	Hunan
FSW/17	SW, brothel	22	illiterate	Jilin
FSW/18	SZ, brothel	20	Senior middle school	Fujian

			(unfinished)	
FSW/19	SZ, brothel	20	Elementary school (finished)	Hubei
FSW/20	SW, KTV	23	Junior middle school (unfinished)	Henan
FSW/21	SW, beauty salon	19	Junior middle school (unfinished)	Chongqing
FSW/22	SW, hair salon	21	Junior middle school (unfinished)	Chongqing
FSW/23	SW, hair salon	22	Senior middle school (finished)	UNK
FSW/24	SW, hair salon	22	Junior middle school (unfinished)	UNK
FSW/25	SW, KTV	18	Junior middle school (finished)	Chongqing
FSW/26	SW, KTV	UNK	UNK	Guangdong
FSW/27	SZ, brothel	18	Junior middle school (finished)	Sichuan
FSW/28	SW, KTV	21	Junior middle school (finished)	Hunan
FSW/29	SW, night club	24	Elementary school (finished)	Jiangxi
FSW/30	SW, beauty salon	20	Junior middle school (finished)	Hunan

One aadditional **expert-interview** in phase two with two employees of the Institute of Population and Family Planning of Shenzhen City, who engaged in a community-based AIDS-prevention program, organized and financed by the Hong Kong NGO “AIDS Care” from 2006 to 2009. This interview is coded with “NGO/Shenzhen”.

Appendix II. Guideline for semi-structured interviews with migrants in urban villages

A. 被访者的基本情况
－ 被访者的姓名、年龄、学历、职位、地缘出处

B. 谈自己在城中村中的居住情况
－ 到广州来的原因、居住城中村的原因
－ 在此村的居住情况（住什么样的房子？已经了居住了多久？）
－ 在到目前居住地居住之前，还住过什么地方？
－ 如果住在出租屋，出租屋多大？自己租还是合租？是和朋友，还是和家人住？
－ 如果住出租屋，通过什么方式得到信息（朋友介绍？房屋中介？地方社区帮助找房？）
－ 为什么会住在这个地方？（离上班地方近、租金便宜？）
－ 每个月挣多少钱？租房每月花多少钱？除了住房和吃饭外，每月生活费还要花多少钱？都花在哪些方面？比例是多少？有剩余吗？剩余的钱怎么花？自己花，买些非日常用品，还是寄给家里？平均每次有多少钱？还是回家的时候一起拿给家里？
。除了住房吃饭外，还经常买些什么？干什么用？
－ 住处是否经常变动，多次时间变一次，搬到什么地方，曾经搬过几次？相距远不远？
－ 居住的基础设施怎样？
。水：有没有自来水？和屋主公用还是单独自来水？主要喝什么水？（自来水？饮水机？过滤过的水？）
。光线：出租屋里采光好吗？出租屋里照明设备怎样？（日光灯、一般灯泡或其他？）
。气温：夏天使用什么降温设备（完全没有降温设备，还是电风扇、空调？这些设备是屋主提供的还是自己买的？）
。噪音（有没有噪音问题？）
。卫生设施：用什么样的厕所？（蹲厕？坐厕？公用还是单独使用的？）用什么样的洗浴设备（淋浴、浴缸？公用还是单独使用的？）
。卫生情况（生活垃圾如何处理？）
。空气质量（城中村的空气质量和村外有没有区别？做饭油烟问题怎样？用煤气、电还是煤球？是不是有独立厨房？）

C.谈自己在城中村中的健康状况、健康策略和健康支持状况
－ 总的来说，你觉得你的健康状况怎样？
－ 和搬入城中村之前相比，你觉得你现在的健康状况是变好了还是变差了？原因是什么？
－ 你觉得城中村的生活环境对你的健康有影响吗？是好的还是坏的影响？原因是什么？

