

# **Country Cooperation Strategy: WHO China**

## **Strategic priorities for 2004-2008**

**The Office of the World Health Organization  
Representative in China**

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## **Preface**

In 2002, the Country Focus Initiative was announced by the Director-General of the World Health Organization (WHO) at the Fifty-fifth World Health Assembly. This initiative builds on strong global support for greater focus on countries. The overall purpose of this initiative is to improve WHO's contribution to health and development within countries, and to enable the countries themselves to exert greater influence on global and regional public health action. The Country Cooperation Strategy is the key instrument to focus WHO's work on countries' priorities. The Country Cooperation Strategy combines realistic assessment of country needs and priorities taking into account corporate priorities and strategies to define strategic priority areas of work for country offices for the medium-term (three to five years).

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## *LIST OF ACRONYMS*

ADB	Asian Development Bank
AIDS	Acquired immunodeficiency disease syndrome
ARV	Antiretroviral
AUSAID	Australian Agency for International Development
CCA	Common Country Assessment
CCDC	China Center for Disease Control
CCS	Country Cooperation Strategy
CHD	Child and Adolescent Health and Development (WPRO programme area)
CIDA	Canadian International Development Agency
CSR	Communicable Disease Surveillance and Response (WPRO programme area)
DALY	Disability-adjusted life year
DOTS	Directly observed treatment (short course chemotherapy)
DSB	Diplomatic Service Bureau
DFID	Department for International Development of UK Government
ECP	External Cooperation and Partnerships (WPRO programme area)
EHA	Emergency and Humanitarian Action (WHO programme area)
EPI	Expanded Programme on Immunizations (WHO programme area)
FAO	Food and Agriculture Organization of the United Nations
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HIN	Health Information and Evidence for Policy (WPRO programme area)
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HRD	Human Resources for Health (WPRO programme area)
HRF	Health Systems Development and Financing (WPRO programme area)
HSA	Health Situation Analysis
HSD	Health systems development
HSE	Healthy Settings and Environment (WPRO programme area)
IBRD	International Bank for Reconstruction and Development (The World Bank)
ICC	Interagency Coordinating Committee
ICP	Inter-country programme
IDA	International Development Association (of the World Bank)
IEC	Information, education and communication
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illness
JICA	Japan International Cooperation Agency
MDGs	Millennium Development Goals
MMR	Maternal mortality ratio
MOH	Ministry of Health
MVP	Malaria and Other Vector-borne and Parasitic Diseases (WPRO programme area)
NCD	Non-communicable Disease/s, including mental health (WPRO programme area)
RMB	Renminbi (Chinese currency)
RPH	Reproductive Health (WPRO programme area)
SARS	Severe Acute Respiratory Syndrome
SAWS	State Agency for Work Safety
SEPA	State Environmental Protection Agency

SFDA	State Food and Drug Administration
SIDA	Swedish International Development Cooperation Agency
STB	Stop TB and Leprosy Elimination (WPRO programme area)
STD	Sexually transmitted diseases
STI	Sexually transmitted Infections
TDR	Programme on Tropical Disease Research
TFI	Tobacco-free Initiative (WPRO programme area)
TRIPS	Trade-related aspects of intellectual property rights
UN	United Nations
UNAIDS	United Nations AIDS programme
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNIDO	United Nation International Development Organization
UNFPA	United Nations Population Fund
UNTGH	United Nations Theme Group on Health
USD	United States dollar/s
US HHS	United States Department of Health and Human Services
WHO	World Health Organization
WPRO	Western Pacific Regional Office (of WHO)
WTO	World Trade Organization

## **Section 1. Introduction to the China Country Cooperation Strategy**

Since the establishment of a WHO Representative Office in China in 1981, China has undergone a dramatic economic and social transition with major impact on health. Since China contains 80 percent of the Region's and one quarter of the world's population, this has important implications for WHO's work at the country, regional and global levels.

China's size and diversity presents unique challenges. Incomes are rising. Birth rates are falling. There is mass migration to urban areas. While non-communicable disease account for over 80 percent of mortality, communicable diseases and malnutrition continue to take their toll in areas where development has lagged, primarily in western China. Progress towards the Millennium Development Goals indicates that China is currently on track with impressive gains in poverty reduction, education and health over the past two decades. However, MDG targets for the environment and HIV/AIDs and TB control have been missed, and progress toward reduced childhood and maternal mortality targets is slowing. Emerging infectious diseases, such as SARS and influenza, are increasingly important, as are health-related trade issues such as food safety.

In the midst lies a dynamic and complex financing environment for health. The initiation of market reforms in the 1980s resulted in decentralized financing of health services to the lowest administrative levels and huge disparities between more and less developed areas. Widespread reliance on service fees to fund health programmes has created barriers to access to basic preventive and curative services for poor populations. While this approach allowed the government to meet increased demands for health services with little increase in public funding, it also led to systematic under-investment in public health and preventive services that do not provide sufficient market returns.

In the spring of 2003, SARS, a deadly disease caused by a new respiratory virus emerged in southern China and spread to major urban centers worldwide, with enormous economic and political consequences. The global cost of the outbreak is estimated at US\$11 billion. The profound political, social and economic consequences of the outbreak constituted a wake-up call to the government and there are signs that an important new chapter may be opening on public health in China, with recent increases in central funding for public health. The current political environment and commitment to redressing long-standing weaknesses in the health system have created unprecedented opportunities to engage the government at the highest levels in health systems reform. Continued advocacy and strong partnerships, however, are needed to ensure long-term political commitment to provision of a basic package of essential public goods for health.

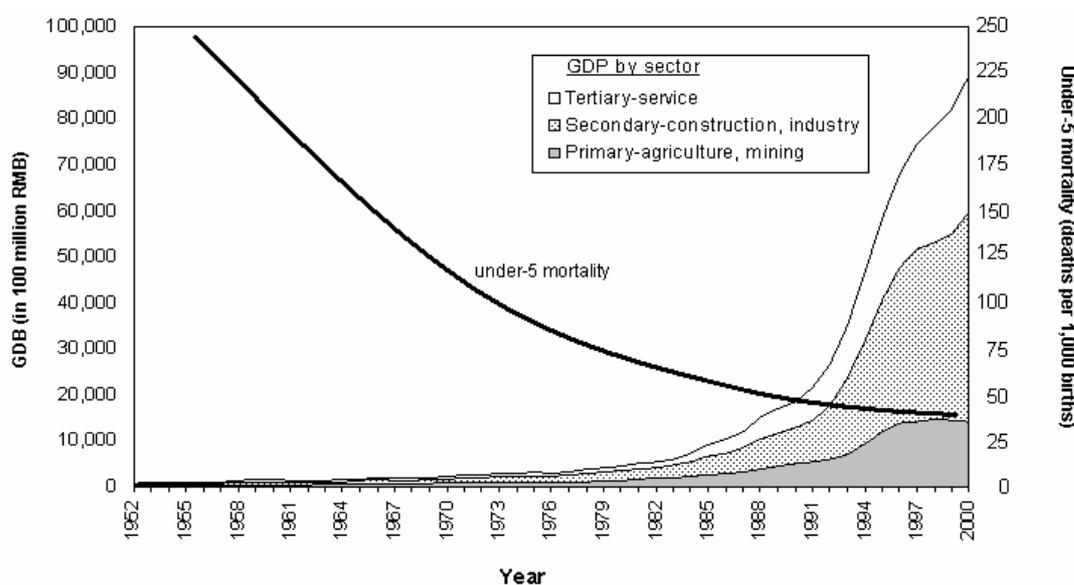
In light of the many and rapid changes in China, a clear analysis of priorities for WHO's work in China is timely and necessary. The Country Cooperation Strategy outlines strategic priorities for the WHO Office in China over the next 3-5 years and was based on an iterative process initiated in mid-2003. It reflects contributions of WHO staff at the country, regional and headquarters levels. In addition, it takes into account other priority-setting processes linked to health, such as the 2003 UN Progress Report China's Progress Towards The Millennium Development Goals, the Health Situation Assessment of the UN Theme Group on Health and Health Partners, and the UN Development Assistance Framework. Finally, careful review of existing data and frank and open discussion with national and international partners regarding WHO's role in China were instrumental in guiding the development of the CCS.

## Section 2. Health and Development Challenges

### The macro picture

In the 1980s, the overall picture of development in China gave way from one of rapid social development and limited economic growth to a period of rapid economic growth with more limited social development (*Figure 1*). The establishment of a solid foundation for education, public health and gender equality following the creation of the People's Republic of China paved the way for the explosive growth following the market reforms and economic liberalization policies implemented in the early 1980s. China's transition from a central planned to a market economy may be an unprecedented success, with annual growth rates averaging 8-9 percent.

