Chapter 3

Health Status of Women and The Health Care System in China

This chapter reviews the health status of women and the health care system in China. While the general health status of women in China has improved as the country advances in socio-economic development, very little services and research have been devoted to women. As a result of participation in the World Summit for Children, China has set a national goal to reduce the 1990 maternal mortality rate by one half by year 2000. This chapter examines recent trends in women's life expectancy, maternal mortality during pregnancy and delivery; concerns of AIDS and HIV positivity among women, and the impact of family planning on women and families. In addition, the Government's health care policies and the organizational structure of health care system are reviewed. The social status of women is discussed later in Chapter 8.

Life Expectancy and Age-Specific Mortality Rates

Figure 3-1 shows the trend in life expectancy for both women and men in China between 1972 and 1990. The projected trend is based on estimates from several sources. On average, life expectancy has increased for both men and women by about 5 years during this period. The life expectancy of women in China is estimated to be about 70 years in 1991, about three years higher than that of men. The difference in life expectancy between women and men is small relative to other countries with similar level of mortality. This small gap has been attributed to higher mortalities among girls and women during infancy (see Chapter 2) and during child birth. The prevalence of maternal mortality in China is discussed later in this chapter.

Figure 3-2 shows the 1989 age-specific mortality rates (ASMRs) of women and men in towns and rural areas of China, expressed in percentages of ASMR in cities. In general, mortality is higher in rural areas than in towns. For men, the largest difference occurs in the early childhood ages. For women, large differences are found in two periods, childhood and child-bearing ages between 26 and 32 years.

Maternal Mortality and Morbidity

In China, it has been estimated that about 10 per cent of pregnancies and deliveries involve serious complications, and an estimated 20,000 women die every year from maternity related causes. This section examines the recent trends in maternal mortality rates (MMR), the areas of the country and women at high risk of mortality, causes of mortality and management.

Maternal Mortality Rate

The maternal mortality rate (MMR) is one of the most sensitive indicators of women's health. Deaths during pregnancy and delivery are closely linked to the basic health and nutrition of women and the services available to them. In most developed countries this rate is less than 10 per 100,000 births. The average for developing countries

is much higher at 400 per 100,000 births. The MMR for China was estimated to be 67 per 100,000 births in 1993, and the average MMR between 1989 and 1993 is 82[21].

Table 3-1 shows the MMRs for the whole country, and for urban and rural areas between 1989 and 1993. The encouraging fact is that the MMR in China has declined fairly rapidly in both urban and rural areas, with the rural rate remaining at more than twice the urban rate through this period. Table 3-2 shows the average MMR range by region, and by provinces in China between 1989 and 1993. The MMR is lowest in the North East and highest in the South West. MMR is also estimated to be much higher in mountainous regions than plains. The provinces with very high MMR above 200 per 100,000 births are Xinjiang, Guizhou, and Tibet.

Table 3-1. Maternal Mortality Rates (MMRs) in China For Urban and Rural Areas, 1989 to 1993.

Year	Whole Country	Urban	Rural
1989	97	50	115
1990	89	46	113
1991	80	46	100
1992	77	43	98
1993	67	39	85
Average 1989 to 1993	82	47	101

Source: "A Situation Analysis of Children in China" National Working Committee for Children and Women, December 1994, Beijing.

Table 3-2. Average Maternal Mortality Rates (MMRs)year) in China Between 1989 to 1993, By Region and By Provinces.

MMR	Region	Province
28 to 49	Dongbei, Huadong (East)	Beijing, Tianjin, Shanghai, Zhejiang, Guangdong, Heilongjiang, Liaoning, Jiangsu
50 to 99	Zhongnan, Huabei (Central)	Shandong, Hainan, Hebei, Jilin, Guangxi, Fujian, Inner Mongolia, Hunan, Jiangxi, Anhui, Shaanxi
100 to 199	Xibei, Xinan (West)	Hubei, Qinghai, Ningxia, Shanxi, Henan, Sichuan, Yunnan, Gansu
200 to 344		Xinjiang, Guizhou, Tibet

Source: "A Situation Analysis of Children in China" National Working Committee for Children and Women, December 1994, Beijing.

21 "A Situation Analysis of Children in China," National Working Committee for Children and Women, December 1994, Beijing

While the overall MMR of women is China is rapidly approaching that of developed countries, some women in the population are at a relatively higher risk of MMR. Among women who died during pregnancy and delivery, there is a higher percentage of women with low education (64 per cent had less than primary education), very low household income (68 per cent came from households with income less than 50 RMB Yuan per mouth), limited prenatal care (59 per cent had two or less prenatal visits, and multiple pregnancies (54 per cent had at least one previous pregnancy). Over 60 per cent of women who died at child birth had delivered their infant at home and about one third had died at home.

Causes of Maternal Complications

Table 3-3 shows the percentage of maternal deaths by cause of death between 1989 to 1993. The leading cause of maternal death is obstetric complications, in particular, obstetric haemorrhage, accounting for almost 50 per cent of maternal deaths. Other obstetric complications resulting in deaths of the mother during pregnancy and delivery include pregnancy induced hypertension, puerperal infection, and other problems. Besides obstetric causes, general health conditions such as cardiac disorders and liver diseases account for about 25 per cent of deaths.

Table 3-3. Percentage of Maternal Deaths Caused By Types of Obstetric and Health Problems, Averaged Between 1989 and 1993.

Cause of Death		Percentage
Obstetric	Haemorrhage	49
	Pregnancy Induced Hypertension	11
	Infection	5
	Other	10
Health Problems	Cardiac Disorders	8
	Liver Disease	3
	Other	14

Source: "A Situation Analysis of Children in China" National Working Committee for Children and Women, December 1994, Beijing.

Obstetrical Haemorrhage. Table 3-4 lists the percentage of haemorrhagic deaths by cause of obstetric haemorrhage in 1989 to 1991, and 1992 to 1993. These two periods were examined separately because there appears to be some change in the prevalence of the different types of haemorrhages. The main cause of bleeding is placental retention, accounting for over 40 per cent of deaths due to haemorrhage. Another cause of bleeding that appears to have increased is uterine atony. Placental retention and uterine atony together account for almost 70 per cent of deaths due to haemorrhage. The prevalence of death due to vaginal tear appears to have declined.

Table 3-4. Percentage Of Haemorrhagic Deaths By Cause of Haemorrhage, 1989 to 1991 And 1992 to 1992.

Reason for Haemorrhage	1989 - 1991	1992 - 1993
Pre-natal		
Placental Previa	9	9
Placental Detachment	3	2
Post-natal		
Placental Retention	45	44
Uterine Atony	23	28
Vaginal Tear	11	7
Other	9	11

Source: "A Situation Analysis of Children in China" National Working Committee for Children and Women, December 1994, Beijing

Another cause of haemorrhage that is also of concern is ectopic pregnancy. Ectopic pregnancy, or tubal pregnancy, is a condition in which a fertilized egg developed in the fallopian tubes instead of the wombs of the mother. If undetected, ectopic pregnancy causes haemorrhages in the first two or three months of pregnancy. A survey in Beijing showed that the incidence of ectopic pregnancy had increased from 3 per thousand in 1973 to 11 per thousand in 1984. The concern is that ectopic pregnancies may be associated with the use of intrauterine contraceptive devices (IUDs). The relative risk of ectopic pregnancy was estimated to be 3 to 4 times higher among users of IUDs than non-users.