－ 你一般生什么病？
－ 如果生病（分为小病和重病），会怎么处理？（忍耐过去、自己买药、上社区健康中心、上私人诊所、上大医院？）这么处理的原因是什么？
－ 比较倾向于看西医还是中医？为什么？
－ 如果生病，有没有通过非正常的治疗手段处理？（如气功、求神拜佛等）
－ 如果上过私人诊所看病，当时的情况如何？（为什么会去？怎么得到诊所的信息？等）
－ 有没有医疗保险？是什么样的医疗保险？你觉得保险的保障够吗？
－ 有没有因为生病要回家乡医治的情况？会利用回家乡的机会治病吗？
－ 在你眼里，和当地相比，家乡的医疗服务怎样？
－ 有没有因为生病向家人、朋友、同事借钱医治的情况？
－ 去看病方便吗？买药方便吗？
－ 你觉不觉得生活的压力大？压力来自什么方面（家里人的期望值、个人的期望值等等）
－ 会常常感到寂寞吗？
－ 在广州的朋友多吗？寂寞或者感到郁闷的时候怎么办？
－ 是否参加或者关注当地的医疗活动（如传染病宣传、儿童免疫、义诊等）
－ 有没有努力保持健康或者让自己更健康？如果有，通过什么手段保持健康？
－ 你觉得目前的生活状况（工作状况、居住条件）对你的健康有什么影响（包括正面和负面的影响）？
－ 在广州的日常饮食怎么解决？（自己做、在工作单位吃、在餐馆吃？）三餐一般都吃什么？和在家乡相比，饮食上有什么变化？这些变化对你的健康有没有影响？（如水土不服？）
－ 收入和消费情况
。你每个月挣多少钱？
。租房每月花多少钱？吃饭花多少钱？平时吃的是什么？
。除了住房和吃饭外，每月生活费还要花多少钱？都花在哪些方面？比例是多少？
。有剩余吗？剩余的钱怎么花？自己花，买些非日常用品，还是寄给家里？多次时间寄一次，平均每次有多少钱？还是回家的时候一起拿给家里？
。除了住房吃饭外，他们还经常买些什么？干什么用？

D. 谈城中村中其他外来人口的居住状况、健康情况和健康策略
－ 当地居民共多少？其中外来人口多少？为什么外来人口聚居于这个社区？
－ 来自什么地方？是否是同乡？还是来自四面八方？
－ 是有组织的形式（如包工队、工程队等），还是松散的形式（如结伴而行），还是家庭形式，还是松散的（单个人）？
－ 性别构成、性别比例?
－ 年龄（那个年龄比重大？规模如何？人数多少？）
－ 外来人员的教育水平（教育程度，上过几年级）？
－ 从事什么样的职业？
－ 外来人员住在哪些地方（地理上的）？当地有没有外来人员聚居的地方？在城中村改造过程中，是否已经或者将要划分当地居民居住区和针对外来人口出租公寓区？
－ 住什么样的房子（公寓、宿舍、出租屋、没有地方住等）
－ 如果租出租屋，通过什么方式得到信息（朋友介绍？房屋中介？地方社区

帮助找房？）
－ 外来人口租房最看重房子的什么？（租金高低、环境设施？）
－ 当地出租屋的租金是多少？环境设施和租金的关系如何？
－ 如果住在出租屋，出租屋多大？自己租还是合租？
－ 是一个人还是和朋友或者家人住在一起？
－ 住处是否经常变动，多次时间变一次，搬到什么地方，曾经搬过几次？相距远不远？
－ 从事的职业、收入和居住情况有什么关系？
－ 居住的基础设施怎样？
。光线：出租屋里采光好吗？出租屋里照明设备怎样？（日光灯、一般灯泡或其他？）
。气温：夏天使用什么降温设备（完全没有降温设备，还是电风扇、空调？这些设备是屋主提供的还是自己买的？）
。噪音（有没有噪音问题？）
。卫生设施：用什么样的厕所？（蹲厕？坐厕？公用还是单独使用的？）用什么样的洗浴设备（淋浴、浴缸？公用还是单独使用的？）
。卫生情况（生活垃圾如何处理？）
。空气质量（做饭油烟问题怎样？用煤气、电还是煤球？是不是有独立厨房？）
。饮水：是不是每家都有自来水？
－ 收入和消费情况
。您认识的外来人员每个月挣多少钱？
。租房每月花多少钱？吃饭花多少钱？平时吃的是什么？
。除了住房和吃饭外，每月生活费还要花多少钱？都花在哪些方面？比例是多少？
。有剩余吗？剩余的钱怎么花？自己花，买些非日常用品，还是寄给家里？多次时间寄一次，平均每次有多少钱？还是回家的时候一起拿给家里？
。除了住房吃饭外，他们还经常买些什么？干什么用？
－ 你感觉中的外来人身体是否健康？
－ 有没有什么不良的生活习惯（抽烟、喝酒、喝生水、不经常洗澡等）
－ 一般生什么病？
－ 如果生病（分小病和大病），会怎么处理？（忍耐过去、自己买药、上私人诊所、上大医院？）
－ 如果生病，有没有通过非正常的治疗手段处理？（如气功、求神拜佛等）
－ 比较倾向于看西医还是中医？为什么？
－ 怎么得到医疗机构（社区医疗点、私人诊所）的信息？
－ 有没有医疗保险？如果有，是什么样的医疗保险？
－ 会不会为了将来可能生病而存钱？（如买保险）
－ 他们会觉得生活的压力大吗？压力来自什么方面（家里人的期望值、个人的期望值等等）
－ 会常常感到寂寞吗？
－ 他们生病的时候会向家人、朋友、同事寻求帮助吗？
－他们平常遇到某些让人难受的事情，心理上有不舒服，或难受的感觉？怎么办？向谁倾诉？他们在感情上能够安慰家人/朋友吗？
－ 他们在感情上能够得到家人/朋友的安慰吗？
－ 当他们感情上需要别人安慰时，会找家人/朋友们吗？
－ 当他们生病的时候，会找家人/朋友帮助吗（比如借钱、互相介绍医生）？