Figure 1. GDP growth by sector and under-5 mortality rates, China, 1952-2000



Source: China Statistical Yearbook 2002 (UNIDO analysis) and Ministry of Health

Unfortunately, the rapid economic growth of the past two decades has not been reflected in increasing public investment in health. As a proportion of GDP, the share of public social sector expenditure has steadily gone down in real terms. Excessive reliance on market incentives has skewed delivery of services and created large inequities in access and health outcomes between eastern and western China, the rich and the poor, and urban and rural populations. Poverty, combined with limited access to quality preventive and clinical services, has placed a disproportionately large burden on the health of the estimated 200 million rural poor and 100 million urban migrants. Overall, an estimated 85% of the population lack health insurance and out-of-pocket payments constitute the majority of growing health expenditures. At the same time, the economic power of some provinces weakens the control that can be exerted by central government, and limited central revenues reduce the potential for financial redistribution between the more and less privileged parts of the country.

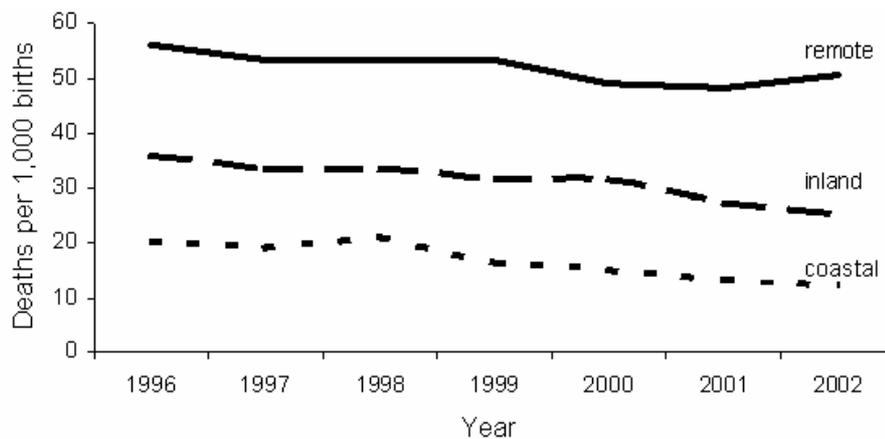
Industrial expansion has fueled migration to urban centers, where an estimated 30 percent of the population now resides. In addition to urbanization, China is also undergoing an unprecedented demographic transition with rapidly falling birth rates and a large and growing

elderly population. These economic, demographic and migratory transitions have an enormous impact on the overall picture of health in China.

### Health profile

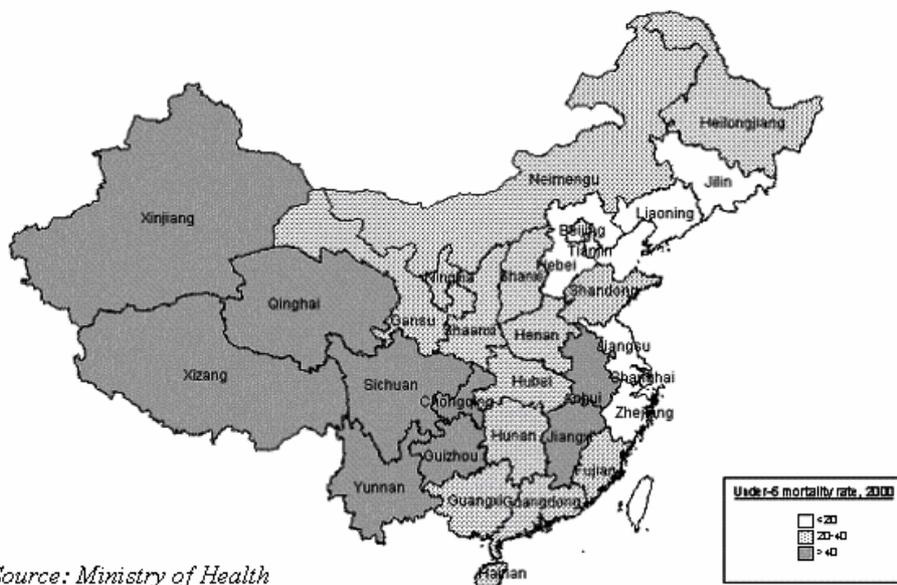
Overall, people in China are living longer and healthier lives. The average life expectancy is 71 years (*World Health Report 2002*). From 1990 to 2000, the infant mortality rate fell from 65 to 31 and under-5 mortality dropped from 61 to 40 (*UN, 2003b*). With the exception of the environment and HIV/AIDS and TB control, China is currently on track to meet the MDG goals by 2015. Progress, however, appears to be slowing in less developed areas of western China (*Figures 2-3*). Infant and under-5 mortality rates, widely accepted and used indicators of access to basic health services, are much higher in western China compared to eastern China, where rates rival those of industrialized countries. A similar geographic pattern emerges for most basic health indicators such as life expectancy and maternal mortality, and largely parallels levels of regional economic development. Without accelerated progress in less developed areas, China may fail to achieve several MDG goals related to health.

Figure 2. Infant mortality rates by region, China, 1996-2002



Source: 2002 Data Compilation of National Surveillance on Maternal and Child Health, Ministry of Health, 2003

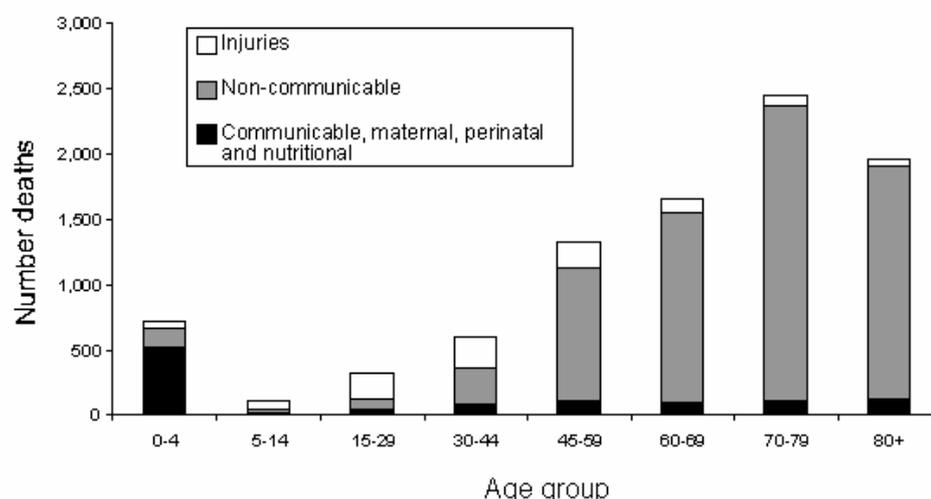
Figure 3. Under-5 mortality by province, China, 2000



Source: Ministry of Health

China's overall disease profile now resembles that of a developed country with more than 80 percent of deaths due to non-communicable diseases and injuries (**Figure 4**). These national averages, however, mask considerable regional disparities with the communicable disease burden concentrated in young children in poor regions.

Figure 4. Estimated mortality by cause and age-group, China, 2002



Source: Global Programme for Evidence in Health Policy, WHO

The leading causes of death and disability-adjusted life years (DALYs) are shown in **Table 1**. Cerebrovascular disease, chronic obstructive pulmonary disease, and heart disease account for approximately 40% of all deaths. The DALY rankings show a slightly different pattern but still highlight the predominance of noncommunicable diseases. Among infectious diseases, only lower respiratory infections, hepatitis B virus infection (the main cause of liver cancer) and tuberculosis account for significant mortality and DALYs lost.

Table 1. Leading causes of death and disability-adjusted life years (DALYs), China, 2002

Rank	Disease or injury	% total deaths	Rank	Disease or injury	% total DALYs
1	Cerebrovascular disease	18.1	1	Cerebrovascular disease	7.3
2	Chronic obstructive pulmonary disease	14.1	2	Unipolar depressive disorders	6.3
3	Ischaemic heart disease	7.7	3	Conditions arising during the perinatal period	5.6
4	Stomach cancer	4.6	4	Chronic obstructive pulmonary disease	4.6
5	Liver cancer <sup>1</sup>	3.6	5	Road traffic accidents	3.7
6	Trachea, bronchus and lung cancers	3.5	6	Self-inflicted injuries	2.8
7	Conditions arising during the perinatal period	3.0	7	Lower respiratory infections	2.6
8	Self-inflicted injuries	3.0	8	Ischaemic heart disease	2.6
9	Lower respiratory infections	3.0	9	Vision disorders, age-related	2.5
10	Tuberculosis	2.9	10	Diarrhoeal diseases	2.5

<sup>1</sup> An estimated 70% of liver cancer deaths in China are caused by chronic hepatitis B infection, usually acquired during early childhood

Source: Global Program for Evidence in Health Policy, WHO

These trends indicate that the main challenges for China's health system will include improving access to quality health services in sustainable and more equitable ways;

strengthening the public health system and improving access to preventive health services; and developing the evidence base and capacity for health policy development, especially in the areas of institutional reforms, financing and regulation.

### Health sector development

While there appears to be growing commitment on the part of government to redress the imbalance between social and economic development, the political and economic context remains complex. The draft Health Situation Assessment report of the Health Partners' Group–UN Theme Group on Health<sup>1</sup> recently analyzed the main issues in health system development in China. The report notes that as China moves toward a desired *xiaokang* society -- in which the resulting economic and social benefits are shared by all -- balancing economic and social development will be critical. The time-frame and role of the government in achieving a *xiaokang* society, however, were not defined. While there are specific health challenges related to the burden of disease and public health, the Government also needs to address the impact upon health of policies concerning economic reform, urbanization, infrastructure development, labour and enterprises and financial market reform.