Infection. Between 1989 and 1993, puerperal infections accounted for about 5 percent of deaths on average. Infection as a cause of death has been reduced in recent years due to the widespread availability of antibiotics. However, post partum fever is still a common complication after delivery.

Other Complications. Other cause of maternal death is pregnancy induced hypertension which accounts for about 11 percent of deaths on average. In the past, the conditions uterine prolapse and urinary fistula are fairly common in rural china because of difficult births and the fact that women tend to have several children. These two problems have almost disappeared in recent years because of a concerted effort to provide gynaecologic treatment for these problems throughout rural China, better care at the time of delivery, and marked reduction in women's fertility rate because of family planning policies.

Management of Maternal Complications

Death during pregnancy and delivery can often be avoided given proper nutrition and prenatal care such that the women can better tolerate the birthing process, improved delivery method to avoid haemorrhage and infection, and proper medical management of complications. For these reasons, obstetric specialists believe that about 89 per cent of maternal deaths in China could have been avoided with improved circumstances for pregnant women.

Pre- and post-natal care. According to the national routine statistics from the Ministry of Health (MOH), about 6.7 million women reported at least one pre-natal visit and/or one postnatal visit in 1992. It is difficult to determine the percentage coverage of maternity services on a national basis because the definition of what constitutes a maternity visit is unclear. Visits and services provided by village level health workers are often excluded in the accounting. It appears that coverage is high in urban populations and more affluent rural areas, but is inadequate in other parts of the country. The study of 300 remote and poor counties found that only 37 per cent of women received any prenatal care. Among women who received prenatal care, only 21 per cent had made three or more visits, and 28 per cent received postnatal care. Proper prenatal care, nutrition, and monitoring of the developments of the infant during pregnancy are important determinants of a safe delivery. For China to work towards reducing maternal mortality rates, concerted efforts should be devoted to ensure that pre- and post-natal health services are available to women.

Delivery Practices. China has given high priority to promoting "modern" delivery practices to decrease the number of deliveries under potentially inadequate circumstances. The 1992 national routine statistics indicate that 85 per cent of deliveries were carried out using "modern" delivery practices. However, this estimate may be over-optimistic because the definition of "modern" varies by province. In some cases a delivery assisted by family members who have received a simple kit (including sterilized gauze and a razor blade) is defined as modern delivery.

The practice of home delivery remains fairly common in China, particularly in rural China. Data from the Study of 300 poor and remote counties showed that, in poor and remote counties of China most births occur at homes, only about 36 per cent of deliveries uses the "modern" delivery methods and, on average, only about 14 per cent of deliveries occurs in hospitals. The 1990 Census, however, showed that the rate of hospital deliveries is about 74 per cent in urban areas, and 36 per cent in rural areas. These estimates appear too high relative to other surveys. Preliminary data from the 1992 Sample Survey on the Situation of Children showed a much higher rate for urban area at 91 per cent but a lower rate for the rural areas at 26 per cent. In rural areas about 71 per cent of births occurred at home. The percentage of births attended by medical professionals, village doctors, or trained midwifes is about 99 percent in urban areas and 76 percent in rural areas.

Management of Complications. The management of complications is often delayed in rural areas because a large proportion of births occur at home. In the event of complications such as haemorrhage, there are no telephones to call for assistance and sometimes transportation to hospitals are inadequate. Some health centres also have limited capability to manage haemorrhages due to lack of transfusion facilities, and a failure to recognize the need to transfer the patient to better equipped hospitals at higher administrative levels. The availability of referral services in case of obstetric emergencies is not readily available in China. The Ministry of Public Health and Provincial Health Bureau intend to expand the network of available referral services in rural areas by improving the quality of obstetric service in central township hospitals. Currently distance and cost form the main barriers to access.

AIDS and HIV Positivity

As of February 1994, 1,140 cases of HIV-positive individuals and 19 cases of AIDS had been identified in China. Given problems with under-reporting and limited screening programmes, it is conservatively estimated that China now has 5,000 to 10,000 HIV/AIDS cases. HIV/AIDS has been found in 21 provinces, autonomous regions and municipalities, with the majority (85 per cent) of the reported infections from Yunnan province. Seventy per cent of the people found to be HIV-positive are intravenous drug users, while 15 per cent are foreigners, and 5 per cent are returning Chinese. The remaining has been among spouses of HIV-positive persons, haemophiliacs, prostitutes and others. The affected population are young to middle-aged adults (80 per cent are 20 to 49 years of age). No perinatal transmission of HIV/AIDs has been discovered in China.

Concerns About AIDS/HIV Positivity in China

Spread. Although the incidence of AIDS is limited in China at this time, it has the potential of rapid spread because the incidence of sexually transmitted diseases (STDs) is rapidly increasing in recent years. In China, the incidence of STDs has almost doubled in the one year between 1991 and 1992. The reported number of STDs (especially syphilis and gonorrhea) has jumped from 85,430 in 1989 to 360,000 in 1992. Increases are observed in almost all provinces, except Yunnan which remains steadily high in recent years.

It has been speculated that AIDS/HIV positivity were introduced into the coastal areas of China by infected overseas visitors, and were transmitted inland through returned labourers. In major urban areas, transmission occurs through sexual contacts with prostitutes and multiple sex partners and often AIDS and HIV complications are transmitted with other STDs. In the southwest border areas of China, transmission of AIDS/HIV positivity is mainly by intravenous drug use.

Risk for women. Women are at risk of AIDS/HIV positivity because the incidence of STDs is rapidly increasing among women. Over the last few years, the outbreak of STDs has increased much more for women than for men. For instance, the ratio of STDs between men and women used to be 5 to 1 in Shanghai in 1987 (that is, for every 5 cases of male STDs there was one case of female STD). The ratio dropped to 2 to 1 in 1991 because there was more STDs among women. In the Panlang district of Kunming and the Chaoyang District of Beijing, the ratio of STD for men and women was also about 2 to 1.

China has not devoted much effort to the management of AIDS/HIV positive problems because they are relatively uncommon. However, careful review and monitoring is necessary to avoid future spread of the problem. The recent increase in STDs in China has been attributed to a resurgence of prostitution in China in recent years. Recent surveys among various population groups have shown that knowledge about STDs and the practice of safe sex is limited. Prostitution, which had largely disappeared in China in the 1950s and 1960s under the Government's efforts to control the spread of STDs, has reappeared in the 1980s and has been increasing. In 1993, more than 240,000 prostitutes were reported to have been detained.[22] Its resurgence has been attributed to changes in the family (such as separation from spouse) and in the economy (i.e. more affordable). In terms of the welfare of the women, a study has been conducted by the Women's Research Institute, a non-governmental

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[22] "Cops battle to check kidnappers of women", China Daily, 24 February 1994.

women's organization, to understand why women submit to prostitution and to help to rehabilitate these women.[23]

Family Planning and Fertility of Women in China

The Chinese Constitution now provides that individuals should practice family planning and that the Government should support family planning services. As mentioned in Chapter 1, China's efforts to slow population growth began with the campaign "Longer, Later, Fewer" in 1973. In 1979, the Third Plenary Session of the 11th National Congress of the Chinese Communist Party made economic development the primary objective of Government, thereby family planning was made a fundamental state policy supportive of economic development and the "one-child per family" policy was adopted.