— 有没有发生过因为生病、受伤回乡的事？如果有，当时是什么情况？
— 是否参加或者关注当地的医疗活动（如传染病宣传、儿童免疫、义诊等）
— 他们有没有小团体（老乡会、工会等）？怎样组织起来的？由谁组织的？主要做些什么事情？有什么活动？
— 如果有的外来人员出了什么事儿，不管是有病，还是受到了侵害，还是意外事故，他们是怎样解决的？通过什么方式解决？由谁牵头办的？

E. 村内的出租屋管理、环境及卫生医疗情况
— 当地哪些管理机构对当地外来人口进行管理？怎样管理？（暂住证政策？）
— 出租屋主把房子租给外来人员，有没有什么规定？（比如每平米可居住的人数的限制、居住环境的规定，如一定要有自来水、厕所、电灯等）这些规定又是怎么实施的？
— 达标出租屋有什么固定标准？达标出租屋和一般出租屋有什么不同？（房租上的差别？）
— 村内的生活垃圾如何处理？（是否有人专门收集？频率如何？什么人组织？费用谁承担？对居民有没有特殊的规定或处罚措施？如果有，居民遵守的情况如何）
— 废水如何处理？（费用谁承担？对居民有没有特殊的规定或处罚措施？如果有，居民遵守的情况如何）
— 公共道路卫生如何管理？（有人专门打扫？住户自己打扫？）
— 上级政府（如区政府、卫生局）有没有对当地卫生环境进行定期监督？
— 村内有以下哪些卫生医疗设施（是公立还是私立？）：药店、诊所、卫生点、保健站、公共厕所、公共浴室等。
— 采取什么样的方式进行卫生知识宣传？（如：宣传栏、上门宣传、卫生知识讲座？）宣传费用由谁承担？宣传哪些内容（如传染病、计划生育）？多长时间一次？参加者是谁（有没有外来人口参加）？
— 有没有提供免费的卫生服务？如果有，有哪些服务（如：免费发放避孕套、注射儿童预防针？预防针注射是不是强制性的）？其中有没有针对妇女、儿童的服务（如孕妇保健、预防针注射）有经费由谁承担？多长时间一次？参加者是谁？
— 当地有没有当地居民享受，但是外来人口却不能享受的福利和服务（尤其是卫生服务）？如果有，是哪些？
— 外来人口要得到卫生服务（比如在社区医疗诊所）有没有什么前提条件（如必须有某些特定证件，比如暂住证）
— 当地有没有专门针对流动人口的医疗服务或措施？如果有，费用由谁承担（免费、病人自己承担还是医疗保险承担）？
— 有没有居民参加医疗保险？如果有，是什么形式的？（合作医疗？公费医疗？医疗保险？商业医疗保险？）参加的居民比例有多少？外来人口有没有参加医疗保险？
— 当地政府（如区政府、村居委会、改制委员会）有没有针对外来人口的优惠政策？
— 居住的城中村有没有打算要改善当地的卫生环境？如果有，在哪些方面？费用谁承担？
— 当地对外来人口的政策在将来会不会有所改变？如果有，会有什么改变？（如接受外来人口参加合作医疗？）