Inclusion of public health in the sweeping market reforms has skewed investment to those services that generate the most revenues rather than those services that offer the most health benefit. Reliance on user-fees has placed a market value on public health care and limits the ability and authority of the government to manage this important "public goods" function. By the late 1990s, the percentage of local public health department revenues derived from service charges reached 60 percent (Liu 2004). Staff bonuses are also based, in part, on the amount of revenue generated by each division with little incentive to provide preventive services. Discussions with stakeholders clearly indicate that systems-related constraints are hampering the effective achievement of health outcomes through the various technical programs in health.

In addition, lack of cohesive central responsibility for health issues constrains the effective and efficient delivery of public health goods. At least nine ministry-level agencies have significant health authority (**Box 1**). In addition to these Ministry-level agencies, key public health institutions, such as national and local Centers for Disease Control, the Chinese Academy of Engineering, the Chinese Academy of Medical Sciences, and the National Institute for Control of Pharmaceuticals and Biological Products, are only publicly funded in part, and generate the balance of operational funds through service charges and product sales.

Other ministries that oversee major industrial sectors, such as the Ministry of Defense, Ministry of Railways and Ministry of Mining, maintain separate clinical and public health systems that are outside the jurisdiction of the Ministry of Health. Health policy is also strongly influenced by policies of the State Development Reform Commission under the State Council. The National Women's Federation plays an influential role in social mobilization and advocacy for children and women's health issues. Despite the recognized fragmentation of health responsibilities, no single health agency is responsible for coordinating health activities and inter-agency collaboration is weak.

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<sup>1</sup> The Ministry of Health is a key member of this group.

Box 1: Ministry-level agencies with health authority

Ministry of Health	Disease control, health statistics, medical administration, rural health insurance, urban health, maternal and child health, emergency response
Ministry of Labor and Social Security	Urban health insurance and occupational health
Ministry of Science and Technology	Health research
Ministry of Construction	Urban water and sanitation
Ministry of Civil Affairs	Rural health security and community health
State Food and Drug Administration	Safety regulation and licensing of food, drugs and biologicals
State Environmental Protection Administration	Air and water quality
State Family Planning Council	Family planning and reproductive health
Administration for Quality, Supervision, Inspection and Quarantine	Health inspection, quarantine and food safety
Administration for Work Safety	Occupational health

Concerns related to human resources in health include quality of skills and imbalances in distribution, with—generally speaking—shortages at the central level and overstaffing at the periphery.

*Key health policy issues: A changing context*

The political fall-out from the 2003 SARS outbreak may well become a watershed event in public health reform in China. SARS made the link between health and economic development immediate and obvious. Moreover, China's early response to the epidemic threw the spotlight on inadequacies of the country's public health system. It is evident from interactions with Government and key development agencies that this is seen as an opportunity to redress long-standing systemic problems. It is equally evident that, even if other agencies are involved as financing partners, the Government (particularly the MOH) will look to WHO for advice and support in this area. The prompt and effective technical assistance given during SARS has clearly increased WHO's credibility with the MOH and its leadership role among partners in the health sector. As China considers reforming its health care system, WHO is well-placed to encourage the government to look at public health as a package of "public goods" it provides to citizens, and indeed, this was a key message in the WHO China report *Public Health Options for China: Using the lessons learned from SARS (WHO China Office 2003)*.

Initial signs indicate that lessons from SARS are being institutionalized and will accelerate ongoing public health reforms. A Vice-Premier remains Minister of Health and has declared rural health reform a priority. A new position of Executive Vice Minister created during the SARS outbreak has strong links to the Ministry of Finance and the State Council. In 2004, an additional 10 billion RMB (US\$1.2 billion) was allocated by the Ministry of Finance and the National Development Reform Commission to strengthen public health infrastructure and public health response. Performance standards for public health institutions are now being developed by the Ministry of Health with analysis of funds needed from various levels.

Health is likely to be listed as a major development priority in the 11<sup>th</sup> 5-Year Plan (2006-2010) with implications for increased political and financial support. However, development of

a more functional health system in China that provides universal access to a basic package of quality preventive and clinical services, especially for rural populations and the urban poor, will require major structural and financial reforms, including central transfers to providers for delivery of preventive and public health services.

### Section 3. Development Assistance: Aid Flows, Instruments and Coordination

In overall financial terms, development assistance accounts for a small fraction (less than five percent) of the national public investment programme of US\$300 billion. This assistance, however, accounts for a much larger part of central investments, as the majority of public investment comes from local governments. As such, these funds facilitate the leverage of central agencies in setting and enforcing policies and disease control programs.

Among UN agencies, WHO plays the central coordinating among health partners. WHO chairs the *UN Theme Group on Health* (UNTGH) and vice-chairs the *UN Theme Group on HIV/AIDS*, and is represented in inter-agency coordinating committees (ICCs) and advisory groups established for specific program areas and global fund activities. Other UN agencies and bilateral partners actively involved in health issues are shown below (**Box 2**). External funding support has primarily focused on the areas of communicable disease control and maternal and child health. Limited funding for environmental and occupational health is provided by UNDP and ILO, respectively. Partner support for non-communicable disease control is limited.

**Box 2: WHO's UN and bilateral health partners in China**

UN country team/ UNDP	UN Development Assistance Framework, UN Millennium Development Goals, Common Country Assessment, environmental health, private sector
UNICEF	Maternal and child health, nutrition, HIV/AIDS
UNFPA	Reproductive health, HIV/AIDS
UNAIDS	HIV/AIDS coordination
ILO	Occupational health and insurance
UNIDO	World Trade Organization, health and trade issues
FAO	Food safety, zoonoses, tobacco control
UNIDO	WTO, food safety, tobacco control
AUSAID	Primary health care, vaccine-preventable diseases, HIV/AIDSs, rural health
CIDA	TB, emerging infectious diseases
DFID	TB, HIV/AIDS, SARS, health systems
JICA	Vaccine-preventable diseases, TB, HIV/AIDS
Luxembourg	Vaccine-preventable diseases
New Zealand	Emerging infectious diseases, health systems development
SIDA	HIV/AIDS
US HHS	Vaccine-preventable diseases, HIV/AIDS, emerging infectious diseases, surveillance, birth defects
World Bank	Rural health, health systems development, health promotion, vaccine-preventable diseases, TB
ADB	Nutrition, surveillance, food safety

The World Bank has a long history of working in health in China. Their health sector portfolio, however, has dwindled in recent years as China is now ineligible for concessional (IDA) loans. The innovative mechanism of “blended”<sup>2</sup> assistance, in which another agency provides a corresponding grant component, has made it possible for World Bank to continue some health projects.

<sup>2</sup> A mechanism through which bilateral grants funds are used to increase the concessionality of IBRD loans.

Global funds grants greatly exceed funding provided by multilateral and bilateral agencies, and play an increasingly important role in influencing the national health agenda. In 2002, a US\$76 million initiative to support introduction of hepatitis B vaccine into the routine immunization programme was funded by Vaccine Fund (US\$36 million) and the government (US\$ 36 million). In 2002, a US\$6.4 million grant for malaria control and a US\$48 million grant for TB control were approved by the Global Fund to fight AIDS, TB and Malaria (the Global Fund). In 2003, an initial Global Fund grant of US\$98 million was approved for control and prevention of HIV/AIDS. In 2004, fourth round Global Fund applications for US\$63 million for HIV/AIDS control and US\$56 million for TB control were approved.

Non-governmental agencies, including universities and foundations, are less established in China but play an important role -- particularly at the grass-roots level.

### **Mechanisms for donor coordination**

Reports suggest that the *UN Theme Group on Health* (UNTGH) and the *UN Theme Group on HIV/AIDS* bring together interests of a wide range of actors and are effective. UNTGH has been involved in preparing the Health Situation Assessment -- a key coordinating process and instrument between partners and the government that will be finalized by the end of 2004. In 2003, the UNTGH was expanded to bring in the many non-governmental organizations working on health. WHO functions as chair and secretariat of this group and the Ministry of Health is a key member. Preparation of the Health Situation Assessment has fostered a valuable sense of collaboration among those involved. Work on Global Fund proposals also seems to have been a positive influence in widening the circle of those involved. These new coordination mechanisms complement the work being done by more traditional forums, such as program-specific interagency coordinating committees.

## Section 4. Current Country Program

Total obligations under plans of action for China in the WHO Programme Budget for the 2002-2003 biennium amounted to US\$11 570 193. However, these figures underestimate total WHO expenditures in China, since inter-country program (ICP) and headquarters funds used in China are not included in the country budget. Obligations by program area for all sources of funds are shown in **Table 2**. Overall, the Expanded Programme on Immunizations and Health Systems Development and Financing accounted for half of total WHO expenditures in China.