Family Planning Goals

Population control and family planning strategies for the 1990s were specified in the National Programme of Action (NPA) for Child Development in China in support of the World Summit Goals and Plan of Action. The NPA advocates maintaining population growth rate to within 12.5 per thousand in the decade. It specifies that services to the people should include: educating people of reproductive age about fertility and contraception, distributing safe and effective contraceptives devices and medications, providing counselling on family planning, reducing birth control complications to 10 per 100,000 utilization by year 2000, and making available counselling services in 60 per cent of all counties (cities) by the end of 1995 to improve the outcomes of pregnancy. In September 1994, the Government of China endorsed the principles and objectives of the NPA at the International Conference on Population and Development (ICPD) which puts individuals at the centre of sustainable development efforts and calls for gender equity including equal participation of men and women on family planning.

Strategies used to encourage compliance with family planning policies include mass education, persuasion, incentives and disincentives of various kinds, including local level population planning targets. The State Family Planning Commission (SFPC) is currently seeking to re-direct the family planning programme strategy from an administrative to a service approach, and to improve the quality of service. The Chinese Government recognizes that a successful family planning policy needs to be supported by other actions that addresses women's status, poverty alleviation, illiteracy elimination, education of girls as well as boys, adequate health care, old age support or insurance, and access to information and quality family planning service.

Family Planning Services

Family planning services in China are delivered through the State Family Planning Commission (SFPC), and the Maternal and Child Health (MCH) Department of the Ministry of Health. The roles of these two agencies are discussed below.

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23 "What Progress We Have Made, 19988-1994", Women's Research Institute, China Academy of Management Science, China's Non-governmental Women's Organization.

The State Family Planning Commission. The SFPC is a ministerial level organization currently headed by the State Councillor who is responsible for family planning, health, women, youth and the disabled. The SFPC is responsible for organizing information and education programmes throughout the country to inform the population about the government's family planning policy, distributing contraceptive devices, and researching on contraceptive methods.

1. Educational Services. The SFPC organizes pre-marriage and post marriage educational programmes for couples, and, in many cases, provides a pre-marriage examination. These programmes are intended to educate both rural and urban people about China's population situation and its relationship to social and economic development. They advocate late marriage and late child bearing[24]; encourage couples to accept small families; and disseminate information about contraceptive methods. With broad outreach, family planning services in China reach most women in child-bearing age group.

2. Contraception Services. The SFPC reports that in 1993, 83 per cent of eligible married couples are using contraceptives. Methods commonly used include female sterilization (almost 40 per cent of cases) and intra-uterine devices IUDs (39 per cent), followed by male sterilization (12 per cent), pills (4 per cent), condom (4 per cent), spermicide and others (1 per cent)[25]. In Sichuan province, male sterilization (used by 34 per cent of couples) is used more frequently than female sterilization (9 per cent) because scalpel-less vasectomy was developed in the province.

The SFPC reports performing about half of all family planning operations in 1992 and 1993, and about half of all IUD insertions. China produces most of its mechanical and hormonal contraceptives, including many varieties of 28-day and once-a-month pills, not all of which have been reviewed by WHO. A small but significant part of China's contraceptive research and production was undertaken with support from UNFPA. China is carrying out trials on IUD insertions, partly in cooperation with external agencies. For twenty years or more China has relied on the Stainless Steel Ring (SSR) IUD. A UNFPA supported study in 1992 has found that the health costs resulting from high failure rates in using the SSR are greater than the costs required for converting the manufacturing of SSRs to that of copper plated IUDs. As a result, the Government has halted the production of SSR as of 1993 and is encouraging a switch to the Copper-T and other forms of more effective IUDs. Contraceptive services and supplies are provided free of charge in the Family Planning Commission network, which is described below.

3. Family Planning Commission Network. The service delivery networks of the SFPC has expanded over the years to cover a large part of the country including rural areas. It includes: village family planning rooms, township family planning clinics, county family planning service stations, prefecture family planning service stations, and provincial family planning research institutions. In 1992, the SFPC network included 272 service institutes at the prefecture level; more than 2,203 service stations at the county level; and 31,748

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24 The legal minimum age for marriage, as set by the 1980 Marriage Law, was 20 years for women and 22 years for men.

25 Estimates from the Chinese Population Information and Research Center, 1992.

service stations in townships. Counties currently without a family planning service station are expected to create one within two years. An increasing number of township family planning service stations are also providing pre-natal and even delivery services. Family planning advocacy, condom distribution, and information, education and communication (IEC) activities are also provided through the China Family Planning Association (CFPA), the People's Liberation Army (PLA), and various factory and work unit facilities.

Maternal and Child Health Department (MCH). The MCH Department of the Ministry of Public Health used to be the chief agency responsible for family planning prior to 1979. The MCH Department is a major provider of family planning technical services, chiefly through its three-tiered service network of the County MCH Institute, the Township Hospital, and village midwives and doctors. Overall, MOH carries the biggest responsibility for more complex family planning operations. The role of the MCH Department is greatest in urban areas and also in the least developed areas where the Family Planning Commission network is not yet well established.

The County Hospitals and MCH Institute implement family planning technical services. The Township Hospital is a key institution for family planning operations, particularly in those townships where there are no family planning service stations. In some townships both hospitals and the service stations provide family planning operations. Statistics on family planning operations are reported through the Family Planning Commission System. At the village level the functions of midwife and family planning worker are often combined in the same person.

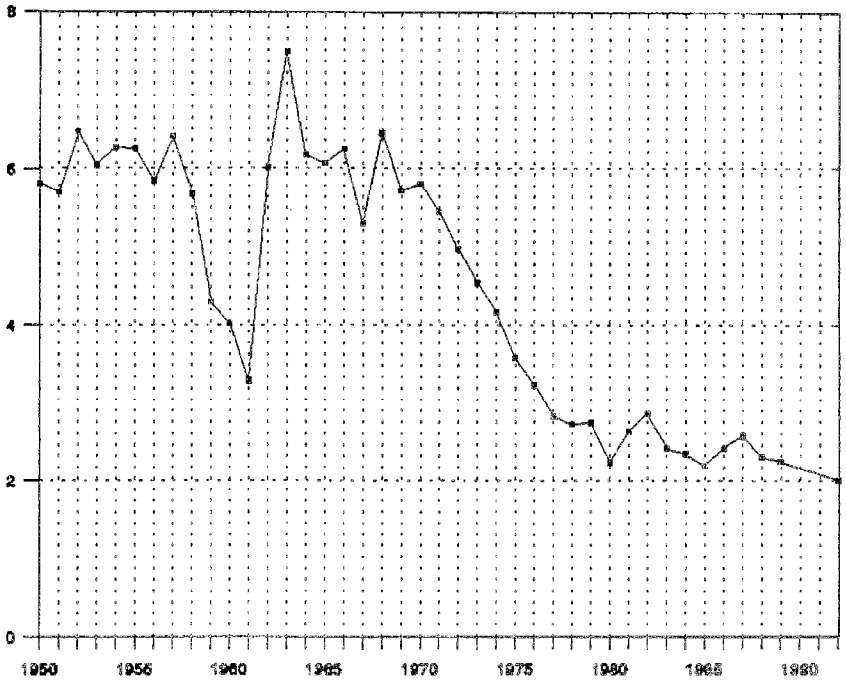
Impacts of Family Planning

The family planning policies in China have direct consequence on women's choices about motherhood, use of contraception, abortions, and family size. Women in China are having fewer children, delaying motherhood until later in life, and are prolonging the intervals between children, and often not having a second child at all. However, women's compliance with the family planning policies is sometimes countered by the traditional preference for a son to continue the family tradition and heritage. This section discusses the impacts of family planning on women's fertility, use of contraception, abortion, and choices of family size and composition.