F. 针对妇女和儿童健康的问题（针对妇女被访者）

－ 有没有接受过针对妇女的健康服务（如产褥期保健）？如果有，费用由谁承担？

－ 有没有参加生育保险？

－ （如被访者是母亲）当时生产的情况如何？（在哪里生产？费用多少？费用由谁承担？）

－ 有没有因为当地生产费用贵，而选择堕胎或是回乡生产的情况？

－ 孩子的整体健康状况怎样？和当地孩子相比呢？如果有差别，原因是什么？

－ 孩子有没有定期接受计划免疫？如果没有，为什么？如果有，信息从什么地方来？费用多少？费用由谁承担？

－ 你觉得在当地的生活环境对孩子的健康有没有影响？如果有，是什么影响？

Appendix III. Guideline for semi-structured interviews with female sex workers

A. 被访者的基本情况
－ 被访者的年龄、学历、地缘出处
－ 居住的情况（一个人住、几个人住、被人包养）

B. 谈自己或他人从事性工作的情况
－ 在做性工作者之前作过什么样的工作？
－ 当初为什么会开始从事性工作的工作？
－ 是怎样进入性工作这个职业的？（朋友、同乡介绍？）
－ 从事性工作有多长时间了？每天平均工作多少小时？具体有什么工作？每天接待客人的次数？
－ 从事性行业都在什么地方工作过？原因是什么？
－ 你从事性工作的收入如何？你怎样分配利用工作收入的？
－ 你所知道的（主要是在当地的）性工作者主要有哪些种类？（站街女、按摩技师、洗脚妹、下工棚的、二奶等？）你觉得她们之间有什么不同的地方？
－ 你打算从事性工作多长时间？将来有什么打算？

C. 谈健康状况、健康策略和健康支持状况

<u>总体健康评价</u>
－ 总的来说，你觉得你的健康状况怎样？
－ 和从事性工作之前相比你觉得你现在的健康状况是变好了还是变差了？原因是什么？
－ 你觉得从事性工作对你健康有什么影响吗？

<u>健康威胁、策略和支持</u>
－ 你和你的同事一般生什么病？（性病、乙肝等？）
－ 你所知道的和性工作相关的疾病是什么？你最担心的和从事性工作相关的疾病或者健康问题是什么？（具体的性病？怕怀孕？怕不能生育？）为什么会怕？
－ 为了预防生病或怀孕，你采用什么样的措施？（避孕套、避孕药、洗液等）怎样的得到相关的信息？（妈咪介绍？朋友、同事交流？其他机构的宣传？）
－ 如果怀孕了怎么办？（堕胎？）如堕胎，选择什么样的医疗机构？为什么？
－ 如果生病（分为平常病和性病），会怎么处理？（忍耐过去、自己买药、上社区健康中心、上私人诊所、上大医院？）这么处理的原因是什么？
－ 怎么得到诊所的信息？（妈咪介绍？朋友介绍？其他同事介绍？）
－ 生病时又没有得到过别人的指导（就医、吃药）和帮助（借钱等）？如果有，得到过什么人的帮助？
－ 你或你的同事是否有过被客人、鸡头伤害的情况？如果有，如何处理？（如报警？）
－ 你的同事里有没有吸毒的现象？如果被发现吸毒，会怎么处理？
－ 有没有努力保持健康或者让自己更健康？如果有，通过什么手段保持健康？

－ 当地有没有过医疗活动？（义诊、性病预防宣传等）是否参加或者关注当地的医疗活动？

心理健康

－ 平时主要和什么人交往？是否因为自己的工作性质有心理压力？
－ 是否定期或非定期回乡？回乡是否会暴露自己的工作性质？老家的家人、朋友怎么看待你的工作性质？他们的看法是否对你的心理带来影响？
－ 你觉得现在给你面临的最大的压力是什么？（个人的压力、外界的压力）？
－ 会不会感到寂寞？如果寂寞或者感到郁闷的时候怎么办？

C. 国际化、性工作者与性病、艾滋病预防
－ 主要的客人群体是哪些？（本地人、港澳客人、外国人？）比例多少？
－ 客人的职业、收入、社会地位情况如何？
－ 那些客人用避孕套的比例比较大？
－ 如果客人不愿意用避孕套怎么办？
－有没有“男朋友”？和男朋友发生性行为是否使用避孕套？
－ 如果发现自己患有性病，怎么办？是否继续接客？
－对艾滋病的理解如何？会不会因为担心传染上艾滋病不做性工作者？为什么？

Appendix IV. Guideline for interviews with local villagers and/or employees in administrative departments of urban villages