Table 2. Total obligations by programme area, WHO Office, China, 2002-2003

Programme Area	Amount (US \$)	%
Child and Adolescent health and development (CHD)	344 746	3.0%
Communicable disease surveillance and response (CSR)	782 684	6.8%
External cooperation and partnerships (ECP)	231 891	2.0%
Emergency and Humanitarian Action (EHA)	35 084	0.3%
Expanded programme on immunizations (EPI)	3 310 817	28.6%
Health information and evidence for policy (HIN)	224 875	1.9%
Human resources for health (HRD)	1 083 468	9.4%
Health systems development and financing (HRF)	2 458 963	21.3%
Healthy settings and environment (HSE)	878 381	7.6%
Sexually transmitted infections, including HIV/AIDS (HSI)	312 416	2.7%
Malaria, other vectorborne and parasitic diseases (MVP)	289 342	2.5%
Noncommunicable diseases, including mental health (NCD)	355 410	3.1%
Reproductive health (RPH)	122 445	1.1%
Stop TB and leprosy elimination (STB)	1 012 203	8.7%
Tobacco free initiative (TFI)	127 468	1.1%
<b>TOTAL (US \$)</b>	<b>11 570 193</b>	<b>100.00%</b>

Source: Plan of Action 2002-2003, Western Pacific Region, World Health Organization

Of these obligations, US\$6 653 494 (58%) were derived from regular budget funds and US\$4 916 699 (42%) were accounted from extra-budgetary funds. With a regular budget expenditure of US\$6 653 494, the country budget of China is the largest of all countries and areas in the Western Pacific Region. Obligations by program area for regular budget funds are shown in **Table 3**. Health Systems Development and Financing received the highest level of financial support from the regular budget in 2002-2003 (US\$2 025 045 or 30.4% of obligations).

Table 3. Regular budget obligations by programme area, WHO Office, China, 2002-2003

Programme Area	Amount (US \$)	%
Child and Adolescent health and development (CHD)	245 390	3.7%
Communicable disease surveillance and response (CSR)	555 276	8.4%
External cooperation and partnerships (ECP)	231 891	3.5%
Emergency and Humanitarian Action (EHA)	35 084	0.5%
Expanded programme on immunization (EPI)	139 009	2.1%
Health information and evidence for policy (HIN)	224 875	3.4%
Human resources for health, including fellowships (HRD)	1 083 468	16.3%
Health systems development and financing (HRF)	2 025 045	30.4%
Healthy settings and environment (HSE)	871 757	13.1%
Sexually transmitted infections, including HIV/AIDS (HSI)	157 031	2.4%
Malaria, other vectorborne and parasitic diseases (MVP)	282 302	4.2%
Noncommunicable diseases, including mental health (NCD)	355 410	5.3%
Reproductive health (RPH)	122 445	1.8%
Stop TB and leprosy elimination (STB)	197 043	3.0%

Tobacco free initiative (TFI)	127 468	1.9%
<b>TOTAL (US \$)</b>	<b>6 653 494</b>	<b>100.00%</b>

Source: Plan of Action 2002-2003, Western Pacific Region, World Health Organization

Obligations by program area for extra budgetary funds are shown in **Table 4**. Extra budgetary resources account for more than half of all funding under the China country budget work plan. Extra budgetary support was focused in selected communicable disease programmes, with 64.5% of these funds obligated for the Expanded Programme on Immunization (US\$3 171 808) and 16.6% for Stop TB and Leprosy Elimination (US\$815 160).

Table 4. Extra budgetary obligations by programme area, WHO Office, China, 2002-2003

Programme Area	Amount (US \$)	%
Child and Adolescent health and development (CHD)	99 356	2.02%
Communicable disease surveillance and response (CSR)	227 408	4.63%
Expanded programme on immunization (EPI)	3 171 808	64.51%
Health systems development and financing (HRF)	433 918	8.83%
Healthy settings and environment (HSE)	6 624	0.13%
Sexually transmitted infections, including HIV/AIDS (HSI)	155 385	3.16%
Malaria, other vectorborne and parasitic diseases (MVP)	7 040	0.14%
Stop TB and leprosy elimination (STB)	815 160	16.58%
<b>TOTAL (US \$)</b>	<b>4 916 699</b>	<b>100.00%</b>

Source: Plan of Action 2002-2003, Western Pacific Region, World Health Organization

With the current process for planning WHO country programmes in China, the ability of WHO to strategically allocate the regular budget to priority programs in collaboration of the Ministry of Health has been limited. The regular budget has traditionally been distributed by the MOH without the benefit of a comprehensive strategic framework, expected results and indicators, or a critical assessment of funding proposals. Funds have been allocated to a variety of institutes that do not always use the funds in a coordinated way or address national health priorities. The *ad hoc* approach to allocation of the regular budget has created an enormous workload and limited public health impact.

Extra budgetary funds, which comprise the majority of resources for some communicable disease programmes such as EPI and TB, have the potential to be used more strategically as funding proposals are initiated and developed in close collaboration with WHO staff. Levels of extra-budgetary funding are closely linked to the presence of WHO professional staff in-country, who play a major role in resource mobilization.

The WHO Office in China currently has 48 fixed and short-term staff. These include seven fixed-term professional staff, five short-term professionals, 11 national staff assigned to specific program areas, 20 general service staff providing office support (secretarial, translation, financial, supplies, travel, drivers, cleaning), one Australian Youth Ambassador, two UN volunteers and two interns. Of the seven professional staff, only two (22%) are funded by the WHO office budget, with the remaining staff largely funded from extra budgetary funds.

At present, national staff fall into three categories: secondment from the Diplomatic Service Bureau (DSB), secondment from the Ministry of Health or State Family Planning Commission, and direct hire. The DSB has agreed that seconded staff from their Bureau can be converted to direct hire status; however, the Ministry of Health has not yet agreed to allow any change in status of staff (National Programme Assistants) seconded from their Ministry.

Office staffing has nearly tripled in the past five years due to expanded support for a greater number of programs—in particular CSR, HIV/AIDS, TB, EPI and HSD—as well as increased numbers of general support staff to improve program management. Since this expansion in staffing has been largely driven by earmarked extrabudgetary funds, under-funded programmes

remain understaffed. For example, there is still no full-time professional staff working on noncommunicable diseases. Additional information on current and projected staffing needs is presented in *Section 7. Implications for the Country Office*.

## **Section 5: WHO Corporate Policy framework: Global and Regional Directions**

### WHO corporate policy framework

WHO's mission, as set out in its constitution, remains the attainment, for all people, of the highest possible level of health. Several challenges have emerged from the significant developments in international health in the last decade, including deeper understanding of the links between poverty and ill-health, the relationship between macroeconomic policies and health and the importance of investing in health; the greater complexity of health systems; increasing prominence for 'safeguarding health' as a component of humanitarian action; and a world increasingly looking to the UN system for leadership. WHO has developed a corporate policy framework to guide its response to this changing global environment and to enable WHO to make the greatest possible contribution to world health.

The policy framework continues to reflect the values and principles articulated in the global Health for All policy, re-affirmed by the World Health Assembly in 1998, emphasizing:

- adopting a broader approach to health within the context of human development, humanitarian action and human rights, focusing particularly on the links between health and poverty reduction;
- playing a greater role in establishing wider national and international consensus on health policy, strategies and standards by managing the generation and application of research, knowledge and expertise;
- triggering more effective action to improve health and to decrease inequalities in health outcomes by carefully negotiating partnerships and catalysing action on the part of others;
- creating an organisational culture that encourages strategic thinking, global influence, prompt action, creative networking and innovation.

### WHO's goal and priorities

The Organization has committed itself to promoting the achievement of the Millennium Development Goals, most of which are either directly or indirectly related to health. With the emergence of HIV/AIDS as a global priority, WHO is also strongly committed to the goal of HIV/AIDS prevention, care and treatment, particularly to achieving the 3 x 5 target--providing 3 million AIDS patients with anti-retroviral (ARV) treatment by the end of 2005. China is a priority country under the 3x5 Initiative in the Western Pacific region.

In addition to these strategic directions, WHO has also defined specific priorities for the biennium 2004-2005, based on criteria including: the potential for significant reductions in the burden of disease using existing cost-effective technologies (particularly where the health of the poor will demonstrably benefit), and the urgent need for new information, technical strategies, or products to reduce a high burden of diseases. The specific priorities are malaria, HIV/AIDS, TB; maternal and child health; mental health; tobacco; non-communicable diseases; food safety; safe blood; and health systems. In light of these priorities, the next Global Programme of Work, for 2006 and beyond, is currently under development.

WHO's overall goals are to build healthy populations and communities and to combat ill-health. To attain these goals, the following four interrelated strategic directions have been set for WHO's areas of work:

- reducing excess mortality, morbidity and disability, especially in poor and marginalised populations;

- promoting healthy lifestyles and reducing factors of risk to human health that arise from environmental, economic, social and behavioural causes;
- developing health systems that equitably improve health outcomes, respond to people's legitimate demands and are financially fair;
- developing an enabling policy and institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.

These four strategic directions are inter-related and mutually supportive, calling for the Organization to build new and broader partnerships. The CCS process in China also follows the recently introduced corporate thrust towards achieving greater country focus and better coordination between the various levels of the organization.