Total Fertility Rate in Women. Figure 3-3 shows the total fertility rate (TFR) of women in China between 1950 and 1993. The TFR in China was much higher in the past, averaging about 6 births per woman in the 1950s and much of the 1960s. The TFR began to decline in the 1970s since the "Longer, Later, and Fewer" policy and averaged below 3 births per woman since the mid 1970s. Declines in TFR actually slowed after 1979 in spite of the "one-child per family" policy, but resumed after 1987. By 1993, the TFR is around 2.0, a record low in recent years.

The slow decline in women's fertility during the 1980s has been attributed to several changes in the country as a result of reforms. The commune systems in China were dissolves in most rural areas, therefore, the local government had less influence over family

Figure 3-3. Total Fertility Rate of Women in China, 1950 to 1993.



Source: Data from the Maternal and Child Care Department, Ministry of Health

decisions on the number and spacing of children. In addition, a household responsibility system (HRS) was introduced for rural production (see chapter 1 for more details on the HRS) which provided farmers with a strong incentive for improved production. This incentive may have rekindled the rural population's desire for more children who will later be valuable helpers in farming the fields. Furthermore, while the one-child per family policy is largely accepted in urban areas, in the rural country side, provincial and local regulations and practice may allow a second child depending on circumstances. In some places a second child is allowed if the first is a daughter, in other places a second child is allowed in all cases, and there are other exceptions. National minorities groups are also allowed two or more children in most cases, and Tibetans (except government employees) have no recommended limits. The strong cultural desire for a son has made it difficult to enforce a one-child policy in rural areas, especially when improved economic conditions have eroded the influence of common incentives and disincentives[26].

Contraception. It has estimated that around 71 per cent of married women in China used contraception through much of the 1980s, the rate increased to about 83 per cent in 1992. However, people's knowledge about contraceptives are still relatively limited. A Knowledge, Attitude and Practice (KAP) survey done in 300 poor counties in 1989 found that between 68 to 80 per cent of respondents were using contraception in these areas, however, only 40 per cent of them were able to identify three different types of contraceptive devices.

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26 Susan Greenhalgh, "The Peasantization of Population Policy in Shaanxi: Cadre Mediation of the State-Society Conflict", Research Division, Population Council, Working Papers No. 21, New York 1990).

There is anecdotal evidence that urban women and men are just as ignorant about the variety of contraceptive devices, even though most of these devices are available over the counter in urban areas. A women's group in Beijing is currently developing a Chinese version of the book "Our Bodies, Ourselves" as one means of educating people about the reproductive functions of the body and how contraceptive devices can be used to avoid a pregnancy.

The use of contraceptives by men is relatively uncommon in China. As mentioned earlier, only 16 per cent of contraceptive users chose male contraception (12 per cent used male sterilization, and 4 per cent used condoms). China's endorsement of the ICPD Programme of Action has called for equal participation of men and women in family planning and therefore the responsibility to use contraception. The advocacy for men to use condoms should be emphasized because it is a means of contraception and prevention of the spread of STDs which puts women and children at health risks. It is known that infants born to women with some forms of STDs are more susceptible to neonatal pneumonia.

Abortion. Abortion is a common procedure in China, estimated at about 46 abortions per 100 live births in 1987. Studies which have explored the reasons for abortion have indicated that about 70 per cent of the abortions in China are due to contraceptive failure. Relative to other countries, the rate of abortion in China was lower than countries such as Cuba and Czechoslovakia; higher than countries such as Denmark, England and Wales, Italy, Norway; but fairly comparable to that in the United States of America which has estimated at 42 abortions per 100 live births in 1985[27].

Family Size and A Preference For A Son. In China, considerable research has been done on people's attitudes about family size and gender of children. In general, Chinese people perceive the ideal family as a two children family with one boy and one girl[28]. The preference for at least one boy is very strong and widespread in China. It was postulated that in much of the 1960s and 1970s, families tended to adopt a "gender-guided stopping rule" in family planning[29], whereby couples prevent further childbearing when they have had the number of sons they want. Several surveys have also shown that having a male child increases the chances that a couple will use contraception, and a permanent form of contraception such as sterilization rather than IUDs and other methods.

The Health Care System In China

This section briefly reviews the organizational structure of the health care system, current health care policies, and the sources of finance for health care services in China. An important change in the administration of health care is that with policy reforms in the mid 1980s, there is now a decentralization in the decision making process. In addition, local governments are made responsible for financing most of the health care costs. The impact of these changes are discussed below.

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27 Stanley Henshaw and Evelyn Morrow, "Induced Abortion, A world Review - 1990 Supplement, Alan Guttmacher Institute", New York, 1990. The Alan Guttmacher Institute reported 42.2 abortions per 100 live births for the United States of American in 1985.

28 He Yupeng and Cao Liqun, "Rural Women's Status, Birth Preference, and Fertility Transition", UNFPA sponsored Seminar on Research on Women's Status, Beijing, April 1993.

29 Ansley J. Coale and Judith Banister, "Five Decades of Missing Females in China", Demography, Vol 31, No. 3, August, 1994, Published by the Population Association of America.

Organizational Structure of Health Care System

The organizational structure of the health care system in China is summarized in Figure 3-4. The Ministry of Health (MOH) is the highest health administrative body of China under the State Council. It is responsible, through its multiple departments and divisions, for formulating national health goals and policies, defining priorities in health activities and supervising all health activities. Most directly involved in the health of children are the Departments of Maternal and Child Health (MCH), and Health and Epidemic Prevention. Bureaux of public health in the provinces, municipalities, autonomous regions, prefectures, counties and districts are responsible for applying the national health goals and policies to the local population. Primary health services in rural areas are organized as a "three tiered" network, which parallels the village, township and county levels of government. The operation of this network is discussed below.

Village level health care. In the first tier of all villages in China, 86 per cent have health staff at the village level, although many village level staff are part-time workers. Villages without health staff must rely on neighbouring villages or higher level services. The village health units used to be the property of the village communities, however ownership of village health units has changed, along with the change in ownership of other state owned enterprises. In 1983, 58 per cent of village health units were owned collectively by village communities, 35 per cent privately by a group of village health staff or individual health staff, and the rest by other organizations. In 1989, 33 per cent were owned collectively by village communities and 58 per cent were privately owned by a group or individual health staff.

At village level there are three types of health workers: village doctors, village health workers and rural birth attendants. Village doctors have passed a qualifying examination given by the county health bureau. They may have had anywhere from nearly no formal training to up to three years of training and they are primarily responsible for clinical services. Village health workers provide much of the preventive health services. Home deliveries are assisted by birth attendants who are usually trained in hygienic delivery methods and who may be the same person as the village health worker.

Township Health Centres. Township health centres provide services to an average of about 18,000 residents in each township. They typically have around 18 staff, including a group of two to four staff devoted for preventive care. This prevention staff is responsible for hygiene, infectious disease prevention and maternal and child health. In many townships there is regular contact with the village level staff via monthly meetings at the township health centre. Townships usually provide hospitalization services, but they have relatively few beds (an average of 15 beds), little equipment and fewer qualified staff and so are often bypassed by patients. In the late 1980s, many township hospitals went bankrupt partly because demand for services at this level was low. The MOH is encouraging an upgrade of the quality of the township health centres so that they can function as the first-level referral centre and the last level of "public sector" administration. This effort has resulted from a mixture of increased concern over quality of care and privatization of village health units.