A. 被访者的基本情况

－ 被访者的姓名、年龄、学历、在此机构中的职位、在此机构工作的状况（已经工作了多久？全职还是兼职？每天工作多少时间？）

B. 当地医疗机构的情况

－ 当地有哪些医疗机构（诊所、医疗站、药店）？
－ 有没有专门治疗特殊疾病（如传染病）的医疗机构？
－ 哪些医疗机构吃香？这些医疗机构是私营的还是公立的？
－ 这些医疗机构是什么时候开始运营的？
－ 这些医疗机构能不能满足当地的医疗需求？
－ 这些医疗机构有没有得到国家或者地方的支持？
－ 村里医疗机构又没有和其他大型医疗机构（如大医院）开展合作（如义诊、无偿鲜血）？如果有，多长时间一次？由谁组织？由谁出资？参加的人是谁？有没有外来人口参加？
－ 有没有对当地的医疗机构进行定期监督？（如营业执照管理、卫生设施检查等等）
－ 对当地的医疗机构实行什么样的税收政策？
－ 这些机构有多少员工？
－ 这些员工受过多少专业培训？
－ 这些医疗机构的医疗器械和药品的来源如何？
－ 这些医疗机构的营业时间
－ 医生的诊断和治疗如何被记录下来？
－ 有没有专门针对流动人口的医疗服务？如果有，这些服务由谁提供？
－ 有没有针对专门群体（如妇女、儿童）的医疗服务。
－ 所提供的服务怎样结算？
－ 每天的门诊人数有多少？
－ 病人要得到医疗服务，有没有什么前提条件（如必须有某些特定证件）？
－ 有没有预防检查服务项目？如果有，是哪些项目？
－ 这些机构能治疗哪些病症？
－ 有没有专门治疗特殊疾病（如传染病）的医疗机构？
－ 有没有提供流动性服务的医疗机构？
－ 有没有打算要扩大服务提供的数量和质量？如果有，在哪些方面？
－ 会有病人被拒绝医治吗？

C. 当地卫生环境

－ 生活垃圾如何处理？（是否有人专门收集？频率如何？什么人组织？费用谁承担？对居民有没有特殊的规定或处罚措施？如果有，居民遵守的情况如何）
－ 废水如何处理？（费用谁承担？对居民有没有特殊的规定或处罚措施？如

果有，居民遵守的情况如何）
－ 公共道路卫生如何管理？（有人专门打扫？住户自己打扫？）
－ 上级政府（如区政府、卫生局）有没有对当地卫生环境进行定期监督？
－ 有没有打算要改善当地的卫生环境？如果有，在哪些方面？费用谁承担？

D. 卫生知识宣传和医疗保险
－ 采取什么样的方式进行卫生知识宣传？（如：宣传栏、上门宣传、卫生知识讲座？）宣传费用由谁承担？宣传哪些内容（如传染病、计划生育）？多长时间一次？参加者是谁（有没有外来人口参加）？
－ 有没有提供免费的卫生服务？如果有，有哪些服务（如：免费发放避孕套、注射儿童预防针？预防针注射是不是强制性的）？有经费由谁承担？多长时间一次？参加者是谁？
－ 有没有居民参加医疗保险？如果有，是什么形式的？（合作医疗？私人医疗？）参加的居民比例有多少？外来人口有没有参加医疗保险？

E. 当地外来人口的情况
a. 外来人口的数量和地缘状况
－ 当地居民共多少？其中外来人口多少？
－ 来自什么地方？是否是同乡？还是来自四面八方？
－ 是有组织的形式（如包工队、工程队等），还是松散的形式（如结伴而行），还是家庭形式，还是松散的（单个人）？
b. 外来人口的构成情况
－ 性别构成、性别比例
－ 年龄（那个年龄比重大？规模如何？人数多少？）

c. 外来人口的业缘情况
－ 从事什么样的职业？
－ 职业和年龄有关系吗？
－ 职业和性别有关系吗？

d. 外来人口的生活条件
－ 外来人员住在哪些地方（地理上的）？当地有没有外来人员聚居的地方？在城中村改造过程中，是否已经或者将要划分当地居民居住区和针对外来人口出租公寓区？
－ 住什么样的房子（公寓、宿舍、出租屋、没有地方住等）
－ 如果租出租屋，通过什么方式得到信息（朋友介绍？房屋中介？地方社区帮助找房？）
－ 外来人口租房最看重房子的什么？（租金高低、环境设施？）
－ 当地出租屋的租金是多少？环境设施和租金的关系如何？
－ 如果住在出租屋，出租屋多大？自己租还是合租？
－ 是一个人还是和朋友或者家人住在一起？
－ 从事的职业和居住情况有什么关系？
－ 居住情况怎样？
。水：有没有自来水？和屋主公用还是单独自来水？
。光线：出租屋里照明设备怎样？（日光灯、一般灯泡或其他？）
。气温：夏天使用什么降温设备（完全没有降温设备，还是电风扇、空调？这些设备是屋主提供的还是自己买的？）