### Regional Emphasis

Within the WHO corporate strategy and in light of emerging health challenges in the Region, the WHO Regional Office for the Western Pacific has tailored its own supporting framework for action around four outcome-oriented themes:

- combating communicable diseases;
- building healthy communities and populations;
- developing a strong health sector; and
- reaching out (which encompasses information technology, external relations and communication).

Recent trends in the Region with potentially significant impacts on health status include large proportions of people living in poverty, the transition to market economies, globalization, population growth, ageing, environmental factors associated with urbanization and industrialization. Although communicable diseases still impose a heavy burden, non-communicable diseases are becoming increasingly important throughout the Region. Emerging and re-emerging diseases have been a major public health issue in several countries of the Region, in particular the outbreak of SARS and, more recently, avian influenza. Tuberculosis is a particularly serious problem—since China is a high burden country, sustained progress here is critical to the success of the regional Stop TB Special Project. Likewise, with an estimated 10 percent of China's population chronically infected with hepatitis B virus and at high risk of developing liver cancer and cirrhosis, successful prevention of hepatitis B infection through childhood immunization is a high priority. Health systems in many countries of the Western Pacific Region are under-developed and several are still struggling to deliver a minimum level of health services to all areas. Consequently, upgrading the Region's health systems is a major challenge.

## Section 6. Strategic Agenda for China: The Next 3-5 Years

### Setting priorities within the CCS

Following discussions with national and international partners, and country, regional and headquarters WHO staff, and analysis of existing data, a priority-setting matrix for development of this CCS was completed. The eight criteria in the matrix included assessment of:

- disease burden
- political prominence as a public health issue
- government commitment and capacity
- type of support needed
- WHO capacity
- WHO comparative advantage
- partnerships
- funding potential

The assessment showed a clear disconnect between the level of effort/staff capacity and funding in WHO and the burden of disease analysis in China—most obvious in relation to communicable versus non-communicable disease work. However, it was equally evident that WHO's country strategy would have to be based on a wider range of considerations, which mix strategic significance with opportunity. These factors include the degree of political prominence afforded different issues, and—on the other side of the fence—the extent to which WHO has both a comparative advantage and the requisite capacity and resources to be effective.

With increasing national capacity and development, the role of WHO in China is changing. Strategic policy analysis and advocacy are important areas for future growth, as are new and neglected programme areas. For more established programme areas, there is increasing need for much more sophisticated technical assistance as the programmes reach beyond basic implementation goals to address issues of quality, safety and equity. Reaching the remaining hard-to-reach populations will require refocusing of efforts in less developed areas and among urban migrants.

There is concern over the effectiveness of spreading efforts and limited resources over many small-scale projects. In some newer and under-funded areas of work, particularly non-communicable diseases and child health, WHO will need to undertake systematic identification of priority issues and strategies. Where WHO capacity is weaker, advocacy and playing the role of broker among partners may be more suitable, particularly through linkage of CCS priorities with the Health Situation Assessment and UN Development Assistance Framework.

There is a strong emerging demand from government for policy advice in various areas, especially for well-prepared syntheses of international experience on relevant policy issues that allow government to make their own judgments about the best solutions, in light of their assessment of local circumstances and feasibility. Given current resource constraints and the existence of other significant players in the sector, there is a need for WHO to be selective in setting strategic priorities and to work through strengthened partnerships.

Based on these considerations, WHO's main areas of work in China fall into four categories (**Box 3**), each of which is discussed in more detail in the following sections.

### Box 3: Main areas of work in China

- |   |  |
|---|--|
| 1. Focusing on core strengths                                   | <ul style="list-style-type: none"><li>• Vaccine-preventable diseases</li><li>• TB prevention and control</li></ul>   |
| 2. Strengthening areas of strategic importance                  | <ul style="list-style-type: none"><li>• HIV/AIDS prevention and control</li><li>• Communicable disease surveillance and response</li><li>• Health systems development</li><li>• Health and trade</li></ul> |
| 3. Strategy development in new and neglected areas              | <ul style="list-style-type: none"><li>• Non-communicable diseases, including injuries</li><li>• Environmental and occupational health</li></ul>  |
| 4. Enhancing partnerships and adding focus to existing programs | <ul style="list-style-type: none"><li>• Maternal and child health, including nutrition</li><li>• Parasitic and vector-borne diseases</li></ul>   |

#### **1. Focusing on Core Strengths**

##### **Vaccine Preventable Diseases (Expanded Programme on Immunizations)**

WHO plays a key leadership and coordinating role in EPI, with strong technical and financial support. EPI accounted for one-third of country obligations in the 2002-2003 biennium. The program benefits from clearly defined organizational vision and strategies with demonstrable impact on mortality and morbidity. Partners include UNICEF, World Bank, the Vaccine Fund and GAVI, JICA, US HHS, AUSAID and Luxembourg.

The national immunization programme has reached a more advanced level where optimizing impact and improving safety are important areas of growth. Introduction of new vaccines is of high priority, particularly for hepatitis B, the leading cause of communicable disease mortality in China. Introduction of hepatitis B vaccine is supported by a US\$76 million grant from the Vaccine Fund and government for 2003-2007. Other new vaccines, such as Japanese encephalitis, meningococcal meningitis and rotavirus, would have marked impact on health, particularly in children. Resolving the end-game issues of poliomyelitis eradication and developing sustainable strategies to achieve measles elimination are new accelerated disease control priorities.

Increasing the benefits of immunization will require stronger efforts to reach remote, poor and migrant children. As immunizable diseases reach very low levels, safety becomes an increasing public concern, requiring attention to detection of and response to adverse events, vaccine quality and injection safety. China is one of the largest producers and consumers of vaccines, and regulation of vaccine safety and new vaccine use is an emerging priority. With strong support from WHO, regulatory capacity for vaccines has markedly improved. WHO pre-qualification of domestically produced vaccines is expected in two to three years, paving the way for China's entry into the global vaccine market.

The financing situation remains complex with central government funding amounting to less than one percent of total programme costs. Responsibility is decentralized to county and township governments, and service-fees remain an important incentive to deliver immunizations in most areas. While this has led to sustainable and reasonably high coverage, it has also placed a market value on childhood immunizations and resulting inequities in access, coverage and disease burden. Measles incidence, for example, is 10-20 times higher in western China than in

eastern China. Further support for the programme will need to address issues of equitable and sustainable financing, increasing demand for services, and strengthened monitoring of immunization service coverage and quality.

In control of vaccine-preventable diseases, WHO will work to:

- a. Strengthen routine services. In addition to continued support to strengthen program planning, management and logistics in poorer areas through capacity building approaches, WHO will support policy initiatives and increase advocacy to increase public financing of the immunization program to increase coverage. Advocacy efforts will be linked to work in health systems and progress toward Millennium Development Goals. Strategies to reach remote, poor and migrant children, including IEC strategies to increase demand for childhood immunizations in remote areas, will be developed, evaluated and scaled-up.
- b. Expand use of under-utilized vaccines: WHO will support increased use of routine vaccines, in particular hepatitis B and measles vaccine, through new regional initiatives, strengthened enforcement of school entry requirements, and support to evaluate the cost-effectiveness of introducing new vaccines.
- c. Strengthen surveillance and monitoring: WHO will support development of integrated surveillance systems and laboratory networks for detection and diagnosis of vaccine-preventable diseases, and provide support to improve the validity and reliability of the routine coverage monitoring system.
- d. Improve immunization safety and vaccine security: The main areas of work will include strengthening vaccine regulatory capacity, facilitating pre-qualification of global priority vaccines, and supporting surveillance for adverse events following immunization.

## **TB Prevention and Control**

The TB programme illustrates the value of a strong country presence. The core of WHO's work in TB lies in building partnerships; supporting policy development in the national TB programme; ensuring consistency of approach between areas financed by different donors; responding to the technical assistance needs of the MOH and associated institutions; helping the MOH to access additional external resources (e.g., from the Global Fund); and strengthening monitoring and evaluation of the national programme.

WHO's TB work at the country level has been considerably strengthened by clear global and regional TB control strategies and targets, along with strategic support from the global and regional levels of the organization. In addition, TB in China, as elsewhere, has benefited from successful global advocacy, which has mobilized the health, finance and planning sectors to participate in global TB summits.

With in-country staff and relatively modest amounts of discretionary resources, WHO is well positioned to contribute to the national TB programme and add value to the efforts of many other partners.

In the area of TB, WHO will:

- a. Maintain a strong country presence to provide continuing technical leadership to support DOTS expansion through continuing and strengthening the functions outlined above. In particular, WHO is in a unique position to play a coordinating role by bringing together various partners to support the national TB control effort.
- b. Support the development of national policies designed to overcome constraints that prevent the country from achieving global TB control targets by 2005. One key aspect of this is to design and implement pilots that will be scaled up if successful. This includes demonstration projects to address HIV/TB; strategies for improving case detection in the public and private sector; and surveillance for increasing rates of infection with multi-drug resistant strains.
- c. Link its TB work more closely with its health systems work, especially in the areas of correcting disincentives in DOTS financing and strengthening the inadequate human resource capacity for DOTS implementation through development of a human resource development plan. On the other side of the coin, our work in TB will provide a window on the effectiveness of health sector reform.