County Level Health Care. At the county level there is a specialized Maternal and Child Health (MCH) station, an Epidemic Prevention Station (EPS), a county hospital providing a basic set of clinical services, and frequently a county health school. Coordination is the responsibility of the county health bureau. County level responsibilities include supervision and upgrading of township and village staff, many of whom have very little basic training.

Health Care Policies

Health for All and Prevention First. Since liberation in 1949, the Chinese Government has adopted the policy of health care for all and prevention first. During much of the 1950s to 1970s, these policies have led to substantial improvement in the health status of women and children. The policy of "health care for all" has led to the development of both rural and urban services supported by many primary care workers at the village and urban street committee level throughout the country. Supervisory and referral services have also evolved at most administrative levels above this grassroots level. The policy of "putting prevention first" in China has led to fairly successful controls against immunizable diseases such as the eradication of small pox in the 1960s, improved control of infectious diseases such as acute respiratory infection and diarrhoeal disease, and reductions of endemic diseases such as iodine deficiency or schistosomiasis. In recent years, the national preventive care programmes in China include: the EPI programme which provides vaccinations against immunizable disease, a programme to distribute iodized salt to counter iodine deficient disorder, and a programme to promote breastfeeding for infants.

A systematic child health care programme, which involved regular child health checkup was introduced in China in the mid-1980s. According to the national health statistics, 35 per cent of children under 7 years of age were registered for systematic child health care in 1990. However, in poor rural areas, only 2.5 per cent of the children were registered. This programme is fairly resource intensive and may not be a good model for all regions in China. Simplified models to monitor child growth and to provide counselling services for care takers are being explored, especially in poor areas with resource constraints.

With the development of a market economy in the 1980s, it has become increasingly difficult to provide equitable access to health care and to maintain basic preventive services in poor areas. Under the current system, individual counties sets different targets for the

type of health care service to provide to its people. Depending on the socio-economic well-being of the county some areas has improved services; however most poor and remote areas have actually experienced setbacks.

1. Monitoring of Local Health Care Services. A statement of the Eighth Five-Year Plan (1991-1995) has reemphasized the Government's goal that about 50 per cent of counties in China should reach "health for all" by 1995. In a multi-sectoral meeting in June 1993, the goal of providing primary health care to all people was reaffirmed. For China to reinforce the "health for all" policy, there is a need to carefully monitor the progress at the county levels. Indicators that can be used to reflect the adequacy of the health care services include: the extent to which local primary health care (PHC) systems are included in the local government's socioeconomic development plan, percentage of the local government budget allocated for health services, infant and maternal mortality rates of the area, and coverage rates of safe drinking water, sanitation, and childhood immunization. Areas with poor records on these indicators may need to receive special assistance from the Government.

2. Allocation of Funds for Preventive Care. Preventive care has suffered similar funding problem. While the ultimate goal is prevention, more resources are currently spent on curative care. In 1989, only about 15 per cent of the government funds given to the health sector were allocated to epidemic prevention institutions, and only 4 per cent were allocated to MCH institutions. The proportional allocation of funds to preventive care programmes have also declined, despite the increase in total health care expenditure. The relative government expenditure for epidemic prevention and funding of the MCH institutions has dropped from 20 per cent in 1979 to 18 per cent in 1989. The allocation of funds for epidemic prevention institutes within total health expenditure has also fallen from almost 4 per cent in 1980 to 2 per cent in 1988.

Another concern about funding for preventive care programmes is that, as a consequence of economic reform, each government institution is made financially self-reliant. This policy works against preventive care programmes because they are not revenue generating commodities. In a developing country such as China, consumers are less likely to demand preventive care relative to other needs, and many health care workers (e.g. grassroots doctors) have shifted the focus of service to curative and revenue generating activities. It is important that leaders in the health care sector should advocate for preventive care services as an issue of human resource development. The provision of preventive care is necessary for the socio-economic development of society and, therefore, funding for its operations should be guaranteed through central resources.

Combining Chinese and Western Systems of Medicine. Another longstanding health care policy in China is to preserve and develop traditional Chinese medicine and practices, while at the same time incorporate and assimilate western system of medical therapy. Currently, the two systems of medicine co-exist at all levels of the health care sector in virtually all health care institutions. Although stopping short of complete integration, most population and health care providers can combine both systems of medicine to effectively manage certain diseases. Chinese doctors are relying more on the diagnostic methods of western practices, but in terms of treatment, the traditional Chinese herbal medicines and acupuncture have proved to be more effective for treating certain conditions then western style medicine.

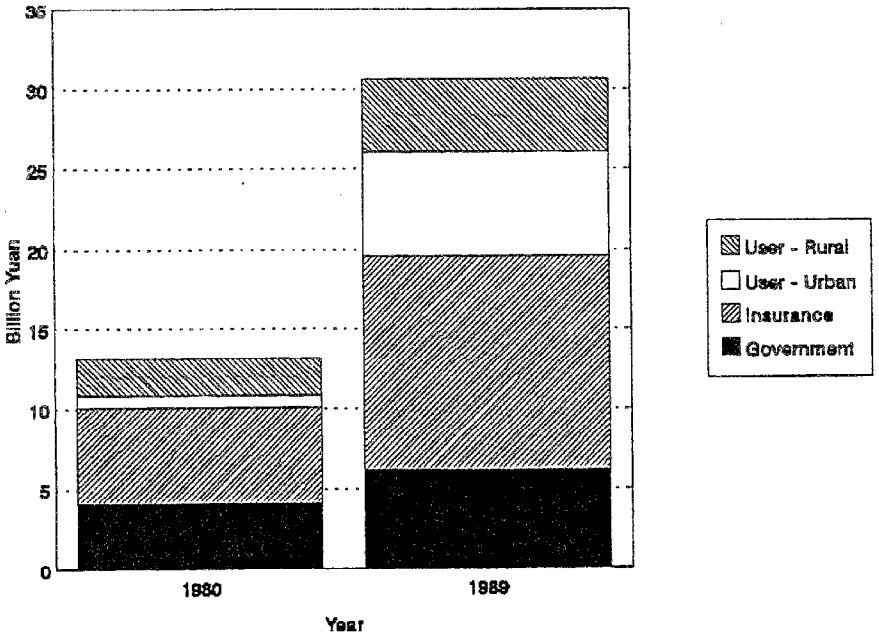
An important issue that needs to be resolved is to set up regulations and quality control systems to ensure the authenticity and quality of pharmaceutical for both traditional Chinese preparations and western formulations. There have been reports of tampering and improper preparations and this issue is currently being examined by the Ministry of Health and the Health Bureaux in China.

Administration and Financing

With decentralization in the mid-1980s, the decision about details of health care programme and strategies for implementation are delegated to the lower administrative levels in the government, although the broad guidance and targets for the development of health care system are initiated from the ministry levels in government. This strategy allows flexibility to plan and operate independently based on local situations. However, the responsibility for delivering health care services also means that local communities must provide most of the costs.

In 1990, approximately 2.6 per cent of the central government budget was allocated to health. Most of the government expenditure in health in China comes from the local governments. However, as shown in Figure 3-5, the sources of health expenditure have changed during the 1980s and the portion of government funding has decreased dramatically. Since insurance covers mostly urban residences, the pattern of expenditure suggests that a relatively large amount of the health services are consumed by the urban population.