。卫生设施：用什么样的厕所？（蹲厕？坐厕？公用还是单独使用的？）用什么样的洗浴设备（淋浴、浴缸？公用还是单独使用的？）
。空气质量（做饭油烟问题怎样？用煤气、电还是煤球？是不是有独立厨房？）
。饮水：是不是每家都有自来水？还是有其他的水源（如桶装水、过滤水等）？

e. 外来人口的健康状况、卫生习惯和就医方式
－ 你感觉中的外来人身体是否健康？
－ 有没有什么不良的生活习惯（抽烟、喝酒、喝生水、不经常洗澡等）
－ 一般生什么病？
－ 如果生病，会怎么处理？（忍耐过去、自己买药、上私人诊所、上大医院？）
－ 工作场所有没有医疗服务？如果有，费用怎么支付？
－ 有没有参加医疗保险？如果有，是哪种形式的医疗保险？
－ 如果有慢性病怎么办？有哪些慢性病？
－ 是否参加或者关注当地的医疗活动（如传染病宣传、儿童免疫等）
－ 当地的外来人口有没有小团体（老乡会、工会等）？怎样组织起来的？由谁组织的？主要做些什么事情？有什么活动？
－ 如果有的外来人员出了什么事儿，不管是有病，还是受到了侵害，还是意外事故，他们是怎样解决的？通过什么方式解决？由谁牵头办的？

f. 收入情况
－ 您认识的外来人员每个月挣多少钱？
－ 租房每月花多少钱？吃饭花多少钱？平时吃的是什么？
－ 除了住房和吃饭外，每月生活费还要花多少钱？都花在哪些方面？比例是多少？
－ 有剩余吗？剩余的钱怎么花？自己花，买些非日常用品，还是寄给家里？多次时间寄一次，平均每次有多少钱？还是回家的时候一起拿给家里？
－ 除了住房吃饭外，他们还经常买些什么？干什么用？

g.当地对外来人口的管理和医疗政策
－ 对当地外来人口怎么管理？（暂住证政策？）
－ 出租屋主把房子租给外来人员，有没有什么规定？（比如每平米可居住的人数的限制、居住环境的规定，如一定要有自来水、厕所、电灯等）这些规定又是怎么实施的？
－ 外来人口要得到卫生服务有没有什么前提条件（如必须有某些特定证件）
－ 如果当地有免费的卫生服务，外来人口能不能享受和当地人一样享受？
－ 对外来人口的政策在将来会不会有所改变？如果有，会有什么改变？（如接受外来人口参加合作医疗？）

Appendix V. Guideline for interviews with doctors of medical facilities

A. 被访者的基本情况

－ 被访者的姓名、年龄、学历、在此机构中的职位、在此机构工作的状况（已经工作了多久？每天工作多少时间？）

B. 医疗机构的情况

<u>机构的经营模式</u>

－ 机构的具体名字是什么？
－ 什么时候开始运营的？
－ 是公立还是私立机构？
－ 是不是营利性的？
－ 有没有经营许可证？
－ 有没有得到国家（如省市卫生部门、城中村整治领导小组、区政府、居委会）的支持（经济支持或者其他支持）？
－ 和其他医疗机构（公立、私立）有没有合作（如转诊、相互介绍病人、共同开展医疗服务，如义诊）？
－ 有没有定期受到国家的监督（如营业执照管理、卫生设施检查等等）？
－ 谁是运营人（老板是谁？是合资经营还是个人经营？）？
－ 营利如何分配？（固定工资？分红？在不同员工之间的分配）

<u>机构的员工</u>

－ 有多少员工？（医生多少？护士多少？其他工作人员多少？他们的工作时间、频率如何？工资多少？）
－ 员工受过什么样的专业培训？（医生、护士有没有执照？医生的身份：聘用的退休医生、大医院医生临时坐诊？）

<u>提供的医疗服务</u>

－ 营业时间
－ 每天的门诊人数有多少？
－ 主要的病人来源如何（当地人、住在城中村的外来人口）？
－ 提供哪些医疗服务？（全科诊所还是专科诊所）
－ 病人要得到医疗服务，有没有什么前提条件（如必须有某些特定证件）？
－ 所提供的服务怎样结算？（挂号费多少？有没有分专家和非专家？免费、病人自己承担还是医疗保险承担）
－ 有哪些医疗器械？新旧程度如何？（如 B 超、X 光、脑电图、心电图）
－ 这些医疗器械的来源如何？（买新的还是买旧的？）
－ 使用的药品的来源如何？（自己有药房，病人一定要在诊所的药房买药；