## **2. Strengthening Areas of Strategic Importance**

### **HIV/AIDS Prevention and Control**

While the incidence and prevalence of HIV infection are still low<sup>3</sup> and limited to certain high-risk populations, rapidly increasing rates of other sexually transmissible diseases during the past 5 years indicate the potential for high rates of heterosexual transmission in the general population.

A total of US\$161 million for HIV/AIDS control in China was approved in 2003-2004 from the Global Fund. In addition to meeting the goals of WHO's 3 x 5 Initiative, a comprehensive SIDA-funded HIV/AIDS control project will be implemented by the WHO in 2004-2006, with funding for two long-term professional staff. This will greatly increase capacity to provide technical assistance and policy advice.

The main areas of work in HIV/AIDS control in the next 3-5 years will include assisting the government strengthen surveillance and information systems, develop effective preventive strategies, and expand access to care and treatment strategies.

Specifically, WHO will:

- a. Strengthen its leadership role in the development of information systems, including development of a Strategic Information Framework for policy development and monitoring. This will include policy development, development and evaluation of national standards and guidelines, technical support, capacity building and donor coordination.
- b. Develop, in collaboration with partners, targeted interventions that focus on condom promotion in the commercial sex industry (100% condom use programme); condom quality; intravenous drug use and harm reduction; STI prevention and treatment; and

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<sup>3</sup> There are currently an estimated 840,000 persons infected with HIV and approximately 80,000 persons living with AIDS in China (*United Nations, 2003*).

migrant populations. Acting as broker and facilitator, WHO's role in direct implementation will increasingly be reduced in favor of supporting the MOH and other organizations to synthesize the policy implications of interventions. In the meantime, WHO through its increased country presence will increasingly support the implementation of policy and advocacy at the provincial level.

- c. Work with MOH to improve blood and injection safety.
- d. Improve access to care and treatment strategies articulated in the 3 by 5 Initiative. While direct engagement in pilot/demonstrations is not precluded, WHO will focus on scaling-up ARV treatment and care through large existing programmes, such as China CARES and the Global Fund project. Technical support will include evaluating, development of protocols and guidelines, assessing and monitoring systems and needs, strengthening capacity for implementing treatment, and assisting the MOH coordinate the inputs of the large number of external partners working in HIV/AIDS.
- e. Continue to work with government, as part of the health policy and systems agenda, on policy issues that influence access to, and quality of, ARV and related drugs. These will include issues in relation to trade policy, production of generics and the changes that will come about through the implementation of TRIPS and other agreements negotiated in the World Trade Organization.

### **Communicable Diseases Surveillance and Response**

As do other countries, China remains vulnerable to the economic, political and health threat posed by infectious diseases with epidemic and pandemic potential. Outbreaks of known and preventable diseases—such as measles, influenza, malaria, cholera and dengue—continue to occur in China despite the availability of effective preventive measures. In addition, there is an ever-present threat from possible emergence of drug resistant or new communicable diseases as well as from chemical or radiological contamination of food, water or the environment. The majority of new emerging infectious diseases have been of zoonotic origin, highlighting the need for close links with national authorities responsible for management of domestic animals and wildlife.

The difficulty in initially recognizing, reporting and responding to SARS in 2003 demonstrated the need for improvements in the alert and response system. The speed with which SARS was brought under control during the later part of the outbreak illustrates China's potential to develop such a system, if sufficient resources, political commitment and planning are available. WHO's role over the coming years is to assist in developing a sustainable and robust alert and response system in China and to support China to fulfill its responsibilities as an important member of the international health community.

In the areas of CSR, WHO will work to:

- a. Improve the early detection of events of public health significance through the development of an integrated surveillance system and strengthening of laboratory diagnostic capacity. Key to this will be the creation of a reporting system that will allow epidemiological, clinical and laboratory information from human and animal health, environment and other relevant sectors to be analyzed and made available to all relevant

decision makers. Training in surveillance methodologies and strengthening local decision-making and diagnostic capacity will be important.

- b. Strengthen the response to events of public health significance through improvements in event investigation skills and in the early application of effective community and hospital based public health interventions. Development of investigative protocols, wider dissemination of effective, evidence based interventions and system development to support quality improvement will be important areas of activity.
- c. Prevent the emergence of infectious diseases through improvements in biosafety, closer collaboration with animal sector and strengthening of nosocomial surveillance and health care facility infection control.
- d. Strengthen public health networks to better utilize limited resources and improve domestic and international integration.

## **Health Systems Development**

Excessive reliance on market principles to fund health services has widened gaps between the rich and poor. Revenue generation is required to keep public health services in operation and negatively impacts delivery of major public health interventions such as childhood immunization and TB therapy. Under-funding has resulted in core system weaknesses in disease surveillance and response, infection control, and public health management capacity. In addition, competition for limited resources also limits the development of a coordinated and effective approach to health. While these issues have been recognized as the major barriers to health development in China for many years, the 2003 SARS outbreak has focused political attention and has created opportunities to accelerate much needed reforms.

A stronger country presence in this area is required to meet increasing demand for support. Health system development activities through the China Country Office, along with support from WPRO and WHO headquarters, play an increasingly important role in addressing policy issues linked with public health access barriers, low health service quality, rapidly increasing health care costs and, in general, the undersupply of public goods in health. Health system accountability and limited capacity for the regulation of food safety, HIV/AIDS drug pricing, vaccines and drugs and China's overall health service costs and quality are also major concerns for health system development.

Building effective support for government in health system development requires extensive partnership to promote evidence-based health policy. Greater capacity for investment planning to advance coordinated use of public expenditures for health calls for new linkages between ministries and levels of government. Further, health system development also requires timely policy-directed responses by WHO to meet the technical assistance needs of the MOH and related ministries. Finally, health system development also includes support for MOH efforts to obtain additional external resources and technical support for improved monitoring and evaluation of China's decentralized health system.

In health systems development WHO will:

- a. Continue to contribute to health partnership development through the Health Situation Assessment (HSA) process of the expanded UN Theme Group for Health Partners and the development of partnership collaboration areas under HSA. This work will include

priority areas such as food safety, health system financing, provider system improvement, health security system development, health services quality improvement and health system accountability, and will be completed in Fall 2004.

- b. Support policy development capacity through the DFID-funded Health Policy Support Project to be launched in 2004. The project is a multi-sectoral project with secretariat based in the Policy and Legislation Department of MOH. Key activity areas include pro-poor evidence based policy development, improved health human resource and health finance policies, further understanding of international policy best practices, institutionalization of health policy capacity, and greater capacity for effective health system regulation of costs and quality.
- c. Continue to give special attention to macroeconomics and health principles announced in the document “Health and Macroeconomics in China” prepared with WHO support by the Ministry of Health, National Development Reform Commission and Ministry of Finance (as well as other agencies and along with WHO) in October 2003, and approved by the State Council. Development of medium-term investment plans and WHO involvement with MOH and other ministries in development of the 11<sup>th</sup> Five Year Plan are major parts of this health system development activity.
- d. Promote greater attention to improved health security in China. Urban social health insurance and the New Community Health Systems for rural areas will merge as urbanization, disease transition, economic development and other major social developments proceed. WHO must provide technical support in this area for policy formulation and implementation and for monitoring and management of this critical health system component.
- e. Promote accountability through its support for Sub-national Health Accounts and improved understanding of sub-provincial flows of funds for health. Where possible, WHO will work with other health partners to encourage health services responsive to patient safety, un-met health care needs for the poor and the elderly and, in general, changing demands for health services in China.
- f. Continue to promote health policy development aimed at equitable, accessible, efficient finance reforms for the health system. These initiatives especially seek greater responsiveness and fairness for the most vulnerable and underserved parts of the population.

### **Health and trade – Vaccine, Drug and Medical Device Regulation and Food Safety**

Special concern for health and trade items will continue to be important for health system development in China. The main focus of WHO work in this area will be strengthening national regulatory authority of SFDA for ensuring efficacy and safety of food, drugs and biological products.

Under a program of strong WHO support, SFDA met all critical WHO regulatory functions for vaccines in 2003, paving the way for China’s entry into the global vaccine market. This experience is being used as a model to strengthen regulation of drugs and medical devices. In addition to regulatory functions, technical support is needed to improve the quality of drugs and vaccines, and control prices. SFDA has a new comprehensive coordination and investigation

role in food safety that presents a pressing opportunity for WHO to technically support and influence the development of best practice.

Food safety concerns linked with WTO agreements are high political priorities. Partners include ADB, FAO, World Bank, and UNIDO. In addition to a growing volume of food exports and imports, food safety issues associated with new emerging zoonotic diseases in food animals, such as avian influenza, have important trade implications. WHO will continue its work in this area to keep pace with the increasing importance of trade issues for health in China. SFDA supports a national program officer in the WHO office. Institutionalizing collaboration between the MOH and other parts of government that oversee agriculture and food production and safety constitutes a major challenge.

In this area, WHO will:

- a. Continue technical assistance to review and strengthen national regulatory functions for vaccines, drugs and medical devices, including development and support for institutional development plans and development of a National Drug Policy.
- b. Support pre-qualification review of domestic products identified as global priority vaccines, and work to improve quality of drugs and medical devices.
- c. Strengthen its food safety efforts to provide guidance and technical assistance to SFDA, MOH, Ministry of Agriculture and other key national counterparts to support coordination and improvement of food safety. In particular, this will focus on development of a comprehensive system for a farm-to-table food safety system, as well as supporting regulations.