Figure 3-5. Sources of Health Expenditure, 1980 and 1990.



Source: Changes in Health Care Financing and Health Status: The case of China in the 1980s, MOH, 1992.

In China, individuals contribute most of the health care costs. Fee-for-service is common, although there is often cost sharing for preventive services (the EPI contract system is an example). In particular, the cost of hospitalization can be prohibitively high for the rural population who tend to have lower income. A small survey was conducted in selected poor to mid-level rural counties in Shanxi and Yunnan. In Yunnan, the average cost of hospitalization for ARI management was 69.4 RMB yuan for an average stay of about 3.7 days, and an average cost for diarrhoeal management was 82.2 RMB yuan. In Shanxi, the average cost for ARI management was 154.9 RMB yuan for an average stay of about 6.3 days, and 90.6 RMB yuan for diarrhoea management. These expenses were expensive given that the average annual per capita income of the area ranged from about 235 to 703 RMB yuan.

In summary, this chapter shows that the number of maternal deaths has declined in China. However, a new concern regarding the health of women is the recent increase in STDs and the potential for AIDS and HIV positivity. Family planning policies in China has successfully reduced women fertilities and has impacted their choice of contraception and family size.

The most significant change in the health care system in China is the process of decentralization and the allocation of finances. With decentralization, the ministry level of government may require some supportive management to ensure that minimum standards are maintained at all administrative levels, and there is a strong need to strengthen the management capacity of health administrators at all levels. The MOH is aware that more public resources should be allocated to preventive care, and to rural health care, particularly in poor areas. Now efforts have to be devoted to convince economic advisers to the government that health care is not a consumption, but an investment in human resource developing.

UNICEF Office for China Beijing

DRAFT:
(Excerpts from 1997 Annual Report -- Not for Quotation)

[From Situation Analysis Update Section]

Compared to the significant and apparently sustainable advances in education during the 1990s, progress in health services has been less promising. A World Bank report published in 1997 on "Financing Health Care" presented a comprehensive analysis of the sector's responses to the challenges of adapting to a market economy, and raises questions of deep problems in financial access to health care, as well as about efficiency and rapidly rising costs in the sector.

Overall spending (including private) on health is increasing rapidly in China, at rates well above the rate of growth in real GDP. However, the report points out concerns about defacto policy and pricing decisions that have skewed investment and treatment decisions towards high-cost, high technology services and overuse of pharmaceuticals, resulting in increasing overall health costs but decreasing health outcomes. The report also flags concerns about trends in under-five mortality, based on fertility surveys and population census data, for which it recommends a more detailed analysis. (China's Ministry of Health reports declines in under-five mortality in the 1990s, based on death registration data).

The World Bank report presents concerns about the weakening financial base and performance in public health, and growing disparities in financial access to health care, drawing in part on data from a UNICEF commissioned study carried out in 1994-95 by researchers from Harvard University and a network of Chinese research institutions. Disparities are pronounced between urban and rural areas, and also within the rural areas, where only 10 percent of the population has access to some form of community-financed health care, down from a peak of 85 percent in 1975. Public spending on health is skewed toward hospitals, while priority public health programmes (including immunization) are increasingly underfunded, and some are beginning to charge for services which leads to reductions in coverage and inappropriate allocation of resources. Decentralization of funding also results in the poorest areas, which have the worst public health problems, having the least capacity to finance public health programmes. Constraints on resources for the sector are exacerbated by inefficiencies arising from duplication of facilities and the excess capacity in some vertical national health programmes. These include urban overlaps among Ministry of Health, state enterprise, and traditional Chinese medicine facilities, and rural duplication and overlap of services between maternal and child health centers, family planning services, township health centers, and epidemic prevention stations.

Some issues raised in the report, including the need to increase emphasis on public health, were subjects of the National Health Conference held in December, 1996. Similar conferences have been held in a number of provinces in 1997. Data on actual changes arising out of these conferences are not yet available, for

example regarding trends in budget allocations by provinces and counties, or changes in the financing policies and organization of health services.

As of September, 1997, 168 AIDS cases had been confirmed in China, including 103 deaths, and there were 8,277 HIV infections reported to the Ministry of Health. The Chinese Academy of Preventive Medicine has estimated that by end 1996 there were 200,000 HIV infections in China. With rapid socio-economic changes and increases in vulnerable populations such as the large migrant populations, some forecasts predict as many as two million persons will be HIV positive in China by 2001, and that these will grow to 10 million by 2010 if no effective interventions are taken. Incidence of STDs continues to rise rapidly, but real figures are extremely difficult to come by, as it appears significant numbers of cases are treated outside the official medical sector. Policy awareness of HIV/AIDS has increased in 1997, especially at the national level and in some provinces. Views of the problem as one which could be controlled by coercive measures appear to be gradually giving way to an awareness of the key role of education and leadership, and a growing openness to learn from experience of other countries, including to benefit from involvement of international NGOs with experience in HIV/AIDS programming. HIV/AIDS day in December, 1997, received a high profile including involvement of the Minister of Health, and release of a report "China Responds to AIDS: HIV/AIDS Situation and Needs Assessment Report" prepared by UNAIDS and other member organizations of the UN Theme Group on AIDS, including UNICEF, in cooperation with the Ministry of Health.

The World Conference on Tobacco and Health took place in Beijing in August, 1997. UNICEF was represented at the conference by the Regional Director. Tobacco use in China is high, and growing rapidly, with prospects of two million deaths annually from tobacco related causes within a few decades. Smoking among youth and women appears to be on the increase. Economic interests of the tobacco industry are powerful. Longer-term strategies, particularly targeted to youth, will be needed to address the tobacco issue, along with dissemination of information on the risks of passive smoking.

In a presentation at UNICEF's State of the World's Children launching on 16 December, 1997, the China Academy of Preventive Medicine reported that nutrition deficiencies affect about 39 percent of Chinese children, anemia affects 29 percent of infants in rural areas, 20-30 percent of children aged 2-5 have subclinical deficiencies in vitamin A and over 25 percent of children have been diagnosed with rickets of varying degrees. Reductions in levels of growth retardation remain slow, especially in the rural areas, and do not always follow the pattern of economic development. While direct causes are nutrient and disease related, such issues as inadequate food and health care for pregnant women and for children, poor access to health services, and poor environmental sanitation are important contributing factors. The study estimated over 300,000 deaths per year could be linked to underlying causes relating to inadequate breast feeding and care practices in infants under six months and protein-energy malnutrition in those aged 6 months to 6 years. The study calculated economic losses of RMB29.6 billion annually (over US$3.5 billion) arising from the combination of growth retardation, iodine deficiency disorders, and complications of iron deficiency anemia.

A Plan of Action for Improving Nutrition in China was issued by the State Council on 25 December, 1997, to be implemented by 15 different State commissions, ministries and organizations (including planning, education, science, civil affairs, finance, industry, poverty alleviation, women's federation), with the Ministry of Health responsible for routine management work, and a State Food and Nutrition Consultation Committee to provide advice. The plan calls for governments at all levels to incorporate nutrition objectives into government social and economic development plans, and include nutrition indicators in local economic monitoring indicators systems. Areas covered under the plan include food production and family food supply; quality of food and drinking water and prevention of infectious diseases; promotion of breast feeding; prevention of micro-nutrient deficiencies; as well as strengthened nutrition education through primary and secondary education curricula, primary health care services, and mass communication. Special attention is to be given to populations living in difficult circumstances, including those in the poverty areas and the disabled.