没有药房，只开方药。如自己有药房，药品是直接和药厂批发还是自己配制）
－ 有没有针对专门群体（如妇女、儿童）的医疗服务（如儿童预防针、避孕套发放、堕胎）， 如果有，费用由谁承担（免费、病人自己承担还是医疗保险承担）？
－ 有没有预防检查服务项目？如果有，是哪些项目，费用由谁承担（如血常规检查、健康年检）？
－ 有没有特殊检查项目？如果有，是哪些项目，费用由谁承担（如 B 超）
－ 有没有提供流动性医疗服务（如上门看病、流动门诊车）？
－ 医生的诊断和治疗如何被记录下来？（如有没有病历，医生保不保留诊断记录）
－ 提供的服务会不会告知消费者？如果是，用什么方式？（通过居委会做宣传、做电视广告、街边广告还是朋友介绍）
－ 有没有打算要扩大服务提供的数量和质量？如果有，在哪些方面？
－ 会有病人被拒绝医治吗？

<u>与外来人口接触的基本情况</u>

－ 来看病的外来人口的比例（病人多数是外来人口还是当地人？）
－ 来看病的外来人口的情况：年龄、职业、源出地、社会等级、生活状况等等
－ 外来人口是怎样了解到诊所提供的服务的？（通过居委会做宣传、做电视广告、街边广告还是朋友介绍）
－ 来看病的外来人口的医疗服务支付情况
来看什么病？有没有出现过付不起诊费的情况？有没有出现过只看病不买药的情况？有没有出现过拒绝进一步治疗（如手术）的情况？如果有，原因是什么（经济原因？其它原因）？有没有发生过诊所和来看病的外来人口的医疗纠纷？
－ 当地政府（如区政府、村居委会、改制委员会）有没有针对外来人口的优惠政策？
－ 诊所有没有专门针对流动人口的医疗服务？如果有，费用由谁承担（免费、病人自己承担还是医疗保险承担）？
－ 你觉得外来人口会来看病的原因是什么？（价格低、离家近、医生有名还是其他原因？）

<u>外来人口的健康状况、卫生习惯和就医方式</u>

－ 你感觉中的外来人身体是否健康？
－ 有没有什么不良的生活习惯（抽烟、喝酒、喝生水、不经常洗澡等）
－ 一般生什么病？
－ 如果有慢性病怎么办？有哪些慢性病？
－ 外来人口又没有心理健康的问题？如果有，是哪些问题？原因是什么？（孤独、工作压力大等？）
－ 如果生病，会怎么处理？（忍耐过去、自己买药、上私人诊所、上大医院？）
－ 是否参加或者关注当地的医疗活动（如传染病宣传、儿童免疫等）
－ 工作场所有没有医疗服务？如果有，费用怎么支付？
－ 有没有参加医疗保险？如果有，是哪种形式的医疗保险？
－ 每年的医疗开支平均是多少？年平均的收入是多少？

— 比较倾向于看西医还是中医？为什么？
— 如果生病，有没有通过非正常的治疗手段处理？（如气功、求神拜佛等）
— 会不会为了将来可能生病而存钱？（如买保险）
— 他们会觉得生活的压力大吗？会常常感到寂寞吗？
— 当他们生病的时候，会找家人/朋友帮助吗（比如借钱、互相介绍医生）？
— 有没有发生过因为生病、受伤回乡（包括回乡医治）的事？如果有，当时是什么情况?
— 外来人口妇女怎样进行产褥期保健？生产选择什么地方？费用如何支付?如果没有钱去大医院生产怎么办？
— 外来人口儿童有没有实行计划免疫？如果有？如果得到相关信息？费用如何支付？在什么地方实行免疫接种？
— 当地的外来人口有没有小团体（老乡会、工会等）？怎样组织起来的？由谁组织的？主要做些什么事情？有什么活动？
— 有没有民间组织或外来人口自发形成组织（如工会）在健康问题上有所作为？（如帮讨工伤赔偿等）
— 你所知道的外来人口医疗保障的情况怎样？（是不是有医疗保险？私人保险还是国家保险？有的话要个人与国家承担的比重如何？）？来看病的外来人口有没有医疗保险？
— 你觉得外来人口在广州，当地生活习惯、饮食习惯对他们的健康有什么影响？（水土不服等）
— 你觉得城中村的生活环境对外来人口健康有什么影响？