### **3. Strategy development in new and neglected areas**

#### **Non-communicable diseases, including injuries**

Important non-communicable diseases in China encompass a highly diverse range of conditions such as cardio- and cerebrovascular diseases, tobacco-related illnesses, injuries and mental illness. The economic impact of NCDs is extremely high and growing.

Smoking-related illness and road accidents provides a clear illustration of the magnitude and complexity of the NCD problem in China. China is the world's largest producer and consumer of cigarettes, with over 1800 billion cigarettes sold each year. The cost of tobacco-related illness is staggering, causing an estimated 900,000 deaths each year (Jin *et al*, 1995, in World Bank, 2002). Rates of smoking among women, a huge untapped market, are increasing and an estimated 53% of children are exposed to second-hand smoke illness (Yang GH, 1997). Although smoking is a leading killer in China, taxes on tobacco are the largest single source of government revenue and a lack of cohesive public policy is the main factor for high smoking rates. Some sectors, such as the government state-owned monopoly for cigarettes—the China National Tobacco Corporation—try to expand tobacco consumption while others, such as the Ministry of Health, have taken steps to improve awareness of smoking risks. China has signed but has not yet ratified the Framework Convention on Tobacco Control. Powerful and persuasive advocacy, however, will be needed to put tobacco control on the political agenda.

Road accidents are another leading NCD cause of mortality and disability. Approximately 250,000 persons each year are killed in traffic accidents. Enforcing motor vehicle regulation,

including speed limits and seatbelt use, and improving road conditions will require coordinated action by the Ministry of Health, the Ministry of Transportation, and the Bureau of Public Security.

With continued economic and health transitions, further delays in prevention of NCDs will result in unavoidably huge future costs. While broader engagement in prevention and treatment of non-communicable diseases is needed if WHO is to have any major impact on health in China, the breadth and diversity of disease conditions and control strategies combined with grossly inadequate resources highlight the need for a strategic framework for such engagement. Work would start with the broadest possible definition of work on NCDs and use the strategy development process to narrow scope, and define approaches consistent with WHO's role and comparative advantage. Thus the strategy will set out priorities, approaches and ways of working in relation to:

- the whole range of non-communicable health conditions, including cardiovascular disease, diabetes, cancers, injuries and mental health;
- the risk factors that contribute to them, such as smoking; and
- the settings with which they are associated, including occupational settings, and explicitly outlining the place of injuries and road safety.

In addition to defining WHO's technical focus, the strategy will identify approaches and ways of working to achieve the overall policy objective set out above. It will consider the relative contribution of research, analysis, risk factor surveillance, media and communications work, network and capacity building, engagement of industry, and global and country based efforts. It will also look at the availability of technical and financial resources (from within and outside WHO) in the context of work being carried out or planned by other partners.

Outputs will include a negotiated strategy for WHO's work on NCDs in China. This may include materials to be used in proposals for mobilizing resources. While it is not appropriate to predetermine the exact components of the strategy at this stage, a clear focus for the work will be needed. For instance, while there may be agreement that WHO will not restrict the range of non-communicable conditions to be addressed, it may be decided to focus on quite a narrow range of functions (such as analysis and dissemination of risk factors). Again, the strategy might also determine, for example, that our work in occupational health should focus only on issues around health insurance (perhaps in partnership with ILO), or that the priority in the whole domain of NCDs for the next two years should be the practical aspects of tobacco control.

Within NCDs, WHO will:

- a) Support the development of a national policy framework and plan to evaluate and identify priority areas, including specific disease conditions, strategies for early detection, risk management and prevention, and clinical therapeutic approaches by end 2004.
- b) Develop a WHO plan and identify resources to establish an adequate technical and operational base in the country office to adequately support implementation of the above policy framework and plan.
- c) Promote increased advocacy to raise political awareness and priority afforded to NCD prevention and control.

## Environmental and occupational health

In its discussion of priorities, the CCS team recognized these as areas of *potential* importance, but one in which WHO needs to address fundamental questions as to how or whether it should engage. Increased urban growth and the rapid industrialization fueling China's economic transition bring environmental problems to greater prominence<sup>3</sup>.

The impact of environmental factors in the physical environment on people's health in China is certainly significant. A recent analysis of the burden of disease from selected risk factors (World Health Report, WHO, 2002) estimates that risk factors and outcomes related to the environment to amount to 17% of total deaths in WPR B<sup>4</sup>. These estimates would include, for example, risks related to transportation such as air pollution, injuries, and a proportion of physical inactivity. The extent of impact of environmental factors, however, and the relative contribution of different factors are less clear. There is also need to consider whether, and to what extent environmental issues are best tackled through environmental interventions and/or to what extent specific engagement of the health sector is needed.

The magnitude of occupational injuries is also unclear but likely to be significant given China's level of industrialization and weak regulation of the workplace environment. Social protection of workers is an area with potential for greater partnership, with WHO providing technical support and advocacy. Both MOH and the State Agency for Work Safety are seeking technical assistance from WHO in a wide range of areas related to occupation health including regulation, organization and supervision of occupational health and safety; training for enforcement personnel; control of occupational accidents; health risk control; agricultural and migrant workers' health; establishment of basic occupational health services; and particular health issues such as pesticide poisonings. ILO has been actively working on occupational injury surveillance and compensation and has also requested WHO assistance in development of technical standards and guidelines.

As WHO capacity and resources to address environmental and occupational health issues are limited, development of partnerships and joint activities in selected areas will be critical entry points to support further strategy development.

In environmental and occupational health, WHO will:

- a. Support a survey of indoor air pollution and sanitation in rural areas and conduct a review and analysis of existing literature on environment and health in China to guide strategy development.
- b. Collaborate with UNICEF and others on projects to assess and improve access to safe drinking water.
- c. Support the development of a five -year plan to improve occupational health and safety and develop an occupation health services network; implementation of an action plan through WHO Collaborating Centres in China acting as focal points; and periodic review of the action plan by WHO/HQ and WPRO.
- d. Support the development of intersectoral policies that address national environmental health priorities, within the context of rapid economic growth. This will include applying integrated health, environmental and economic assessment methods to priority issues to be identified by China, as part of the global Health and Environment Linkages Initiative

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<sup>3</sup> Air pollution in six major cities in China ranks among the worst in the world (World Health Report, 2002).

<sup>4</sup> WPR B is a sub region of the Western Pacific region, in which China accounts for 84% of the population.

(for example, the health impact of urban transport policies which include addressing air pollution, injuries, physical activity, climate change).

#### **4. Enhancing partnerships and adding focus to existing programs**

##### **Maternal and Child Health, including nutrition**

Clearly, the achievement of better health outcomes for women and children, are of paramount importance. Over the past decade, childhood and maternal mortality rates have dropped by one-third and China is currently on track to meet MDG goals for reductions in maternal and childhood mortality. Rates of childhood mortality, maternal mortality, infectious diseases of childhood, and malnutrition, however, are much higher in less-developed areas where progress is lagging.

Successful strategies to reduce maternal and infant mortality by increasing hospital delivery have been developed in China and are being scaled up with strong government commitment and funding. A 2000-2001 US\$24 million government-funded project to increase clean and hospital delivery in Western China had demonstrable impact on reducing maternal and neonatal deaths, and has been extended.

Other strategies to improve child health and nutrition have been more modest. The government has supported implementation of the Integrated Management of Childhood Illness (IMCI) strategy, but in a relatively small number of moderately developed counties. Targeted strategies to address micronutrient deficiencies, in particular salt iodination, have also been successfully scaled up by the government with strong support from UNICEF, WHO and the World Bank. Improving child health and nutritional status of children overall, however, has largely been seen by the government as a problem best addressed through policies to accelerate economic growth in western China and by strengthening access to, and the quality of, the basic health system.

China is one of four WPR countries that contribute significantly to the number of childhood deaths globally. In recognition of the lagging progress in child survival, in September 2003, the 54<sup>th</sup> Regional Committee for the Western Pacific adopted a resolution endorsing Member States to place child health higher on the political, economic and health agendas, prioritize child survival interventions, and provide sufficient resources for them. Given existing capacity in country and organizational resources, therefore, the question is one of focus and form of WHO support to maternal/reproductive health and child health and nutrition, in the context of broader constraints in the health system as well as the limited resources to address these issues within WHO. In addition to a health systems approach to addressing maternal/reproductive and child health and nutrition at the country-level, increased advocacy and leadership by WHO will be needed to identify priorities and strengthen partnerships to support achievement of MDG goals for child health.

In the areas of maternal and child health, including nutrition, WHO will:

- a. Conduct a country assessment through disaggregated analyses of sub-regional, age and cause-specific morbidity and mortality in children under-five, including mapping the coverage of essential life-saving interventions and their delivery strategies and examining their effectiveness, and assessing health system capacity to scale up essential child survival interventions with a specific emphasis on human resources and financing of child health care in areas and populations in greatest need.