[From Section Reviewing Health programme and projects]
Health Programme

The Health programme remains UNICEF's largest (1997 implementation of US$8.382 million), and accounts for 41 percent of UNICEF's overall programme expenditure in 1997. Of the project budget, 33 percent represents supplementary contributions including US$1.5 million from the U.S. Center for Disease Control for polio vaccines.

The Health programme is implemented through eight projects: EPI, MCH, BFHI, Nutrition, IDD, PHC, Health Education, and Health Financing. The first seven of these, taken together, are expected to develop initiatives and interrelated approaches for achieving China's health and nutrition-related NPA goals. The eighth, Health Financing, supports a consortium of medical universities to carry out county, township and village-level action research experiments, in ten different counties of nine provinces, for re-establishing rural cooperative medical financing systems, especially in the poverty areas.

Progress continued during 1997 towards achieving some of the major NPA goals relating to Health, particularly in areas of polio eradication (no indigenous wild poliovirus reported since 1994), IDD elimination, and promotion of breast feeding. Issuing of a National Plan of Action on Nutrition (see above) also represents an important milestone.

The EPI project [1997 budget: US$3.419 million] is carried out in close coordination with other agencies which are very active in supporting immunization, including WHO, JICA, Center for Disease Control (CDC) USA; and the World Bank. Project inputs helped improve both polio eradication and NNT surveillance systems (AFP incidence reporting doubled from 0.5 cases to above 1 case per 100,000 population in 1997). Enhanced attention has been given to high risk, poorer provinces, both for surveillance and to strengthen management, with special initiatives in Guizhou province, one of China's poorest where immunization coverage levels have lagged behind. A five-provinces NNT evaluation found

progress in implementing mass vaccination campaigns for women in high risk areas. Plans are being developed for measles control. A survey and study on immunization of floating populations was also carried out, leading to formulation of guidelines on service to these populations. US$1.174 million of the budget (half of it phased forward from planned 1998 allocations) was spent to procure vehicles for the cold chain in 120 counties.

An EPI sub-project "Strengthening Epidemic Prevention Training" is training county health and epidemic prevention managers in applied management and epidemiology, in six provinces. The activities have developed guidelines and training materials for planning and management of public health activities at the decentralized (county) levels, trained provincial trainers and in 1997 trained 540 county health management personnel. More work is still required to adapt training materials and case studies to local realities and priorities, to improve quality monitoring of training, and to strengthen follow-up supervision and support of the trainees.

The second major project in the Health cooperation is MCH [1997 budget: US$2.231 million] implemented in 416 counties which have a total population of 210 million. These include 305 counties from the previous cooperation cycle (253 of them either national or provincially designated poor counties). For UNICEF's 1996-2000 cycle, the MCH project has divided counties according to their conditions and progress into three subgroups according to their conditions and capacities. One MCH sub-project covers 115 new counties and 20 old ones, whose earlier progress had lagged behind. In 1997 these counties carried out locally adapted refresher training, on topics which were identified in their baseline surveys as local priority problems. A second MCH subproject, implemented in 180 counties and 177 related prefectures, developed simplified service protocols for the health workers, and management protocols to strengthen monitoring, supervision and planning by township and county level personnel. Training in 1997 reached over 2,200 MCH supervisors in those counties. In addition, a major new programme for a 3-4 months programme of clinical practice training is being developed to strengthen skills of MCH township-level workers in managing premature births, asphyxia, and maternal complications. These have emerged as key problem areas of neo-natal and maternal mortality, in areas where control of acute respiratory infections and diarrhoeal diseases have already been successfully addressed. 20,000 MCH workers received the first phase of this training in 1997. Inclusion of prefectural personnel in training during this new cycle is expected to strengthen supervision and develop local capacity to replicate some of the training in non-project counties in the prefectures. For a third group of 105 counties, a new training component was developed in 1997 on Community Health Interventions. This township-level training targets township leaders and hospital directors, MCH workers, and Women's Federation cadres. It provides skills in community diagnosis, local planning and implementation of priority interventions to promote family behavioral change, social mobilization, and supervision and evaluation. During 1997, 700 trainers were trained for this new approach, and "echo training" was carried out for 8,400 persons in 105 counties.

Supplementary funding amounting to US$483,000 in 1996-97 has been programmed through the MCH project to strengthen NNT elimination activities in 73 NNT high-risk counties. The funds from Johnson and Johnson's contributions through the U.S. National Committee for UNICEF have provided a total of 10,979 MCH kits for workers and birth attendants, and training on safe delivery has been carried out for 4,500 MCH workers.

The MCH department of the Ministry of Health is implementing a second project under the cooperation, for the Baby-Friendly Hospital Initiative [1997 budget: US$460,000]. Over 1,500 hospitals have applied to be assessed for baby-friendly status in 1997, and the total number of BFHI certified hospitals in China should reach 6,000 by the end of the year. An international assessment team reviewed the experiences during 1997, including an expansion now underway of the "baby friendly" concept to take it from the hospital to the community. This "Baby Friendly Cities Initiative" in six major cities includes improved policies on maternal leave, and employment of community workers for follow up household visits that support mothers to maintain exclusive breast feeding, and at the same time to monitor and advise on immunization and other aspects of families' infant care practices. BFHI is also being implemented in poorer areas, though access to the BFHI hospital services in the poorer counties is limited by both poverty and geographical constraints, and better coordination will be needed among BFHI, MCH and Family Planning Services delivery systems in such counties in order to reach a larger percentage of such poor rural populations.

The UNICEF-supported IDD project [1997 budget: US$1.23 million] supported advocacy, communication and social mobilization activities relating to the annual IDD day; developed school health education materials; strengthened the national surveillance system and laboratories to monitor salt iodization and IDD prevalence; implemented an epidemiology survey; designed and pretested software for a national information network for IDD control, including health and salt sectors; and trained over 3000 prefecture and county management and technical personnel in 14 provinces. Rate of use of qualified iodized salt in China reached 70 percent, and should improve further once a World Bank loan has been fully implemented for iodized salt production. There was also a nearly 50 percent drop in the goitre rate of school children aged 8-10, from 20.43 percent in 1995 to 10.86 percent in 1997. The project benefits from high-level political support, but there has been a decline in donor support. Problems remain in IDD elimination, including quality assurance systems for iodized salt, and "black market" non-iodized salt especially in poorer areas. Issues raised by the 1996 international review of IDD, for example relating to coordination between health and salt sectors for communication and marketing efforts, have yet to be addressed. Up to this time, there has been no official response from the government to the recommendations of those 1996 assessments supported by international donors.

The Nutrition project [1997 budget: US$190,000] supported the Chinese Academy of Preventive Medicine to improve nutrition surveillance, with 1997 preparations for 1998 field surveys including work on questionnaires, methodologies and training materials, along with designing of surveillance guidelines, development of computer software, and training of some provincial

trainers. UNICEF also supported the preparation of the Regional Technical Assistance (RETA) studies, mentioned earlier. A second sub-project with the Ministry of Health food inspection division developed advocacy and pilot nutrition interventions for county-level pilot interventions (30 counties), including training of village doctors, and parents classes. County base-line surveys have found surprisingly high prevalence rates of malnutrition in some of the poor project counties, (ranging as high as 48.2 percent in one project county), and very low levels of nutrition knowledge among parents.