村内的环境和卫生医疗情况

— 当地哪些管理机构对当地外来人口进行管理？怎样管理？（暂住证政策？）
— 出租屋主把房子租给外来人员，有没有什么规定？（比如每平米可居住的人数的限制、居住环境的规定，如一定要有自来水、厕所、电灯等）这些规定又是怎么实施的？
— 村内的生活垃圾如何处理？（是否有人专门收集？频率如何？什么人组织？费用谁承担？对居民有没有特殊的规定或处罚措施？如果有，居民遵守的情况如何）
— 废水如何处理？（费用谁承担？对居民有没有特殊的规定或处罚措施？如果有，居民遵守的情况如何）
— 公共道路卫生如何管理？（有人专门打扫？住户自己打扫？）
— 上级政府（如区政府、卫生局）有没有对当地卫生环境进行定期监督？
— 村内有以下哪些卫生医疗设施（是公立还是私立？）：药店、诊所、卫生点、保健站、公共厕所、公共浴室等。
— 采取什么样的方式进行卫生知识宣传？（如：宣传栏、上门宣传、卫生知识讲座？）宣传费用由谁承担？宣传哪些内容（如传染病、计划生育）？多长时间一次？参加者是谁（有没有外来人口参加）？
— 有没有提供免费的卫生服务？如果有，有哪些服务（如：免费发放避孕套、注射儿童预防针？预防针注射是不是强制性的）？其中有没有针对妇女、儿童的服务（如孕妇保健、预防针注射）有经费由谁承担？多长时间一次？参加者是谁?
— 当地有没有当地居民享受，但是外来人口却不能享受的福利和服务（尤其是卫生服务）？如果有，是哪些？
— 外来人口要得到卫生服务（比如在社区医疗诊所）有没有什么前提条件（如必须有某些特定证件，比如暂住证）

－ 当地有没有专门针对流动人口的医疗服务或措施？如果有，费用由谁承担（免费、病人自己承担还是医疗保险承担

－ 居住的城中村有没有打算要改善当地的卫生环境？如果有，在哪些方面？费用谁承担？

Appendix VI. Guideline for expert interview with employees of "AIDS CARE"

机构的基本情况

- 成立这个机构的原因是什么？
- 机构的员工有多少？都是什么人？
- 机构是以什么样的形式注册的？
- 机构的活动影响地点是哪些？
- 机构的经费如何解决？
- 机构的人员如何解决？

机构的活动

- 机构的活动有哪些？
- 以什么样的形式活动？
- 活动中存在哪些困难？

机构的关注对象

- 机构关注的对象（性工作者/嫖客）的存在哪些主要的健康问题？
- 机构怎样对她们进行干预？

机构的生存与发展

- 政府对机构持什么样的态度？
- 有没有遇到什么困难？
- 有没有和其他的 NGO 或者机构进行合作？如何合作？
- 觉得机构运行至今的成果和不足都有哪些？
- 对未来机构的发展或者相关领域的发展有什么期望和建议？

Appendix VII. Coding tree for evaluation of the interviews with migrants living in urban villages in Guangzhou

Basic information of the interviewee

- Age
- Education
- Place of origin
- Family background
- Job
- Reason of migration

Situation of living and working in Guangzhou and urban villages

- Income
- Household expenditure
- Reason for living in urban villages
- Living condition in urban villages
- Diet and drinking water

Self-reported health status and health seeking behaviors

- General health evaluation
- Change of health situation since migrating into the city
- Health problem (former and current illness) and countermeasures
- Health consciousness and the ways to keep healthy
- Mental health
- Influence of living condition on health
- Influence of working condition on health
- Behaviors regarding giving birth

Medical insurance

- Medical insurance
- Work-related injury insurance

- Maternity insurance

Migrant management and health service in urban villages

- General demographical characteristics of migrants living in the urban village
- Policies of migrant management in urban villages
- Management of renting house in urban villages
- Waste collection and public hygiene
- Health education
- Health facilities and service they provide
- Health service for children
- Health service for women

Social network and among migrants

The role of NGOs regarding providing service for migrants

Other information

Appendix VIII. Coding tree for evaluation of the interviews with female sex workers in Shenzhen

Basic information of the interviewee

- Age
- Education
- Place of origin
- Family background
- Future plan

Basic information of prostitution

- Working form and location
- Reason of being FSW
- Duration of prostitution
- Income
- Clients
- Living condition
- Working arrangement
- Diet
- Leisure

Health problems and risks, health attitude and health seeking behaviours

- Diseases/health risks related to prostitution
- Physical injury related to prostitution
- Other diseases/health risks
- Unexpected pregnancy
- Drug use
- Smoking and alcohol consumption
- Mental health
- (Sexual) relationship with clients
- (Sexual) relation others than clients
- Condom usage
- Physical examination
- Other health seeking behaviors

Knowledge about STD/AIDS

- Understanding of STD/AIDS
- Approaches to STD/AIDS knowledge

Social network

- Family relationship
- Relationship with panderess
- Relationship with other FSWs
- Relationship with other persons

Comments about other FSW

Mobility

- Mobility of FSW
- Mobility of clients