- b. Assess unmet needs in child survival/health and identify an optimal mix of priority child health interventions and their delivery strategies, and develop a national plan for taking cost-effective interventions to scale with clearly defined targets;
- c. Identify resource gaps and support mobilization of necessary resources;
- d. Provide technical and advocacy support in the implementation of the national plan to improve child survival;
- e. Support the achievement of set goals and specified targets through regular monitoring of progress against core indicators in child health;
- f. Strengthen partnerships and coordination within WHO, government counterparts and partner agencies by reviewing and consolidating child survival goals, building on demonstrated strengths and addressing identified gaps, linking work with health system development, and establishing a mechanism for continued dialogue and joint responsibility.

### **Parasitic and vector-borne diseases**

China's schistosomiasis control program is a strong and well-established program that is regarded as a highly successful model. In some areas, however, reduced funding and attention have resulted in increased rates, particularly in the reservoir areas of the Three Gorges Dam. This program receives limited but important technical support from WPRO and WHO/HQ. In 2001, China received a USD 6 million grant for malaria control from the Global Fund to fight AIDS, TB and Malaria. Malaria and other vector-borne diseases are largely supported and coordinated by the Tropical Diseases Research (TDR) program and the Regional Office. Greater cohesiveness in WHO support to these program areas could be achieved by more country involvement in coordination of activities and planning.

## **Section 7. Implications for the Country Office**

As stated previously, the role of WHO in China has changed and as a result of this Country Cooperation Strategy will change further. There will be greater emphasis on areas of strategic importance such as health systems and HIV/AIDS as well as more cooperation in some new or neglected areas such as chronic diseases. There is a demand from the Government of China for more sophisticated technical assistance based on sound analysis. All of this will lead to continued expansion of the WHO programmes in China with major implications on programme management, relationships with Government and other partners, staffing and the organization of the office.

### Program management

The total country programme budget will continue to increase along with the proportion funded by extrabudgetary sources. At present the regular budget component supports a large number of small projects, which are not always coordinated between them, or integrated with the extra-budgetary funded components, and often lack focus.

In order to ensure that the Country Cooperation Strategy is fully reflected in the programme budget and that the budget is fully integrated, it is proposed that a strategic framework be developed which could be agreed with the Ministry of Health. The Framework would detail strategic approaches and expected results to be achieved for the priority areas of cooperation. The Framework would form the basis for the development of the Programme Budget for 2006-2007 and should be developed in 2004. The MOH would use the expected results in developing the regular budget proposals for 2006-2007.

This should result in a more strategic use of the 2006-2007 Regular Budget and also increase the effectiveness of WHO's work in previously under-resourced areas such as NCDs, environmental health, occupational health, maternal and child health, and nutrition.

### Resource mobilization and direction

The CCS has clearly identified the country priorities and needs, areas for change, and gaps in resources. It will form a key input for the programme budget 2006-2007. However for 2004-2005 lack of resources or imbalance in resource allocation constrains progress in a number of important programme areas. A resource mobilization strategy should be developed for under-resourced programmes. It is also anticipated that the CCS will influence resource flows within the organization.

Besides the Country Cooperation Strategy, the Health Situation Analysis will also be an important process for setting country priorities and influencing partners through a negotiated process that takes into account views of the government and a wide range of partners. This process, which should be completed by the end of 2004, will help to define priority areas for partner cooperation.

### Working relationships with government

The large number of ministry-level agencies with significant health authority has implications for how WHO works in China. While the MOH remains the primary focal point, several key areas of work are the responsibility of other ministries or require a coordinated effort by several ministries. WHO plays an important role in facilitating initial exchange and collaboration between ministries, and in the process has established direct relationships and lines of communications with the SFDA, Ministry of Science and Technology, and Ministry of

Agriculture. Given the expanding scope of work and activities in which WHO will be involved in China, it will be important to maintain and strengthen these relationships to work effectively.

In addition to breadth, depth of working relationships is also an important consideration. With China's size, diversity and largely decentralized funding for health, advocacy, policy advice, and technical assistance at sub-national levels can have enormous impact. In addition, China is increasingly looking to experience in well-documented large-scale projects (one or more provinces) to guide central policy formulation and guidelines. This has implications for increasing work at sub-national levels and focusing of efforts to western China, where the needs are greatest.

In addition to government agencies, increasing country collaboration with the WHO Collaborating Centres in China may be an effective way to strengthen work in new and under-resourced areas. At July 2004 there were more than 70 WHO Collaborating Centres in China. Many of these institutions are recognized centres of excellence. However, a number of them have no active collaboration with WHO. Ongoing review of the Collaborating Centres should continue and increasing the depth of collaboration with a smaller number of Collaborating Centres is a priority.

### Staffing

Progress in the first two program categories—which include vaccine preventable diseases, TB, communicable disease surveillance response, HIV/AIDS, health systems development, and health and trade—is largely on track. These areas enjoy strong government and partner support, as well as significant extra-budgetary resources to either continue previously high levels of support, or permit substantial expansion in new areas.

On the flip side are important neglected areas such as NCDs, in particular cardiovascular disease, smoking-related illness, accidents, mental health and occupational health. Progress in these areas depends on increased resources including greater country presence, and more effective use of limited Regular Budget resources.

To balance the need for increasing advocacy in new program areas and for broad structural and health system reforms, established country presence in areas of technical strengths should be sustained at current levels. These programs, however, will focus increasingly on less developed areas in western China and urban migrants, expanding impact by reaching previously unreached populations and introduction of new technologies, improving programme safety, and strengthening links to work in health systems.

In the area of new program development, advocacy and increased capacity to deliver timely and compelling information through a variety of formats will play an important role in increasing WHO's effectiveness at the country level. Additional capacity to strengthen media relationships and allow the country office to fully utilize existing communication and dissemination channels, such as the internet, is urgently needed. WHO China has an admirable track record in media relations, one that sprang from the critical role media played in the SARS outbreak and again in the Avian Influenza outbreak. A fully funded post for an experienced media professional is necessary not just for outbreak situations. WHO China plays an increasingly important role advising China on policy through speeches and position papers, which need the attention of a skilled editor and coordinator. The office also operates English and Chinese-language web sites and has started to produce CD-ROMs of workshops and related materials. All of these tasks need expertise and experience.

Overall, this analysis indicates the need for expansion of the office over the next 3-4 years in order to scale up new priority areas, after which gradual reduction is anticipated.

### Recruitment and hiring

National Program Assistants are playing an increasingly important role in the WHO country office, and consistent with a longer-term vision of reducing WHO's international staff levels as levels of expertise increase. Currently, all Program Assistants are seconded by the Ministry of Health and paid according to a WHO Beijing pay scale. In all, 55% of the basic salary package is deducted by MOH.

A proposal to move to direct recruitment has been submitted to MOH. This would allow national staff to become vested in the pension and benefits of organization and would help to promote recruitment of more Chinese nationals for long-term professional positions within WHO. China is currently under-represented in the organization. Given the large numbers of highly qualified health professionals in China with good language skills, this under-representation is of concern and clearly indicates the need for more aggressive recruitment of Chinese nationals for professional long-term posts within the organization.

In addition, the salary scale for National Program Officers doing comparable work at other UN agencies in China, is higher than the WHO/Beijing pay scale for programme assistants and threatens WHO's competitiveness in recruiting the most qualified staff. To increase WHO's competitiveness to hire qualified national staff it will be important for MOH and WHO to reach agreement on a policy of direct recruitment of national staff.

Following Government agreement to direct recruitment WHO should consider introducing the NPO scale in the WHO China Office.

There is a need—which is expected to become more acute with the introduction of the Global System of Management—for a staff learning and development programme to be developed for the office, particularly focusing on strengthening capacity in administration, management and use of existing information systems. For national staff, such training should also include English language skills as well as computer software training.

### Office organization

Management of the office is coordinated through an Office Management Team that consists of the WR, Senior Program Management Officer, and Coordinators of teams in the major program areas. This team meets regularly and has been effective. The structure should be reviewed following expansion of additional programs. The review should also take into consideration supervisory responsibilities given the large number of professional and national staff employed. While a handful of programs have adequate staff and funds, there are a large number of programs that are not strategic priorities but do generate considerable work. A mechanism to adequately support these programs while minimizing diversion of staff resources is needed.

Health systems will increasingly form a core part of many areas of work and a process to ensure that those links are established and mutually reinforced is needed. This same process could also facilitate regular sharing of experiences in cross-cutting technical areas, such as health information systems and surveillance, monitoring and evaluation, training, communication, and financing.

## **Conclusion**

The CCS combines an analysis of current and projected priority issues in health in China and outlines the ways in which WHO can assist China address them. While this CCS anticipates medium-term priorities for WHO's work in China, the pace of China's economic and social development is unprecedented and has a complex relationship with health that is also difficult to predict. In addition, other priority setting processes such as the Health Situation Assessment report of the Health Partners' Group–UN Theme Group on Health and the UN Development Assistance Framework, were ongoing when this document was finalized. Thus, while the CCS outlines broad priorities for WHO's work in China over the next 3-5 years, it is clear that periodic review of progress and updating of priorities during the period of the CCS is called for, to reflect changing needs of the country.

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