The "Primary Health Care and Hospitals" project [1997 budget: US$255,000] published and distributed training materials in 10 provinces, covering treatment protocols for diarrhoea and ARI, as well as neonatal resuscitation and use of oxygen and heater systems in the small hospitals. More than 1200 doctors from remote county hospitals of five poorer provinces were given case management skills training under one sub-component of the project. Another component focuses on training personnel from hospitals and health stations at the lower levels of townships and villages, especially on treatment protocols for ARI and diarrhoeal diseases. Some 1997 efforts were made to improve the coordination of implementation of the two subprojects, which are being vertically implemented by two separate departments of the same directorate.

In the Health Education project [1997 proposed budget: US$253.000] counterpart officials and UNICEF OCB failed to reach agreement on the annual plan of action. The project sought to continue in 1996-2000 with a 1990-95 approach of a vertically organized pilot initiative, and sought support for this from UNICEF including supplies, equipment, and training subsidies for intensive work in 18 project pilot counties. The programme plan of operations as approved for this project in 1995 had foreseen that it would develop strategies and plans of action that could bring professionalism to NPA-related health education in at least 700 counties by year 2000. Despite extensive consultations over a six months period, the gap of expectations between UNICEF and project management could not be bridged. A limited number of activities (totaling US$45,600) were approved to develop materials and carry on with evaluations of past activities, while the remaining project funds for which no PPA could be approved were rephased into country programme intersectoral reserves, for reprogramming in 1998.

The Health Finance project [1997 budget: US$104,000] carried out baseline surveys in eight additional pilot counties, designed intervention protocols based on these, and established the indicator systems for monitoring and evaluating the health finance pilot interventions. All ten counties have now developed their protocols. Intensive process monitoring was also carried out in the two counties which started in 1996, in which village level experiments in community financing of medical care have already begun. UNICEF also supported meetings to bring the researchers and local project implementors together to share experiences and strengthen their research and intervention protocols, including involvement of county and township leaders from government and health sector. Issues to be given greater research attention in 1998 include constraints on financing arising in the very poor counties, refinement of payment models, design of cost controls and

essential health services. Additional funds are also needed to support the training of local staff.

Staffing constraints in UNICEF's Health section during 1997 prevented sufficient management attention to fundamental issues of strategy reorientation in the sector. While there was evident progress in implementation of the individual health projects during 1997, basic issues affecting the overall health programme remained largely unaddressed. The sector has not moved towards evolving a unified strategy and approach for addressing the problems of the poverty areas, nor is it clear how it will move forward towards a rights-based approach in its cooperation with UNICEF.

Some of the key issues needing attention, from the broader perspective of the health programme, are:

-- Problems of inefficiencies, overlaps and lost synergies arising from the highly verticalized organization of the sector and the projects. These constrain development of strategies to "go to scale" with pilot interventions for achieving NPA goals. For example, the vertical initiatives of MCH, nutrition, BFHI, PHC and hospitals, and health education, each in their own pilot counties, are addressing interrelated issues, developing their own training and health education materials that often overlap with each other, and with the health worker training and health education components of national programmes such as EPI and IDD. At township and village levels where service delivery actually takes place, these vertical projects are using the same grassroots delivery systems.
-- Overreliance on donors, for example for basic cold chain equipment, to pay annually for vaccines of the polio eradication drive, to support essential in-service training in such areas as disease surveillance, IDD, and MCH; these reflect unaddressed issues of financing and sustainability of public health responsibilities, and fallback on external support only delays necessary action on the critical issues of programme sustainability.
-- While MOH departments are active individually in seeking funds, the sector as a whole lacks a unified strategy for resource mobilization for public health and for children and women. A credible resource mobilization strategy will need to be linked to managerial reforms that reduce overlaps and maximize efficiency of use of resources in the sector.
-- Most planning and budgeting for the social sectors are being done at decentralized levels, but decentralized capacities remain weak in health assessment, analysis and planning, especially in the poorer areas. Project-based initiatives to improve those capacities usually have narrow and verticalized objectives, and these approaches are insufficient to enable achievement of NPA goals.
-- Local leaders need guidance, coordinated technical support, and clear lines of accountability to achieve NPA goals. At present, they receive guidelines only from vertical programmes, often with overlapping requirements and consequent high costs.
-- Data collection and analysis on children and women in health remains weak, with data collection scattered across departments, and not widely shared on a timely basis. This situation weakens efforts both of the sector and of

intersectoral partners to strengthen planning, advocacy and resource mobilization for children and women. Basic policy decisions are also needed on disaggregation of data and its use in planning and priority setting.

HIV/AIDS Initiatives

UNICEF Beijing supports a National-Level HIV/AIDS sub-project [1997 budget: US$171,000], implemented through the AIDS division of the MOH, and also a province-based initiative in China's southwestern Yunnan province (1997 allocation: US$154,000), funded under regional project funds provided by the Netherlands government for HIV/AIDS control work in the five-countries' Mekong river basin.

Efforts in Yunnan have focused on developing capacity for coordination and implementation by the provincial government, local governments, and local organizations. Thus, UNICEF has been working closely with the Vice-Governor's office to advocate and build capacity for a multisectoral approach, and to upgrade and expand the staffing of the Yunnan AIDS Office. The capacity for increased coordination and implementation are being built similarly with prefecture, county and township equivalents, along with strategic selection of project sites to cover minorities as well as Han; rural as well as urban; and with special attention to high HIV-prevalence border areas where populations move frequently across the borders. Extensive experience exchange and training activities have been organized with Thailand, including a six weeks professional attachment for seven officials drawn from provincial, prefectural and county levels, in order to transfer the experiences and lessons learned from Thailand for development of pilot activities in China.

Focus of pilot initiatives have been on a small number of sectors able to reach young people, school children and women effectively, such as linkage with the Yunnan/Australian Red Cross Peer Education Project, the Women's Federation, and the China Association for Science and Technology. Multi-country links are also being strengthened through planned cross-border meetings with Northern Vietnam, Myanmar and Northern Thailand, including a 10-day study visit planned and financed by Yunnan provincial and prefectural officials.

Based on such exposure to successful experiences elsewhere, a range of initiatives are being developed for pilot implementation in Yunnan, including women's training, textbook preparation, training of non-formal teachers from border and minority population areas, training of entertainment establishment owners, peer education programmes (with Yunnan/Australian Red Cross), and promotion of participatory, school-based communication activities (developed by SCF-UK with the Yunnan Education Commission).

The national project attempts to expedite linkages and multisectoral approaches to HIV/AIDS control. Professional consultancies by officials who have pioneered multisectoral approaches in Thailand helped Chinese government officials to develop plans. With its Yunnan experiences as a base, UNICEF national activities also seeks to disseminate examples of intersectoral approaches through

activities of the national project, The National Level project is also supporting the beginning of a pilot project for harm reduction among drug users in Xinjiang province. Another national, school based pilot project was begun in 1997 with Beijing Medical University and the State Education Commission.

Challenges remain to institutionalize the kind of multi-sectoral approach needed to succeed in HIV/AIDS control, in the contexts of vertically organized government structures. To get into a position to go to scale with these initiatives will require nurturing of successful examples of the approach, at grass-roots levels, capacity building of HIV/AIDS control officials to plan and promote such approaches, combined with continuing strong advocacy with higher-level government officials, particularly to ensure that HIV/AIDS control efforts are based on the needs and realities of members of the risk groups whom they are targeting.